18 December 2017

Prevocational medical training programme implementation review

This letter is to confirm that at its meeting of 13 September 2017, Council revisited its decision outlined in the notice of March 2017 for recommendations 16, 17 and 18 of the prevocational training programme review report. At its December 2016 meeting Council had initially resolved to accept Recommendation 16 and 17, but not to accept Recommendation 18 (related to supervision of interns in the Auckland region).

However, upon further review, at their meeting in September 2017, Council rescinded its December 2016 decision, and instead resolved that ***Recommendation 18*** on the Prevocational medical training implementation review report be accepted. This means that interns in the Wellington or Auckland region may have a prevocational educational supervisor located in one of the other DHBs within the same region. In these cases, the following conditions apply:

- Quarterly meetings must occur between prevocational educational supervisors and interns (at the beginning of the intern year and at the end of each clinical attachment) and must be held in person (as opposed to via telephone or email). Council resolved that this condition is specific to the Auckland metropolitan DHBs (acknowledging that this is not relevant to the Wellington-region DHBs at this point in time).
- If the intern has been identified as needing additional support, then ideally a prevocational educational supervisor should be appointed who is at the same site as the intern. Alternatively a shared care system including support from a local onsite prevocational educational supervisor should be put in place. The role of the local onsite prevocational educational supervisor is to provide immediate support to the intern and assistance with communication with clinical supervisors if needed. If an additional local onsite prevocational educational supervisor is used, then they should also be involved in review of the intern's progress with the Advisory Panel at the end of PGY1 and at the end of PGY2.

Council further resolved that the efficacy of the supervisory arrangements in the Auckland region will be explicitly reviewed when the three Auckland metropolitan DHBs undergo a reaccreditation assessment in 2018 and 2019. As part of this, Council will seek reassurance that the DHBs are meeting the conditions of Council's decision, including that the meetings between prevocational educational supervisors and interns are being held in person, as opposed to via the telephone or email.

Further actions arising from all the recommendations will be incorporated into Council's work programme and implemented from 2017 onwards.

Mr Andrew Connolly

Chairman

Medical Council of New Zealand

13 December 2016

Prevocational medical training programme implementation review

The Medical Council of New Zealand (Council) is pleased to publish a report on an independent review of the implementation of the prevocational medical training programme for interns. The review was carried out following extensive changes implemented by the Council with the aim of improving the educational experience for interns and to assist in the continuum of learning prior to vocational training.

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 Implementation Review Group, which sought input from a range of stakeholders, considered if the changes 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.

Overall, the Implementation Review Group found that the changes to prevocational medical training had been effectively implemented and that the changes provided a greater level of transparency for all involved in intern education. This had contributed to an increased level of interaction between clinical supervisors and interns on clinical attachments and better quality feedback. The collective changes were contributing to a positive change in the perception and culture of prevocational medical training in New Zealand.

On behalf of Council, I would like to thank Dr Clark, the members of the Implementation Review Group and all other stakeholders involved, for their time and expertise in contributing to this important review and developing this excellent report.

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 is developing a work programme around these.

Council's decision on some recommendations differed from that proposed by the Implementation Review Group. These related to:

- ***Recommendation 1:*** That Council includes an explanation that any mix of the options for interns attaining learning outcomes from the *New Zealand Curriculum Framework for Prevocational Medical Training* will be satisfactory, as long as progression through the intern years is demonstrated.
- ***Recommendations 4 and 5:*** Council agreed in principle with these recommendations about the number of learning outcomes an intern should attain, but proposed a change in the way requirements are expressed to:

  > *"Each intern is expected to make progress in attaining the learning outcomes in the NZCF. To be considered sufficient, interns should record the attainment of at least 75% (279) of the learning outcomes by the end of PGY1 and 95% (354) by the end of PGY2".*

- ***Recommendations 16 and 17*** were accepted, ***recommendation 18*** was not accepted. These three recommendations will be combined and changed to:

  > "The prevocational educational supervisor whenever possible should be the same person for the entire year. However if the intern moves to another DHB during the year then a new prevocational educational supervisor must be appointed for that intern at the new DHB, to ensure that the intern and prevocational educational supervisor work at the same DHB and can meet in person."

