15 and 16 August 2017
Council
Strategic and Policy Directions
4.0 Strategic and Policy Directions
Item 4.1

Information and discussion

Report on progress of strategic directions – 12 month report

Purpose

1. To report on progress with strategic directions and initiatives for the 12 month period of 1 July 2016 to 30 June 2017.

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 2016/17 Council's four strategic directions were:
   - Fitness to practise.
   - Cultural competence, partnership and health equity.
   - Medical education.
   - Accountability to the public and stakeholders.

8. Each strategic direction links to one or more of Council's strategic goals (see Appendix 1, Council's business plan 2016/17). As the initiatives within the strategic directions are implemented, Council moves closer to achieving its goals.

9. This report is a summary of the progress with key initiatives over the 12 months from 1 July 2016 to 30 June 2017. Ongoing priorities for the next 6 months are noted.

Direction one - Fitness to practise

Key outcome of the fitness to practise strategic direction

10. *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 requirements for vocationally registered doctors

11. The *Consultation on strengthening recertification for vocationally registered doctors* was published on Council's website and circulated widely to stakeholders and the profession in January 2017.

12. An analysis of the feedback received in response to the consultation and the 149 submissions received were considered by Council at its July meeting.

13. Further work in this area will be carried out in the 2017/2018 business year with the aim to improve understanding and gather support from the sector. A small representative working group, and an advisory group, will be formed to work through the detail of the proposed recertification model and make recommendations to Council. There will also be a stakeholder engagement and communications strategy which includes presentations and meetings with key groups.

Evaluation of RPR

14. In July 2014, Malatest International commenced its evaluation of RPR as implemented through the recertification programme for general registrants administered by bpac^{nz} on behalf of Council.

15. The evaluation findings are based on self-reported changes from the reviewed doctors which are captured through surveys and interviews. Data is being collected at two points in time, 2 weeks after receipt of the RPR report by on-line survey, with opportunity to have an in depth interview, and 12 months after the RPR.

16. Two substantial evaluation reports were received in the 2016/2017 business year. The *Evaluation report – August 2016: Evaluation of the Regular Practice Review Programme* and the *Evaluation report – March 2017: Evaluation of the Regular Practice Review Programme*, thatbuilds on the August 2016 report and incorporates the most recent survey results with 295 survey responses and 58 interviews completed 2 weeks post-RPR. It also includes 133 responses and 21 interviews conducted 12 months after RPR.

17. Findings in the March evaluation report include:
    - Two weeks after RPR, nearly half (46%) of the doctors who completed the post-RPR survey reported that they had already made changes to their practice as a result of participating in RPR and a further 13% intended to make changes.
    - Of the doctors who completed both surveys (2 weeks post-RPR and 12 months post-RPR) 42% reported making changes to their practice. Fifty-one percent of this group of doctors had previously reported making changes to their practice in the initial survey (2 weeks post-RPR). The information suggests changes made in response to RPR were maintained for many doctors.
    - Many doctors found participating in RPR a more positive experience than anticipated. Nearly three-quarters (71%) agreed it was a positive experience, 67% found the RPR report useful and more than half (57%) would positively recommend a review to colleagues.

18. A further substantive report is due at the beginning of September 2017. Malatest International will provide a short presentation on the findings from this report to Council at its September meeting. The evaluation will continue through until 2020.

Collegial relationships

19. A review of the effectiveness of collegial relationships within the recertification programme for doctors registered in a general scope of practice will be undertaken in the 2017/2018 business year, with a view to clarifying expectations of colleagues and strengthening requirements. There are also doctors registered in a vocational scope of practice who are working outside their vocational scope and they also have a collegial relationship requirement. The review will also consider implications of any changes for this group of vocationally registered doctors.

Direction two – Cultural competence, partnership and health equity

Key outcome of the cultural competence strategic direction

20. *Council expects that doctors will be culturally competent. Council will further encourage doctors and health organisations to establish and strengthen their partnerships with Māori organisations, with the aim of including Māori participation within their governance structures. The aim of these endeavours is to improve Māori health outcomes and reduce health inequity, through Council's role as the medical regulator responsible for professional standards and ensuring doctors' competence.*

21. Council's joint work programme with Te Ohu Rata o Aotearoa (Te ORA) on cultural competence, partnership and health equity commenced with a symposium held on 1 June 2017. The symposium included presentations from Te ORA, medical colleges, a panel discussion, and a workshop. The concepts of unconscious bias and critical consciousness in relation to an individual's cultural competence were noted as particularly useful by attendees. At the end of the symposium attendee's had a better understanding of their organisations role and responsibility in ensuring culturally competent doctors, in creating culturally safe environments, and of the importance of working in partnership with Māori. A report on the symposium was provided to Council at its July 2017 meeting.

