

Our reference: **CHSFOI25-26.11**

Dear [REDACTED]

DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by Canberra Health Services (the Directorate) on **Monday 22 September 2025**.

This application requested access to:

'In relation to CHSFOI25-26.05, the contents and related attachments of the ministerial briefs titled the following:

- *Initiated Brief: Update on RANZCOG Accreditation – May 2025 (MCHS25/303).*
- *Initiated Brief: Proposal to cease Attention Deficit Hyperactivity Disorder (ADHD) assessments through Adult Community Mental Health Services (MCHS25/294).*
- *Initiated Brief – Formalising a Territory-wide Neurology Service (MCHS25/326).*
- *Initiated Brief: Freedom of Information (FOI) Application from [REDACTED] – Copy of the most recent internal audit or performance review concerning patient discharge delays, hospital bed availability and other ED reports/information (MCHS25/316).*
- *Initiated Caveat Brief – Tuberculosis (TB) Exposure (MCHS25/368).*
- *Caveat Brief – North Canberra Hospital (NCH) allegations (MCHS25/444).*
- *Caveat Brief – Minister for Health – Canberra Hospital ICU Incident – 5 August 2025 (MCHS25/452).*
- *Initiated Brief: Update on RANZCOG Accreditation – July 2025 (MCHS25/411).*
- *Initiated Brief: (Minister for Health) Canberra Health Services Internal Audits undertaken in 2024-2025 (MCHS25/369).'*

I am an Information Officer appointed by the Chief Executive Officer of the Directorate under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. The Directorate was required to provide a decision on your access application by **Tuesday 4 November 2025**.

I have identified additional information that is considered health records for the purposes of the *Health Records (Privacy and Access) Act 1997*. The identified information is directly related to correspondence to the Minister for Health regarding the treatment, health, illness, or disability of consumers of the Directorate. Section 12 of the FOI Act specifies that the FOI Act does not apply to health records. This information has not been assessed in this response.

I have identified ten documents holding the information within scope of your access application. These are outlined in the schedule of documents included at [Attachment A](#) to this decision letter.

Decisions

I have decided to:

- grant full access to five documents; and
- grant partial access to five documents.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

Full Access

I have decided to grant full access to the documents at references 1-2, 7-8 and 10.

Partial Access

I have decided to grant partial access to the documents at references 3-6 and 9. These documents contain information that I consider, on balance, to be contrary to the public interest to disclose under the test set out in section 17 of the FOI Act.

The documents at references 3-5 and 9 partially comprised of information which may prejudice the protection of an individual's right to privacy of both ACT Government and non-ACT Government employees.

The documents at references 5-6 are partially comprised of information which may prejudice the business affairs of an agency.

Additionally, the attachment to the document at reference 3 was not provided as it is publicly available on the Directorate's disclosure log. Under sections 43(1)(d) and 45(a) of the FOI Act, the Directorate may refuse with an application in part if the information is already publicly available. The document can be found at the following link:

https://www.act.gov.au/_data/assets/pdf_file/0004/2869609/CHSFOI24-25.28-Response_DL.pdf

Public Interest Factors Favouring Disclosure

The following factors were considered relevant in favour of the disclosure of the documents:

- Schedule 2, 2.1 (a)(i) promote open discussion of public affairs and enhance the government's accountability; and
- Schedule 2, 2.1 (a)(ii) contribute to positive and informed debate on important issues or matters of public interest.

Public Interest Factors Favouring Non-Disclosure

The following factors were considered relevant in favour of the non-disclosure of the documents:

- Schedule 2, 2.2 (a)(ii) prejudice the protection of an individual's right to privacy or any other right under the Human Rights Act 2004;
- Schedule 2, 2.2(a)(xi) prejudice trade secrets, business affairs or research.

On balance, the factors favouring disclosure were outweighed by the factors favouring nondisclosure as the redacted information is comprised of personal information relating to the individual personal circumstances of ACT Government Employees, identifying information of non-ACT Government employees and the name of private businesses which if disclosed would cause reputational harm. Therefore, I determined the information identified is contrary to the public interest and I have decided not to disclose this information.

Charges

Processing charges are not applicable to this request.

Disclosure Log

Under section 28 of the FOI Act, the Directorate maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision.

Please be aware that no personal information will be included in the published information all other information will be published on <https://www.act.gov.au/open/foi-disclosure-logs/act-health-directorate-and-canberra-health-services-disclosure-logs>.

Ombudsman review

My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published on the Directorate's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Allara House
15 Constitution Avenue
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
<http://www.acat.act.gov.au/>

Further assistance

Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Stevenson' with a stylized initial 'N'.

Nicole Stevenson

Senior Director

Office of the Chief Executive Officer
Canberra Health Services

04 November 2025

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access. Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately. Information about what is published on open access is available online at: <http://www.health.act.gov.au/public-information/consumers/freedom-information>

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
	<i>In relation to CHSFOI25-26.05, the contents and related attachments of the ministerial briefs titled the following:</i> <i>Initiated Brief: Update on RANZCOG Accreditation – May 2025 (MCHS25/303).</i> <i>Initiated Brief: Proposal to cease Attention Deficit Hyperactivity Disorder (ADHD) assessments through Adult Community Mental Health Services (MCHS25/294).</i> <i>Initiated Brief – Formalising a Territory-wide Neurology Service (MCHS25/326).</i> <i>Initiated Brief: Freedom of Information (FOI) Application from [REDACTED] – Copy of the most recent internal audit or performance review concerning patient discharge delays, hospital bed availability and other ED reports/information (MCHS25/316).</i> <i>Initiated Caveat Brief – Tuberculosis (TB) Exposure (MCHS25/368).</i> <i>Caveat Brief – North Canberra Hospital (NCH) allegations (MCHS25/444).</i> <i>Caveat Brief – Minister for Health – Canberra Hospital ICU Incident – 5 August 2025 (MCHS25/452).</i> <i>Initiated Brief: Update on RANZCOG Accreditation – July 2025 (MCHS25/411).</i> <i>Initiated Brief: (Minister for Health) Canberra Health Services Internal Audits undertaken in 2024-2025 (MCHS25/369).</i>	CHSFOI25-26.11

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
1.	1 - 3	MCHS25/294 - Ministerial Brief - ADHD Assessments through ACMHS		Full Release		
2.	4 - 29	MCHS25/303 - Ministerial Brief - Update on RANZCOG Accreditation		Full Release		
3.	30 - 32	MCHS25/316 (CHSFOI24-25.28) Ministerial Brief		Partial Release	Section 45(a) Publicly Available Schedule 2, 2.2 (a)(ii) Privacy	
4.	33 - 50	MCHS25/326 - Ministerial Briefing - Formalising a Territory-wide Neurology Service		Partial Release	Schedule 2, 2.2 (a)(ii) Privacy	
5.	51 - 52	MCHS25/368 - Caveat Brief - Minister for Health - TB Exposure 2025		Partial Release	Schedule 2, 2.2 (a)(ii) Privacy Section 2.2(a)(xi) Business Affairs	
6.	53	MCHS25/368 - Update - 2 July 2025 - Caveat Brief - Minister for Health - TB Exposure		Partial Release	Section 2.2(a)(xi) Business Affairs	
7.	54 - 69	MCHS25/369 - Ministerial Brief - CHS Internal Audits Undertaken in 2024-2025		Full Release		
8.	70 - 98	MCHS25/411 - Ministerial Brief - Update on RANZCOG - July 2025		Full Release		
9.	99 - 100	MCHS25/444- CHS Caveat Brief - Allegations at North Canberra Hospital		Partial Release	Health Record Schedule 2, 2.2 (a)(ii) Privacy	
10.	101 - 102	MCHS25/452 - Caveat Brief - Minister for Health - Intensive Care Unit Incident - 5 August 2025		Full Release	Health Record	
Total Number of Documents						
10						



Canberra Health Services

To:	Minister for Health Minister for Mental Health	Tracking No.: MCHS25/294
Date:	20/05/2025	
CC:	Dave Pepper, Chief Executive Officer, Canberra Health Services	
From:	Janet Zagari, Deputy Chief Executive Officer, Canberra Health Services	
Subject:	Proposal to cease Attention Deficit Hyperactivity Disorder assessments through Adult Community Mental Health Services.	
Critical Date:	18/06/2025	
Critical Reason:	To enable works to continue with service planning.	

Recommendations

That you:

1. Note the information contained in this brief;

Noted / Please Discuss

Rachel Stephen-Smith MLA/...../.....

Minister's Feedback

Background

1. Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS) is currently consulting with internal and external stakeholders on a proposal to cease completion of Attention Deficit Hyperactivity Disorder (ADHD) assessments for adults.
2. This is consistent with the national approach where ADHD is not being assessed or treated in the tertiary health system. In the absence of any co-occurring major mental health issues, ADHD assessments alone do not meet the public mental service threshold in terms with respect to clinical priority or risk. We understand that

Western Australia currently provide these assessments as part of their public mental health services, however, this issue is also under consideration there.

3. Concurrent to the changing context relating to ADHD, there is a changed context for the mental health service system more broadly with significant increasing demand in all components of the service system.
4. In 2018, significant reform was undertaken to the Adult Community Mental Health Services (ACMHS) program area. At this time, Access Comprehensive was created, and the responsibility for ADHD assessments were transferred from the regional Community Mental Health Teams to the newly created, Access Comprehensive.
5. Access Comprehensive provides services for consumers who require short term mental health assessment and treatment interventions, typically for a period of no longer than three months. At any given time, Access Comprehensive has more than 300 active consumers.
6. Recent years have seen a significant increase in adult diagnosis of ADHD with recognition of a strong genetic link between children diagnosed with ADHD and their parents. There is also some divergence in clinical opinion on the efficacy and modality of treating ADHD in adults. Some consumers may favour pharmacological treatment in place of behavioural or psychological support; this contrasts evidence which that non-pharmacological should be explored initially or at least as an adjunct to medication. Despite this, there has been significant developments in the private system to diagnose and treat adults with ADHD.
7. In May 2024, the ACT Chief Psychiatrist outlined a move of ADHD assessment and treatment towards primary practice and this work continues to progress. Discussions have also occurred with the Canberra Health Services (CHS) GP Liaison unit and further consultation through Capital Health Network is planned.

Issues

Waitlist

8. As of April 2025, Access Comprehensive, as a linkage point for moderate mental illness, had 330 consumers. Of these, 27 were waiting for an ADHD assessment. The wait time is over 24 months and any focus on directing resources to address this is at the expense of people with an acute mental illness.
9. As part of this proposal, consumers who are already on the waitlist will not be disadvantaged and will remain on the waitlist for ADHD assessment, treatment and care.
10. Ceasing of ADHD assessments will only be applied to any further referrals received after cessation of service.

Financial Implications

11. MHJHADS was not previously funded or otherwise resourced to provide an ADHD service, with initial service offering established informally ten years ago in ACMHS. This was in direct response to the sudden departure of two private psychiatrists in the ACT who had provided ADHD treatment to a number of people in the ACT.

Consultation

Internal

12. Internal consultation has occurred within CHS with the Network Operational Committee and MHJHADS Governance Committee. Both committees were in support of ceasing ADHD assessments considering the above.

Cross Directorate

13. Nil.

External

14. Broader consultation will occur with external stakeholders such as, Capital Health Network, Mental Health Consumer Network, Australian Medical Services, Unions, The Human Rights Commission, Chief Psychiatrist Office, Official Visitor, Carers ACT, Mental Health Suicide Prevention and the Health Care Consumer Association.

Work Health and Safety

15. Nil.

Benefits/Sensitivities

16. Nil.

Communications, media and engagement implications

17. Information will be provided on the CHS website as well as through the Access Mental Health Team to advise consumers on where and how they can get support for ADHD. This will include a list of private practitioners within the ACT and NSW who are currently providing these assessments.

Signatory Name: Bruno Aloisi

Phone:

Action Officer: Lydia Thomas

Phone:



Canberra Health Services

To: Minister for Health

Tracking No.: MCHS25/303

Date: 03/06/2025

From: Dave Pepper, Chief Executive Officer, Canberra Health Services

Subject: Update on Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Accreditation

Critical Date: Not applicable

Critical Reason: Not applicable

Recommendation

1. That you note the information contained in this brief.

Noted / Please Discuss

Rachel Stephen-Smith MLA/...../.....

Minister's Office Feedback

Background

1. A brief, included at Attachment A, was provided to you on 24 March 2025 on the updates of progress on the outcomes from the RANZCOG Accreditation Review Visit (ARV) in May 2024 and the subsequent Virtual Site visit in November 2024.
2. You requested Canberra Health Services (CHS) provide expected completion dates for actions that remain outstanding and how CHS will review/audit the changes to ensure they remain in place and are working positively.

Issues

3. An update on the actions undertaken to date in response to each item is provided at Attachment B, including expected completion dates where applicable. Some actions are intended to transition into business-as-usual (BAU) operations and will therefore remain ongoing without a defined completion date.
4. To aid the sustainability and effectiveness of recent changes, to ensure they remain in place and are working positively, CHS has implemented a multi-faceted review and audit framework. This includes both formal and informal mechanisms to monitor progress and identify areas for continuous improvement:
 - **Education Attendance:** Attendance at educational sessions is being formally audited to track engagement and identify trends over time. This data will inform future scheduling and content planning to maximise participation and relevance.
 - **Mandatory Training Compliance:** Completion rates for mandatory training modules are being systematically monitored to ensure all staff meet required standards. Non-compliance is followed up through established governance processes.
 - **Junior Medical Officer (JMO) Feedback:** JMO-related issues are being informally audited through monthly meetings, providing a regular forum for feedback, discussion, and responsive action. This approach allows for timely identification and resolution of emerging concerns.
 - **Primary Operator Numbers:** Procedural exposure and primary operator numbers are being audited to ensure equitable access to training opportunities and to support competency development across the workforce.

This comprehensive approach will be reviewed periodically to ensure it remains fit for purpose. Adjustments will be made as necessary to maintain a high standard of clinical education, training, and workforce support.

5. CHS acknowledges the delay in meeting **Condition 3**, as outlined in section 3.2.5, there has been significant and proactive steps taken to address the challenges in recruiting Obstetrics and Gynaecology (O&G) consultants.

In response to the national workforce shortage, CHS has implemented a multi-pronged recruitment strategy. Recent campaigns in late 2024 and early 2025 have targeted both O&G Staff Specialists and alternative workforce models, including Career Medical Officers (CMOs) and Senior Career Medical Officers (SCMOs). These roles are designed to attract experienced clinicians, including those with international qualifications who may not yet hold specialist recognition with RANZCOG. While the most recent campaign did not yield suitable candidates, this approach reflects CHS' commitment to exploring all viable workforce solutions.

CHS continues to actively pursue local recruitment, despite the competitive challenges posed by higher remuneration packages offered interstate and by locum agencies. To

enhance our competitiveness, CHS is reviewing recruitment incentives and exploring innovative workforce models.

International recruitment efforts have shown promise, with several candidates progressing through the pipeline. Although onboarding timelines are extended due to regulatory and qualification processes, these candidates represent a valuable medium-term solution. CHS is working closely with relevant authorities to streamline these processes wherever possible.

Importantly, CHS is investing in the future workforce by supporting current O&G trainees expected to achieve fellowship within the next 12 months. These individuals are being actively considered in workforce planning and budget allocations to ensure a sustainable pipeline of qualified specialists.

In parallel, CHS has initiated discussions on restructuring leadership roles and clinical portfolios to better align with evolving service needs. These discussions are being informed by ongoing recruitment outcomes and the availability of clinicians with the requisite skills and experience.

CHS remains committed to delivering high-quality care and is taking decisive, forward-looking action to strengthen the O&G workforce in the ACT.

Most recently CHS conducted interviews for O&G Senior Registrar positions, two applicants were found suitable; one is due to commence in August 2025 and the other in February 2026.

6. CHS recognises the importance of ensuring trainees are appropriately supported and encouraged to act as primary operators in line with their level of training and competency. In response to **Condition 6**, CHS has developed a structured framework to ensure clarity, accountability, and continuous improvement in this area which includes:

Clear Guidelines and Shared Expectations

- CHS is finalising a set of guidelines outlining expectations for trainees to act as primary operators, tailored to their year level and demonstrated ability.
- These guidelines are being embedded into departmental orientation materials and reinforced through regular team briefings to ensure a shared understanding across the department.

Credentialing and Supervision

- Trainee credentialing is formally reviewed by both the Registrar and Learning Supervisor at three-month and six-month intervals.
- These reviews assess procedural competency, readiness to act as primary operator, and alignment with training goals.

Tracking and Escalation Mechanisms

- CHS is actively encouraging the use of QR code-linked forms, to allow trainees to log primary operator experiences in near real-time and with relative anonymity.
- Data collected will be reviewed regularly at consultant meetings to ensure accountability, identify gaps, and escalate concerns where necessary.

Enhancing Exposure and Opportunities

- Efforts are underway to increase surgical exposure for trainees through improved rostering, prioritisation of training cases, and equitable distribution of procedural opportunities.
- Surgical skill workshops have been developed to provide trainees with hands-on experience prior to participating in live operations. These workshops are designed to build confidence and competence in a controlled environment.

CHS is committed to fostering a supportive and structured training environment that prioritises both patient safety and the professional development of junior medical staff. These measures will be regularly reviewed to ensure they remain effective and aligned with best practice.

Financial Implications

7. Nil.

Consultation

Internal

8. Nil.

Cross Directorate

9. Nil.

External

10. Nil.

Work Health and Safety

11. Work is continuing to create a positive work culture within the multidisciplinary teams in Women, Youth and Children and across the broader CHS.

Benefits/Sensitivities

12. RANZCOG noted since the May 2024 visit, Canberra Hospital has been acting to improve the training program and cultural safety for trainees.
13. If RANZCOG training accreditation is suspended, there will be an impact on staffing with loss of RANZCOG Integrated Training Program (ITP) registrars from Canberra Hospital.

