14 and 15 August 2018
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 of the strategic directions and initiatives for the 12 month period of 1 July 2017 to 30 June 2018.

Executive summary

2. This report is a summary of the progress with key initiatives over the 12 months from 1 July 2017 to 30 June 2018.

Council's strategic goals

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

4. **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.

5. **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.

6. **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.

7. **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

8. In 2017/18 Council's five strategic directions were:
   a. Accountability to the public and stakeholders.
   b. Promoting competence.
   c. Cultural competence, partnership and health equity.
   d. Medical education.
   e. Research and evidence-based regulation.

9. Each strategic direction links to one or more of Council's strategic goals (see Appendix 1, Council's business plan 2017/18). As the initiatives within the strategic directions are implemented, Council moves closer to achieving its goals.

Direction one – Accountability to the public and stakeholders

Key outcome of the accountability to the public and stakeholders strategic direction

10. *The Council is accountable to the public, to Parliament, and to the profession. 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. The best interests of the public are integral to all Council strategic planning, policy development and business activity.*

Prevocational Medical Education Forum Brisbane

11. Joan Simeon, Antonia O'Leary and Elmarie Stander attended the 22nd Australia and New Zealand Prevocational Medical Education Forum (ANZPMEF) held on 12 – 15 November 2017 in Brisbane.

12. Dr Kenneth Clark and Joan Simeon attended as keynote speakers at the forum. Dr Clark presented on *Training and developing the New Zealand medical workforce: What we think we are doing well and what we are working on.* He also covered the prevocational work we have completed and how this has contributed to better quality training, as well as the review of the New Zealand Curriculum Framework (NZCF) which is currently underway.

13. Joan presented on *Cultural competence, partnership and health equity.* Joan discussed how our decisions are affected by our own conscious and unconscious bias, often brought about by our own life experience. Her presentation sparked some robust discussions and thought-provoking questions from the audience.

14. Antonia provided a demonstration of ePort. There was strong interest from the Australian attendees, who are considering a similar system in Australia – although they are grappling with significant inter-jurisdictional challenges.

15. The 23rd ANZPMEF conference is scheduled to be held from 11 –14 November 2018 in Melbourne with the focus being "next level, exploring new horizons". Joan and Elmarie will be attending on behalf of Council.

Consumer Advisory Group (CAG)

16. Council uses the services of the HDC's Consumer Advisory Group, which meets twice each year. The purpose of the CAG is to discuss regulatory developments and issues that are relevant to healthcare consumers.

17. The CAG met in November 2017 and April 2018 and discussed a range of topics, including proposed changes to Council's statements on *Complementary and alternative medicine; Safe practice in an environment of resource limitations;* and *Professional boundaries in the doctor-patient relationship*.

18. The next CAG meeting is scheduled for 8 November 2018.

Stakeholder engagement and consultation to inform policy development

19. In July 2017, Council consulted the profession and stakeholders on its proposed changes to the statement on *Doctors and CAM (Complementary and Alternative Medicine)*. While the contents of the previous statement (dated March 2011) were still applicable, Council sought to improve its

flow and clarity by re-ordering some clauses and revising some of the wording. The revised statement emphasises that doctors who practise CAM are expected to adhere to their professional, legal and ethical obligations as a doctor, and provides further guidance on discussing CAM with patients, advertising CAM services and associating with a CAM clinic, therapy or device.

20. Council finalised and signed off on the proposed changes to the CAM statement in November 2017, and the updated statement was posted to Council's website in December 2017.

21. Council is currently consulting the profession and stakeholders on proposed changes to the statement *Safe practice in an environment of resource limitation*. The consultation is open until July 2018.

MCNZ/DHB MoU oversight group

22. The MCNZ/DHB MoU oversight group provides a forum for discussion about the MoU, which defines the roles and responsibilities of each party with regard to the regulation of doctors. The group usually meets three times per year.

23. The group met in July, November and March and discussed a range of issues, including:
    a. prevocational medical training (including Council's revised accreditation standards for community-based clinical attachments and PGY1 time requirements)
    b. changes to Council's policy on reference requirements for applications for registration
    c. the introduction of the electronic portfolio of international credentials (EPIC) service
    d. sharing of information with DHBs relating to practising certificates.