22. The Cultural Competence, Partnership and Health Equity Governance Group, led by Council's Chair, met in May to agree the draft programme scope, the terms of reference for the Advisory Group, and the agenda for the 1 June symposium. The Governance Group membership is:
    - Andrew Connolly, Chair, Council.
    - Nathan Joseph, Chair, Te ORA.
    - Philip Pigou, Chief Executive Officer, Council.
    - Kim Ngārimu, lay member, Council.
    - Papaarangi Reid, Tumuaki, Deputy Dean (Māori) Faculty of Medical and Health Sciences, Auckland University or her delegate.
    - Curtis Walker (ex-officio) Council member and Board member, Te ORA.

23. The Cultural Competence, Partnership and Health Equity Advisory Group, led by Dr Curtis Walker, is responsible for providing advice and guidance regarding the work programme deliverables and reports to the Governance Group. The Advisory Group met in June to discuss the framework for cultural competency and the review of Council's statements and guidance on cultural competence. It was agreed that the framework should have both descriptive and prescriptive elements and it should be integrated into normal business using accreditation standards, recertification requirements and other tools and levers already in use. The members for the Advisory Group are:
    - Curtis Walker, Council member and Board member, Te ORA.
    - Kim Ngārimu, lay member, Council.
    - Rawiri Jansen, Taumata, Te ORA.
    - Rees Tapsell, Taumata, Te ORA.
    - Rhys Jones, Taumata, Te ORA.
    - Alan Merry, Chair, Health Quality and Safety Commission.
    - Philip Pigou, Chief Executive Officer, Council.
    - Joan Crawford, Strategic Programme Manager, Council.

- Aleyna Hall, Deputy Registrar, Council.

24. There will be a major focus on the cultural competence work programme over the 2017/2018 business year. The next steps are to further define the parameters of the cultural competency framework and review Council's written guidance and material on cultural competence.

Direction three – Medical education

Key outcome of the medical education strategic direction

25. *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.*

Prevocational medical training

26. The majority of initiatives regarding the changes to the prevocational medical training programme have been completed over the past 2 years.

Review of the implementation of the prevocational medical training programme

27. An independent review of the implementation of the prevocational medical training programme for interns was undertaken in 2016. The independent review was commissioned by Council and carried out by an Implementation Review Group chaired by Dr Kenneth Clark, Chair of the National District Health Board Chief Medical Officer Group. The review considered if the changes to prevocational medical training had been effectively implemented, how processes and structures were working, and how well the changes had been accepted by interns, training providers and all those involved in intern education.

28. The review group reported that the changes are contributing to an increased level of interaction between clinical supervisors and interns with better quality feedback, a change in culture and attitudes to prevocational medical training and an overall greater level if transparency for all involved in intern education and training.

29. A detailed set of recommendations were made by the Implementation Review Group and these were considered by Council in December 2016. Council accepted without amendment the majority of the recommendations and a work programme has been developed to action these. The report was circulated in March 2017.

30. In June 2017 each DHB CEO (with copies to CMOs and prevocational educational supervisors) were advised of the changes made to prevocational medical training in response to the recent review.

31. A schedule of the decisions with the progress to date is attached as Appendix 2.

Community based attachments (CBAs) for prevocational medical training

32. The CBA Governance Group meeting was held on 16 May 2017. The group noted that most DHB CEO and CMOs are supportive of prevocational community attachments however there continue to be concerns raised about the need for additional funding.

33. Dr Ken Clark chairs the National Workforce Strategy Group and he reported that the group accept that all interns will have a community attachment in their first 2 years by the end of 2020 and that the 100% target for compliance was non-negotiable.

34. At its June meeting, Council decided to set a goal of 50 percent of interns to complete a CBA (over their 2 year internship) by the end of 2018, and further resolved that a letter be sent to each DHB Chief Executive encouraging each individual DHB to work towards this.

35. The governance group agreed and has asked the CBA Management Group to consider and report back on some specific issues, including any perceived implications for CBAs from the new collective employment agreement for RMOs, urgent care placements in rural settings that have work hours outside normal business hours, and have requested the group work with the RNZCGP and medical schools on the national coordination of general practice placements.