Communications, media and engagement implications

14. RANZCOG training accreditation has previously attracted media attention. Media lines will be prepared as required.

Dave Pepper, Chief Executive Officer

Phone: 5124 4700

Dr Jane Van Diemen, Divisional Clinical
Director, Women, Youth and Children

Phone: 5124 7500

Attachments

Attachment	Title
Attachment A	MCHS25/145 – RANZCOG Report Update
Attachment B	RANZCOG Standard Summary Actions in response to Conditions



MINISTERIAL BRIEF

Canberra Health Services

To:	Minister for Health	Tracking No.: MCHS25/145
Date:	24/03/2025	
From:	Dave Pepper, Chief Executive, Canberra Health Services	
Subject:	Update on Royal Australian and New Zealand College of Obstetrics and Gynaecology Accreditation	
Critical Date:	Not applicable	
Critical Reason:	Not applicable	

Recommendation

1. That you note the information contained in this brief.

Noted / Please Discuss

Rachel Stephen-Smith MLA  16/4/25

Minister's Office Feedback

Please provide expected completion date for actions that remain outstanding at the next update. Please also provide information in the next update on how CHS will review/audit the changes to ensure they remain in place and are working positively. I am concerned that the required action at 3.2.5 was supposed to be implemented from the start of the 2024 clinical year and appears to be still under review. I recognise this probably cannot be fully addressed until senior staffing is stabilised, but it is unclear what action was taken for 2024 and the beginning of the 2025 training year. Also please discuss Condition 6.

Background

1. A brief was provided to you on 31 January 2025 on the outcomes from the Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Accreditation Review Visit (ARV) in May 2024 and subsequent Virtual Site visit in November 2024 (Attachment A).

Issues

2. Canberra Health Services 'Partially Met' all six standards as reported by RANZCOG, however was provided actions to address against each standard. An update to the actions undertaken to date to address each of these is outlined at Attachment B.
3. Mandatory training continues to be a focus for the Division of Women, Youth and Children (WYC).

Financial Implications

4. Nil.

ConsultationInternal

5. Nil.

Cross Directorate

6. Nil.

External

7. Nil.

Work Health and Safety

8. Work is continuing to create a positive work culture within the multidisciplinary teams in WYC and across the broader Canberra Health Services.

Benefits/Sensitivities

9. RANZCOG noted since the May 2024 visit, Canberra Hospital has been acting to improve the training program and cultural safety for trainees.
10. If RANZCOG training accreditation is suspended, there will be an impact on staffing with loss of RANZCOG Integrated Training Program registrars from Canberra Hospital.

Communications, media and engagement implications

11. RANZCOG training accreditation has previously attracted media attention. Media lines will be prepared as required.

Jane Van Diemen, Divisional Clinical Director,
Women, Youth and Children

Phone: 5124 7500

Attachments

Attachment	Title
Attachment A	MCHS25/24 – RANZCOG Report Update
Attachment B	RANZCOG Standard Summary Actions in response to Conditions

RANZCOG Standard Summary Actions in response to Conditions

		2023	2024
Number of Standards Unchanged	25		
Number of Standards Improved	31		
Number of Standards Worsen	4		
Number of MET		16	42
Number of Partially MET		21	21
Number of UNMET		23	8

STANDARD 1 – SUPPORT FOR RANZCOG OFFICERS AND ENGAGEMENT WITH TRAINING SITE ACCREDITATION PROCESSES				
Standard				
1.1	Access for the ITP coordinator			
	2023	Met	2024	Met
1.1.2	Assisting with the provision of training opportunities and experiences, and the communication of trainee issues			
	2023	Not Met	2024	Partially Met
Recommendation A	Monitoring of training and service needs should continue to ensure trainees within the ITP can meet training requirements, alongside improved relationships and flexibility with other sites in the ITP.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	CHS continue to assess and adjust training support as needed while also fostering stronger relationships and greater flexibility with other sites within the ITP to enhance the overall training experience.			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
1.2	Where a RANZCOG ITP Coordinator is employed by the Training Site, they are provided with a minimum of one paid and protected session per fortnight to enable them to carry out their duties effectively.			
1.2.1	Training site support			
	2023	Not Met	2024	Partially Met
Recommendation B	Support for the ITPC should continue at a hospital level, with a view to optimising the training opportunities available on site and within the ITP.			

CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	A Training and Accreditation Officer has been appointed to support the ITP			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
1.3	The Training Site engages with and facilitates training site accreditation processes.			
1.3.1	Accreditation Visit			
	2023	Met	2024	Met
1.3.2	Progress reports and other interactions			
	2023	Met	2024	Met
OVERALL ASSESSMENT OF STANDARD 1				
	2023	Not Met	2024	Partially Met
STANDARD 2 – APPOINTMENT AND SUPPORT OF TRAINING SUPERVISORS				
2.1	An appropriate number of Training Supervisors has been appointed to ensure FRANZCOG trainees receive effective education and clinical supervision			
2.1.1	Ratio of Training Supervisors and Onsite Presence			
	2023	Partially Met	2024	Met
2.2	Training Supervisors receive support from the Training Site to undertake their supervisory roles.			
2.2.1	Support for Training Supervisors			
	2023	Not Met	2024	Met
2.3	Training Supervisors undertake training and professional development activities in order to perform their supervisory role			
2.3.1	Training Supervisor workshops and upskilling activities			
	2023	Met	2024	Met
2.4	Training Supervisors carry out their roles and responsibilities as outlined in the RANZCOG Training Supervisor Position Description.			
2.4.1	Roles and Responsibilities			

	2023	Partially Met	2024	Met
Recommendation C	The clinical workload at a consultant level should be monitored on an ongoing basis to ensure that Training Supervisors are able to fulfil their roles and responsibilities in a sustainable manner. It would be beneficial for this to include ensuring that job plans are up to date and accurate, with minimal lastminute adjustments			
2.4.2	Training Program Requirements			
	2023	Met	2024	Met
2.4.3	Rosters			
	2023	Not Met	2024	Not Met
Condition 1	Training Supervisors must have oversight and involvement in roster development for trainees in order to ensure that training opportunities (in particular the allocation of operating lists) are distributed equally and in line with individual training needs. It should be clear to all staff who has responsibility for and oversight of the rostering for different aspects of training (e.g. labour ward, clinics, theatre lists, education, leave allocations).			
CHS response (as of 20-1-25)	Clinical oversight for roster provided by O&G Senior Registrar, in conjunction with training supervisors, to ensure appropriate and equitable allocation for trainees.			
CHS response (as of 17-3-25)	A structured monthly meeting with the ITPC and the O&G Senior Registrar has been established to ensure clinical oversight of roster and appropriate and equitable allocation for trainees.			
CHS response (as of 19-5-25)	The ITPC and the O&G Senior Registrar meet regularly to ensure clinical oversight of roster and appropriate and equitable allocation for trainees.			
OVERALL ASSESSMENT OF STANDARD 2				
2023	Partially Met	2024	Partially Met	
STANDARD 3 – CONSULTANT INVOLVEMENT WITH AND SUPPORT FOR FRANZCOG TRAINEES				
3.1	There is an adequate number of senior medical staff to provide effective training, support and supervision of FRANZCOG trainees.			
3.1.1	Consultant staffing			
	2023	Not Met	2024	Partially Met

Recommendation D	Future efforts to support consultant staffing numbers and recruitment should focus on sustainability in consultant rostering and protection against burnout, and ensuring that senior staffing levels remain such that the full extent of training available remains accessible			
CHS response (as of 20-1-25)	Current recruitment round for consultants being finalised.			
CHS response (as of 17-3-25)	Consultant recruitment has been finalised. One FTE will commence in May 2025. A second Staff Specialist has been recruited with the start date pending due to an international relocation and AHPRA requirements.			
CHS response (as of 19-5-25)	The first Consultant is now due to commence in June 2025. A three year recruitment plan has been developed for the department. Phase 1 expected completion end 2025. Phase 2 expected completion end 2026. Phase 3 expected completion end 2027.			
3.1.2	Consultant provision of training, support and supervision			
	2023	Not Met	2024	Partially Met
Recommendation E	When recruiting for consultants, the hospital is encouraged to offer greater flexibility in working arrangements in order to attract a wider range of consultants who may provide longer-term commitment to a role if bespoke arrangements can be accommodated.			
CHS response (as of 20-1-25)	Current recruitment round for consultants being finalised.			
CHS response (as of 17-3-25)	CHS has strengthened its partnership with stakeholders from the consultant group, particularly the unit lead, as well as the People and Culture and Talent Acquisition streams, to address this recommendation.			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
3.2	FRANZCOG Consultants are actively involved and engaged in the teaching and training of Registrars in theatre, clinics and on the wards and birthing suite.			
3.2.1	Consultant position description or statement of duties			
	2023	Met	2024	Met
3.2.2	Appropriate Consultant Support			
	2023	Not Met	2024	Partially Met
Recommendation F	As the culture continues to stabilise and further improve, it would be beneficial for the consultant attendance audit to adapt in line with this and promote a culture of trust and support.			

CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	Attendance and expectations discussed at monthly consultant meeting. In collaboration with the clinical and unit leads, consultant guidelines (rules) have been drafted to outline these expectations. Each staff specialist has reviewed and provided a signed copy of these guidelines (rules).			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
3.2.3	Appropriate After-Hours Supervision and Teaching			
	2023	Not Met	2024	Not Met
Condition 2	Further work must be done on the after-hours roster (particularly in terms of structure) in order to ensure that trainees regularly have access to teaching and training opportunities in an after-hours setting. It was suggested that there could be more thought to the composition (in terms of pairing juniors and seniors, being mindful of ability/training, and an overall understanding of the general acuity in the service).			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	A structured monthly meeting with the ITPC and the O&G Senior Registrar has been established for clinical oversight of roster to ensure trainees have access to teaching and training opportunities in an after-hours setting.			
CHS response (as of 19-5-25)	Structured meetings are occurring regularly with the ITPC and the O&G Senior Registrar to ensure clinical oversight of roster so that trainees have access to teaching and training opportunities in an after-hours setting.			
3.2.4	On-call Arrangement			
	2023	Partially Met	2024	Partially Met
Recommendation G	All trainees (and other staff in the department) should be aware of how to escalate non-attendance from consultants when on call, and should be assured there are no consequences for appropriate escalation and reporting.			
Commendation 1	The cohort of regular locum consultants are to be commended for the excellent support provided afterhours and as part of the on-call roster.			
CHS response (as of 20-1-25)	Trainees advised of appropriate methods of escalation and reporting non-attendance from consultants after-hours.			
CHS response (as of 17-3-25)	As above.			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			

3.2.5	Team Structure			
	2023	Not Met	2024	Not Met
Condition 3	An update is required on the team structure implemented from the start of the 2024 clinical year. In refining this further, the department are encouraged to utilise creative solutions and focus on the outcomes (high quality and continuity of patient care whilst maximising teaching, learning and training opportunities) rather than feeling tied to a more traditional team structure that may not be fit for purpose in the context of the unit.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	It is anticipated that additional recruitment of consultants may in part address this condition. Further restructure to be considered when final 2025 recruitment numbers established (pending overseas appointment).			
CHS response (as of 19-5-25)	Discussions have begun regarding restructure of leadership positions and portfolios, however this is entirely dependent on the both the recruitment of a sufficient number of candidates and the recruitment of clinicians with sufficient skills and experience.			
3.2.6	Role of consultant			
	2023	Not Met	2024	Partially Met
Recommendation H	Consultants should be physically present on ward rounds more often in order to support teaching and learning in this setting			
Recommendation I	Ongoing support for the consultant cohort from the executive team is encouraged to continue, contributing to meaningful two-way dialogue between the consultants and the hospital which will reinforce the progress made so far.			
CHS response (as of 20-1-25)	Increased presence of consultants at ward rounds. Clinical Director appointed for Division of Women, Youth and Children to provide additional executive support to O&G Medical Director and consultant group.			
CHS response (as of 17-3-25)	The emphasis remains on enhancing consultant presence during ward rounds Clinical Director appointed for Division of Women, Youth and Children to provide additional executive support to O&G Medical Director and consultant group.			
CHS response (as of 19-5-25)	VMOs/Registrars/Trainees are encouraged and enabled to develop necessary skills to run ward rounds, both with direct and indirect consultant supervision. Work is in progress with more focus being put into job plans to prevent a potential mismatch of expectations.			
3.2.7	Consultant Support in Clinics			
	2023	Not Met	2024	Partially Met

Recommendation J	While there have been some improvements to the running of clinics it would be beneficial to continue this and ensure that clinics are consultant-led, trainees are able to take advantage of the training available to meet their training needs, and that there is a more equitable training experience.			
CHS response (as of 20-1-25)	Continuing.			
CHS response (as of 17-3-25)	Continuing improvements.			
CHS response (as of 19-5-25)	CHS is consistently rostering two consultants to clinics where one consultant provides direct patient care and the other is available and “roaming” for the junior doctors to consult/seek assistance as required.			
OVERALL ASSESSMENT OF STANDARD 3				
2023	Not Met	2024	Partially Met	
STANDARD 4 – PROVISION OF CLINICAL SUPERVISION AND EXPERIENCE				
4A.1	Trainees are provided with the appropriate clinical supervision and experience to meet training program requirements and to ensure the progression of clinical competence from ‘novice’ to ‘proficient’.			
4A1.1	Clinical Experience			
	2023	Not Met	2024	Partially Met
Recommendation K	Given the increased stability at the hospital (as the base hospital for the ITP), it would be beneficial to assess the different experiences available across the ITP and ensure that the pathway(s) taken when training in the Canberra ITP are optimised and make the most of that variety of experience.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	Regular meetings between ITPC and trainees and opportunities to provide feedback, both formal and informal, are being established.			
CHS response (as of 19/5/25)	Clinical experience is demonstrated with the ongoing arrangement TCH has with NCH. A Memorandum of Understanding between CHS and NSW Health is being finalised to further streamline the seconded learning pathways available at rural hospitals. Expected completion is July 2025.			

4A1.2	Assessment of Procedural and Surgical Skills (APSS)			
	2023	Not Met	2024	Met
4A1.3	Increased Responsibilities			
	2023	Met	2024	Met
Recommendation L	Efforts should be made to stick to the agreed job plans wherever possible, with changes communicated well in advance, to ensure that trainees are prepared for specific areas of training that meet their needs.			
4A1.4	Roster Requirements – Basic Trainees			
	2023	Not Met	2024	Partially Met
Recommendation M	The identified areas (caesarean section lists, ward round attendance, and ultrasound) alongside other key training areas should be consistently included in rosters and equitably available to all trainees			
CHS response (as of 17-3-25)	Rostering adheres to the job plans of the individual registrars. Monthly meetings occur with the senior registrar, unit lead, and operations manager to ensure schedules are locked in, including caesarean lists, ward rounds, and ultrasounds. There is an ongoing monthly, rostered arrangement for dedicated ultrasound to address training requirements, with registrars rotating through for this support. Fortnightly education sessions, alternating between Registrar Teaching and Journal Clubs, have become part of the roster, with outpatient and acute rostering considerations made to maximise attendance.			
CHS response (as of 19-5-25)	Ongoing clear communication with the Basic Trainees in regard to their roster.			
Recommendation N	Rosters should be better managed in terms of notice and it should not be the responsibility of the trainee to manage day-to-day cover			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	Rosters are now published in advance for the trainees for the term.			
CHS response (as of 19-5-25)	The ITPC has received positive feedback regarding these changes. CHS consider this recommendation as met and imbedded as business as usual.			
4A1.5	Support by Colleagues and Juniors for FRANZCOG Trainees, including After Hours			
	2023	Partially Met	2024	Met
4A1.6	Experience in Clinics			
	2023	Partially Met	2024	Partially Met
Recommendation O	It would be beneficial to adjust the processes for booking and managing clinics to ensure they are not overbooked, and able to be used for teaching rather than just service.			
CHS response	Under review.			

(as of 20-1-25)	
CHS response (as of 17-3-25)	Monthly meetings occur with the O&G senior registrar, unit lead, and operations manager to ensure schedules are locked in. Booking and scheduling now aligns with registrar availability, and schedules are not booked unless their attendance are confirmed.
CHS response (as of 19-5-25)	Monthly meetings continue to occur with the O&G senior registrar, unit lead, and operations manager to ensure schedules are locked in.
4A1.7	Policies, Procedures and Clinical Guidelines
	2023 N/A 2024 Partially Met
Recommendation P	Obstetrics decision making should be monitored to ensure that trainees are exposed to best practice and up to date, evidence-based care, and there are clear expectations set across all O&G staff.
CHS response (as of 20-1-25)	Under review.
CHS response (as of 17-3-25)	CHS Maternity Model of Care and Model of Service documents currently undergoing review and redesign.
CHS response (as of 21-5-25)	The Network Operation Committee discussed and endorsed the Model of Care/Model of Service at the 19 May 2025 meeting.
4A1.8	Birth Suite Handover
	2023 Partially Met 2024 Met
Recommendation Q	It would be beneficial (and contribute to continued respectful discourse) to focus on the educational opportunities in birth suite handover, highlighting the evidence-based practice in use and expanding on the detail and information where possible.
4A1.9	Training in Expanded Settings
	2023 Met 2024 Met
4A1.10	FRANZCOG Trainee In-Training Site Credentialing
	2023 Partially Met 2024 Not Met
Condition 4	There must be zero tolerance for staff requesting trainees to perform procedures that they are not credentialed for.
Recommendation R	It would be beneficial for the credentialing document to extend across all types of training/oversight, with an emphasis on building a transparent and accountable culture.
CHS response (as of 20-1-25)	A register of skills/credentialing document has been re-established as an accessible means of tracking skill level and procedure capability for trainees.
CHS response (as of 17-3-25)	Credentialing/tracking skill level and procedure capability for trainees continues. Document to be updated every six (6) months, with online copy available and hard copy available in Delivery Suite.