24. The first meeting for the 2018/2019 year will be held on 18 July 2018.

Annual meeting of the medical colleges

25. The annual meeting of the medical colleges was held on 27 October 2017 at Te Papa, with approximately 80 attendees. Medical college representatives included a number from Australia. Several DHB CMOs also attended.

26. The main focus of the agenda was cultural competence, partnership and health equity and this was led by Dr Curtis Walker. Recertification for vocationally registered doctors was also discussed and colleges and DHBs expressed general support to the direction Council is taking with this work. Other agenda items included a presentation of the latest data from the evaluation of RPR, a discussion about the role of colleges in competence, conduct and health processes and an update about Council statements.

27. The next annual meeting with medical colleges is scheduled to be held on 11 September 2018. The focus for this meeting will be strengthening recertification for vocationally registered doctors.

Executive meeting of medical colleges

28. Executive office holders are invited to attend the Executive meeting of medical colleges for discussions on Council's upcoming strategy and policy work.

29. The Executive meeting was held on Wednesday 2 May 2018 and was well attended with representatives from most colleges. Council's work on strengthening recertification was the key topic on the agenda, while other discussions were around Council's 5 year strategic plan and policy updates.

Stakeholder engagement

30. A stakeholder engagement report for June 2018 is attached as Appendix 2, 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 3.

31. A summary of all stakeholder engagement for the period 1 July 2017 and 30 June 2018 is attached as Appendix 4. Council attended 201 meetings with stakeholders this year compared to 213 meetings during the 2016/2017 business year.

Direction two – Promoting competence

Key outcome of the promoting competence strategic direction

32. *Council will apply the principles of 'right touch' regulation to ensure all doctors maintain competence, have up-to-date knowledge and are fit to practise throughout their medical career. Council's focus is on changing behaviour through the use of education and non-regulatory levers. 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

33. Council developed and widely consulted on a proposed framework for strengthening recertification activities in early 2017.

34. At its meeting in July 2017, Council decided that given the large amount of interest during the consultation, further engagement with stakeholders was required, beginning with establishing a working group to consider an approach.

35. The working group, which includes employers and medical colleges, met and considered the feedback received from Council's consultation, the potential sources of data that could be used to identify a doctor's development needs, and what would be required to ensure a strengthened approach. The group was also cognisant of the direction of the Medical Board of Australia (MBA).

36. Joan Simeon attended two meetings with the MBA in November 2017 and February 2018, where the Australian approach was discussed. At a principled level, many similarities in strategy and direction were recognised, however there were also two key differences: The first being the MBA's intended approach regarding the ageing doctor; and the second being their intention to use the process to identify poor performance.

37. In May 2018, Council staff presented high level thinking about the possible next steps towards strengthening recertification at the Executive Meeting of Medical Colleges, which was positively received.

38. The revised approach places emphasis around doctors undertaking recertification activities that are meaningful and appropriate for a doctor's individual learning needs, and that recertification processes needed to be supported by employers. Other key elements include reducing or removing duplication of activities across processes including credentialing, annual appraisal and recertification; and ensuring flexibility for medical colleges to design recertification programmes appropriate to their scope.

39. The outcome of the working group's discussions are to be presented to Council at its July 2018 meeting. The intention is to then undertake further engagement with the profession, medical colleges and other stakeholders before final recommendations are provided to Council.

Evaluation of Regular Practice Review (RPR)

40. 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.

41. 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, with opportunity to have an in-depth interview; and 12 months after completing the RPR.

42. In August 2017, a substantive report was provided by Malatest International, *Evaluation of the Regular Practice Review Programme: August 2017*. Findings from this evaluation report were presented to Council at its September meeting.

43. The latest report from Malatest International, *Evaluation of the Regular Practice Review Programme: March 2018,* further updates the substantive August 2017 report with information to the end of January 2018. The report includes some early information about doctors who have been reviewed for the second time. There have been 865 reviews to the end of February 2018, including 104 doctors who have been reviewed twice. Doctors working in general practice settings account for 52% of first reviews and 90% of second reviews.

44. Findings of interest in the March report include:
    a. After RPR, nearly half (first RPR 43%, second RPR 47%) of doctors said they had made changes to their practice due to their review. A further 12% (first review) and 16% (second review) intended to make changes in the future.
    b. In response to the post-RPR survey, 42% (first review) 52% (second review) of doctors thought that participating in RPR improved the care they deliver to their patients and/or helped in other ways (first review 50%, second review 52%).
    c. Many doctors found participating in RPR a more positive experience than anticipated. Following their first review, over half (57%) of doctors agreed it was a positive experience compared to 31% before their review. Over half (56%) of responding doctors would recommend RPR to a colleague.