Actions arising from all the recommendations will be incorporated into Council's work programme and implemented over the 2017 year.

Mr Andrew Connolly
Chairman
Medical Council of New Zealand

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PREVOCATIONAL MEDICAL TRAINING IN NEW ZEALAND CHANGE PROGRAMME

Report of the Implementation Review Group

November 2016

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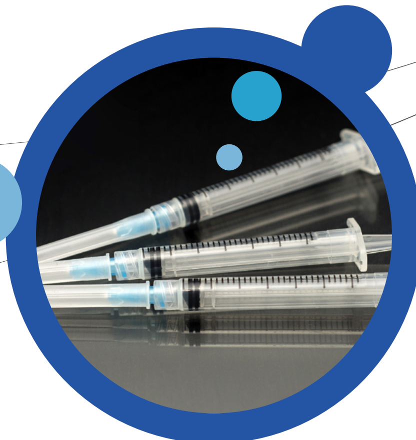


FOREWORD

...a need to evolve training to best match future models of care, to better balance service requirements and training, and to better integrate training with the years prior to and following the prevocational years, are seen as the key drivers for Council's strategy.

Over the last two years the Medical Council of New Zealand (Council) has made a number of bold changes to the ways in which first and second year postgraduate doctors are trained. Prevocational medical training has changed very little in this country for several decades and yet New Zealand has enjoyed a strong reputation for the quality of the doctors it has produced.

What then is the rationale for change? Indeed this has been tested and debated within the health and education sectors and a need to evolve training to best match future models of care, to better balance service requirements and training, and to better integrate training with the years prior to and following the prevocational years, are seen as the key drivers for Council's strategy. Modern, user-friendly training tools for both trainees and trainers were also seen as being highly desirable and overdue.

This review is a first step in evaluating the implementation of these changes. Council has had the foresight to involve many external stakeholders in the review and the findings and recommendations that follow should serve the profession and the broader health sector well in ensuring effective implementation of the training changes and in adjusting and further refining the change programme still to come.

New Zealand performs well in training doctors fit to serve its people and refocussing and further developing how we train is essential to our producing the best equipped doctors for our future.

Dr Kenneth Clark
Chair, National District Health Board Chief Medical Officer group

1. EXECUTIVE SUMMARY

1.1 Introduction and context of the review

After graduation, doctors in New Zealand commence an internship. The internship is designed to build on the prior learning, experience, competencies, attitudes and behaviours acquired during medical school and provide a broad general experience prior to entering vocational training. Intern education and training is delivered by the 19 District Health Boards (DHBs) nationwide.

Council commenced a review of prevocational medical training in late 2010, focusing on the issues relating to the education and training of doctors during the first 2 years following graduation from medical school. Following extensive consultation, decisions made in 2013 led to a number of key changes to prevocational medical training. A transitional implementation plan was developed to manage the change programme, with the first changes taking effect in November 2014 and further changes in November 2015.

The Prevocational Implementation Review Group was set up to consider if the changes made to prevocational medical training have been effectively implemented and accepted by interns, training providers and all those involved in intern education. The purpose of this review is to consider key questions regarding the implementation process, structures and outputs of the prevocational medical training changes to date. The recommendations from this review will be used to inform further changes and improvements over the course of the 2017 year.

A formal external evaluation of the performance and outcomes of the changes to prevocational medical training will be undertaken in 2018.

1.2 Review group members

The prevocational medical training change programme Implementation Review Group Members are:

Dr Ken Clark (Chair), National DHB Chief Medical Officer (CMO) group Chair, CMO MidCentral DHB

Dr Martin Thomas, CMO, Lakes DHB

Dr Wayne de Beer, Clinical Training Director, Waikato DHB

Dr Philippa Poole, Head Department of Medicine, University of Auckland

Pat Hartung, Director Human Resources & Corporate Support Services, Northland DHB

Dr Suzanne Busch, Prevocational Educational Supervisor, Nelson Marlborough DHB

Dr Huib Buyck, Prevocational Educational Supervisor, Capital and Coast DHB

Dr Jules Schofield, Prevocational Educational Supervisor, Waikato DHB

Dr Magnus Cheesman, New Zealand Medical Association Doctors in Training Council (NZMA DiTC) member