4A.2	Advanced trainees are provided with the appropriate clinical opportunities to enable them to undertake either a 'Generalist' or 'Non-Generalist' Pathway and relevant Advanced Training Modules (ATMs) during their Advanced Training.			
4A2.1	Advanced Clinical Experience			
	2023	N/A	2024	Met
4A2.2	Professional Attributes			
	2023	N/A	2024	Met
4A.3	Training Sites have processes in place that allow trainees to access patient information for training purposes.			
	Patient Consent			
	2023	Met	2024	Met
4.B	Trainees are provided with sufficient gynaecological surgical experiences, under appropriate supervision, to meet training requirements and to ensure the progression of surgical competence from 'novice' to 'proficient'.			
4B.1.1	Gynaecological Surgery Lists			
	2023	Partially Met	2024	Not Met
Condition 5	Regardless of ITP performance, Canberra Hospital must continue making significant progress towards two-thirds of the >23 procedures target per six-monthly training period (i.e. an average of >15.33 major procedures as primary operator per Basic Trainee) by the training period February 2025-August 2025. Refer to Strategies for Training Hospitals to improve trainee Gynaecological Surgery Procedure Numbers.			
Recommendation S	Access to operating lists should be balanced and proportionate to staffing, and allocation (based on training needs and ability) should not be the responsibility of the registrar in charge of rosters, as this can contribute to a poor atmosphere in the registrar cohort.			
Recommendation T	At an ITP level and in conjunction with Canberra North Hospital, it would be beneficial to support operating on a regular basis at Queanbeyan Hospital (similar to the arrangement which was previously in place).			
CHS response (as of 20-1-25)	New rural rotation (Lismore) included for trainees to allow for increased exposure to major procedures. CHS is currently undertaking a review into list allocation for surgical teams.			
CHS response (as of 17-3-25)	Ongoing.			
CHS response (as of 19-5-25)	CHS continues to review list allocations for surgical team in addition to the creation of full day operating lists to increase efficiency, in conjunction with rotational experience gained at NCH and Queanbeyan hospitals.			
4B1.2				
	2023	Partially Met	2024	Not Met

Condition 6	There must be clear guidelines and expectations set around trainees (relevant to their year level and ability) being able and encouraged to act as the primary operator. This must be a shared understanding by the department as a whole with a means to track and escalate accordingly. Some measures used in other base hospitals include a QR code/associated form to track in close to real-time and with relative anonymity, with accountability via a regular consultant meeting.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	CHS to undertake discussions with RANZCOG to access trainee logbooks to support midterm reporting.			
CHS response (as of 19-5-25)	Credentialling meeting conducted between trainee and learning Supervisor occurs every 3 months. Surgical skill workshops developed to expose trainees to surgical procedures prior to commencing to operation.			
4B1.3	Primary Operator Experience – Basic trainees			
	2023	N/A	2024	Met
Recommendation U	Consideration should be given to a formal arrangement where more junior trainees can (as appropriate) act as an assistant to Advanced trainees, or act as Primary Operator with the supervision of an Advanced trainee			
4B1.4	Priority Access to O&G Theatre Lists			
	2023	Partially Met	2024	Partially Met
Recommendation V	This is another area in which it would be beneficial for someone with an overall view of training/supervision needs on site (in conjunction with the ITPC) to have oversight, in order to appropriately prioritise access to training opportunities, and ensure flexibility in rostering arrangements (see 1.2.1 for further discussion).			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	A Training and Accreditation Officer has been appointed to support the ITP			
CHS response (as of 19-5-25)	Additional responsibility given to Senior Registrar to assist the ITPC and Training & Accreditation Officer with oversight. Rostering of two trainees for operating lists is now embedded to maximise exposure and training.			
4C1.1	Ultrasound			
	2023	Not Met	2024	Met
4D1	Structured colposcopy training is in place to enable FRANZCOG trainees to meet the required competencies, including completion of their Colposcopy In-Training Site Clinical Assessments (IHCA)			
4D1.1	Colposcopy			
	2023	Partially Met	2024	Met
Recommendation W	As part of providing a holistic training experience, care should be taken that colposcopy clinics are a setting where training (including in-room supervision) is provided and prioritised.			

4E1	FRANZCOG trainees are provided with a range of opportunities and experiences in family planning, including clinics and relevant surgical opportunities (acknowledging any limitations on contraceptive and family planning training due to site-specific ethics guidelines)
4E1.1	Family Planning
	2023 Partially Met 2024 Met
Commendation 2	This clinic and the termination of pregnancy service offer both a valuable clinical service for the population and an excellent training opportunity, which the hospital are encouraged to continue including as part of rostered training.
4E1.2	Long-Acting Reversible Contraception (LARC)
	2023 Met 2024 Met
OVERALL ASSESSMENT OF STANDARD 4	
2023	Not Met 2024 Partially Met
STANDARD 5 – PROVISION OF STRUCTURED EDUCATION PROGRAMS, TEACHING SESSIONS AND LEARNING OPPORTUNITIES	
5.1	A comprehensive education program is provided that includes Consultant-led hospital teaching, rounds, lectures, case presentations, ultrasound teaching, mortality and morbidity meetings, journal club, discussions, audits and reviews is provided.
5.1.1	Coordination of Education Program
	2023 Not Met 2024 Met
5.1.2	Education Program Content
	2023 Not Met 2024 Partially Met
Recommendation X	Embedding the education program at a set time (which allows for most trainee access) and with a roster/topics in advance for consultants will allow for consistency in quality and content.
CHS response (as of 20-1-25)	Education program developed with established times/days and topics published in advance.
CHS response (as of 17-3-25)	Education program established. Plan for midterm feedback and evaluation of program.
CHS response	Current mid-term assessments underway.

(as of 19/5/25)				
	2023	Partially Met	2024	Met
Commendation 3	The hospital is commended for the efforts made to stress the importance of regular guideline review and audit activity, and involve the trainees on a structured basis			
5.2	Rostering arrangements and strategies are in place to ensure that all FRANZCOG trainees have protected time to attend education sessions. FRANZCOG trainees are not rostered for other duties when education sessions are scheduled, except for the provision of emergency cover.			
5.2.1	Paid and Protected Non-Clinical Time			
	2023	Not Met	2024	Not Met
Condition 7	Efforts must be made to better protect education time (ideally by rostering unaccredited registrars to clinical duties at that time), and there must be a mechanism in place to ensure the same person does not miss out on education sessions.			
CHS response (as of 20-1-25)	A QR code system has been implemented for trainees to sign in to education sessions to allow for mapping of attendance. Unplanned repeated absences of trainees will be followed up.			
CHS response (as of 17-3-25)	QR code attendance system continues. Unplanned absences are followed up with trainee's supervisors.			
CHS response (as of 19/5/25)	CHS has revised the scheduling of the journal club to occur within standard working hours and aligned clinical duties accordingly. As a result of these adjustments, attendance has significantly improved.			
5.3	Formal basic obstetric skills training sessions are provided for all Year 1 FRANZCOG trainees.			
5.3.1	Basic Obstetric Surgical Skills Training			
	2023	Met	2024	Met
5.4	Simulation training is offered to all FRANZCOG trainees.			
5.4.1	Simulation Training			
	2023	Not Met	2024	Partially Met
Recommendation Y	It would be highly beneficial for the hospital to support the department in expanding their access to more simulation training opportunities, particularly for more junior trainees. This includes access for the gynaecology department to new simulation initiatives in the surgical space.			
CHS response (as of 20-1-25)	Currently seeking quotes for updated surgical simulation equipment and systems for consideration.			
CHS response (as of 17-3-25)	Ongoing.			

CHS response (as of 19/5/25)	Awaiting outcome for funding stream for purchase of surgical simulation equipment. Expected outcome decision expected July 2025.			
5.5	FRANZCOG trainees have the opportunity to attend external education activities, meetings, courses and workshops.			
5.5.1	External Education Program			
	2023	Partially Met	2024	Met
5.6	FRANZCOG trainees are provided with regular opportunities to teach prevocational medical staff and medical students.			
5.6.1	Teaching Residents and Medical Students			
	2023	Met	2024	Met
5.7	FRANZCOG trainees undertaking Advanced Training are provided with additional educational opportunities.			
5.7.1	Advanced Courses, Workshops and Academic Development			
	2023	N/A	2024	Met
5.7.2	Teaching and Assessing of FRANZCOG Basic trainees			
	2023	N/A	2024	Met
5.7.3	Administration Duties			
	2023	N/A	2024	Met
5.8	In Training Sites with five consultants or more, at least one Consultant is a FRANZCOG Examiner, or has been within the last 10 years			
5.8.1	FRANZCOG Examiners			
	2023	Met	2024	Met
Recommendation Z	It would be beneficial to have more coordinated, consultant-led exam preparation accessible for trainees within the ITP who are undertaking exams.			
5.9	The O&G Department provides an adequate range of education resources to support the learning environment.			
5.9.1	Facilities for FRANZCOG trainees			
	2023	Met	2024	Met
5.10	Research opportunities and support and protected research/study time are provided to FRANZCOG trainees to undertake private study and their compulsory research project.			
5.10.1	Research Support and Commitment to Research			
	2023	Partially Met	2024	Met

Recommendation AA	The following areas could be further supported in order to ensure research is an ongoing priority: • Allocation of dedicated time (which trainees could be rotated through) • Research nurse/other support staff • Consideration for involvement in national trials • Utilising audits as part of a structured research program			
5.11	The Training Site provides an easily accessible obstetric database to assist FRANZCOG trainees with audit and research.			
5.11.1	Obstetric Database			
	2023	Met	2024	Met
5.12	The O&G Department conducts regular minuted Consultant meetings.			
5.12.1	Consultant Meetings			
	2023	Partially Met	2024	Met
OVERALL ASSESSMENT OF STANDARD 5				
	2023	Not Met	2024	Partially Met
STANDARD 6 – WORKPLACE CULTURE, REGISTRAR STAFFING, SAFE WORKING HOURS, LEAVE ARRANGEMENTS AND ASSISTANCE FOR RURAL ROTATIONS				
6.1	A supportive, harmonious workforce culture and team environment is evident.			
6.1.1	Consultants and Workplace Culture			
	2023	Not Met	2024	Partially Met
Recommendation BB	An update is requested on the progress to implementing a 360-degree feedback mechanism within the department, recognising that this kind of initiative must have the necessary support systems in place.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	Process to establish program underway.			

CHS response (as of 19-5-25)	O&G consultant group has engaged in a formal program (Herrmann Brain Dominance Index (HBDI)) to develop leadership skills. Initial planning sessions are underway with an expected completion of December 2025, due to the volume and availability of consultants.			
6.1.2	Organisational Culture			
	2023	Not Met	2024	Partially Met
Recommendation CC	Continuing from the steps taken already, it would greatly benefit the department to see proactive engagement and advocacy from an organisational perspective. A forum with ongoing discussion, tangible actions, and transparent decision making would be strongly encouraged.			
CHS response (as of 20-1-25)	Development of organisation-wide CHS Wellness Strategy and creation of and recruitment into CHS Chief Medical Wellness Officer role.			
CHS response (as of 17-3-25)	Recent feedback from short-notice hospital assessment reported positive organisational culture was evident.			
CHS response (as of 19/5/25)	CHS Wellness Strategy and CHS Chief Medical Wellness Officer role now well established. There has been positive feedback on Organisational Culture from hospital wide consultation.			
6.1.3	Bullying, harassment, and discrimination			
	2023	Partially Met	2024	Not Met
Condition 8	Steps must be taken to ensure these issues are addressed in the appropriate manner, and that the current policy is fit for purpose. Appropriate lines of communication must be in place (particularly with regards to key areas such as rostering and theatres) to ensure all staff are able to voice their needs. The following may be useful resources as a starting point:			
Recommendation DD	Consideration should be given to translating the BHD policy and associated online training into a face-to-face experience with multidisciplinary participation			
CHS response (as of 20-1-25)	A number of immediate steps have been taken to address these issues, including: • O&G Consultant group participated in Emotional Intelligence and Compassion Workshop • O&G Consultant group participated in RANZCOG Respectful Workplace Workshop • O&G Consultant group participated in Speaking up for Safety (SUFS) face-to-face training workshop • Three-part Cultural Diversity and Inclusion program developed specifically for O&G Consultant group, to be delivered at regular monthly consultant meetings. • SUFS training for all new JMO's, registrars and trainees now including in 2025 CHS mandated orientation training days. • Introduction of two-day program specifically for CHS International Medical Graduate (IMG) doctors, designed to orientate international graduates to the Australian health system, including escalating concerns, speaking up for safety and safe communication.			

	Session held with International Medical Graduates (IMG's) within O&G speciality regarding speaking up to report inappropriate behaviours, including bullying and racism, within the workplace. Session facilitated by the CHS Director - IMG & Hospital Non-Specialist Doctors Education and Training and the CHS Director of Medical Training.			
CHS response (as of 17-3-25)	- All new CHS junior medical staff, including registrars completed mandatory training at orientation, including Cultural Awareness training and Speaking up For Safety (SUFS). - Three-part Cultural Diversity and Inclusion program developed specifically for O&G Consultant group, to be delivered at regular monthly consultant meetings.			
CHS response (as of 19-5-25)	Final Cultural Diversity and Inclusion program to be delivered and completed by June 2025.			
6.1.4	Support for trainees in difficulty			
	2023	Partially Met	2024	Met
6.2	A suitable number of junior medical staff is employed to ensure sufficient training opportunities exist for FRANZCOG trainees to meet training requirements, over and above meeting service requirements.			
	Trainee Staffing			
	2023	Not Met	2024	Partially Met
Recommendation EE	The focus in this area going forward should be on balancing the different training and support needs of junior staff, and ensuring flexibility in rostering arrangements so that the experience can be matched to the appropriate group(s).			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	A structured monthly meeting with the ITPC and the O&G Senior Registrar has been established to ensure clinical oversight of roster and appropriate and equitable allocation for trainees.			
CHS response (as of 19/5/25)	Additional recruitment of JMOs is underway. CHS has successfully recruited two Senior Registrars, with anticipated commencement dates in August 2025 and February 2026, respectively.			
6.3	The Training Site complies with award conditions relating to working hours and shift work relevant to the region in which it is located.			
6.3.1	Award Conditions – Working Hours			
	2023	Partially Met	2024	Met
6.3.2	Guide to Appropriate Hours			
	2023	Partially Met	2024	Partially Met

Recommendation FF	Rostered hours should continue to be monitored to ensure they align with appropriate working hours for a FRANZCOG Trainee and allow for the best access to training opportunities across the cohort. Efforts should be made to ensure staffing remains adequate to support this			
CHS response (as of 20-1-25)	CHS requested additional trainee position to be endorsed by RANZCOG to address trainee staffing shortages with planned and unplanned leave. RANZCOG declined to endorse additional trainee position at present. CHS will continue to make efforts to ensure staffing remains adequate.			
CHS response (as of 17-3-25)	Consultant roster was amended to align with the RANZCOG recommendations, and split shifts for weekends are occurring.			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
6.3.3	Physical Safety and Security			
	2023	Met	2024	Met
6.4	The Training Site permits FRANZCOG trainees to undertake fractional training subject to the requirements of the Training Site and prospective approval by the Chair of the relevant State/Territory/New Zealand TAC.			
6.4.1	Fractional Training			
	2023	N/A	2024	Met
6.4.2	Leave Arrangements			
	2023	N/A	2024	Met
6.3.4	Training Whilst Pregnant			
	2023	N/A	2024	Met
6.4.4	Training After Taking Leave			
	2023	N/A	2024	Met
6.5	A mentor is offered and available if requested or recommended, in addition to the Training Supervisor.			
6.5.1	Mentor			
	2023	Partially Met	2024	Partially Met
Recommendation GG	It would be beneficial to provide some kind of structure to mentoring at the hospital, which could extend across the ITP to share the load and expose trainees to different consultants and learning experience			
CHS response (as of 20-1-25)	A rotational system has been implemented for 2025 to ensure trainees are exposed to different consultants and mentors.			
CHS response (as of 17-3-25)	Ongoing.			
CHS response (as of 19/5/25)	Mentoring is currently being delivered on an individual basis, with variable outcomes. A formal review of the approach is scheduled for August 2025 to assess effectiveness and identify opportunities for enhancement.			

6.7	The Training Site has in place a process for critical incident management, including the immediate and longer-term care of FRANZCOG trainees involved in critical incidents such as adverse maternal or perinatal outcomes.			
6.7.1	Critical Incident Management			
	2023	Not Met	2024	Partially Met
Recommendation HH	An update on the implementation and effectiveness of the critical incident response process is requested at the time of the next activity			
CHS response (as of 20-1-25)	Implementation of second-on-call consultant role to respond to clinical needs of the department following a critical event, allowing the team involved to 'hot debrief'. This is in addition to the introduction of regular clinical supervision for nursing/midwives, and utilising existing CHS resources (EAP, CHS Wellness Strategy, Doctors 4 doctors etc). This process has worked well for the critical incidents that have occurred in the last 6 months. Further training for clinicians to lead the 'hot debrief' to occur as required.			
CHS response (as of 17-3-25)	Process of 'hot debriefs' instituted and working well.			
CHS response (as of 19/5/25)	Process of 'hot debriefs' are audited regularly at the O&G Consultant meeting.			
OVERALL ASSESSMENT OF STANDARD 6				
2023	Not Met	2024	Partially Met	



Canberra Health Services

To:	Minister for Health	Tracking No.: MCHS25/316 (CHSFOI24-25.28)
Date:	18/06/2025	
From:	Dave Pepper, Chief Executive Officer	
Subject:	Freedom of Information application from [REDACTED] requesting A copy of the most recent internal audit or performance review concerning patient discharge delays, hospital bed availability and other ED reports/information.	
Critical Date:	18/06/2025	
Critical Reason:	FOI delivered to applicant on this day.	

Recommendation

That you:

1. Note Canberra Health Services' response at Attachment A.

Noted / Please Discuss

Rachel Stephen-Smith MLA/...../.....