45. A further substantive report is due at the beginning of August 2018.

Review of collegial relationships

46. Doctors registered within a general scope of practice (except PGY2s and doctors completing a vocational training programme) are required to establish a collegial relationship with a doctor who is registered within a vocational scope in the same or closely related area of medicine in which they work. The main purpose of the collegial relationship is to ensure that the doctor's professional development plan and CPD activities are appropriate for, and focused on the actual work that the doctor is undertaking. Within some collegial relationships this opportunity is not well utilised.

47. A review of the effectiveness of collegial relationships within the recertification programme for doctors registered in a general scope of practice was completed in 2017/18. A working group was established to consider the strengths, weaknesses, and opportunities for improvement in the current collegial relationship model. The working group included Dr Jonathan Fox (Council member), Dr Michael Roberts (CMO, Northland DHB), Nigel Thompson and Tony Fraser (bpac[nz]) and Council staff.

48. The group sought feedback from general registrants and collegial relationship providers via a short survey to gain a better understanding of their views. The group considered the feedback and will make the following recommendations to Council at its July meeting:

a. Develop structured guidance for collegial relationship meetings.
b. Develop a video based introduction to the meeting guidance that will be made available within the *Inpractice* eportfolio.
c. Make improvements to the *Inpractice* collegial relationship meeting record.
d. Update the *Inpractice* guide regarding collegial relationships, including the addition of the PDP Review and Development Guide.
e. Gather baseline data to review the effectiveness of the structured guidance and updates to the *Inpractice* collegial relationship meeting record.

49. Consideration was given to the impact of any recommendations on the other two groups of doctors requiring a collegial relationship:
    a. Doctors registered in a vocational scope of practice who are working outside their vocational scope.
    b. Doctors whose practice of medicine is deemed so low risk that they do not need to participate in a recertification programme.

    A report regarding strengthening collegial relationships for these doctors will be presented to a future Council meeting.

Direction three – Cultural competence, partnership and health equity

Key outcome of the cultural competence strategic direction

50. *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.*

Cultural competence, partnership and health equity work programme

51. Work is underway via a partnership approach with Te Ohu Rata o Aotearoa (Te ORA) Māori Medical Practitioners Association. A governance group and an advisory group have been formed, alongside an evaluation advisory group to advise on an evaluation programme.

52. The Advisory Group, led by Dr Curtis Walker, met in September 2017 to discuss the work programme and initiatives that will enable the key outcomes to be achieved. The group also considered opportunities to influence and facilitate change and how an evaluation framework could be developed.

53. Te ORA has been contracted to review and update Council's statements and resources on cultural competence. These include:
    a. *Statement on cultural competence*.
    b. *Statement on best practices when providing care to Māori patients and their Whānau*.
    c. *Best health outcomes for Māori: Practice implications* (a guidance resource).

54. Once received, these documents will be reviewed by the Cultural Competence, Partnership and Health Equity Advisory Group and Governance Group before coming to Council.

Cultural Competence, Partnership and Health Equity evaluation

55. The Evaluation Advisory Group met in February 2018 to begin work towards developing a framework to gather baseline data that will eventually be used to evaluate whether the cultural competence, partnership and health equity work programme is achieving the desired outcomes.

56. The Evaluation Advisory Group agreed some parameters for the evaluation programme, as well as potential sources for gathering the baseline data.

57. A Request for Proposal (RFP) for the collection of baseline data is under development and once reviewed by the evaluation, advisory and governance groups, will be provided to Council.

Tikanga Māori and Te Reo training for Council staff

58. Associate Professor Papaarangi Reid (Head of Department of Māori Health, University of Auckland) facilitated a workshop for all Council staff, covering a range of cultural competence concepts on 10 November 2017. Papaarangi discussed cultural competence, cultural safety, and conscious and unconscious bias and how these contribute to health inequities.

59. Arrangements have since been made for the first cohort of Council staff to undertake training in Tikanga Māori and Te Reo over an eight-week course beginning in August 2018.

