12 and 13 August 2014
Council
Strategic and Policy Directions
4.0 Strategic and Policy Directions
Item 4.1

Information and discussion

Report on progress of strategic directions: 2013/2014 business year (EMA02.02.04)

Purpose

1. To report on progress with strategic directions and initiatives for the year 1 July 2013 to 30 June 2014.

Council's strategic goals

2. **GOAL ONE –** Optimise mechanisms to ensure doctors are competent and fit to practise.

3. **GOAL TWO –** Improve Council's relationship and partnership with the public, the profession, and stakeholders to further Council's primary purpose – to protect the health and safety of the public.

4. **GOAL THREE –** Promote good regulation of the medical profession by providing standards of clinical competence, cultural competence and ethical conduct and ensuring that the standards reflect the expectations of the public, the profession and stakeholders.

5. **GOAL FOUR –** Improve medical regulatory and workforce outcomes in New Zealand by the registration of doctors who are competent and fit to practise and their successful integration into the health service.

6. **GOAL FIVE –** Promote good medical education and learning environments throughout the under-graduate / postgraduate continuum to help ensure all doctors have achieved the necessary standards for their practice.

Strategic directions

7. In 2007/8 Council established four strategic directions:
   - Fitness to practise.
   - Medical workforce.
   - Medical education.
   - Accountability to the public and stakeholders.

8. Each strategic direction links to one or more of Council's strategic goals. As the initiatives within the strategic directions are implemented, Council moves closer to achieving its goals.

9. During the 2013/2014 year we have continued to implement the initiatives within our four strategic directions. This report is a summary of the progress of key initiatives over the 12 months from 1 July 2013 to 30 June 2014.

10. Benefits maps (Appendix 1) demonstrate the link between each of the strategic directions and Council's strategic goals. The benefits maps also demonstrate the outcomes, the benefits and the value to Council of completing the initiatives, and the progress made within each strategic direction.

Direction one - Fitness to practise

Key outcome of Fitness to practise strategic direction

11. *"We will apply right touch regulation to ensure doctors are competent and fit to practise throughout their medical career. The key outcome of this strategic direction is to continually improve the current high quality of medical practice in New Zealand. The Council will continue to provide leadership to the profession and work collaboratively and constructively with key stakeholders to achieve this outcome".*

Recertification for doctors registered in a general scope of practice

12. The recertification programme (*Inpractice*) for general registrants that is administered by bpac^{nz} has now been in place for 2 years.

13. At 31 May 2014 there were 1719 members working across the breadth of medical practice including:
- 415 completing house officer runs
- 406 working in general practice
- 134 working in emergency medicine
- 99 working in internal medicine
- 92 working in orthopaedic surgery
- 91 working in psychiatry
- 90 working in general surgery
- 71 working in obstetrics and gynaecology
- 59 working in paediatrics
- 262 working across a range of other areas of medicine.

14. Facilitation and support is provided by bpac^{nz} to doctors to assist them in achieving their CPD goals. Bpac^{nz} completed an audit of each of the doctor's e-portfolios at the end of each of the doctor's CPD cycles, coinciding with the practising certificate cycle. Those who failed to complete the required number of collegial relationship meetings by the end of their CPD cycle were monitored closely for compliance with the schedule on the subsequent cycle. In the 12 months to June 2014, 262 doctors were monitored to ensure they undertake and recorded collegial relationship meetings.

15. In the 12 months to June 2014, 262 doctors were referred from the *Inpractice* programme for unsatisfactory participation, as they had not completed the minimum requirements of collegial relationship meetings and the essentials quiz. A further 22 doctors were referred to Council for non-participation, as no CPD activities were recorded at the date of renewal.

16. In each of these instances Council staff initiated an escalation process, which resulted in Council considering nine individual cases, when doctors did not reengage with the *Inpractice* programme. All nine doctors had conditions placed on their practising certificates. Of these nine doctors, one of these subsequently had suspension of registration imposed by Council, but managed to achieve compliance within the 2-week period Council gave him to do so, one had suspension of registration delayed to the August 2014 meeting, pending a health assessment, one was required to join the RCUC vocational training programme and withdrew from *Inpractice*, one has until 11 August 2014 to get up to date with requirements of his conditions, one is no longer practising in New Zealand, and four are now considered to be actively participating in *Inpractice*.

Regular Practice Review (RPR)

17. Regular Practice Review (RPR) is a supportive and collegial review of a doctor's practice by peers, in a doctor's usual practice setting. The primary purpose of RPR is to help maintain and improve the standards of the profession. RPR is a quality improvement process. It may also assist in the identification of poor performance which may adversely affect patient care.

18. The Council's approach to RPR differs depending on whether a doctor is registered in a vocational or general scope of practice.

19. _General scope_
The recertification programme administered by bpac^{nz} requires RPR to be undertaken 3 yearly, with the first review to be undertaken 3 years after the doctor gains registration in a general scope of practice.

20. In the first year of the implementation of RPR in the *Inpractice* programme, 204 visits have been completed, all in the primary care setting.

21. The focus is now on implementing RPR for hospital based doctors registered in a general scope of practice. Bpac^{nz} has a workshop scheduled on 7 August 2014 with internal medicine and obstetrics and gynaecology representatives, as well as Council's Medical Advisers to work through:
    - what competencies to review
    - what tools are best suited
    - DOPS process and MSF tool for DOPS feedback
    - practicalities of implementation in hospital setting
    - recruitment of reviewers
    - level of expertise versus work role.