Minister's Office Feedback

Background

1. On 5 May 2025, [REDACTED] submitted an access application under the *Freedom of Information Act 2016* (the Act) to the Canberra Health Services (CHS) requesting:

'1. Regarding the internal audit or performance review on patient discharge delays and hospital bed availability:

I am specifically seeking a copy of the most recent internal audit or internal performance review document conducted between 1 January 2024 and 31 March 2024 that focuses on issues relating to delays in patient discharge and the availability of hospital beds across ACT public hospitals. If no single document addresses both topics, I am happy to receive separate documents that cover each aspect individually.

2. Regarding strategies to improve ED throughput and reduce bottlenecks:

Thank you for confirming that CHS holds information relevant to this point. I would like to request documents showing strategies planned or implemented between 1 January 2024 and 31 March 2024 to improve emergency department throughput and reduce system bottlenecks, including any benchmarks or evaluation criteria.

3. Regarding complaints related to emergency care delays:

I understand that CHS is unable to report directly on ED care delays, and that information involving personal health details is outside the scope of the FOI Act. However, I would still appreciate summary-level information or aggregated reports, if available, showing the number of complaints received between 1 January 2024 and 31 March 2024 specifically related to emergency department delays, and any general (non-personalised) Directorate responses or policy actions taken in response to recurring issues.'

Issues

2. A search was conducted of all relevant records systems. CHS has identified 24 documents containing the information that meets the scope of the request.
3. The decision letter and accompanying documents released to [REDACTED] are at Attachment A.

Financial Implications

4. Processing fees are not applicable to this request.

Consultation

Internal

5. Not applicable

Cross Directorate

6. Not applicable

External

7. Not applicable

Work Health and Safety

8. Not applicable

Benefits/Sensitivities

9. Not applicable

Communications, media and engagement implications

10. Media talking points have not been prepared and can be by the CHS media team should any media issues arise.

11. The decision letter and accompanying documents in response to [REDACTED] FOI access applications will be uploaded to the ACTHD Disclosure Log in accordance with the Act.

Signatory Name: Dave Pepper
Chief Executive Officer

Phone: (02) 5124 4700

Action Officer: Michelle Ramsay
Assistant Director
Office of the Deputy Chief Executive
Officer

Phone: (02) 5124 5804

Attachments

Attachment	Title
Attachment A	CHS Response



Canberra Health Services

To:	Minister for Health	Tracking No.: MCHS25/326
Date:	05/06/2025	
From:	Dave Pepper, Chief Executive Officer	
Subject:	Formalising a Territory-wide Neurology Service and associated Australian and New Zealand Association of Neurologists Accreditation	
Critical Date:	25/06/2025	
Critical Reason:	Associated with the Australian and New Zealand Association of Neurologists accreditation visit scheduled for late June 2025 and recruitment timing for the Clinical Director of Neurology and Stroke Services	

Recommendations

That you:

1. Note the information contained in this brief;

Noted / Please Discuss

2. Agree to the establishment of a formal Territory-wide Neurology Service for the ACT;

Agreed / Not Agreed / Please Discuss

Rachel Stephen-Smith MLA/...../.....

Minister's Feedback

Background

1. Neurology services across the Territory are predominantly focused on general neurological conditions, with limited sub-specialisation. As with many specialist services in the ACT, many areas of acute neurology require a critical mass case load to be sustainable.
2. This has meant attraction of Neurologists, particularly those with specialist skill set has been challenging for both Canberra Hospital and North Canberra Hospital.
3. In March 2025, Canberra Health Services (CHS) made the decision to appoint an interim Cross-Territory Clinical Director of Neurology and Stroke Services, to lead Canberra Hospital and North Canberra Hospital Neurology Departments in the development of a cross-territory model of care.
4. The timing of this decision, although pressured by the resignation of the then Unit Director at Canberra Hospital, was based upon the above identified challenges for the delivery and sustainability of neurological care in the ACT.
5. This appointment has meant the service can start to step through sustainable changes in services delivery and combine specialty areas in a meaningful way, which will remove recruitment competition between the two hospitals, and see critical case load optimised.
6. CHS has been notified by the Australia and New Zealand Association of Neurologists (ANZAN) and the Royal Australian College of Physicians (RACP) that CHS will undergo accreditation during the month of June 2025.
7. The newly endorsed RACP Neurology curriculum is yet to be implemented but we understand, ANZAN will be considering CHS accreditation for 2026 onwards based on the proposed curriculum.
8. Summary of minimum requirements:
 - 100 clinics per year for each accredited registrar;
 - Minimum Nerve Conduction Studies (NCS) 75 per registrar including 50 hands on;
 - Minimum Electroencephalograms (EEG) 75 per registrar;
 - Dedicated Advanced Trainee (AT) room;
 - Dedicated teaching sessions for EEG and NCS; and
 - Attendance at mandatory ANZAN meetings including brain school.

Issues

9. There have been some challenges within the Consultant Group at Canberra Hospital to agree to providing formal supervision to Registrars, which has been raised as a risk at the Executive Level.

10. The interim Cross-Territory Clinical Director, Neurology and Stroke Services and the Executive Director, Division of Medicine have been working with the team to resolve this situation, and believe the Territory does and will meet ANZAN requirements for ongoing accreditation.
11. Attachments A and B provide the CHS submission to ANZAN, who we anticipate will undertake their associated site visit during the month of June 2025.

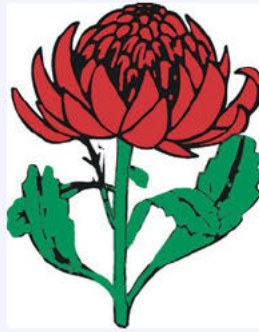
Benefits/Sensitivities

12. CHS anticipates there may be several recommendations from ANZAN:
 - A dedicated Registrar office;
 - Expanded outpatient clinic space;
 - A dedicated teaching timetable;
 - Additional Neurophysiologist (estimated 0.8 - 1.0 FTE); and
 - Reclassification and uplift of Specialist Nursing workforce (Advanced Practice Nurse conversion of existing FTE and estimated 2.0 FTE Nurse Practitioner).
13. The first three potential recommendations listed above are immediately achievable with a minor uplift in funding.
14. If we continue with formalisation of a Cross-Territory service, the last potential recommendation listed above would become a key priority within the service roadmap, which will also include the development of Models of Care for sub-specialty areas:
 - Multidisciplinary clinics for movement disorders, Multiple Sclerosis, neuroimmunology, and neuromuscular disorders.
 - Epilepsy rapid access first seizure clinic, reliable EEG service and capacity to provide paediatric EEG service.
 - Hybrid Stroke Service which includes Nurse Practitioners to streamline services across the Territory and lead Transient Ischaemic Attack and Stroke follow up clinics.
 - Neurophysiology medical leads for EEG and NCS/Electromyography (EMG), service provision to meet demand and continue to meet Registrar training requirements
15. Formalisation of Cross-Territory Neurology and Stroke Service will require incremental service development over 2025-26 and 2026-27 financial years, although it will provide comprehensive general neurology and sub-specialty care with performance comparative to peer services.

Signatory Name: Dave Pepper, Chief Executive Officer Phone: 5124 4700

Attachments

Attachment	Title
Attachment A	CHS accreditation submission the ANZAN
Attachment B	AT Timetable



Site Accreditation and Re-accreditation Form

APPLICATION FOR RE-ACCREDITATION OF CORE TRAINING POSITION(S) IN NEUROLOGY

Hospital *

Canberra Health Services - Neurology

Address *

Yamba Drive, Garran ACT 2605

Street Address

Street Address Line 2

Canberra

City

ACT

State / Province

2605

Postal / Zip Code

Head of Neurology Department *

Ronak

First Name

Patel

Last Name

Head of Department email *

ronak.patel@act.gov.au

example@example.com

Number of accredited core positions

3

Number of position(s) to be re-accredited *

3

Supervisors (Please list ALL Potential supervisors of AT's)

Probable Supervisor #1 *

Ronak

First Name

Patel

Last Name

FTE *



Date last attended RACP Supervisor Workshop *

29/06/2022 

Date

Indicate which RACP training modules have been undertaken?

Completed all SPDP modules
SPDP1 29/06/2022
SPDP2 30/11/2020
SPDP3 06/07/2021

Probable Supervisor #2 *

Chandi

First Name

Das

Last Name

FTE *



Date last attended RACP Supervisor Workshop *

02/12/2020 

Date

Indicate which RACP training modules have been undertaken?

Composite SPDP certification 20/06/2022, SPDP 3 - 2/12/2020

Separately list ALL potential Advanced Trainee Supervisors

Dr Andrew Hughes
 Dr Anna Willard
 Dr Shaun Zhai
 Dr Camilla Jozwik
 Dr Carmela Sales
 Dr Philip Fletcher
 Dr Rajat Lahoria

List all neurology consultant staff Indicate FTE – Staff or VMO, indicate who has undertaken the RACP training modules and which ones

Dr Ronak Patel, [REDACTED] FTE, all SPDP modules completed
 Dr Andrew Hughes, [REDACTED] FTE, all SPDP modules completed
 Dr Camilla Jozwik, [REDACTED] FTE, all SPDP modules completed
 Dr Shaun Zhai, [REDACTED] FTE, all SPDP modules completed
 Dr Carmela Sales, [REDACTED] FTE, all SPDP modules completed
 Dr Peter Park, [REDACTED] FTE, SPDP2 and registered for SPDP1 and SPDP3
 Dr Mihirini Abeywickrama, [REDACTED] FTE
 Dr Chandi Das, [REDACTED] FTE, SPDP3 modules completed, registered for SPDP2 and SPDP1
 Dr Rajat Lahoria, [REDACTED] FTE, all SPDP modules completed
 Dr Phillip Fletcher, [REDACTED] FTE
 Dr Anna Willard, [REDACTED] FTE, all SPDP modules completed
 Dr Steven Evans, [REDACTED] FTE (yet to commence employment)
 Dr Duncan Austin, [REDACTED] FTE (yet to commence employment)

Dr Ram Malhotra - VMO
 Dr Craig McColl - VMO

A. Dr John Brown –consultant, 0.4 FTE , RACP Modules 1,2,3

Total FTE for the Unit:

EMG Supervisor *

Andrew

First Name

Hughes

Last Name

EMG Level *

3

Hours spent supervising *

41

8

EEG Supervisor *

Anna

First Name

Willard

Last Name

EEG Level *

3

Hours spent supervising *

8

Please list all Consultants who are accredited by ANZAN for NCS/ EMG & EEG – at which Level

Dr Andrew Hughes - NCS/EMG & EEG, Level 3
Dr Rajat Lahoria - NCS/EMG, Level 3
Dr Ram Malhotra - NCS/EMG, Level 3
Dr Chandi Das - EEG & NCS/EMG, Level 2
Dr Anna Willard - EEG, Level 3

Potential supervisors

Dr Ronak Patel - Applying for EEG & NCS/EMG, Level 2
Dr Shaun Zhai - Applying for EMG/NCS, Level 2

eg: Dr xxx – EMG level 2

Please list ALL junior medical staff working on the unit

3 Basic Training Physician Registrars (The Canberra Hospital), ■ FTE
4 RMOs (3 at The Canberra Hospital & 1 at North Canberra Hospital), ■ FTE
3 Neurology Fellows (2 at The Canberra Hospital & 1 at North Canberra Hospital), ■ FTE
3 Neurology ATs (2 at The Canberra Hospital & 1 at North Canberra Hospital), ■ FTE

a. Include the position (ie Intern, SMO, BPT , Fellow etc) and FTE devoted to the Unit. b. How staff are covered for their ambulatory clinics including EMG sessions and teaching sessions such as Brain School
c. The on call roster for each AT

Trainees and Training

Mandatory requirements for Core training of an AT :

Note: below are on average over 12 months.

1. AT's should be undertaking on average minimum of two ambulatory/ OPD clinics a week **(expected to be mandatory from 2026)**
2. One hands on EMG/ NCS clinic a week on average - supervised by a Consultant
3. Quarantined time to attend Brain school
4. Weekly EEG education session.
5. Dedicated office space for each AT

Please include a timetable of the Unit (an example can be found as an image below) including which consultants are undertaking the clinics: Please include all teaching sessions (ie EEG) and departmental meetings attended by the trainees.

**Please attach the
timetable separately**

General Timetable for the Neurology & Stroke Unit:

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Movement Disorders & Epilepsy Clinic (Dr) Case based EMG teaching (Dr)	Div of Medicine Xray & Clinical Case Meeting Neuro-immunology/ General clinic (Dr)	 Grand Round	NCS/EMGclinic (Dr) Neuroimmunology clinic (Dr) Neuro-imm/ General clinic (Dr)	
PM	Epilepsy Clinic (Dr) Stroke Clinic (Dr) TIA Clinic	Movement Disorders clinic (Dr) NCS/EMG clinic (Dr) TIA Clinic	EEG Tutorial (Dr) Brain school NCS clinic TIA Clinic	Neurology Clinical Case Meeting Discharge Audit meeting TIA Clinic	Neurology clinic Stroke / Botox Clinic (Dr) TIA Clinic

Please detail the weekly roster of each AT core training position (an example can be found as an image below).

1. Include the OPD clinic and the name of the consultant(s) who supervise the trainee in this clinic.
2. Please include the specific consultant who supervises the NCS/ EMG clinic including which consultants are undertaking the clinics
3. The on-call roster for each AT including duties
4. The times re on call re weekends/after hours/first on call/remote call etc
5. Please provide the current AT log books for NCS/EMG & EEG – for each core trainee at your site.

Please attach the weekly roster separately

Please see example below

Consults registrar (AT1):

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Consults Alt week Case based EMG & EEG teaching (Dr)	Neuro-immunology/ General clinic (Dr)	Consults	Consults NCS/EMG clinic (Dr)	Consults
PM	Consults	Movement Disorders clinic (Dr)	Grand Round – LMH EEG Tutorial (Dr) Brain school every month	Neurology Clinical Case Meeting Discharge Audit meeting	Neuro radiology meeting- Neurology Clinical Case/ neuropath -

|

Ward registrar (AT2):

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	Ward round Alt week Case based EMG & EEG teaching (Dr)	Ward round NCS/EMG clinic (Dr)	Ward round	Ward round Neuroimmunology clinic (Dr)	Ward round

Year(s) for which accreditation is sought *

- ☐ 2024
- ☒ 2025
- ☒ 2026
- ☒ 2027
- ☒ 2028

Number of inpatient beds *

TCH - 24, NCH - 16 e.g., 23

Quality assurance program? *

AuSCR

Quality Assurance Program

Attach files to application

On call for emergencies during normal working hours? *

- ☒ Yes
- ☐ No

On call for emergencies after hours?

☒ Yes

☐ No

No. of Ambulatory Care (outpatients) Clinics/Week *

24 including 4 NCS across the network

Average no. of inpatient consultations/week *

30 plus per week across the network

Number of Part-time Neurologists in the Department? *

11 e.g., 23

Number of Full-time Neurologists in the Department? *

3 e.g., 23

Training

Number of EEGs/Week *

10 e.g., 23

Number of EMGs/Week *

15-20

e.g., 23

Number of EPs/Week *

0 - Education on the topic to be provided

CT Scan? *

☒ Yes

☐ No

Angiography? *

☒ Yes

☐ No

Ready access to MRI? *

☒ Yes

☐ No

Weekly neuroradiology review meetings? *

☒ Yes

☐ No

Monthly Neuropathology Meeting? *

☒ Yes

☐ No

Neurosurgery Service *

☒ Yes

☐ No

Psychiatry Service *

☒ Yes

☐ No

One Supervised Neuro-rehabilitation session/week for 6 months: *

☒ Yes

☐ No

(*) If the Neuro-rehabilitation session is off-site please nominate facility

University of Canberra Hospital

Quarantined Time for trainee participation in National Brain School *

☒ Yes

☐ No

Location of video-conferencing facilities at hospital: (including contact details of technical support person):

Neurology Registrar office

Will Hospital or Area Health Authority allow access to these facilities at no cost to trainee:

☒ Yes

☒ No

Other sub-specialty training available? If yes nominate specialties

Multiple Sclerosis, Movement Disorders,

Please indicate any changes in resources since the last accreditation:

Since last accreditation, the Neurology services across the ACT network have been combined with single Unit Director providing governance.
The Neurology consultants are getting cross credentialised for both hospitals. There are plans to combine the neurology outpatient services with a single waitlist and have a single territory wide afterhours on call roster.