Direction four – Medical education

Key outcome of the medical education strategic direction

60. *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 the implementation of the prevocational medical training programme

61. 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. 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.

62. The recommendations from the report have now been completed and all actions have been addressed. The review group met in March to consider the extent to which the recommendations had been implemented. The group's final report will be provided to Council at its July meeting.

New Zealand Curriculum Framework (NZCF) for prevocational medical training

63. A steering group was established in 2017 to review the NZCF, consider possible improvements and make recommendations to Council. The steering group, led by Professor John Nacey (Education Committee Chair), has membership from a wide range of key stakeholders, including a CMO, universities, clinical directors of training, prevocational educational supervisors, interns and the NZRDA.

64. The group has met three times, most recently in June 2018, to consider feedback on the current NZCF model from those involved in intern training, and suggestions about how it could be improved.

65. The group is considering a model similar to Entrustable Professional Activities (EPAs) as developed by the Association of American Medical Colleges, which could assist with clustering and reducing the number of learning outcomes in the NZCF. A sub-group of the working group is currently developing this concept further within the New Zealand context, and the steering group will consider progress on this at its next meeting.

Feedback on interns' educational experience

66. One of the recommendations from the review of the implementation of the prevocational medical training programme was to provide a tool for DHBs to gather feedback from interns on their educational experience in each clinical attachment. As part of accreditation requirements, training providers need to show Council they have gathered intern feedback and that this has been incorporated into quality improvement strategies.

67. After conducting research and seeking the views of stakeholders, Council decided that the Postgraduate Hospital Educational Environment Measure (PHEEM) tool, with some local adaptations, would be suitable for use by DHBs.

68. At its September 2017 meeting, Council decided to offer the New Zealand version of the PHEEM tool to DHBs to use on a voluntary basis. The tool was provided in electronic form to DHBs in October 2017.

Multisource feedback (MSF) for prevocational medical training

69. At its meeting in July 2013, Council decided that MSF would be implemented as part of the changes to prevocational medical training. In 2017, the MSF advisory group was established to discuss issues and provide guidance to Council prior to the introduction of an MSF tool in ePort. The MSF advisory group brings together representatives from Council, across DHBs, NZRDA and NZMA DiTC.

70. Recommendations from the MSF advisory group were considered by Council in December 2017. Council approved the draft MSF tool for prevocational medical training for use in a pilot among PGY2s in a selection of small and large DHBs during quarter two of the 2018 intern year. Twenty prevocational educational supervisors were recruited from a selection of DHBs to assist Council with running the pilot and they received training in early February. The pilot closed at the end of May.

71. The MSF advisory group will consider the findings from the pilot in July. Final recommendations from the group will be provided to the Education Committee in August and Council in September.

Accreditation review project

72. New accreditation standards and assessment processes for prevocational medical training providers were introduced in 2014 and now that all DHBs have been assessed against the standards, Council decided it was timely to review these to ensure they were fit for purpose. This review has been completed and Council approved the updated *Accreditation standards for training providers, Accreditation standards for clinical attachments* and the *Definition of a community-based attachment* at its meeting in December 2017. The amended documents were circulated to stakeholders following Council's decision, with the revised standards in effect from 1 July 2018.

73. All additional accreditation documentation was reviewed and updated to match the revised standards.

Community based attachments (CBAs) for prevocational medical training

74. In June 2017, Council set a goal of 50 percent of interns completing a CBA (over their 2-year internship) by the end of 2018, with the aim of reaching 100% by November 2020.

75. Dr Kenneth Clark (CMO MidCentral DHB, Chair of the National Workforce Strategy Group) 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 is non-negotiable.

76. In July 2017, the definition of a community attachment was reconsidered by the Accreditation Review Advisory Group to provide for the opportunity for suitable public health clinical attachments to be included.

77. Council received a summary report from the NZRDA on the CBA experiences of interns for 2017. The report demonstrates that feedback from doctors about their experience on CBAs continues to be predominately positive, with General Practice being the most common placement among interns, followed by Hospice and Urgent Care. Overall, from the reports received from interns, there have been improvements in the CBA experience over time as the concept has developed. The report includes two recommendations to be considered by the CBA Governance Group at its meeting on 8 August 2018.