22. Reviewer training will be held in September, and RPR visits for general registrants will commence in hospital settings in October 2014. RPR for surgical scopes will commence in February 2015.

23. *Vocational scope*

The Council is encouraging Vocational Education and Advisory Bodies (VEABs) to develop RPR processes for doctors registered in a vocational scope of practice, and make these available as part of the Continuing Professional Development (CPD) programme on a voluntary basis.

24. A number of medical colleges are currently developing and implementing RPR process as part of their CPD programmes. Those who have already implemented RPR include the RACP, Royal New Zealand College of General Practitioners (RNZCGP), Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG), and the New Zealand Orthopaedic Association (NZOA).

25. Council has compiled data from the colleges who have implemented RPR and undertaken initial evaluation of the process. With the consent of the colleges the data has been shared with stakeholders. There was much commonality of the various small evaluations that have taken place, and although each contained small numbers, overall the feedback indicated that doctors who have undertaken a RPR, have found it useful and have used it to inform their CPD activities. A summary of the data was presented and discussed at the annual meeting of Medical Colleges on 20 September 2013 and at the IPAC conference on 29 September 2013.

26. *Council of Medical Colleges (CMC) project – Framework for doctors registered in a vocational scope of practice*

A project is being undertaken by the CMC, in partnership with the Ministry of Health, DHB CMO group, RNZCGP and Council focusing on the links between various tools used in the assessment of doctors. The project will explore whether information and tools from one process such as RPR, credentialling and performance appraisal can be shared and utilised by another process. Philip Pigou is on the steering group and Kevin Morris and Joan Crawford are members of the expert advisory group.

Evaluation of RPR

27. An invitation to submit an expression of interest (EOI) to manage an evaluation programme that looks at the effectiveness of RPR as implemented through the recertification programme administered by bpac^{nz} on behalf of Council was released on 31 May 2013.

28. At its meeting on 10 December 2013, Council considered the proposal and resolved to:

- enter into contract negotiations with Malatest International to deliver the programme of work as set out in their proposal with development of the detailed work plan commencing in February 2014
- approve the expenditure of $254,075 over the years 2014 – 2020, providing there is an ability to terminate at any time and that the duration and scope of the monitoring years can be altered if necessary.

29. An agreement has now been signed with Malatest International to undertake the evaluation programme. A detailed work plan for the evaluation has been developed and agreed to and the questionnaires and surveys for doctors, collegial relationship providers, and reviewers have been finalised. The evaluation programme commenced in July 2014.

30. A project update from Malatest International is attached (Appendix 5).

Medical officers

31. In March 2011, with the support of (and at the request of) the National DHB CMO group, Council decided that Medical Officers who meet set requirements would not be required to enrol in the Council approved recertification programme for general scope doctors called *inpractice,* administered by bpac^{nz}. An alternative recertification programme was put in place for doctors who are:

- employed as a Medical Officer, and
- employed solely in a public hospital, and
- employed in a permanent position (not fixed term or locum), and
- already participating in a Medical College or VEAB recertification programme prior to 14 March 2012, and
- undertaking both credentialling and professional development reviews annually that are overseen by the CMO.

32. The reason for Council's decision was that doctors employed as Medical Officers by DHBs and registered on a general scope of practice who are participating in a medical college recertification programme relevant to the area of medicine in which they work usually also undertake additional processes that contribute to the assurance of competence, such as credentialling and annual appraisal processes. These processes are done under the oversight of the CMO, and together satisfy the CPD requirements set by Council.

Council resolved that the above arrangement would be in place for a transition period of two years ending 14 March 2014.

33. The medical colleges were advised that they had an option to extend their programmes to provide the additional elements and meet the quality standards of the Council approved programme administered by bpac^{nz} for doctors registered in a general scope. If their recertification programme provided the following elements by 14 March 2014, then the current participants of their programme may be grandfathered and remain in the medical college recertification programme, and would not be required to join the recertification programme administered by bpac^{nz}:

- implementation of regular practice review (RPR) (undertaken by each doctor once every 3 years)
- multisource patient and colleague feedback (undertaken by each doctor once every 3 years)
- a professional development plan for each doctor
- auditing of a minimum of 10% of the participants per annum to ensure the CPD activities are compliant with the standards set
- a structured remediation plan for those whose performance in a specific area or overall, has been less than satisfactory
- monitoring to ensure all doctors are participating in the required activities including collegial relationship meetings.

34. The above elements are in addition to Council's requirements for recertification of 50 hours of CPD per year and include:

- Collegial relationship meetings (four meetings per year for general registrants).

- Audit of medical practice (participation in one audit of medical practice per year).
- Peer review (a minimum of 10 hours per year).
- Continuing medical education (CME) (a minimum of 20 hours per year).

35. The transitional period ended on 14 March 2014. The RACP (16 Medical Officers) and ANZCA (14 Medical Officers) both extended their recertification programme to meet the additional elements. The RANZCP, ACEM and RACS did not extend their recertification programme. This means that out of the 67 medical officers who were meeting recertification requirements through their medical college, 37 were required to enrol in the recertification programme administered by bpac^{nz}, and 16 remained with the RACP and 14 with ANZCA.

36. The doctors affected by this had practising certificates that expired over the four quarters of the year, and are being transitioned into the *Inpractice* programme at the date of each new practising certificate cycle.

Multisource (colleague and patient) feedback

37. The purpose of this project was to identify and implement a valid and reliable multisource (colleague and patient) feedback tools for use within Council's PAC and VPA processes.