Dr Sam Holford, New Zealand Resident Doctors' Association (NZRDA) National Executive member

Terina Davis, Portfolio Manager Workforce Operations, Northern Regional Alliance

David Brandts-Giesen, Team Leader Resident Doctors Support Team, Canterbury DHB

Irene Warren, Medical Management Unit Coordinator, Lakes DHB

Professor John Nacey, Education Committee Chair, Council

Philip Pigou, Chief Executive, Council

Joan Crawford, Strategic Programme Manager, Council

1.3 Review findings

The review group considered data and evidence gathered from the ePort system which records and tracks each intern's progress as well as that gathered by Council as part of its accreditation processes. It also accessed feedback from each of the national District Health Board (DHB) groups including Chief Executives, Chief Medical Officers, Chief Operating Officers, General Managers of Human Resources and Resident Medical Officers (RMO) Managers as well as from each individual DHB. There were members from the NZ Resident Doctors Association and the NZ Medical Association Doctors in Training Council on the review group who consulted small focus groups for intern feedback.

Overall, the changes to prevocational medical training have been effectively implemented.

The changes have resulted in a greater level of transparency for all involved in intern education and training.

This is contributing to an increased level of interactions between clinical supervisors and interns on each clinical attachment and better quality feedback. The introduction of ePort as a tool for recording and monitoring intern progress means there is more quantitative and qualitative data available to those involved in education and training, to interns and to Council.

All of the changes together are contributing to a change in culture and attitudes to prevocational medical training in New Zealand.

1.4 Review group recommendations

The review found a number of important issues that need to be addressed. Arising from these are the following recommendations:

1. A drop down box is inserted in the NZCF log in ePort to allow interns to record the manner in which they have attained a learning outcome. This will ensure clarity for all involved about the attainment of learning outcomes. The options in the drop down box should be:
    a. The intern has demonstrated competence in the learning outcome.
    b. The intern has participated in the learning outcome.
    c. The intern has knowledge of the learning outcome (either through self-directed learning or through formal or informal teaching).
    d. Attained as part of prior learning during the final year at medical school.
2. The various ways an intern can attain each learning outcome should be emphasised to interns, prevocational educational supervisors, clinical supervisors and all those involved in prevocational medical training.
3. The proposed changes in ePort that will allow an intern to record a 'learning activity' and assign numerous learning outcomes to that one learning activity should be implemented for the 2017 intern year.
4. Each intern should record a minimum of 270 learning outcomes by the end of PGY1 in order to be considered sufficient to apply for registration in a general scope of practice (with an endorsement).
5. Each intern should record the attainment of all 373 learning outcomes by the end of PGY2 in order to have the endorsement removed from their practicing certificate.

6. Training about functionality in ePort should continue to be included as part of ongoing clinical supervisor training workshops.

7. The requirement for interns to make their goals 'SMART' (specific, measurable, attainable, realistic and time bound) should be removed.

8. An exemplar list of appropriate goals needs to be developed and available within ePort as a resource to interns, clinical supervisors and prevocational educational supervisors.

9. Each training provider should include a session in their formal intern teaching programme, within the first month of the intern year, which focuses on goal setting in the PDP.

10. The role of the clinical supervisor in ensuring appropriate goals are set at the beginning of each clinical attachment needs to be emphasised and training providers will need to be involved in this process.

11. Each intern should set at least three goals for each clinical attachment, with a maximum of eight. The prevocational educational supervisor should encourage interns to set goals across more than one domain (from the New Zealand Curriculum Framework (NZCF)) and a drop downbox should be added to ePort under 'My goals' to facilitate choosing of the section headings from the NZCF. The goals should be focused on the current attachment, however some may be longer term.

12. A separate place should be made available in ePort for interns to record their career aspirations and related goals. The current "Personal statement" should be replaced with "Current/future career plans". Functionality to upload documents should be included to the career goals area. Exemplars of career goals and links to career sites should be included in a help button.

13. Further guidance needs to be developed about supervision for relief clinical attachments to ensure interns are provided quality supervision and feedback.

14. The wording of 'marginal pass' should change to 'conditional pass' to encourage clinical supervisors to use this rating when appropriate. The wording change will better reflect that the pass is conditional upon specific improvements being made on the next clinical attachment.