36. The CBA indicative report (Appendix 3) demonstrates the following self-reported information from DHBs:

- One hundred and thirty nine interns (approximately 30% of interns nationally) will be completing a CBA over their 2-year internship in 2017.
- Every DHB has interns placed in community placements for 2017. There are 76 interns placed in general practice, 54 outside of general practice including hospice, older persons' health and mental health and nine interns placed in urgent care.
- A total of 65 community attachments, that if filled for each of the four quarters, would provide 260 intern community placements are nationally.

There continues to be growth in integrated care and urgent care attachments.

37. A question was raised relating to the definition and standards for community attachments, specifically about whether a public health clinical attachment might meet the criteria for CBAs. This will now be considered by the accreditation review advisory group, before a recommendation is made to Education Committee.

Multisource feedback (MSF) for prevocational medical training

38. At its meeting in July 2013, Council decided that MSF would be implemented as part of the changes to prevocational medical training.

39. An MSF advisory group has been established to discuss issues and provide guidance to Council prior to the introduction of an MSF tool in ePort. The group brings together representatives from Council, across DHBs, NZRDA and NZMA DiTC.

40. Following an initial teleconference in early March, where the group considered MSF generally in relation to prevocational medical training, a face to face meeting chaired by Auckland DHB CMO, Dr Margaret Wilsher, was held in June 2017. The minutes are attached as Appendix 4. The group considered a range of possible MSF tools and agreed that the next step was to socialise the concept and present an early draft prototype at the first prevocational educational supervisor's annual meeting at the end of August. The group also made some preliminary recommendations on a range of other issues such as the appropriate frequency of undertaking MSF, who should participate, and how and when it should be implemented.

41. Following the next meeting, Council staff hope to be in a position to present a report with recommendations for the implementation of MSF for interns to the Education Committee in November.

Postgraduate Hospital Educational Environment Measure (PHEEM) tool

42. Council intends to introduce the PHEEM tool into ePort as a voluntary option for DHBs to use to gather intern feedback about their educational experience on each clinical attachment. DHBs would not be required to use this specific tool, but do need to show (as part of the accreditation process) they are gathering feedback from interns and acting on areas where issues have been identified.

43. At the June MSF advisory group meeting, Council took the opportunity to seek the group's guidance on the intention to implement the PHEEM tool. The advisory group gave general support for Council to progress towards implementation.

The next step is for a prototype to be developed by bpac^{nz} in consultation with Council staff and this will be provided to the Education Committee and then Council for consideration.

Accreditation review project

44. The new accreditation process for training providers commenced in August 2015. Seventeen out of 19 training providers will have completed accreditation visits by 31 July 2017. The final two visits are scheduled to be completed by October 2017.

45. The accreditation review advisory group was formed to review the prevocational medical training accreditation standards and accompanying documentation. This is a quality assurance and quality improvement initiative designed to review and refine processes to ensure they are effective and efficient ahead of the second cycle of accreditation assessments commencing in 2018.

46. The accreditation review advisory group held its first meeting on 19 July 2017. Once the group has completed its review the recommendations will be provided to the Education Committee before being considered by Council.

Memorandum of Understanding with medical schools

47. A draft MoU has been developed and discussed with representatives of both medical schools. The content and format of the MoU has been largely agreed. This work is being led by Council's Registrar.

48. Senior Council staff are scheduled to attend the Otago and Auckland medical school deans meeting on 11 August 2017 where the draft MoU will be discussed. Council are awaiting feedback on the MoU which is currently being further reviewed by the medical schools.

Sixth year medical student progress in ePort

49. Medical students in their final year of medical school have access to ePort to allow them to record the attainment of NZCF learning outcomes and the setting and completion of goals in the professional development plan. One of the recommendations from the *Report of the Implementation Review Group* was that there should be further collaboration between Council and the medical schools in encouraging Year 6 medical students to fully utilise ePort functionality.

50. Reports demonstrating progress Year 6 medical students have made in ePort have been circulated to the medical schools (Appendix 5). Although there is a difference in uptake between the two medical schools, there has been a steady and increasing uptake by the medical students at the University of Otago since the progress reports have been circulated and the staff of the university are more encouraging of the use of ePort.

NZCF and an evaluation of prevocational medical training changes

51. A review of the NZCF is scheduled to commence later this calendar year.

52. A comprehensive external evaluation of the prevocational medical training programme will consider whether the intended outcomes have been achieved and this is scheduled for 2018.