38. Following an extensive process evaluating a variety of multisource feedback (MSF) tools, Council decided that the GMC tools were most appropriate for Council use. Council has contracted bpac^{nz} to administer MSF using the GMC tool. Implementation of the MSF process in VPAs and PACs commenced in June 2014.

39. An initial review of the MSF processes will be undertaken after 20 MSF assessments have been completed, with a full review 12 months after implementation.

Annual International Physicians Assessment Coalition (IPAC) conference 2013

40. Council hosted the IPAC 2013 annual conference in Queenstown from 30 September to 2 October. The theme of the conference was *Closing the loop: best practice for doctors' performance* and the focus for the presentations and discussion were:
    - How to evaluate the effectiveness of models of assessment of performance of doctors.
    - New approaches and models of assessment that can be applied proactively to provide assurance of the performance of doctors (when no concern has been raised), identify aspects of practice that can be improved that can inform professional development activities, and thereby improve the standards of the practice of doctors.
    - Evidence-based tools that can be used to assess performance, in response to concerns being raised.
    - The evidence that links the performance assessment of doctors to an improvement in practice.

41. There were 81 attendees from 10 countries with a number of jurisdictions attending for the first time, with feedback being very positive.

Direction two - Medical workforce

Key outcome of Medical workforce strategic direction

42. *"The Council aims to ensure that its registration and other processes ensure the competence and fitness to practise of doctors working in New Zealand, and their successful integration into the health system. We do this to protect the health and safety of the public. We also recognise that the failure of DHBs and other service providers to provide health services is a risk to the health and safety of the public. We will work in a collaborative and equal relationship with relevant stakeholders to ensure our roles and responsibilities in the regulation of doctors and related workforce issues are clear.*

The New Zealand medical workforce is heavily reliant on international medical graduates with 41 percent of doctors practising in New Zealand holding a primary medical qualification from overseas, although this figure reduces to around 26 percent if those doctors with a New Zealand or Australasian postgraduate medical qualification are removed from the calculation. The Council registers up to 1200 international medical graduates every year.

The key outcome of this strategic direction is to assist all doctors, including international medical graduates to integrate safely and successfully into the New Zealand medical workforce".

Training workshops for supervisors of IMGs

43. Since the introduction of the workshops in 2009, 21 workshops have been held, and approximately 500 supervisors have attended the training. Sue Hawken and Richard Fox from Connect Communications have facilitated the workshops, along with one of Council's Medical Advisers and senior staff from Council office.

44. These workshops have been suspended for an interim period, while focus moves to training for supervisors of interns which is commencing in August 2014.

Approved practice settings (APS)

45. Accreditation as an APS demonstrates that appropriate support and supervision is available and provided to IMGs. It is an alternative option to providing individual supervision plans for each IMG employed at a service. Benefits of being accredited as an APS include:

- Recognition of a service or practice that spans more than one site and providing a mechanism to streamline their internal processes and policies.
- Quicker processing time for registration of IMGs.
- Decrease need for paperwork, for example individual supervision plans and supervision reports do not need to be submitted to Council.

46. Although a number of services have expressed interest for accreditation as an APS, the applications are slow to be completed. Only five services have been accredited as an APS.

Special purpose scope of practice, locum tenens pathway

47. An internal review of qualifications to meet requirements for the special purpose scope locum tenens pathway has commenced by the Registration Team. As part of this work a consultation with stakeholders will commence in August 2014.

Proactive sharing of information on doctors with International Association of Medical Regulatory Authorities (IAMRA) and international medical regulators

48. The Physicians Information Exchange (PIE) Working Group of IAMRA met by teleconference on

14 August 2013. The primary activity for the group during this period was to develop a proposal to be put to the Management Committee at the Strategic Planning Meeting held in Auckland in October 2013, for a number of initiatives the PIE Group wished to pursue. A further teleconference was held on 17 January 2014.

49. The goals and objectives below were agreed to and will be carried forward by the PIE Working Group:
Promote and encourage members to share fitness to practise/disciplinary information on doctors proactively.

1. Promote and encourage members to sign up to the *IAMRA Statement of Intent on Proactive Information Sharing.*
2. Develop criteria for IAMRA to provide a service to members that would allow them to proactively share information on doctors attempting to register with fraudulent documents; and send alerts on doctors with fitness to practise/disciplinary actions that pose an immediate threat to the public.
3. Develop a resource on the IAMRA website which will direct regulators to the databases of other medical regulatory authorities.
4. Survey members on the issuing of Certificates of Good Standing/Certificates of Current Professional Status and on criminal conviction information they collect at registration and beyond and make this information available as a resource on the IAMRA website.
5. Develop a resource on the IAMRA website with information on members' current practices for issuing Certificates of Good Standing/Certificates of Current Professional Status.
6. Develop a resource on the IAMRA website with a map that indicates which members have entered into bilateral memoranda of understanding on Certificates of Good Standing/Certificates of Current Professional Status.
7. Develop guidance on good practice in setting up and managing public registers.

Online capability to facilitate applications for practising certificates and registration

50. Development work on this project has largely been completed. Once the development work has been thoroughly tested, we will be looking to roll this out to doctors over the next 12 months. Subject to no major faults being found during the testing phase, we expect this to be completed by the end of September 2014.

Direction three – Medical education

Key outcome of the Medical education strategic direction

51. *"Ensuring and promoting the competence of doctors through their education and training programmes, from undergraduate to postgraduate education, is a function of the Council. The key outcome of this strategic direction is to ensure a quality educational experience for all doctors and medical students".*

Review of prevocational training

52. The key priority for the Strategic team in the 2013/2014 year has been implementing the changes to prevocational training. The programme of work was broken into eight work streams, each developed with a separate project plan, project leader, and project team.