15. The wording 'areas to focus on for improvement' should change to 'areas to focus on for further development'. This features in both the end of clinical attachment assessment and in the PDP section in ePort.

16. The prevocational educational supervisor whenever possible should be the same person for the entire year.

17. If an intern is working across multiple sites within the same DHB they should continue with the same prevocational educational supervisor if at all possible.

18. If an intern moves to another DHB they must have a prevocational educational supervisor at that DHB. However interns in the Wellington or Auckland region may have a prevocational educational supervisor located in one of the other DHBs within the same region. The following conditions apply:
    - Quarterly meetings occur. These may be by telephone (if in person is not practical) but only if the prevocational educational supervisor and the intern have held their first meeting in person.
    - If the intern has been identified as needing additional support, then ideally a prevocational educational supervisor should be appointed who is at the same site as the intern. Alternatively, a shared care system including support from a local onsite prevocational educational supervisor should be put in place. The role of the local onsite prevocational educational

supervisor is to provide immediate support to the intern and assistance with communication with clinical supervisors if needed. If an additional local onsite prevocational educational supervisor is used, then they should also be involved in review of the intern's progress with the Advisory Panel at the end of PGY1 and at the end of PGY2.

19. If an intern has more than one prevocational educational supervisor over the course of the year:
    - A verbal handover should occur between the prevocational educational supervisors to discuss the intern's progress and any concerns.
    - A meeting should be held between the intern and new prevocational educational supervisor as soon as the change occurs to form the supervisory relationship.
20. Further opportunities for interns to provide feedback about their prevocational educational supervisors, RMO units, and others involved in intern education should be explored by training providers.
21. Training providers should hold regular appraisal meetings with clinical supervisors and prevocational educational supervisors for quality assurance and quality improvement processes.
22. Training for clinical supervisors is important and needs to continue and should be made available locally and regionally (using local and regional trainers) and this needs to be enabled by training providers.
23. Regular feedback should be sought from interns about their educational experience on each clinical attachment. This allows training providers to identify problems within the learning environment early and provides opportunity for continuous quality improvement. It is recommended that the Postgraduate Hospital Educational Environment Measure (PHEEM) questionnaire is implemented in the ePort system as the tool used nationally by all training providers. Council will not have access to feedback from interns but will request a collation of the results (annual data to give longitudinal perspectives) and reports demonstrating what changes, if any, training providers have made as a result of the feedback. Council will use this information at the time of training provider accreditation.
24. Further collaboration needs to occur with the universities to ensure medical students in their final year fully utilise the ePort functionality available to them including attainment of NZCF learning outcomes and the setting and completion of goals in the PDP. Use of ePort by medical students must be encouraged.
25. The new requirements for PGY2 should continue to be promulgated to all those involved in intern education.
26. Interns may continue to enter vocational training in PGY2, however they will still be required to record their learning in ePort, including clinical supervisor End of clinical attachment assessments, prevocational educational supervisor meetings, NZCF learning outcomes and goals in their PDP.
27. An intern should complete their PGY2 year prior to being appointed to a registrar position that is not undertaking vocational training.
28. The maximum number of clinical supervisors per clinical attachment should remain at four.
29. Each training provider must appoint a small group of relief attachment clinical supervisors. The relief attachment clinical supervisor will require additional support to ensure they understand the different nature of their role and how to be effective when providing support to interns they are not directly working with.

30. To provide feedback and complete the intern's assessment the clinical supervisor of a relief attachment needs to seek feedback from those who have worked with the intern over the course of the clinical attachment including consultants, registrars and nurses amongst others.

31. Accreditation visits should place particular focus on ensuring interns on relief attachments are appropriately supported and receiving feedback.

32. Training providers should be encouraged to upload additional information, for example objectives for the clinical attachments into the clinical attachment accreditation application.

33. Training providers should make interns and all those involved in intern education aware of accreditation reports being publically available on Council's website.

34. Training providers should be encouraged to share resources and knowledge about prevocational medical training, including those relating to accreditation processes as well as policies and protocols, across DHB and regional boundaries.

35. A review should take place 12 months from the date of this report reviewing the extent to which the recommendations in this report have been implemented. Ideally this should be undertaken by the members of the Implementation Review Group.