Thank you for completing this form

Name *

Ronak

First Name

Patel

Last Name

Signature *

 Sign Here

Please send the completed form and attachments to admin@anzan.org.au

- ☒ 1. On-call roster for each Advanced Trainee
- ☒ 2. Unit Timetable inclusive of department meetings and teaching sessions.
- ☒ 3. Weekly Roster of each Advanced Trainee, inclusive of training sessions and OPD Clinic

Canberra Health Services, Neurology AT weekly timetable

3 accredited Neurology ATs will do 3 terms of 4 months each

2 ATs will be at The Canberra Hospital (TCH) & 1 AT will be at North Canberra Hospital (NCH)

The ATs will spend 8 months at TCH and 4 months at NCH

The Canberra Hospital (TCH)

Neurology AT 1

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	EMG/NCS clinic – Dr Das	Epilepsy Clinic – Dr Willard	Ward consults Grand rounds, 12 – 1 pm	Movement Disorder clinic – Dr Das	Ward Consults Neuroradiology Meeting, 12 – 1 Pm Clinical Neurology Meeting, 1 – 2 Pm Monthly Neuropathology Meeting, 1 – 2 pm
PM	General Neurology clinic – Dr Fletcher	EEG teaching – Dr Willard	Ward consults Brain School, once a month	Journal Club, 12 – 1 pm Ward consults	Clinical Neurosciences Meeting, 1 – 2 Pm Monthly Neuropathology Meeting, 1 – 2 pm

Neurology AT 2

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Ward consults	Botox clinic – Dr Das	TIA clinic Grand rounds, 12 – 1 pm	EMG/NCS clinic – Dr Lahoria	Neuroimmunology Clinic – Dr Lahoria
PM	Ward consults	EEG teaching – Dr Willard	Ward consults Brain School, once a month	Journal Club, 12 – 1 pm General Neurology clinic – Dr Evans or Dr Austin	Clinical Neurosciences Meeting, 1 – 2 Pm Monthly Neuropathology Meeting, 1 – 2 pm Ward consults

- TCH Neurology ATs will be first on call, 1 in 4 weeks to cover after hours Acute stroke and General Neurology calls

North Canberra Hospital (NCH) – Weekly Timetable

Neurology AT 3

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Ward rounds Journal Club, 12 – 1 Pm	Physicians CME 8 – 9 Am Ward rounds	Ward rounds Grand rounds, 12 – 1 pm	Ward rounds	Neuroradiology Meeting, 8 – 9 Am Ward rounds
PM	General Neurology clinic – Dr Hughes Option to cover leave - Dr Zhai or Dr Jozwik	Ward consults EEG teaching – Dr Willard at TCH	Ward consults Brain School, once a month	General Neurology – Dr Patel Option to cover leave – Dr Sales	EMG/NCS clinic – Dr Hughes at TCH

- NCH Neurology AT will be first on call, 1 in 4 weeks to cover after hours Acute stroke and General Neurology calls



Caveat Brief | Canberra Health Services**OFFICIAL Sensitive****TRIM Ref: CHS25/368****To:** Rachel Stephen-Smith MLA, Minister for Health**Date:** 20 June 2025**CC:** Janet Zagari, Deputy Chief Executive Officer
Dave Pepper, Chief Executive Officer**From:** Lisa Gilmore, General Manager, Canberra Hospital**Subject:** Identified TB index case with contact tracing required within [REDACTED]
[REDACTED]

- ACT Health has identified a case of tuberculosis (TB) in a person who worked across two locations: the [REDACTED] [REDACTED] and [REDACTED] in Canberra.
- The individual ('the index case') was unknowingly infectious between 6 November 2024 and 14 February 2025. [REDACTED]
[REDACTED]
- Initial contact tracing identified three household contacts with latent TB infection:
 - One tested positive on the initial screen.
 - Two others initially tested negative but returned positive results ten weeks later, indicating transmission.
 - There is no ongoing risk to children, staff, the wider [REDACTED] community or the public.
- The index case unknowingly had the disease; due to privacy their identity will not be disclosed and does not change the process. Extended contact tracing will assist ACT health to continue their risk assessment and identify possible infection for

management. It is uncommon to identify further cases but screening will be offered out of an abundance of caution, especially with children.

- Index case worked [REDACTED].
- A risk assessment and contact tracing for the [REDACTED] will begin next week (week starting Monday 23 June 2025), with the [REDACTED] remaining the immediate priority.
- The CHS TB Clinic is leading the response, in collaboration with the ACT Public Health Unit (PBU) and relevant clinical contacts.
- Ongoing communication is in place with the [REDACTED] manager. The Manager of [REDACTED] has been advised of the exposure and has been informed not to disclose this information to staff or parents until after the visit on Monday 23 June 2025.
- TB nurse and public health will undergo a site visit at [REDACTED] on Monday 23 June 2025 to help contact tracing nurse visualise the space and perform a risk assessment.
- Information letters for staff and families at the [REDACTED] will be provided after the site visit scheduled for Monday 23 June 2025.
- TB screening will be conducted at the TB Clinic at CHS.

Noted/Please Discuss

Rachel Stephen-Smith MLA
Minister for Health

CHS Executive: Rebekah Ogilvie, Executive Director, Division of Medicine
Action Officer: Kristi Vaughan, Executive Officer, Division of Medicine

Caveat Brief | Canberra Health Services**OFFICIAL Sensitive****TRIM Ref: MCHS25/368****To:** Rachel Stephen-Smith MLA, Minister for Health**Date:** 2 July 2025**CC:** Janet Zagari, Chief Executive Officer**From:** Lisa Gilmore, General Manager, Canberra Hospital**Subject:** Identified TB index case with contact tracing required within [REDACTED]
[REDACTED] - update

- Canberra Health Services (CHS) provided you with a Caveat Brief (MCHS25/368) on Friday 20 June 2025 regarding an identified case of tuberculosis (TB) in a person who worked across two locations in Canberra.
- The [REDACTED] named in the brief was incorrect and the location for the [REDACTED] identified is the [REDACTED] and not the [REDACTED]. All other information provided remains factual.
- A site visit occurred at [REDACTED] on Monday 23 June 2025 and the following was identified:
 - The number of [REDACTED] attending the [REDACTED] is approximately 130-140.
 - The total number of staff recommended for TB testing is 37.
 - The total number of children recommended for TB testing is 32.
- Letters to all families/staff and identified contacts will be sent on 3 July 2025 – this is to ensure that the TB team is available to answer any questions the families or [REDACTED] staff might have once they are distributed.
- Families who are not identified as a contact can still request screening if they are concerned.

Noted/Please Discuss

Rachel Stephen-Smith MLA
Minister for Health

CHS Executive: Rebekah Ogilvie, Executive Director, Division of Medicine**Action Officer:** Kristi Vaughan, Executive Officer, Division of Medicine



Ministerial Brief

To:	Minister for Health	Tracking No.: MCHS25/369
Date:	13/08/2025	
From:	Janet Zagari, Chief Executive Officer, Canberra Health Services	
Subject:	Canberra Health Services Internal Audit Report FY 2024-2025	
Critical Date:	Not applicable.	
Critical Reason:	Provide the Annual Report on internal audit activity within CHS that occurred during the 2024-2025 financial year	

That you:

1. Note the information contained in this brief.

Noted / Please Discuss

Rachel Stephen-Smith MLA/...../.....

Minister's Feedback

Background

1. In August 2024, you requested Canberra Health Services (CHS) provide you with an annual report of internal audit activity that took place within the 2024-2025 financial year.

Issues

2. The internal audits completed in the 2024-2025 financial year include:
 - Cancer Services Performance Measures Review
 - Finance and Human Resources (HR) Delegations

Choose an item.



- Risk Management
 - Capital Works
 - Asset Management (Clinical Equipment)
 - Clinical Practice Management – Variations of Care
3. While the findings of each audit were varied and specific to that focus area, key themes arose from the recommendations including gaps around documentation of internal processes, staff engagement and collaboration, governance arrangements, risk management and monitoring.
 4. There has been a focus to close any open recommendations from previous audits that are significantly overdue for closure. From 30 June 2024 to 30 June 2025, the Internal Audit team has reduced the percentage of significantly overdue audit recommendations from 68 per cent to 24 per cent in collaboration with lead areas within CHS and key stakeholders. These include recommendations initiated from internal audits and the ACT Audit Office.
 5. Work is in progress to address and close internal audit recommendations in a timely way to address identified gaps and areas for improvement.
 6. There has been significant progress in developing artefacts and implementing processes that enhance the maturity of the internal audit function at CHS. These include reviewing the Audit and Risk Management Committee (ARMC) and Internal Audit Charters, streamlining of audit recommendation reporting and closure, review of ARMC processes, review of internal audit planning processes with budgetary considerations and partnering with stakeholders within the organisation to build awareness and capability.
 7. The Head of Internal Audit confirms and declares the ongoing independence of the internal audit function throughout the 2024-2025 financial years.

Financial Implications

8. Nil

Consultation

Internal

9. Nil

Cross Directorate

10. Nil

External

11. Nil

Work Health and Safety

12. Nil

Choose an item.

**Benefits/Sensitivities**

13. Nil

Communications, media and engagement implications

14. Nil

Signatory Name: Josephine Smith

Phone: MS Teams

Action Officer: Mea van der Ploeg

Phone: MS Teams

Attachments

Attachment	Title
Attachment A	CHS Internal Audit Annual Report



Internal Audit Report 2024-25

July 2025



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Information about the directorate can be found on the website:

www.canberrahealthservices.act.gov.au



Acknowledgement of Country

Canberra Health Services acknowledges the Ngunnawal people as traditional custodians of the ACT and recognises any other people or families with connection to the lands of the ACT and region. We acknowledge and respect their continuing culture and contribution to the life of this region.

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Accessibility 📞 call (02) 5124 0000



Interpreter 📞 call 131 450

canberrahealthservices.act.gov.au/accessibility



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Introduction

This annual report covers internal audit activity that occurred within Canberra Health Services (CHS) for the 2024-25 financial year. This report summarises CHS' key changes in the internal audit function, internal audit activity, findings and recommendations that have arisen, and progress towards addressing recommendations.

Significant changes in 2024-25

There were several significant changes within the Internal Audit function, including:

=

Change in internal audit service provider for CHS

KPMG have been the Internal Audit service provider for CHS since 2019. In November 2024, following a procurement process, O'Connor Marsden (OCM) were contracted as the new service provider for CHS.

The OCM team have gone through an onboarding process to CHS including orientation to key strategic documents and current enterprise risks, introduction to key stakeholders, including Executive and delivery of the remainder of the 2024-25 Internal Audit Plan (IAP).

Appointment of four new Audit and Risk Management Committee (ARMC) members

A procurement process was undertaken in December 2024 for revised Chair and membership to the CHS ARMC. This arose following review of the ARMC Charter and alignment with relevant standards, guidelines and best practice for audit committees.

One Chair and three new members were appointed and undertook a face-to-face induction process which included provision of key documents and presentations from key CHS Executive. The new Chair and members commenced over March-May 2025 ARMC meetings with a formal handover provided by the previous Chair.

Internal Audits completed

The following internal audits were completed between 1 July 2024 and 30 June 2025.

Internal Audit	Provider	Completion date
Cancer Services Performance Measures Review	KPMG	September 2024
Finance and Human Resources (HR) Delegations	KPMG	December 2024
Risk Management	KPMG	December 2024
Capital Works	KPMG	December 2024
Asset Management (Clinical Equipment)	KPMG	March 2025
Clinical Practice Management – Variations of Care	KPMG	May 2025

The below key themes have been observed across the completed internal audits:

- Documentation of internal processes – opportunities were identified to improve documentation of performance measures, delegations for asset disposal, project management, strategic asset management, asset procurement and clinical variations.
- Staff engagement/collaboration – there were varying levels of awareness of key processes/requirements and engagement from staff, including collaboration between business areas or other Directorates.
- Governance arrangements – opportunities were identified to strengthen oversight by governance committees.
- Risk Management and Monitoring – inconsistent approaches to risk management and monitoring were noted, including capital works projects reviewed, strengthening controls and for clinical variations.

A summary of key findings and issues can be found at [Attachment A](#) (below) and includes linkages to key themes.

As at 30 June 2025, there were several audits in progress from the 2024-25 IAP, due to be completed early in the 2025-26 financial year:

Internal Audit	Provider	Expected Completion date
Credit Cards	OCM	July 2025



Internal Audit	Provider	Expected Completion date
Physical Security and Incident Management	OCM	September 2025
Service Contract Management	OCM	September 2025
Medications Management	OCM	December 2025

Key activities to date: Maturing the Internal Audit function at CHS

Work was undertaken, led by the Head of Internal Audit, to review Internal Audit processes and build maturity within the Internal Audit function, including:

- Reviewing the ARMC and Internal Audit Charters. These artefacts were endorsed by the ARMC in December 2024.
- Development of the audit recommendations dashboard to assist clarity in reporting.
- Significant progress in streamlining the audit recommendation follow up processes, with closure of 28 recommendations of which 26 (93 per cent) were significantly overdue. Refer below to [Figure one](#) which demonstrates the progress made on reducing significantly overdue recommendations since 30 June 2024.
- Reviewing ARMC meeting processes, such as meeting papers, communication with business areas and ARMC members.
- Formal process implemented around induction of ARMC members, including a face-to-face induction which included orientation to CHS and introduction to key Executive.
- Reviewing Internal Audit Planning processes and budgetary considerations.
- Lifting the profile of Internal Audit within CHS with increased reporting and communication with CHS Governance Committees, Executive, business areas and the creation of an Internal Audit intranet page.

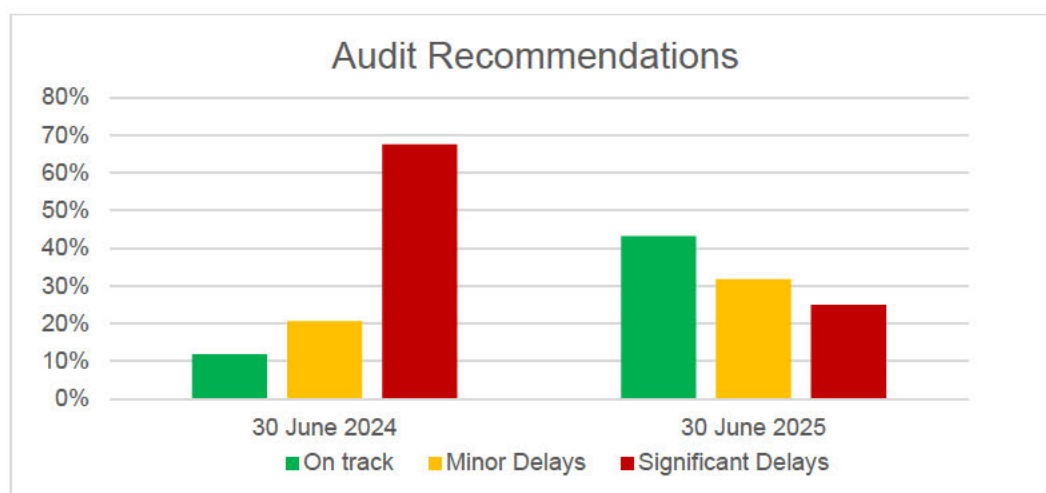
Further work is planned in the 2025-26 financial year to continue to build maturity in the Internal Audit function and broader CHS, including:

- Development of an Internal Audit Strategy and manual.
- Self-assessment against the IIA Global Standards for Internal Audit, including establishment of a Quality Assurance Improvement Program.
- Commissioning of an Assurance map as part of the IAP to identify key gaps in assurance and potential areas for future internal audits.



- Continue efforts to raise the profile of Internal Audit within CHS.

Figure one: Status of Audit Recommendations – June 2024 vs June 2025



Note - Minor Delays: up to three months passed due date, **Significant Delays:** greater than three months passed due date

NB: These figures are as at the completion of the May ARMC meeting as this is the last meeting of the financial year.

Internal Audit Annual Planning

The proposed 2025–26 Internal Audit Plan for CHS has been collaboratively developed by the CHS Internal Audit, Risk and Compliance team and its service provider, OCM, following consultation with key members of the CHS Network Executive throughout March and April 2025. These discussions focused on identifying priority areas where internal audit could deliver the most value. Following these consultations, a prioritisation process was undertaken with the Chief Executive Officer (CEO). The resulting proposed plan was then presented to the Network Executive Committee for endorsement, ahead of its formal approval by the ARMC in May 2025 and the CEO in June 2025.



Once finalised, the IAP will be regularly monitored with a mid-cycle review scheduled to ensure it remains current and aligned with strategic priorities and enterprise risks. In the next financial year, OCM and the Internal Audit, Risk and Compliance team will look to develop a three-year Internal Audit Plan to allow for a strategic forward view of the internal audit schedule as well as to assist areas in preparing and planning for internal audits.

Annual Independence declaration

The Head of Internal Audit (HIA) confirms the ongoing independence of the internal audit function throughout the 2024-25 financial year. As the HIA is also the Senior Director Internal Audit, Risk and Compliance, there may be a perceived impairment of independence during the conduct of the Risk Management internal audit. Safeguards to ensure independence was preserved included:

- An external service provider, KPMG, conducted the internal audit and reported the results to the Audit Sponsor.
- The Audit Sponsor was the Deputy Chief Executive Office (DCEO), which the HIA does not functionally or administratively report to.
- Consultation included the Director, Risk Management, Executive Group Manager (EGM), Quality, Safety and Governance (QSG), and DCEO.
- The HIA reviewed the report, however results and recommendations were directly discussed and reviewed by the EGM QSG and DCEO.
- Final review and endorsement was obtained through the ARMC.

There were no other incidents where independence may have been impaired.



Attachment A - Summary of Internal Audits completed in 2024-25

Internal Audit and objective	Key findings and issues	Key recommendations
Cancer Services Performance Measures Review Objective: Review Cancer Services' current performance measures relating to cancer services.	• Cancer Services performance measures align to the National Safety and Quality Health Service (NSQHS) standards and CHS frameworks and policy. Measures relating to the NSQHS are reported on regularly to support compliance with the standards, with governance arrangements in place. • There is limited documentation of performance measures (outside of required reporting relating to the National Safety and Quality Health Service standards) with varying levels of awareness and monitoring within the division. (D,S)	• Document and map performance measures for Cancer Services. Status: Significantly delayed, implementation of this recommendation is well underway; however, an extension has been approved to allow time for the Digital Support Division to build the capability to extract the required reports from the Digital Health Record.
Finance and HR Delegations Objective: Examined the finance and HR delegation frameworks and assessed the processes underpinning their management to ensure delegation instruments and schedules are relevant, appropriately maintained, updated, authorised and understood by staff.	• CHS is using a risk-based approach to the delegation hierarchy that empowers personnel to undertake actions calibrated to their capabilities. • Limited delegations are in place for the approval of asset disposal. (D)	• Investigate the appropriateness of the current delegation related to asset disposals and write offs. Status: Implemented within the required timeframe.