53. Council reviewed progress at its meeting on 11 June 2014 and made a number of key decisions in each of the workstreams, which are being implemented. A comprehensive paper was

provided to Council at that time, therefore only an update on two key areas is provided below.

54. *E-portfolio*
An Evaluation Panel that included Ted Christiansen (Health Information Standards Information Group, National Health Board), Ken Clark (Chair National DHB CMO group), Council's Chair, Education Committee Chair, CEO and Strategic Programme Manager reviewed the 17 proposals received and shortlisted five. The Evaluation Panel met with the five shortlisted proposers, who presented detailed presentations about their proposals. Following this the Evaluation Panel made a recommendation to Council about a preferred provider.

55. Council considered the recommendation from the Evaluation Panel about a provider of an e-portfolio system for prevocational training via a paper circulated on 2 July 2014. Council agreed with the Evaluation Panel's recommendation and resolved to approve that the CEO further advance negotiations with bpac^{nz} as provider of the system.

56. An initial teleconference between bpac^{nz}, Council's CEO, Strategic Programme Manager and Project Coordinator was held on 11 July to discuss the content of an agreement between bpac^{nz} and Council with an agreed implementation date of 3 November 2014. A contract is being drafted reflecting the agreement.

57. A meeting between key project representatives from bpac^{nz} and Council is scheduled for 30 July 2014. The purpose of this meeting will be to discuss the parameters of the e-portfolio project, Council's decisions and the timeframes for development.

58. An expert advisory group will be formed which will include members from the following groups:
- DHB CMOs
- prevocational educational supervisors ((Intern Supervisors)
- clinical supervisors
- RMO coordinators
- interns (and potentially medical students).

The first meeting of the group will be held near the end of August.

59. Health Workforce New Zealand (HWNZ) are funding the development of the e-portfolio, and a contract has been signed with them to this effect.

60. *Training for supervisors of interns*
Training for supervisors of prevocational training is commencing. The training is being held in partnership with HWNZ and the DHBs. HWNZ is providing funding which will cover the cost of Connect Communications facilitating the one day workshops, and travel costs of Council staff. Council are seeking support from DHBs in providing time for supervisors to attend (this could potentially be part of CPD), the venue where possible, and possibly catering. Council will cover the cost of the prevocational educational supervisors travel, however travel costs for others, such as clinical supervisors to attend, will need to be covered by the DHB

61. At the end of the teaching day the participants will be resourced to be:
1. Conversant with, and able to demonstrate awareness of Council's processes and

requirements for prevocational education and clinical supervisors of interns (PGY1 and PGY2 doctors).
2. Conversant with, and able to demonstrate best practice supervision, including: maps and models of supervision, supervision tools, giving feedback, dealing with difficult and poorly performing interns.
3. Able to confidently identify and appropriately manage situations in which their interns require support.
4. Able to understand and prioritise their supervisory role as strong and primary advocates of patient safety.
5. Confident in the dyad of the supervisory relationship: handling authority and recognising one's own bias.
6. Able to confidently identify and manage the intern who may have health problems (such as depression, anxiety or a chronic illness) which impact on their work, balancing the dual requirements of support and boundaries.
7. Able to appropriately complete the *End of clinical attachment assessment* form, in particular identifying areas that the intern should focus on for improvement, making an overall global summative assessment.

62. There are three workshops scheduled in August primarily for prevocational educational supervisors, CMOs (or delegates) and Clinical Directors of Training with the following sessions being rolled out to clinical supervisors. This will build upon the leadership in each DHB in prevocational training to ensure the changes are implemented successfully.

63. Training will be held on the following dates:

- 4 August 2014 – Ko Awatea at Middlemore Hospital
- 8 August 2014 – Council office in Wellington
- 25 August 2014 – Rangitoto room at Auckland City Hospital
- 31 October 2014 – tentatively booked for Christchurch
- 3 November 2014 – Waikato Hospital
- 7 November 2014 – Hutt Hospital
- 26 November 2014 – Palmerston North Hospital.
- TBC – Dunedin Hospital.

64. One further workshop, at a venue yet to be determined, will be held before the end of November, and a further seven workshops will be scheduled between July and November 2015.

65. *Guide for Prevocational Educational Supervisors*
A draft guide is attached for Council's review and feedback. (Appendix 6)

Trainee intern (TI) registration

66. The working group reconvened on 13 November 2013. The purpose of the meeting was to provide feedback to Dawn Brook, *Senior Adviser, Workforce Education Intelligence and Planning, HWNZ* who is drafting a paper on this issue to inform the Minister of Health. Dawn was interested in gaining the views from the working group members about what they perceived were the advantages and issues related to TI registration.

67. The working group comprises representatives from the medical schools, the National DHB CMO

group, the New Zealand Medical Association (NZMA) Doctors in Training Council (DiTC), the New Zealand Medical Students Association (NZMSA), Council's Education Committee and Council staff.

68. The group agreed that the registration of TI's should proceed and that the benefits such as providing opportunity for an improved continuum of learning, an enhanced learning environment for 6th year medical students, and early and effective engagement between the Council and TI's would outweigh any challenges.