Direction four - Accountability to the public and stakeholders

Key outcome of the accountability strategic direction

53. *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 achieved 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.*

Prevocational Medical Education Forum Hobart

54. Council's Strategic Programme Manager attended the 21st Prevocational Medical Education Forum held on 6 – 9 November 2016 in Hobart, Tasmania. Joan's presentation was focused on the first 2 years of the implementation of the prevocational medical training programme for PGY1 and PGY2 interns in New Zealand. This plenary session was well received.

55. The AMC in Australia are further reviewing their intern requirements and are engaging about Council's work in this area.

56. The 22nd Prevocational Medical Education Forum is scheduled to be held 12 – 15 November 2017 in Brisbane. Dr Kenneth Clark will be a keynote speaker at the forum.

Consumer Advisory Group (CAG)

57. Council uses the services of the HDC's Consumer Advisory Group. The purpose of the CAG is to discuss regulatory developments and issues that are relevant to healthcare consumers.

58. The CAG met in April 2017. The meeting agenda included:
- Raising concerns about doctors, using Council's website.
- An update on the statement on doctors and performance enhancing medicines in sport, and a discussion on the *Statement on complementary and alternative medicine*.
- An update by Professor Warwick Bagg, Barbara O'Connor and Dr Papaarangi Reid on the Vision for the University of Auckland Medical Programme for Steady State of 300 students.
- Suggestion from CAG that the medical school curriculum include raising students' awareness about disability in the community.

59. The next CAG meeting has been scheduled for 9 November 2017.

MCNZ/DHB MoU oversight group

60. The MCNZ/DHB MoU oversight group meeting provides a forum for discussion about a range of issues and Council's strategic priorities, including prevocational medical training.

61. The oversight group met on 1 December 2016 and 28 April 2017. The topics discussed included:
- RACS Surgical Education and Training programme.
- Changes to prevocational medical training, including flexibility in PGY2.
- Police checks as a requirement for gaining registration.
- Doctors acting as supervisors whilst under HDC investigation.
- Queries regarding practising certificates and reporting processes.

62. The next MCNZ/DHB MoU oversight group is scheduled for 20 July 2017.

Annual meeting of the medical colleges

63. The annual meeting of the medical colleges was held on 10 October 2016. The meeting was attended by 65 representatives from the colleges and some of their Australian counterparts including executives and fellows. The following topics were covered:
- Cultural competence, partnership and health equity.
- RPR evaluation programme.
- Proposed changes to recertification requirements.

- Review of changes to prevocational medical training.
- Building a culture of respect.
- IMG assessments for vocational registration.
- An update on the Council statements currently being reviewed.

64. The next annual meeting with medical colleges is scheduled to be held on 27 October 2017. Topics on the agenda for this meeting are:
    - Cultural competence, partnership and health equity.
    - Strengthening recertification for vocationally registered doctors.
    - The role of colleges with competence, conduct and health.

Medical colleges Executive Office meeting

65. The medical colleges Executive Officers meeting was held at the Copthorne Hotel on Friday 5 May 2017. The main topics discussed were:
    - The role of colleges in competence, conduct and health concerns.
    - Recertification requirements for vocationally registered doctors.

MoU with New Zealand Police

66. Council's Registrar and senior staff at New Zealand Police have reached agreement over the final MoU format and content.

67. The signing of the MoU between New Zealand Police and the Medical Council is scheduled to occur on Wednesday 30 August 2017. The MoU will be signed by the NZ Police Commissioner and Council's CEO.

Stakeholder engagement

68. A stakeholder engagement report for June and July 2017 is attached as Appendix 6, listing the stakeholder meetings which have taken place since the last Council meeting. A matrix report linked to the stakeholder report is attached as Appendix 7.

69. A summary of all stakeholder engagement for the period 1 July 2016 and 30 June 2017 is attached as Appendix 8. Council attended210 meetings with stakeholders this year compared to 225 meetings during the 2015/2016 business year.

Attachments

70. Appendix 1 – Business plan from 1 July 2016 to 30 June 2017
71. Appendix 2 – Prevocational Implementation Review – Status report
72. Appendix 3 – Community Based Attachment Indications (May 2017)
73. Appendix 4 – MSF Advisory Group meeting minutes
74. Appendix 5 – Sixth year medical student progress in ePort (June 2017)
75. Appendix 6 – Stakeholder meetings report (June 2017)
76. Appendix 7 – Stakeholder matrix report (June 2017)
77. Appendix 8 – Summary of stakeholder engagement for the period 1 July 2016 to 30 June 2017

Recommendation

78. Council receives the report on progress of the strategic directions for the 12 month period of 1 July 2016 to 30 June 2017, and provides feedback.

Joan Crawford
Strategic Programme Manager

July 2017