Internal Audit and objective	Key findings and issues	Key recommendations
Risk Management Objective: Assess the effectiveness of the current overarching Risk Management framework and practices within CHS and provide a view of the maturity of current risk management practices.	- There was observed engagement with and awareness of the risk management framework throughout the organisation, with mature systems for risk governance, assessment, monitoring and reporting. - WHS risks, which were documented and monitored in separate risk registers and forums to clinical and corporate risks, were not always aligned with enterprise risks in the process of communicating and escalating risks. (G, R, S) - There are inconsistent practices and understanding of procedures around risk reporting and escalation of risks, as well as closing the feedback loop from Executive or committee action (G, R, S)	- Review the processes to integrate high and extreme WHS risks into the central integrated risk register for the operational level business area, enabling escalation as appropriate. Status: Significantly delayed, work is ongoing to implement this recommendation and is anticipated to be closed at the September 2025 meeting. - Review the communication, escalation and decisions made around risks, including through committees, across divisions and other management structures. Status: Significantly delayed, work is ongoing to implement this recommendation and is anticipated to be closed at the September 2025 meeting.
Capital Works Objective: Assess the effectiveness of planning and delivery of capital projects for CHS, with a consideration of how to improve the delivery estimation, timing, cost, and original scope and manage change.	- There is consistent documentation from Project Control Group meetings and monthly reporting. - The procedures and practices of project management governance are poorly defined, documented and implemented, resulting in risk of project cost overrun and/or delays. (D, G) - Deficiencies were found in the documentation of schedule management,	- Establish CHS governance body to strengthen second line assurance, which includes review of project reports and project controls. Status: Minor delays, work is ongoing to implement this recommendation and is anticipated to be closed at the September 2025 meeting. - Review where responsibility should lie to capture project management policy and



Internal Audit and objective	Key findings and issues	Key recommendations
	risk management, contingency calculations and management, and change control procedures throughout the project lifecycle. (D,R,S) Cost planning guidelines (<i>NSW Health Cost Planning and Reporting guidelines and the CHS Supplementary Cost Planning guidelines</i>) and reporting standards are not being sufficiently complied with. (G)	guidance and undertake gap analysis of CHS project governance arrangements including updating existing governance resources / documents and outlining iCBR's scope on non-designated projects. Status: Minor delays, work is ongoing to implement this recommendation and is anticipated to be closed at the September 2025 meeting. - CHS to investigate actions to improve the integrated project control environment (schedule, cost, risk, change control and documentation) and level of required adequate assurance processes. Status: Minor delays, work is ongoing to implement this recommendation and is anticipated to be closed at the September 2025 meeting. - Develop a comprehensive user group engagement strategy and change control process that clearly outlines early stakeholder engagement, timelines, and mechanisms to capture, implement, and highlight impacts of end user feedback. Status: Minor delays, work is ongoing to implement this recommendation and is anticipated to be closed at the September 2025 meeting.

Internal Audit and objective	Key findings and issues	Key recommendations
Asset Management (Clinical Equipment) Objective: Review the approach to Clinical Equipment Asset Management within CHS. The review considered frameworks, policies, and practices, including the integration into the budget, planning and reporting process.	• There is established collaboration between relevant teams, including Shared Services, with monthly reporting on performance trends and projects. • Limited documentation is available around strategic asset management and to support the procurement, operation, maintenance and disposal of the assets sampled for detailed testing. (D) • Variances were noted in the values, dates and lifespans of assets between the Asset Register (Mainpac) and the financial records. (R) • There is a need for sufficient consultation throughout the procurement cycle. (S) • Demand for frontline support related to healthcare technology assets is increasing. (S, R) • There is inconsistent compliance with procurement procedures. (D, S, R)	• CHS to finalise the Management of Healthcare Technology Operational Procedure. Investigate accountability and relevant governance arrangements as they pertain to clinical assets. Development of SAMP by responsible area. Status: On track to be implemented within the required timeframes. • Investigate increased involvement for HTM in procurement processes, for example during the contract negotiation phase. Status: On track to be implemented within the required timeframes. • Explore ways and provide options to enhance the controls surrounding Mainpac and the Financial Records. Status: On track to be implemented within the required timeframes. • Investigate ways to optimise the support provided by HTM resources including Frontline Support staff. Status: On track to be implemented within the required timeframes.

Internal Audit and objective	Key findings and issues	Key recommendations
Clinical Practice Management – Variations of Care Objective: Assess the effectiveness of current practices in identifying, evaluating, tracking, reporting, and responding to clinical variations.	- For the committees in scope, there was consistent recording of risks and safety and quality improvements. - Practices were largely reactive and not undertaken for the purpose of capturing variations in clinical care. (G, R) - Lack of endorsed organisation wide frameworks, policies and guidance to support CHS' alignment with NSQHS clinical governance standard 1.28 and maintain a consistent approach. (D, G, R) - Lack of clear ownership and responsibility for maintaining consistency in outcomes. (G, R)	- Develop a standardised policy and/or guidance document relating to clinical variations. Status: On track to be implemented within the required timeframes. - Develop an implementation plan to operationalise the policy and/or guidance relating to clinical variations. Status: On track to be implemented within the required timeframes.

Linkage to key themes:

D: Documentation of internal processes

S: Staff engagement/collaboration

G: Governance arrangements

R: Risk management and monitoring





Choose a Directorate:

Ministerial Brief

To:	Minister for Health	Tracking No.: MCHS25/411
Date:	04/08/2025	
From:	Janet Zagari, Chief Executive Officer	
Subject:	Update on Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Accreditation	
Critical Date:	15/08/2025	
Critical Reason:	RANZCOG will be attending Canberra Hospital on 15 August 2025 for the Reaccreditation of the Maternal Fetal Medicine Unit	

Recommendation

That you:

1. Note the information contained in this brief.

Noted / Please Discuss

Rachel Stephen-Smith MLA/...../.....

Minister's Feedback

Background

1. On 29 May 2025, you were provided with an update on the progress to the outcomes of the RANZCOG Accreditation Review Visit (ARV) conducted in May 2024, as well as the subsequent Virtual Site visit in November 2024 (Attachment A).

Issues

2. An update on the actions taken to date for each item is provided at [Attachment B](#), along with expected completion dates where applicable. Some actions are intended to become part of business-as-usual (BAU) operations and will remain ongoing without a specific completion date.
3. Canberra Health Services (CHS) has embedded an additional eleven initiatives into business as usual (BAU) practices to support trainee development and clinical oversight:
 - **Regular Supervisor Meetings:** Ongoing meetings with training supervisors ensure clinical oversight of the roster and equitable allocation of duties for trainees.
 - **Integrated Training Program Oversight:** Regular coordination between the Integrated Training Program Coordinator and the Senior Registrar ensures structured teaching and training opportunities, particularly in after-hours settings.
 - **Clear Escalation Pathways:** Trainees have been informed of the appropriate processes for escalating concerns and reporting consultant non-attendance during after-hours.
 - **Monthly Schedule Coordination:** The Senior Registrar, Unit Lead, and Operations Manager meet monthly to finalise schedules, including caesarean lists, ward rounds, and ultrasounds. A standing monthly ultrasound roster supports training needs, with rotating registrar participation.
 - **Education Sessions Embedded:** Fortnightly education sessions, alternating between Registrar Teaching and Journal Clubs, are now integrated into the roster. Outpatient and acute rosters are adjusted to facilitate trainee attendance.
 - **Advance Roster Publication:** Trainee rosters are now published ahead of each term to improve planning and communication.
 - **Clinic Scheduling Aligned with Roster:** Monthly coordination meetings ensure clinic bookings align with registrar availability. Clinics are not scheduled unless registrar attendance is confirmed.
 - **Credentialing Oversight:** Credentialing progress is monitored by both the Registrar and Teaching Supervisor to ensure increased procedural exposure and opportunities for trainees to act as primary operators.
 - **Theatre Training Prioritisation:** The Senior Registrar and two designated trainees are responsible for prioritising access to training opportunities in Operating Theatre lists.
 - **Bully, Harassment and Discrimination Measures Embedded:** All strategies to address bullying, harassment, and discrimination (including workshops, training, and targeted programs) have been fully embedded.
 - **Consultant Roster Review:** Consultant rosters have been amended and are under continuous review to ensure appropriate hours and support staff availability, maximising training access for trainees.
 - **Hot Debrief Process:** A formalised 'hot debrief' process has been instituted and is regularly audited during Consultant meetings.

4. For your awareness, RANZCOG will be attending Canberra Hospital on 15 August 2025 for the Reaccreditation of the Maternal Fetal Medicine Unit. In preparation for this site visit, Women, Youth and Children submitted the Application for Accreditation as a Maternal Fetal Medicine Training Unit and supporting documentation on 15 July 2025.

Financial Implications

5. Nil

Consultation

Internal

6. Nil

Cross Directorate

7. Nil

External

8. Nil

Work Health and Safety

9. Work is continuing to create a positive work culture within the multidisciplinary teams in Women, Youth and Children and across the broader CHS.

Benefits/Sensitivities

10. RANZCOG noted that since the May 2024 visit, Canberra Hospital has been acting to improve the training program and cultural safety for trainees.
11. If RANZCOG training accreditation is suspended, there will be an impact on staffing with loss of RANZCOG Integrated Training Program (ITP) registrars from Canberra Hospital.

Communications, media and engagement implications

12. RANZCOG training accreditation has previously attracted media attention. Media lines will be prepared as required.

Signatory Name: Janet Zagari, Chief Executive Officer Phone: 5124 6799

Action Officer: Dr Jane Van Diemen, WYC Clinical Director Phone: 5124 7500

Attachments

Attachment	Title
Attachment A	MCHS25/303 – RANZCOG Report Update
Attachment B	RANZCOG Standard Summary Actions in response to Conditions



Canberra Health Services

To: Minister for Health

Tracking No.: MCHS25/303

Date: 03/06/2025

From: Dave Pepper, Chief Executive Officer, Canberra Health Services

Subject: Update on Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) Accreditation

Critical Date: Not applicable

Critical Reason: Not applicable

Recommendation

1. That you note the information contained in this brief.

Noted Please Discuss

Rachel Stephen-Smith MLA

20/7/25

Minister's Office Feedback

Thank you for the update and apologies for the delay in formally signing off.

Background

1. A brief, included at Attachment A, was provided to you on 24 March 2025 on the updates of progress on the outcomes from the RANZCOG Accreditation Review Visit (ARV) in May 2024 and the subsequent Virtual Site visit in November 2024.
2. You requested Canberra Health Services (CHS) provide expected completion dates for actions that remain outstanding and how CHS will review/audit the changes to ensure they remain in place and are working positively.

Issues

3. An update on the actions undertaken to date in response to each item is provided at Attachment B, including expected completion dates where applicable. Some actions are intended to transition into business-as-usual (BAU) operations and will therefore remain ongoing without a defined completion date.
4. To aid the sustainability and effectiveness of recent changes, to ensure they remain in place and are working positively, CHS has implemented a multi-faceted review and audit framework. This includes both formal and informal mechanisms to monitor progress and identify areas for continuous improvement:
 - **Education Attendance:** Attendance at educational sessions is being formally audited to track engagement and identify trends over time. This data will inform future scheduling and content planning to maximise participation and relevance.
 - **Mandatory Training Compliance:** Completion rates for mandatory training modules are being systematically monitored to ensure all staff meet required standards. Non-compliance is followed up through established governance processes.
 - **Junior Medical Officer (JMO) Feedback:** JMO-related issues are being informally audited through monthly meetings, providing a regular forum for feedback, discussion, and responsive action. This approach allows for timely identification and resolution of emerging concerns.
 - **Primary Operator Numbers:** Procedural exposure and primary operator numbers are being audited to ensure equitable access to training opportunities and to support competency development across the workforce.

This comprehensive approach will be reviewed periodically to ensure it remains fit for purpose. Adjustments will be made as necessary to maintain a high standard of clinical education, training, and workforce support.

5. CHS acknowledges the delay in meeting **Condition 3**, as outlined in section 3.2.5, there has been significant and proactive steps taken to address the challenges in recruiting Obstetrics and Gynaecology (O&G) consultants.

In response to the national workforce shortage, CHS has implemented a multi-pronged recruitment strategy. Recent campaigns in late 2024 and early 2025 have targeted both O&G Staff Specialists and alternative workforce models, including Career Medical Officers (CMOs) and Senior Career Medical Officers (SCMOs). These roles are designed to attract experienced clinicians, including those with international qualifications who may not yet hold specialist recognition with RANZCOG. While the most recent campaign did not yield suitable candidates, this approach reflects CHS' commitment to exploring all viable workforce solutions.

CHS continues to actively pursue local recruitment, despite the competitive challenges posed by higher remuneration packages offered interstate and by locum agencies. To

enhance our competitiveness, CHS is reviewing recruitment incentives and exploring innovative workforce models.

International recruitment efforts have shown promise, with several candidates progressing through the pipeline. Although onboarding timelines are extended due to regulatory and qualification processes, these candidates represent a valuable medium-term solution. CHS is working closely with relevant authorities to streamline these processes wherever possible.

Importantly, CHS is investing in the future workforce by supporting current O&G trainees expected to achieve fellowship within the next 12 months. These individuals are being actively considered in workforce planning and budget allocations to ensure a sustainable pipeline of qualified specialists.

In parallel, CHS has initiated discussions on restructuring leadership roles and clinical portfolios to better align with evolving service needs. These discussions are being informed by ongoing recruitment outcomes and the availability of clinicians with the requisite skills and experience.

CHS remains committed to delivering high-quality care and is taking decisive, forward-looking action to strengthen the O&G workforce in the ACT.

Most recently CHS conducted interviews for O&G Senior Registrar positions, two applicants were found suitable; one is due to commence in August 2025 and the other in February 2026.

6. CHS recognises the importance of ensuring trainees are appropriately supported and encouraged to act as primary operators in line with their level of training and competency. In response to **Condition 6**, CHS has developed a structured framework to ensure clarity, accountability, and continuous improvement in this area which includes:

Clear Guidelines and Shared Expectations

- CHS is finalising a set of guidelines outlining expectations for trainees to act as primary operators, tailored to their year level and demonstrated ability.
- These guidelines are being embedded into departmental orientation materials and reinforced through regular team briefings to ensure a shared understanding across the department.

Credentialing and Supervision

- Trainee credentialing is formally reviewed by both the Registrar and Learning Supervisor at three-month and six-month intervals.
- These reviews assess procedural competency, readiness to act as primary operator, and alignment with training goals.

Tracking and Escalation Mechanisms

- CHS is actively encouraging the use of QR code-linked forms, to allow trainees to log primary operator experiences in near real-time and with relative anonymity.
- Data collected will be reviewed regularly at consultant meetings to ensure accountability, identify gaps, and escalate concerns where necessary.

Enhancing Exposure and Opportunities

- Efforts are underway to increase surgical exposure for trainees through improved rostering, prioritisation of training cases, and equitable distribution of procedural opportunities.
- Surgical skill workshops have been developed to provide trainees with hands-on experience prior to participating in live operations. These workshops are designed to build confidence and competence in a controlled environment.

CHS is committed to fostering a supportive and structured training environment that prioritises both patient safety and the professional development of junior medical staff. These measures will be regularly reviewed to ensure they remain effective and aligned with best practice.

Financial Implications

7. Nil.

Consultation

Internal

8. Nil.

Cross Directorate

9. Nil.

External

10. Nil.

Work Health and Safety

11. Work is continuing to create a positive work culture within the multidisciplinary teams in Women, Youth and Children and across the broader CHS.

Benefits/Sensitivities

12. RANZCOG noted since the May 2024 visit, Canberra Hospital has been acting to improve the training program and cultural safety for trainees.
13. If RANZCOG training accreditation is suspended, there will be an impact on staffing with loss of RANZCOG Integrated Training Program (ITP) registrars from Canberra Hospital.

Communications, media and engagement implications

14. RANZCOG training accreditation has previously attracted media attention. Media lines will be prepared as required.

Dave Pepper, Chief Executive Officer

Phone: 5124 4700

Dr Jane Van Diemen, Divisional Clinical
Director, Women, Youth and Children

Phone: 5124 7500

Attachments

Attachment	Title
Attachment A	MCHS25/145 – RANZCOG Report Update
Attachment B	RANZCOG Standard Summary Actions in response to Conditions

RANZCOG Standard Summary Actions in response to Conditions

		2023	2024
Number of Standards Unchanged	25		
Number of Standards Improved	31		
Number of Standards Worsen	4		
Number of MET		16	42
Number of Partially MET		21	21
Number of UNMET		23	8

STANDARD 1 – SUPPORT FOR RANZCOG OFFICERS AND ENGAGEMENT WITH TRAINING SITE ACCREDITATION PROCESSES				
Standard				
1.1	Access for the ITP coordinator			
	2023	Met	2024	Met
1.1.2	Assisting with the provision of training opportunities and experiences, and the communication of trainee issues			
	2023	Not Met	2024	Partially Met
Recommendation A	Monitoring of training and service needs should continue to ensure trainees within the ITP can meet training requirements, alongside improved relationships and flexibility with other sites in the ITP.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	CHS continue to assess and adjust training support as needed while also fostering stronger relationships and greater flexibility with other sites within the ITP to enhance the overall training experience.			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
1.2	Where a RANZCOG ITP Coordinator is employed by the Training Site, they are provided with a minimum of one paid and protected session per fortnight to enable them to carry out their duties effectively.			
1.2.1	Training site support			
	2023	Not Met	2024	Partially Met

Recommendation B	Support for the ITPC should continue at a hospital level, with a view to optimising the training opportunities available on site and within the ITP.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	A Training and Accreditation Officer has been appointed to support the ITP			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
1.3	The Training Site engages with and facilitates training site accreditation processes.			
1.3.1	Accreditation Visit			
	2023	Met	2024	Met
1.3.2	Progress reports and other interactions			
	2023	Met	2024	Met
OVERALL ASSESSMENT OF STANDARD 1				
	2023	Not Met	2024	Partially Met
STANDARD 2 – APPOINTMENT AND SUPPORT OF TRAINING SUPERVISORS				
2.1	An appropriate number of Training Supervisors has been appointed to ensure FRANZCOG trainees receive effective education and clinical supervision			
2.1.1	Ratio of Training Supervisors and Onsite Presence			
	2023	Partially Met	2024	Met
2.2	Training Supervisors receive support from the Training Site to undertake their supervisory roles.			
2.2.1	Support for Training Supervisors			
	2023	Not Met	2024	Met
2.3	Training Supervisors undertake training and professional development activities in order to perform their supervisory role			
2.3.1	Training Supervisor workshops and upskilling activities			
	2023	Met	2024	Met