Joint accreditation processes for Australasian specialist colleges

69. Several joint accreditation processes have now been undertaken. At the accreditation team level these reportedly went well with Australian team members working to ensure the Council's additional criteria were met. CEO Philip Pigou and Professional Standards Manager, Susan Yorke, attended the AMC's Accreditation Team Chairs meeting early in 2014 and also had the opportunity to discuss administrative processes to further improve the collaborative approach.

Accreditation of New Zealand specialist colleges

70. Work towards developing consistent standards for New Zealand only Colleges is progressing. Following completion of stakeholder feedback on the consultation paper *Standards and processes for recognition and accreditation of New Zealand colleges in 2013,* the standards have now been approved by Council but we are doing further work on supporting documentation and developing a process for implementation. It is anticipated these will be before Council later this year or early in 2015.

Accountability to the public and stakeholders

Key outcome from Accountability strategic direction

71. *"The Council is accountable to the public, to Parliament, and to the profession. Within this model there are many individuals and groups with whom we collaborate in the performance of our functions. The key outcomes of this strategic direction are through engagement with the public and stakeholders to raise awareness of Council's role and functions, obtain valuable feedback into our strategic and policy development and improve how we perform our functions".*

Consumer Advisory Group (CAG)

72. The Consumer Advisory Group (CAG) provides advice and feedback to the Health and Disability Commissioner on strategic issues including the handling of consumer complaints about health and disability services, public interest issues and policy. The HDC have agreed that Council may use the services of the CAG three times each year. The purpose of using the CAG is to gain feedback into strategic and policy development.

73. Three CAG meetings were held on 15 August 2013, 12 December 2013 and 13 March 2014, the following items were discussed:

- Our statement on Safe Practice in an Environment of Resource Limitation.
- Internal protocols for communication with complainants and other stakeholders.
- The perception that MCNZ protects doctors.
- Whether giving the public more information about outcomes of competence and conduct proceedings can enhance public health & safety.

- Council statement on *A doctor's duty to help in an emergency*.
- Council's principles for the assessment and management of complaints and notifications
- Cultural competence
- Council's statement on *Advertising*
- The professionalism and communication sections of the NZCF.

Develop a Memorandum of Understanding with primary health organisations (PHO)

74. The purpose of the MoU is to clarify our respective roles and responsibilities related to the regulation of doctors in New Zealand, including the management of any competence, performance, conduct and health issues, and to enable PHOs and Council to work in a collaborative and equal relationship.

75. A MoU has been drafted and circulated to the working group, which has members from PHOs and a variety of other stakeholders. The draft MoU has been informed by previous working group meetings, as well as internal review. A further meeting of the working group is scheduled on 14 August 2014, and feedback to the draft MoU will be the main agenda item.

Develop a MoU with Southern Cross Hospitals

76. The MoU between Southern Cross Hospitals and Council was signed on 7 December 2012.

77. All doctors "credentialled" by Southern Cross have been noted on Council's databases as non-public register information. Council staff now inform Southern Cross when a doctor is referred to a PAC or PCC (in the same way that employers are notified). Council staff will also update Southern Cross on APC and registration issues.

MCNZ/DHB MoU oversight group

78. The oversight group has met three times over the past year and considered a range of issues. The group meetings also provided a useful mechanism to provide updates to the various DHB national group representatives on progress with a range of strategic initiatives, including prevocational training.

Annual meeting of Medical Colleges

79. The Annual Meeting of Medical Colleges was held on Friday 20 September 2013. The focus of the meeting was protecting the public and ensuring competence, as well as the changes to prevocational training. Council's Chair, John Adams discussed some aspects of Council's draft vision at the meeting, in particular how we can better ensure competence of doctors, and how the medical colleges and Council can play a role in this area.

80. The meeting was attended by 59 representatives from Vocational Education and Advisory Bodies (VEAB), 12 Council staff and two Council members, John Adams, Council Chair and John Nacey, Chair, Education Committee.

81. Some of the discussion and feedback indicated there was support for targeting the bottom 5% of underperforming doctors. The importance of credentialling for ensuring competence was also discussed.

82. Twenty-six of the 59 VEAB representatives provided feedback. Sixty-eight percent of respondents felt the overall quality of the meeting was very good or excellent with 84% of

respondents saying the relevance of the topics was very good or excellent. Twenty-five of the 26 respondents said they would recommend the meeting to a colleague.

83. Comments in the feedback demonstrated that attendees found the discussions on recertification and RPR of most value. Attendees enjoyed the openness of the discussions and having the opportunity to provide feedback.

84. The next meeting will be held on 22 October 2014.

Health Regulatory Authorities New Zealand (HRANZ)

85. The HRANZ conference was held in Wellington on 28 May 2014. The draft programme and workshops can be found at **Programme** **and** **workshops**. Harry Cayton, CEO, Professional Standards Authority presented the key note address discussing quality assurance for regulators, and Harry also discussed the Francis report later in the afternoon.

86. Andrew Connolly participated in a panel discussion about the future of regulation for ensuring safe and competent practitioners, and chaired a panel discussion about issues affecting health regulators. Joan Crawford led a workshop about the strengthened recertification programme for doctors registered in a general scope of practice and regular practice review.

Vocational Educational and Advisory Bodies (VEAB) Executive Office meeting

87. The Executive Officers of the VEABs were invited to a meeting held on 4 June 2014. The meeting was chaired by Philip Pigou and included the following agenda items:
- Identifying and managing poor performers.
- Sharing information about competence, conduct and health.
- Review of processes for advising Council on IMG's applying for registration in a vocational scope of practice.
- Changes to the MoU between Council and VEABs.