Evaluation of all changes to prevocational medical training requirements

78. The majority of changes to the prevocational medical training programme have now been in place for 3 years. In December 2017, Council initiated an evaluation of the programme to ensure it is providing a quality training experience for interns and delivering against the intended outcomes. Baseline data about key aspects of the programme changes was collected by an external provider, Malatest International, just prior to the implementation in November 2014.

79. An evaluation group, chaired by Dr Kenneth Clark, has been established to consider the evaluation approach and Malatest International was chosen to undertake this work.

80. The group met to refine Malatest International's proposal and these revisions were incorporated into the final agreed approach.

81. The evaluation began in June 2018 and the first findings from the evaluation are expected in September 2018.

Training for clinical supervisors of interns – online module

82. In November 2017, Council released an online clinical supervision skills training course (level 1) for clinical supervisors of interns as an introductory or refresher course. The course was developed In place of training for supervisor workshops previously provided by Council and is available to clinical supervisors and prevocational educational supervisors in ePort.

83. The online module consists of two parts:
    a. An interactive session produced by Connect Communications, including training on effective supervision techniques.
    b. A session produced by Council staff which consists of web-based tutorials on ePort functionality.

84. Separate to this, Connect Communications has also developed a level 2 applied supervision skills face-to-face course which is now available to DHBs.

Enhancement of ePort

85. The key focus for the 2018/2019 business year is to further refine and update ePort, as well as develop and implement an application on mobile devices for interns to record learning on the go. This work is now underway.

Collaboration with medical schools to create a quality transition process for medical students

86. Council staff have been working with the University of Auckland and the University of Otago medical schools on ways to smooth the transition process for medical students moving into intern training. In particular, work in underway to improve the timing and data requirements for entering students into ePort, to allow access earlier in their final year of medical school. Antonia O'Leary

and Krystiarna Jarnet also demonstrated ePort to a group of surgical medical students at the Wellington Campus.

87. Antonia and Krystiarna are also looking to develop an online module for students to access via the medical school's Moodle (online information management system).

Direction five – Research and evidence-based regulation

Key outcome of the accountability strategic direction

88. *Council is aware of the fast pace of technological and communication advancement and the need to ensure policy and standards are developed using valid and reliable evidence. The key outcome of this strategic direction is to ensure all strategic and policy decisions are supported by valid and reliable evidence, with the public interest at the centre.*

Evaluate strategic and policy initiatives to consider the effectiveness of regularly interventions

89. This strategic direction sits across all directions and accordingly, there are several evaluations underway for a range of initiatives, which will inform and contribute to strategic, policy and process improvements across Council's work programmes. Examples include:
    a. Evaluation of RPR (strategic direction two).
    b. Evaluation of the cultural competence, partnership and health equity (strategic direction three).
    c. Evaluation of changes to prevocational medical training (strategic direction four).

Use of workforce data to contribute to health workforce flexibility and planning

90. Council surveys doctors at the time they renew their practising certificates to collect detailed workforce data. This data is then analysed and reported to the Ministry of Health (MoH) and Health Workforce New Zealand (HWNZ) as aggregated statistics. Council also collects a significant amount of non-survey data from doctors through performing our registration functions and answers any additional requests for workforce statistics. This includes requests from the MoH and HWNZ, as well as other stakeholders in the health sector, both in New Zealand and overseas.

Analysing and interpreting Council collected data to inform policy and strategy development

91. A review was undertaken to explore the demographic information of doctors required to undertake educational programmes, areas of focus in the educational programme, previous conduct, competence, and health history, and educational programme outcomes. The report identified that older, male doctors who work in general practice are over-presented in terms of being required to undertake educational programmes. Analysis also found that 66% of the doctors in this group had previous competence or conduct history with Council, suggesting that previous performance and behaviour can be a predictor for future Council involvement. These findings are in line with international research.

92. Council will be provided with a report on the wider analysis of performance and conduct processes in September 2018.

Attachments

93. Appendix 1 – Business plan from 1 July 2017 to 30 June 2018
94. Appendix 2 – Stakeholder meetings report (June 2018)
95. Appendix 3 – Stakeholder matrix report (June 2018)
96. Appendix 4 – Summary of stakeholder engagement for the period 1 July 2017 to 30 June 2018

Recommendation

97. Council receives the report on progress of the strategic directions for the 12 month period of 1 July 2017 to 30 June 2018, and provides feedback.

Raylene Bateman
Strategic Programme Manager

July 2018