2.4	Training Supervisors carry out their roles and responsibilities as outlined in the RANZCOG Training Supervisor Position Description.			
2.4.1	Roles and Responsibilities			
	2023	Partially Met	2024	Met
Recommendation C	The clinical workload at a consultant level should be monitored on an ongoing basis to ensure that Training Supervisors are able to fulfil their roles and responsibilities in a sustainable manner. It would be beneficial for this to include ensuring that job plans are up to date and accurate, with minimal lastminute adjustments			
2.4.2	Training Program Requirements			
	2023	Met	2024	Met
2.4.3	Rosters			
	2023	Not Met	2024	Not Met
Condition 1	Training Supervisors must have oversight and involvement in roster development for trainees in order to ensure that training opportunities (in particular the allocation of operating lists) are distributed equally and in line with individual training needs. It should be clear to all staff who has responsibility for and oversight of the rostering for different aspects of training (e.g. labour ward, clinics, theatre lists, education, leave allocations).			
CHS response (as of 20-1-25)	Clinical oversight for roster provided by O&G Senior Registrar, in conjunction with training supervisors, to ensure appropriate and equitable allocation for trainees.			
CHS response (as of 17-3-25)	A structured monthly meeting with the ITPC and the O&G Senior Registrar has been established to ensure clinical oversight of roster and appropriate and equitable allocation for trainees.			
CHS response (as of 19-5-25)	The ITPC and the O&G Senior Registrar meet regularly to ensure clinical oversight of roster and appropriate and equitable allocation for trainees.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			

OVERALL ASSESSMENT OF STANDARD 2				
2023	Partially Met		2024	Partially Met
STANDARD 3 – CONSULTANT INVOLVEMENT WITH AND SUPPORT FOR FRANZCOG TRAINEES				
3.1	There is an adequate number of senior medical staff to provide effective training, support and supervision of FRANZCOG trainees.			
3.1.1	Consultant staffing			
	2023	Not Met	2024	Partially Met
Recommendation D	Future efforts to support consultant staffing numbers and recruitment should focus on sustainability in consultant rostering and protection against burnout, and ensuring that senior staffing levels remain such that the full extent of training available remains accessible			
CHS response (as of 20-1-25)	Current recruitment round for consultants being finalised.			
CHS response (as of 17-3-25)	Consultant recruitment has been finalised. One FTE will commence in May 2025. A second Staff Specialist has been recruited with the start date pending due to an international relocation and AHPRA requirements.			
CHS response (as of 19-5-25)	The Consultant is due to commence in June 2025. A three year recruitment plan has been developed for the department. Phase 1 expected completion end 2025. Phase 2 expected completion end 2026. Phase 3 expected completion end 2027.			
CHS response (as of 20-7-25)	The revised O&G Consultant start date is October 2025, due to delays in AHPRA recognition and immigration. An additional recruitment process for O&G Consultants is due to commence in September 2025.			
3.1.2	Consultant provision of training, support and supervision			
	2023	Not Met	2024	Partially Met
Recommendation E	When recruiting for consultants, the hospital is encouraged to offer greater flexibility in working arrangements in order to attract a wider range of consultants who may provide longer-term commitment to a role if bespoke arrangements can be accommodated.			

CHS response (as of 20-1-25)	Current recruitment round for consultants being finalised.			
CHS response (as of 17-3-25)	CHS has strengthened its partnership with stakeholders from the consultant group, particularly the unit lead, as well as the People and Culture and Talent Acquisition streams, to address this recommendation.			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
3.2	FRANZCOG Consultants are actively involved and engaged in the teaching and training of Registrars in theatre, clinics and on the wards and birthing suite.			
3.2.1	Consultant position description or statement of duties			
	2023	Met	2024	Met
3.2.2	Appropriate Consultant Support			
	2023	Not Met	2024	Partially Met
Recommendation F	As the culture continues to stabilise and further improve, it would be beneficial for the consultant attendance audit to adapt in line with this and promote a culture of trust and support.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	Attendance and expectations discussed at monthly consultant meeting. In collaboration with the clinical and unit leads, consultant guidelines (rules) have been drafted to outline these expectations. Each staff specialist has reviewed and provided a signed copy of these guidelines (rules).			
CHS response (as of 19-5-25)	CHS consider this recommendation as met and imbedded as business as usual.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
3.2.3	Appropriate After-Hours Supervision and Teaching			
	2023	Not Met	2024	Not Met
Condition 2	Further work must be done on the after-hours roster (particularly in terms of structure) in order to ensure that trainees regularly have access to teaching and training opportunities in an after-hours setting. It was suggested that there could be more thought to the composition (in terms of pairing juniors and seniors, being mindful of ability/training, and an overall understanding of the general acuity in the service).			

CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	A structured monthly meeting with the ITPC and the O&G Senior Registrar has been established for clinical oversight of roster to ensure trainees have access to teaching and training opportunities in an after-hours setting.			
CHS response (as of 19-5-25)	Structured meetings are occurring regularly with the ITPC and the O&G Senior Registrar to ensure clinical oversight of roster so that trainees have access to teaching and training opportunities in an after-hours setting.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
3.2.4	On-call Arrangement			
	2023	Partially Met	2024	Partially Met
Recommendation G	All trainees (and other staff in the department) should be aware of how to escalate non-attendance from consultants when on call, and should be assured there are no consequences for appropriate escalation and reporting.			
Commendation 1	The cohort of regular locum consultants are to be commended for the excellent support provided afterhours and as part of the on-call roster.			
CHS response (as of 20-1-25)	Trainees advised of appropriate methods of escalation and reporting non-attendance from consultants after-hours.			
CHS response (as of 17-3-25)	As above.			
CHS response (as of 19-5-25)	Issues are escalated as required.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
3.2.5	Team Structure			
	2023	Not Met	2024	Not Met
Condition 3	An update is required on the team structure implemented from the start of the 2024 clinical year. In refining this further, the department are encouraged to utilise creative solutions and focus on the outcomes (high quality and continuity of patient care whilst maximising teaching, learning and training opportunities) rather than feeling tied to a more traditional team structure that may not be fit for purpose in the context of the unit.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	It is anticipated that additional recruitment of consultants may in part address this condition. Further restructure to be considered when final 2025 recruitment numbers established (pending overseas appointment).			

CHS response (as of 19-5-25)	Discussions have begun regarding restructure of leadership positions and portfolios, however this is entirely dependent on the both the recruitment of a sufficient number of candidates and the recruitment of clinicians with sufficient skills and experience.			
CHS response (as of 20-7-25)	Discussions regarding restructure of leadership positions and portfolios is ongoing.			
3.2.6	Role of consultant			
	2023	Not Met	2024	Partially Met
Recommendation H	Consultants should be physically present on ward rounds more often in order to support teaching and learning in this setting			
Recommendation I	Ongoing support for the consultant cohort from the executive team is encouraged to continue, contributing to meaningful two-way dialogue between the consultants and the hospital which will reinforce the progress made so far.			
CHS response (as of 20-1-25)	Increased presence of consultants at ward rounds. Clinical Director appointed for Division of Women, Youth and Children to provide additional executive support to O&G Medical Director and consultant group.			
CHS response (as of 17-3-25)	The emphasis remains on enhancing consultant presence during ward rounds Clinical Director appointed for Division of Women, Youth and Children to provide additional executive support to O&G Medical Director and consultant group.			
CHS response (as of 19-5-25)	VMOs/Registrars/Trainees are encouraged and enabled to develop necessary skills to run ward rounds, both with direct and indirect consultant supervision. Work is in progress with more focus being put into job plans to prevent a potential mismatch of expectations.			
CHS response (as of 20-7-25)	Work is ongoing.			
3.2.7	Consultant Support in Clinics			
	2023	Not Met	2024	Partially Met
Recommendation J	While there have been some improvements to the running of clinics it would be beneficial to continue this and ensure that clinics are consultant-led, trainees are able to take advantage of the training available to meet their training needs, and that there is a more equitable training experience.			
CHS response (as of 20-1-25)	Continuing.			
CHS response (as of 17-3-25)	Continuing improvements.			
CHS response (as of 19-5-25)	CHS is consistently rostering 2 consultants; 1 consultant is seeing the patients, and the other is available and “roaming” for the junior doctors to consult/seek assistance if required.			

CHS response (as of 20-7-25)	The feedback from the second consultant being rostered for the trainees to consult with in the clinic has been positive. This rostering will continue.			
OVERALL ASSESSMENT OF STANDARD 3				
2023	Not Met		2024	Partially Met
STANDARD 4 – PROVISION OF CLINICAL SUPERVISION AND EXPERIENCE				
4A.1	Trainees are provided with the appropriate clinical supervision and experience to meet training program requirements and to ensure the progression of clinical competence from ‘novice’ to ‘proficient’.			
4A1.1	Clinical Experience			
	2023	Not Met	2024	Partially Met
Recommendation K	Given the increased stability at the hospital (as the base hospital for the ITP), it would be beneficial to assess the different experiences available across the ITP and ensure that the pathway(s) taken when training in the Canberra ITP are optimised and make the most of that variety of experience.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	Regular meetings between ITPC and trainees and opportunities to provide feedback, both formal an informal, are being established.			
CHS response (as of 19/5/25)	Clinical experience is demonstrated with the ongoing arrangement TCH has with NCH. A Memorandum of Understanding between CHS and NSW Health is being finalised to further streamline the seconded learning pathways. Expected completion is July 2025.			
CHS response (as of 20-7-25)	MOU progressing. Revised completion date September 2025.			
4A1.2	Assessment of Procedural and Surgical Skills (APSS)			
	2023	Not Met	2024	Met
4A1.3	Increased Responsibilities			
	2023	Met	2024	Met
Recommendation L	Efforts should be made to stick to the agreed job plans wherever possible, with changes communicated well in advance, to ensure that trainees are prepared for specific areas of training that meet their needs.			

4A1.4	Roster Requirements – Basic Trainees			
	2023	Not Met	2024	Partially Met
Recommendation M	The identified areas (caesarean section lists, ward round attendance, and ultrasound) alongside other key training areas should be consistently included in rosters and equitably available to all trainees			
CHS response (as of 17-3-25)	Rostering adheres to the job plans of the individual registrars. Monthly meetings occur with the senior registrar, unit lead, and operations manager to ensure schedules are locked in, including caesarean lists, ward rounds, and ultrasounds. There is an ongoing monthly, rostered arrangement for dedicated ultrasound to address training requirements, with registrars rotating through for this support. Fortnightly education sessions, alternating between Registrar Teaching and Journal Clubs, have become part of the roster, with outpatient and acute rostering considerations made to maximise attendance.			
CHS response (as of 19-5-25)	Ongoing clear communication with the Basic Trainees in regard to their roster.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
Recommendation N	Rosters should be better managed in terms of notice and it should not be the responsibility of the trainee to manage day-to-day cover			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	Rosters are now published in advance for the trainees for the term.			
CHS response (as of 19-5-25)	The ITP has received positive feedback regarding these changes. CHS consider this recommendation as met and imbedded as business as usual.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
4A1.5	Support by Colleagues and Juniors for FRANZCOG Trainees, including After Hours			
	2023	Partially Met	2024	Met
4A1.6	Experience in Clinics			
	2023	Partially Met	2024	Partially Met
Recommendation O	It would be beneficial to adjust the processes for booking and managing clinics to ensure they are not overbooked, and able to be used for teaching rather than just service.			
CHS response (as of 20-1-25)	Under review.			

CHS response (as of 17-3-25)	Monthly meetings occur with the O&G senior registrar, unit lead, and operations manager to ensure schedules are locked in. Booking and scheduling now aligns with registrar availability, and schedules are not booked unless their attendance are confirmed.			
CHS response (as of 19-5-25)	Monthly meetings continue to occur with the O&G senior registrar, unit lead, and operations manager to ensure schedules are locked in.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
4A1.7	Policies, Procedures and Clinical Guidelines			
	2023	N/A	2024	Partially Met
Recommendation P	Obstetrics decision making should be monitored to ensure that trainees are exposed to best practice and up to date, evidence-based care, and there are clear expectations set across all O&G staff.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	CHS Maternity Model of Care and Model of Service documents currently undergoing review and redesign.			
CHS response (as of 21-5-25)	The Network Operation Committee discussed and endorsed the Model of Care/Model of Service at the 19 May 2025 meeting.			
CHS response (as of 20-7-25)	The Model of Care/Model of Service is undergoing staged implementation.			
4A1.8	Birth Suite Handover			
	2023	Partially Met	2024	Met
Recommendation Q	It would be beneficial (and contribute to continued respectful discourse) to focus on the educational opportunities in birth suite handover, highlighting the evidence-based practice in use and expanding on the detail and information where possible.			
4A1.9	Training in Expanded Settings			
	2023	Met	2024	Met
4A1.10	FRANZCOG Trainee In-Training Site Credentialing			
	2023	Partially Met	2024	Not Met
Condition 4	There must be zero tolerance for staff requesting trainees to perform procedures that they are not credentialed for.			
Recommendation R	It would be beneficial for the credentialing document to extend across all types of training/oversight, with an emphasis on building a transparent and accountable culture.			
CHS response (as of 20-1-25)	A register of skills/credentialing document has been re-established as an accessible means of tracking skill level and procedure capability for trainees.			

CHS response (as of 17-3-25)	Credentialling/tracking skill level and procedure capability for trainees continues. Document to be updated every six (6) months, with online copy available and hard copy available in Delivery Suite.			
CHS response (as of 20-7-25)	Credentialling/tracking skill level and procedure capability for trainees continues. Document to be updated every six (6) months, with online copy available and hard copy available in Delivery Suite.			
4A.2	Advanced trainees are provided with the appropriate clinical opportunities to enable them to undertake either a 'Generalist' or 'Non-Generalist' Pathway and relevant Advanced Training Modules (ATMs) during their Advanced Training.			
4A2.1	Advanced Clinical Experience			
	2023	N/A	2024	Met
4A2.2	Professional Attributes			
	2023	N/A	2024	Met
4A.3	Training Sites have processes in place that allow trainees to access patient information for training purposes.			
	Patient Consent			
	2023	Met	2024	Met
4.B	Trainees are provided with sufficient gynaecological surgical experiences, under appropriate supervision, to meet training requirements and to ensure the progression of surgical competence from 'novice' to 'proficient'.			
4B.1.1	Gynaecological Surgery Lists			
	2023	Partially Met	2024	Not Met
Condition 5	Regardless of ITP performance, Canberra Hospital must continue making significant progress towards two-thirds of the >23 procedures target per six-monthly training period (i.e. an average of >15.33 major procedures as primary operator per Basic Trainee) by the training period February 2025-August 2025. Refer to Strategies for Training Hospitals to improve trainee Gynaecological Surgery Procedure Numbers.			
Recommendation S	Access to operating lists should be balanced and proportionate to staffing, and allocation (based on training needs and ability) should not be the responsibility of the registrar in charge of rosters, as this can contribute to a poor atmosphere in the registrar cohort.			
Recommendation T	At an ITP level and in conjunction with Canberra North Hospital, it would be beneficial to support operating on a regular basis at Queanbeyan Hospital (similar to the arrangement which was previously in place).			
CHS response (as of 20-1-25)	New rural rotation (Lismore) included for trainees to allow for increased exposure to major procedures. CHS is currently undertaking a review into list allocation for surgical teams.			

CHS response (as of 17-3-25)	Ongoing.			
CHS response (as of 19-5-25)	CHS continues to review list allocations for surgical team in addition to the creation of full day operating lists to increase efficiency in conjunction with NCH and Queanbeyan hospitals.			
CHS response (as of 20-7-25)	Ongoing.			
4B1.2				
	2023	Partially Met	2024	Not Met
Condition 6	There must be clear guidelines and expectations set around trainees (relevant to their year level and ability) being able and encouraged to act as the primary operator. This must be a shared understanding by the department as a whole with a means to track and escalate accordingly. Some measures used in other base hospitals include a QR code/associated form to track in close to real-time and with relative anonymity, with accountability via a regular consultant meeting.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	CHS to undertake discussions with RANZCOG to access trainee logbooks to support midterm reporting.			
CHS response (as of 19-5-25)	• Credentialling by Registrar and learning Supervisor at every 3 and 6 months. • Increase exposure and opportunities. • Surgical skill workshops developed to expose trainees to surgical procedures prior to commencing to operation.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
4B1.3	Primary Operator Experience – Basic trainees			
	2023	N/A	2024	Met
Recommendation U	Consideration should be given to a formal arrangement where more junior trainees can (as appropriate) act as an assistant to Advanced trainees, or act as Primary Operator with the supervision of an Advanced trainee			
4B1.4	Priority Access to O&G Theatre Lists			
	2023	Partially Met	2024	Partially Met
Recommendation V	This is another area in which it would be beneficial for someone with an overall view of training/supervision needs on site (in conjunction with the ITPC) to have oversight, in order to appropriately prioritise access to training opportunities, and ensure flexibility in rostering arrangements (see 1.2.1 for further discussion).			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	A Training and Accreditation Officer has been appointed to support the ITP			

CHS response (as of 19-5-25)	Additional responsibility given to Senior Registrar, rostering 2 x trainees for Operating Theatre lists.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
4C1.1	Ultrasound			
	2023	Not Met	2024	Met
4D1	Structured colposcopy training is in place to enable FRANZCOG trainees to meet the required competencies, including completion of their Colposcopy In-Training Site Clinical Assessments (IHCA)			
4D1.1	Colposcopy			
	2023	Partially Met	2024	Met
Recommendation W	As part of providing a holistic training experience, care should be taken that colposcopy clinics are a setting where training (including in-room supervision) is provided and prioritised.			
4E1	FRANZCOG trainees are provided with a range of opportunities and experiences in family planning, including clinics and relevant surgical opportunities (acknowledging any limitations on contraceptive and family planning training due to site-specific ethics guidelines)			
4E1.1	Family Planning			
	2023	Partially Met	2024	Met
Commendation 2	This clinic and the termination of pregnancy service offer both a valuable clinical service for the population and an excellent training opportunity, which the hospital are encouraged to continue including as part of rostered training.			
4E1.2	Long-Acting Reversible Contraception (LARC)			
	2023	Met	2024	Met
OVERALL ASSESSMENT OF STANDARD 4				
	2023	Not Met	2024	Partially Met