Attachments

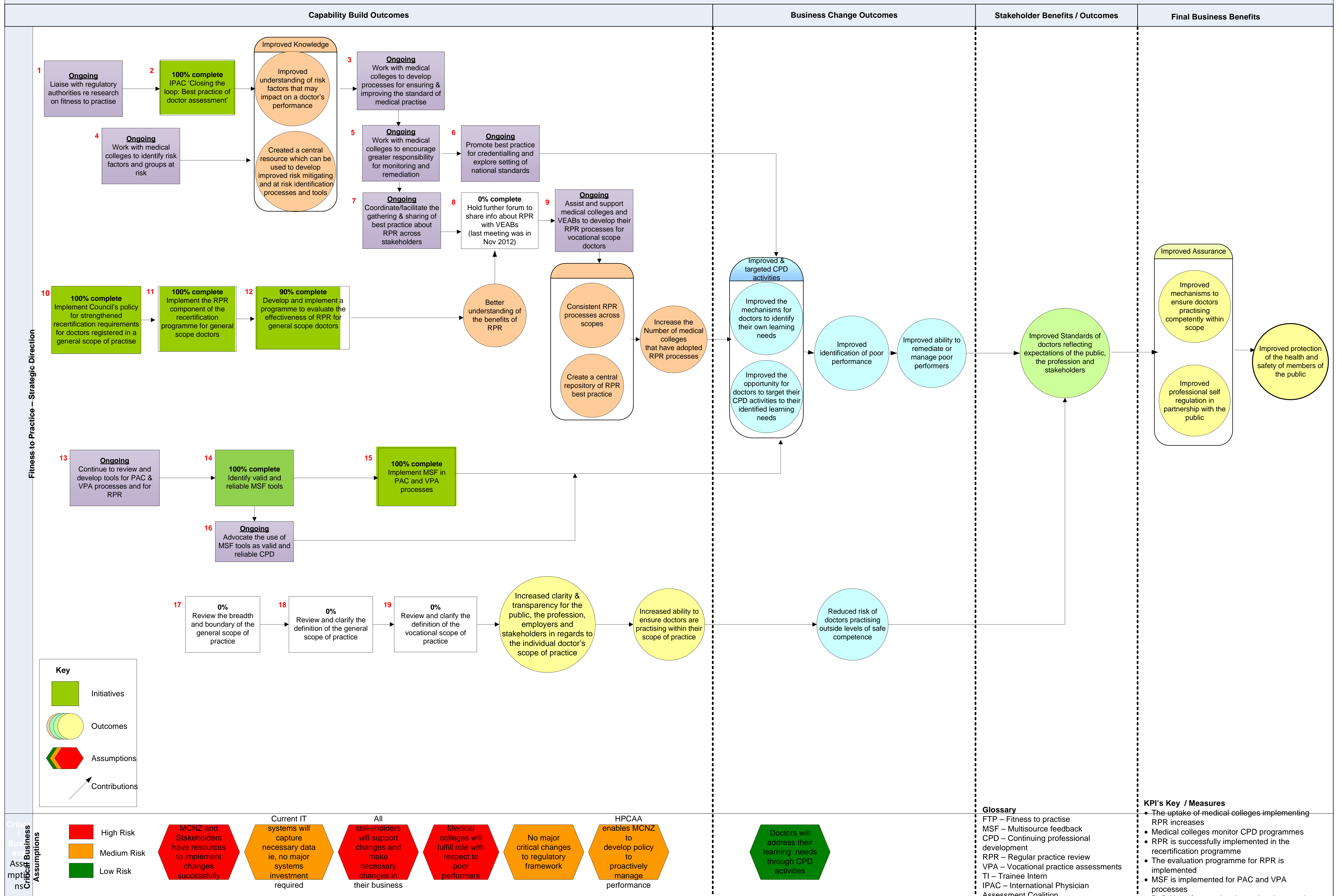
88. Appendix 1 – Benefits maps

Recommendation

89. **Council receives the report on progress of the strategic directions for the year 1 July 2013 to 30 June 2014, and provides feedback.**

Joan Crawford
Strategic Programme Manager

29 July 2014



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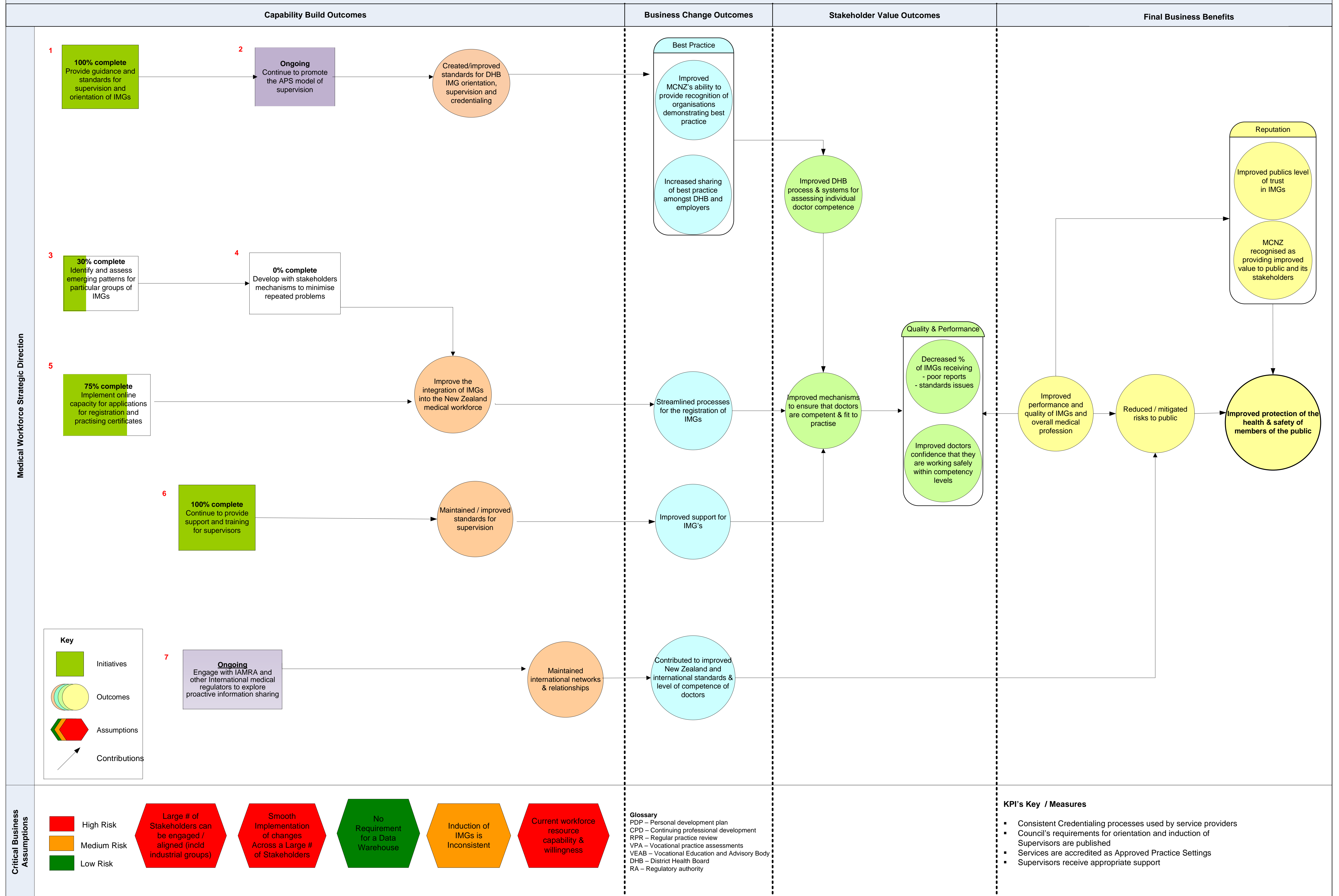

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Direction three - MEDICAL EDUCATION - benefits map for business plan year 1 July 2013 – 30 June 2014

Medical Education Strategic Direction

Capability Build Outcomes

1 **100% complete** Review prevocational training requirements for doctors in NZ

Key stakeholders consulted

2 **100% complete** Consider the consultation feedback

Key stakeholders have bought into The changes

3 **100% complete** Develop and implement a stakeholder communications plan

4 **80% complete** Engage with HWNZ to explore funding and setting of KPIs to ensure quality of training

5 **100% complete** Develop an implementation plan

Implement changes to prevocational training

6 **100% complete** Consider stakeholder feedback and approve the final NZCF

7 **100% complete** Release to stakeholders as per the comms plan

8 **100% complete** Embed NZCF in assessment and accreditation work streams

9 **50% complete** Consider the cost implications to both internal and external stakeholders

10 **100% complete** Develop a framework and content for training and supporting all those involved in supervising interns

11 **50% complete** Educational supervisor training workshops

12 **0% complete** Clinical supervisor training workshops

13 **80% complete** Develop and implement the framework for assessment of interns

14 **100% complete** Finalise and approve assessment framework

15 **100% complete** Develop a scope of work for an RFP for an e-portfolio.

16 **50% complete** Implement e-portfolio and assessment framework

17 **80% complete** Set standards and develop a process for accreditation for clinical attachments and training providers

18 **75% complete** Release to DHBs and training providers

19 **50% complete** Implement transitional plan for accreditation process

20 **50% complete** Develop guidance for community based attachments and seek to eliminate barriers

21 **0% complete** Implement the MSF element of the framework for assessment

22 **50% complete** Develop a framework to evaluate the effectiveness of the changes

Assessment tools are adequate to measure whether standards are met

23 **30% complete** Explore potential of registration for TIs under the HPCAA

24 **0% complete** Develop a discussion paper for engagement with stakeholders about registration of TIs

25 **0% complete** Develop and implement communications plan for consultation

26 **0% complete** Consider feedback & determine registration requirements for medical students

Business Change Outcomes

Ongoing dialogue maintained with stakeholders

- Created assessment process which will be used to assess individual doctors
- Improved ability to effectively integrate the framework into operation
- Ensured quality of training by service provider

Achieved setting of required standard of education & training for Interns

- Improved ability to identify and manage FTP for medical students
- Improved ability to define clinical responsibilities for medical students particularly in TI1
- Increased awareness of MCNZ standards & processes

Stakeholder Benefits / Outcomes

Improved competency levels of Interns

Created ability to intervene earlier and target interventions

Final Business Benefits

Quality of training for interns

- Doctors are competent and fit to practise in a general scope
- Improved standards of doctors
- A better vertical integration for doctors on the continuum of training
- Greater accountability by training providers
- Improved prevocational training