STANDARD 5 – PROVISION OF STRUCTURED EDUCATION PROGRAMS, TEACHING SESSIONS AND LEARNING OPPORTUNITIES				
5.1	A comprehensive education program is provided that includes Consultant-led hospital teaching, rounds, lectures, case presentations, ultrasound teaching, mortality and morbidity meetings, journal club, discussions, audits and reviews is provided.			
5.1.1	Coordination of Education Program			
	2023	Not Met	2024	Met
5.1.2	Education Program Content			
	2023	Not Met	2024	Partially Met
Recommendation X	Embedding the education program at a set time (which allows for most trainee access) and with a roster/topics in advance for consultants will allow for consistency in quality and content.			
CHS response (as of 20-1-25)	Education program developed with established times/days and topics published in advance.			
CHS response (as of 17-3-25)	Education program established. Plan for midterm feedback and evaluation of program.			
CHS response (as of 19/5/25)	Currently mid-term assessments underway.			
CHS response (as of 20-7-25)	Mid-term feedback has been provided to trainees.			
	2023	Partially Met	2024	Met
Commendation 3	The hospital is commended for the efforts made to stress the importance of regular guideline review and audit activity, and involve the trainees on a structured basis			
5.2	Rostering arrangements and strategies are in place to ensure that all FRANZCOG trainees have protected time to attend education sessions. FRANZCOG trainees are not rostered for other duties when education sessions are scheduled, except for the provision of emergency cover.			
5.2.1	Paid and Protected Non-Clinical Time			
	2023	Not Met	2024	Not Met

Condition 7	Efforts must be made to better protect education time (ideally by rostering unaccredited registrars to clinical duties at that time), and there must be a mechanism in place to ensure the same person does not miss out on education sessions.			
CHS response (as of 20-1-25)	A QR code system has been implemented for trainees to sign in to education sessions to allow for mapping of attendance. Unplanned repeated absences of trainees will be followed up.			
CHS response (as of 17-3-25)	QR code attendance system continues. Unplanned absences are followed up with trainee's supervisors.			
CHS response (as of 19/5/25)	CHS has revised the scheduling of the journal club to occur within standard working hours and aligned clinical duties accordingly. As a result of these adjustments, attendance has significantly improved.			
CHS response (as of 20-7-25)	The revised journal club schedule continues to facilitate improved attendance by registrars.			
5.3	Formal basic obstetric skills training sessions are provided for all Year 1 FRANZCOG trainees.			
5.3.1	Basic Obstetric Surgical Skills Training			
	2023	Met	2024	Met
5.4	Simulation training is offered to all FRANZCOG trainees.			
5.4.1	Simulation Training			
	2023	Not Met	2024	Partially Met
Recommendation Y	It would be highly beneficial for the hospital to support the department in expanding their access to more simulation training opportunities, particularly for more junior trainees. This includes access for the gynaecology department to new simulation initiatives in the surgical space.			
CHS response (as of 20-1-25)	Currently seeking quotes for updated surgical simulation equipment and systems for consideration.			
CHS response (as of 17-3-25)	Ongoing.			
CHS response (as of 19/5/25)	Awaiting funding stream for update of surgical simulation equipment. The expected outcome for the funding decision is due in July 2025.			
CHS response (as of 20-7-25)	CHS development of a clinical simulation program to be embedded in the regular education schedule. Awaiting outcome of surgical simulation equipment funding decision.			
5.5	FRANZCOG trainees have the opportunity to attend external education activities, meetings, courses and workshops.			
5.5.1	External Education Program			
	2023	Partially Met	2024	Met

5.6	FRANZCOG trainees are provided with regular opportunities to teach prevocational medical staff and medical students.			
5.6.1	Teaching Residents and Medical Students			
	2023	Met	2024	Met
5.7	FRANZCOG trainees undertaking Advanced Training are provided with additional educational opportunities.			
5.7.1	Advanced Courses, Workshops and Academic Development			
	2023	N/A	2024	Met
5.7.2	Teaching and Assessing of FRANZCOG Basic trainees			
	2023	N/A	2024	Met
5.7.3	Administration Duties			
	2023	N/A	2024	Met
5.8	In Training Sites with five consultants or more, at least one Consultant is a FRANZCOG Examiner, or has been within the last 10 years			
5.8.1	FRANZCOG Examiners			
	2023	Met	2024	Met
Recommendation Z	It would be beneficial to have more coordinated, consultant-led exam preparation accessible for trainees within the ITP who are undertaking exams.			
5.9	The O&G Department provides an adequate range of education resources to support the learning environment.			
5.9.1	Facilities for FRANZCOG trainees			
	2023	Met	2024	Met
5.10	Research opportunities and support and protected research/study time are provided to FRANZCOG trainees to undertake private study and their compulsory research project.			
5.10.1	Research Support and Commitment to Research			
	2023	Partially Met	2024	Met
Recommendation AA	The following areas could be further supported in order to ensure research is an ongoing priority: • Allocation of dedicated time (which trainees could be rotated through) • Research nurse/other support staff • Consideration for involvement in national trials • Utilising audits as part of a structured research program			

5.11	The Training Site provides an easily accessible obstetric database to assist FRANZCOG trainees with audit and research.			
5.11.1	Obstetric Database			
	2023	Met	2024	Met
5.12	The O&G Department conducts regular minuted Consultant meetings.			
5.12.1	Consultant Meetings			
	2023	Partially Met	2024	Met
OVERALL ASSESSMENT OF STANDARD 5				
	2023	Not Met	2024	Partially Met
STANDARD 6 – WORKPLACE CULTURE, REGISTRAR STAFFING, SAFE WORKING HOURS, LEAVE ARRANGEMENTS AND ASSISTANCE FOR RURAL ROTATIONS				
6.1	A supportive, harmonious workforce culture and team environment is evident.			
6.1.1	Consultants and Workplace Culture			
	2023	Not Met	2024	Partially Met
Recommendation BB	An update is requested on the progress to implementing a 360-degree feedback mechanism within the department, recognising that this kind of initiative must have the necessary support systems in place.			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	Process to establish program underway.			
CHS response (as of 19-5-25)	O&G consultant group has engaged a formal in-program (Herrmann Brain Dominance Instrument (HBDI)) to develop leadership skills. Initial planning sessions are underway with an expected completion of December 2025, this is due to the volume and availability of consultants.			
CHS response (as of 20-7-25)	Awaiting confirmation of availability of internal provider for HBDI sessions.			
6.1.2	Organisational Culture			

	2023	Not Met	2024	Partially Met
Recommendation CC	Continuing from the steps taken already, it would greatly benefit the department to see proactive engagement and advocacy from an organisational perspective. A forum with ongoing discussion, tangible actions, and transparent decision making would be strongly encouraged.			
CHS response (as of 20-1-25)	Development of organisation-wide CHS Wellness Strategy and creation of and recruitment into CHS Chief Medical Wellness Officer role.			
CHS response (as of 17-3-25)	Recent feedback from short-notice hospital assessment reported positive organisational culture was evident.			
CHS response (as of 19/5/25)	CHS Wellness Strategy and CHS Chief Medical Wellness Officer role now well established. There has been positive feedback on Organisational Culture from hospital wide consultation.			
CHS response (as of 20-7-25)	The Office of Clinical Training and Wellness is offering ongoing Medical Officer Learning and Teaching including Communication and Professional Development workshops and Teaching for Clinicians.			
6.1.3	Bullying, harassment, and discrimination			
	2023	Partially Met	2024	Not Met
Condition 8	Steps must be taken to ensure these issues are addressed in the appropriate manner, and that the current policy is fit for purpose. Appropriate lines of communication must be in place (particularly with regards to key areas such as rostering and theatres) to ensure all staff are able to voice their needs. The following may be useful resources as a starting point:			
Recommendation DD	Consideration should be given to translating the BHD policy and associated online training into a face-to-face experience with multidisciplinary participation			
CHS response (as of 20-1-25)	A number of immediate steps have been taken to address these issues, including: • O&G Consultant group participated in Emotional Intelligence and Compassion Workshop • O&G Consultant group participated in RANZCOG Respectful Workplace Workshop • O&G Consultant group participated in Speaking up for Safety (SUFS) face-to-face training workshop • Three-part Cultural Diversity and Inclusion program developed specifically for O&G Consultant group, to be delivered at regular monthly consultant meetings. • SUFS training for all new JMO's, registrars and trainees now including in 2025 CHS mandated orientation training days. • Introduction of two-day program specifically for CHS International Medical Graduate (IMG) doctors, designed to orientate international graduates to the Australian health system, including escalating concerns, speaking up for safety and safe communication. • Session held with International Medical Graduates (IMG's) within O&G speciality regarding speaking up to report inappropriate behaviours, including bullying and racism, within the workplace. Session facilitated by the CHS Director - IMG & Hospital Non-Specialist Doctors Education and Training and the CHS Director of Medical Training.			

CHS response (as of 17-3-25)	- All new CHS junior medical staff, including registrars completed mandatory training at orientation, including Cultural Awareness training and Speaking up For Safety (SUFS). - Three-part Cultural Diversity and Inclusion program developed specifically for O&G Consultant group, to be delivered at regular monthly consultant meetings.			
CHS response (as of 19-5-25)	Three-part Cultural Diversity and Inclusion program has been delivered.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
6.1.4	Support for trainees in difficulty			
	2023	Partially Met	2024	Met
6.2	A suitable number of junior medical staff is employed to ensure sufficient training opportunities exist for FRANZCOG trainees to meet training requirements, over and above meeting service requirements.			
	Trainee Staffing			
	2023	Not Met	2024	Partially Met
Recommendation EE	The focus in this area going forward should be on balancing the different training and support needs of junior staff, and ensuring flexibility in rostering arrangements so that the experience can be matched to the appropriate group(s).			
CHS response (as of 20-1-25)	Under review.			
CHS response (as of 17-3-25)	A structured monthly meeting with the ITPC and the O&G Senior Registrar has been established to ensure clinical oversight of roster and appropriate and equitable allocation for trainees.			
CHS response (as of 19/5/25)	Additional recruitment of JMOs is underway. CHS has successfully recruited two Senior Registrars, with anticipated commencement dates in August 2025 and February 2026, respectively.			
CHS response (as of 20-7-25)	Ongoing.			
6.3	The Training Site complies with award conditions relating to working hours and shift work relevant to the region in which it is located.			
6.3.1	Award Conditions – Working Hours			
	2023	Partially Met	2024	Met
6.3.2	Guide to Appropriate Hours			
	2023	Partially Met	2024	Partially Met

Recommendation FF	Rostered hours should continue to be monitored to ensure they align with appropriate working hours for a FRANZCOG Trainee and allow for the best access to training opportunities across the cohort. Efforts should be made to ensure staffing remains adequate to support this			
CHS response (as of 20-1-25)	CHS requested additional trainee position to be endorsed by RANZCOG to address trainee staffing shortages with planned and unplanned leave. RANZCOG declined to endorse additional trainee position at present. CHS will continue to make efforts to ensure staffing remains adequate.			
CHS response (as of 17-3-25)	Consultant roster was amended to align with the RANZCOG recommendations, and split shifts for weekends are occurring.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
6.3.3	Physical Safety and Security			
	2023	Met	2024	Met
6.4	The Training Site permits FRANZCOG trainees to undertake fractional training subject to the requirements of the Training Site and prospective approval by the Chair of the relevant State/Territory/New Zealand TAC.			
6.4.1	Fractional Training			
	2023	N/A	2024	Met
6.4.2	Leave Arrangements			
	2023	N/A	2024	Met
6.3.4	Training Whilst Pregnant			
	2023	N/A	2024	Met
6.4.4	Training After Taking Leave			
	2023	N/A	2024	Met
6.5	A mentor is offered and available if requested or recommended, in addition to the Training Supervisor.			
6.5.1	Mentor			
	2023	Partially Met	2024	Partially Met
Recommendation GG	It would be beneficial to provide some kind of structure to mentoring at the hospital, which could extend across the ITP to share the load and expose trainees to different consultants and learning experience			
CHS response (as of 20-1-25)	A rotational system has been implemented for 2025 to ensure trainees are exposed to different consultants and mentors.			
CHS response (as of 17-3-25)	Ongoing.			
CHS response (as of 19/5/25)	Mentoring is currently being delivered on an individual basis, with variable outcomes. A formal review of the approach is scheduled for August 2025 to assess effectiveness and identify opportunities for enhancement.			

CHS response (as of 20-7-25)	Prof Rod Peterson conducted at Hot Debrief session with the registrars. Feedback from the registrars was positive and they found the session beneficial.			
6.7	The Training Site has in place a process for critical incident management, including the immediate and longer-term care of FRANZCOG trainees involved in critical incidents such as adverse maternal or perinatal outcomes.			
6.7.1	Critical Incident Management			
	2023	Not Met	2024	Partially Met
Recommendation HH	An update on the implementation and effectiveness of the critical incident response process is requested at the time of the next activity			
CHS response (as of 20-1-25)	Implementation of second-on-call consultant role to respond to clinical needs of the department following a critical event, allowing the team involved to 'hot debrief'. This is in addition to the introduction of regular clinical supervision for nursing/midwives, and utilising existing CHS resources (EAP, CHS Wellness Strategy, Doctors 4 doctors etc). This process has worked well for the critical incidents that have occurred in the last 6 months. Further training for clinicians to lead the 'hot debrief' to occur as required.			
CHS response (as of 17-3-25)	Process of 'hot debriefs' instituted and working well.			
CHS response (as of 19/5/25)	Process of 'hot debriefs' are audited regularly at the O&G Consultant meeting.			
CHS response (as of 20-7-25)	CHS consider this recommendation as met and imbedded as business as usual.			
OVERALL ASSESSMENT OF STANDARD 6				
2023	Not Met		2024	Partially Met

Caveat Brief | Canberra Health Services

OFFICIAL Sensitive

TRIM Ref: MCHS25/444

To: Minister for Health

Date: 4 August 2025

From: Janet Zagari, Chief Executive Officer, Canberra Health Services

Subject: To provide you with and update on recent allegations at North Canberra Hospital

1. [REDACTED]
2. [REDACTED], the patient made allegations of inappropriate physical contact by a male nurse while in the ED to the Resident Medical Officer (RMO). These allegations were documented in the Digital Health Record (DHR) with the patients consent and reported to the Clinical Nurse Consultant (CNC).
3. The patient reported that while [REDACTED], a male nurse had pulled down her tracksuit pants and placed his hands on her private area. The patient said that she did not report the incident while in the in [REDACTED].
4. The [REDACTED] liaised with Social Work who recommended a police report be made by the patient. An appointment for Legal Aid was made by Social Work for [REDACTED] and a Riskman report was completed.
5. The [REDACTED] advised the patient that she make a police report however the patient declined at this time, requesting the hospital make the report on her behalf.
6. The patient requested female only care. This request was immediately accommodated and has continued throughout her admission.
7. [REDACTED] the patient informed the CNC that she wanted to proceed with a police report. The [REDACTED] Coordinator and Social Work attended the patient and Social Work assisted her to contact the police to make a formal report. A referral to the Canberra Rape Crisis Centre was also made.
8. As of 1 August 2025, ACT Policing is yet to attend to take a statement from the patient.

9. The [REDACTED] Assistant Director of Nursing has contacted the relevant staff member [REDACTED] until Monday 4 August 2025.
10. The [REDACTED] Assistant Director of Nursing is assessing the allegations and will complete a preliminary assessment process.
11. There are no previous allegations or behaviours of concern on record for this staff member.
12. In accordance with the Work health safety Act (2011), CHS work health safety team have made a report to WorkSafe.

Noted/Please Discuss

Rachel Stephen-Smith MLA
Minister for Health

CHS Executive: Deborah Plant, Acting General Manager, North Canberra Hospital
Action Officer: Megan Curran, Executive Director, Medicine and Critical Care, NCH

Caveat Brief | Canberra Health Services**OFFICIAL Sensitive****TRIM Ref: MCHS25/452**

To: Rachel Stephen-Smith MLA, Minister for Health

Date: 6 August 2025

From: Janet Zagari, Chief Executive Officer

Subject: Canberra Hospital ICU Incident - 5 August 2025

1. On [REDACTED], patient admitted to Elective Day Stay Unit. [REDACTED] patient transferred to operating theatre.
2. Patient was agitated in recovery and transferred to ICU at [REDACTED] hours and was re-intubated.
3. [REDACTED]
[REDACTED].
4. Patient was observed to be verbally abusive towards family members. At [REDACTED] patient threatening physical violence towards other patients and staff, Code Black was called.
5. At [REDACTED] hours, patient transferred from ICU to Building 5 [REDACTED].
6. At [REDACTED] hours, Ward [REDACTED] raised concern over patient barricading both himself and his partner in room [REDACTED] and verbally abusing his partner, stating if she left the room he would 'punch her in the head'.
7. At [REDACTED] hours ACT Policing were called. Patient verbally abused staff member and has damaged Canberra Health Services property (bed).
8. ACT Policing arrived at [REDACTED] hours and worked collaboratively with staff and Executive to form a plan.
9. With police attendance, the situation was deescalated, and his partner was permitted to leave/released from the room.
10. Patient remains on the ward for further investigation and discharge planning.
11. An escalation plan is in place and staff are aware.
12. A RiskMan notification was raised by ICU following the incident and a debriefing has been organised with staff involved.

13. No staff members have taken Occupational Violence leave following this incident.

14. Regular contact will continue to be provided directly to the staff members involved to ensure they are psychologically supported.

Noted/Please Discuss

Rachel Stephen-Smith MLA
Minister for Health

CHS Executive: Margot Green, Ag Executive Director, Division of Surgery
Action Officer: Brittany Kent, Business Manager, Office of Professional Leadership,
Canberra Hospital