Medical students fit and competent to be registered in a general scope

Improved continuum of training from university to interns to vocation

Improved protection of the Health & Safety of members of the Public

Key

- Initiatives
- Outcomes
- Assumptions
- Contributions

Critical Business Assumptions

- High Risk
- Medium Risk
- Low Risk

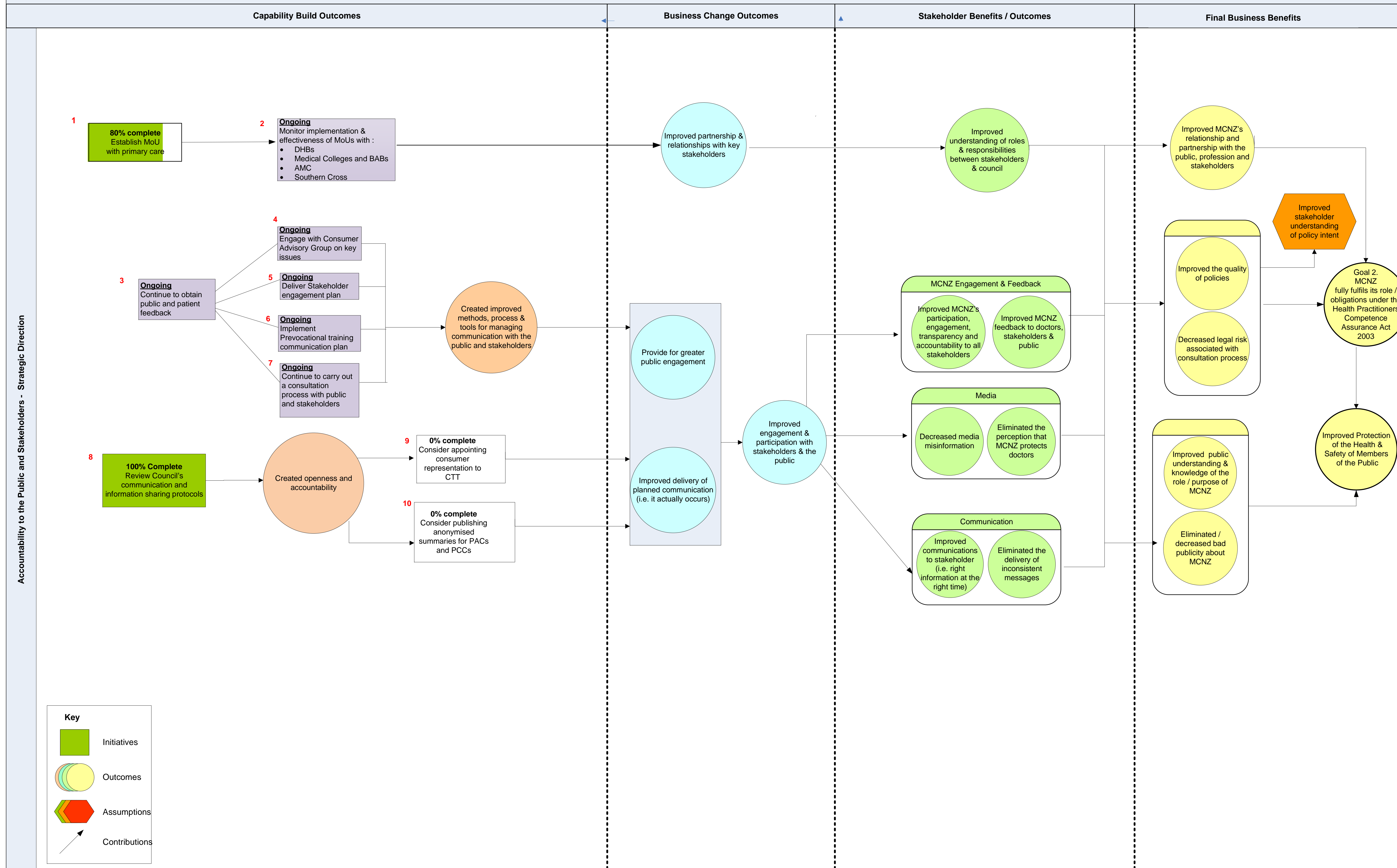
Glossary

NZCF – *New Zealand Curriculum Framework for Prevocational Medical Training*
Intern – PGY1 and PGY2
MSF – Multisource feedback
PDP – Personal development plan
CPD – Continuing professional development
VEAB – Vocational education and advisory body
DHB – District Health Board
RA – Regulatory authority
TI – Trainee Intern

KPI's / Key Measures of Success

Prevocational framework implemented
Assessment tools are developed
Training plan for SMOs is implemented
List of core competencies for vocational scopes agreed
Improved transition from trainee intern to intern
Early intervention and rehabilitation for students with health concerns

Direction four - ACCOUNTABILITY TO THE PUBLIC AND STAKEHOLDERS - benefits map for business plan year 1 July 2013 – 30 June 2014



Critical Business Assumptions

Risk level	
High Risk	
Medium Risk	
Low Risk	

- IT & other systems will support tracking of comms & correspondence
- Increased involvement by stakeholders in policy development will lead to better policies
- Public has a need or desire to know more about the MCNZ role & services
- MCNZ has sufficient resources and capacity to implement changes
- Other Agencies want / need increase in collaboration

Glossary

FTP – Fitness to practise
PDP – Personal development plan
CPD – Continuing professional development
RPR – Regular practice review
VPA – Vocational practice assessments
BAB – Branch advisory body
DHB – District Health Board
RA – Regulatory authority

KPI's Key / Measures

- Created processes which promote and support self-regulation in partnership with the public
- Achieved optimal standards of medical practice as agreed by all stakeholders

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