2. INTRODUCTION AND CONTEXT

2.1 Background

Council is a statutory body that operates under the Health Practitioners Competence Assurance Act 2003 (HPCAA). The Council's purpose is to ensure that doctors are competent and fit to practise medicine in order to protect the health and safety of the public. The Council has a number of responsibilities which include ensuring doctors who are registered are competent and fit to practise.

It is also Council's responsibility to ensure that the satisfactory completion of requirements set for New Zealand or Australian medical graduates to gain a general scope of practice (during their provisional period) provides assurance of their competence to practise within that scope. Council achieves this by setting the training and education requirements to be satisfactorily completed for the provisional period, ensuring that these provide an opportunity for interns to further learn, develop and demonstrate clinical and professional skills, under the supervision of senior doctors and through an exposure to differing clinical settings.

2.2 Context

Council's strategic direction in medical education has focused on issues relating to prevocational medical training since 2010. The key outcome is to improve the quality of education and training for interns, thereby contributing to the quality of care for patients and enhancing public safety. Decisions made in 2013 led to a number of key changes to prevocational medical training. A transitional implementation plan was developed to phase in these changes, with the first changes taking effect in November 2014 and others in November 2015.

2.3 Rationale and purpose

The changes to prevocational medical training are now almost two years into their implementation and Council considers this an appropriate and important time for a review. The purpose of this review is to consider key questions regarding the implementation process, structures and outputs of the prevocational medical training changes to date. The recommendations from this review will be used to inform further changes and improvements over the course of the 2017 year.

Council commenced a review of prevocational medical training in late 2010, focusing on the issues relating to the education and training of doctors during the first 2 years following graduation from medical school. The review was undertaken by Council with support from Health Workforce New Zealand (HWNZ).

Over recent years there have been numerous reports from reviews of medical education, training and workforce matters. Building on these reports, along with the information Council received through its hospital accreditation visits, Council identified a number of aspects of the prevocational medical training arrangements that required improvement:

- the balance between increasing service demand with increasing training requirements
- the desire for interns to obtain broad based core competencies
- the need for better vertical integration on the continuum of training
- for training to be less hospital focused
- to ensure the continuity of high quality training through postgraduate year 2
- the need for greater accountability by training providers.

Two consultations took place:

1. May 2011: *A review of prevocational training requirements for doctors in New Zealand* proposing options for enhancing the prevocational training framework
2. February 2013: *A review of prevocational training requirements for doctors in New Zealand: Stage 2* proposing a number of changes to prevocational medical training.

At its meeting in July 2013, Council considered the consultation feedback and made a number of decisions. The *Report on the feedback and decisions following the consultation of: A review of prevocational training requirements for doctors in New Zealand: stage 2* outlines the feedback and Council's decisions.

These key decisions led to a number of key changes to prevocational medical training. A transitional implementation plan was developed to phase in these changes, with the first changes taking effect in November 2014 and others in November 2015.

2.4 Prevocational medical training programme of work

Council's recommendations were divided into eight work streams, each with a dedicated working group and clearly defined deliverables. The changes that have been implemented include:

- Developing and implementing the *New Zealand Curriculum Framework for Prevocational Medical Training* for PGY1s and PGY2s.
- Introduction of ePort as an electronic portfolio for recording and tracking each intern's progress.
- A strengthened process of assessment that links to each intern's professional development plan.
- Extension of the prevocational programme and supervision into PGY2.
- Training for clinical supervisors and prevocational educational supervisors.
- New accreditation standards and processes for training providers and for clinical attachments.
- Establishing Advisory Panels to review the overall performance of each intern at the end of PGY1.

A more comprehensive description of the changes that have been implemented as part of the prevocational medical training programme of work is included in Overview of changes to prevocational medical training.

The following initiatives will continue to be implemented in 2016/2017:

- Community based clinical attachments.
- Multisource feedback.
- Introduction of an 'App' for interns to access ePort.

2.5 Scope of the review

The review will focus on the changes described in the programme of work through the implementation period from the end of November 2014 until the end of September 2016. The purpose of the review is:

1. To determine if the changes to prevocational medical training have been widely and satisfactorily implemented with appropriate systems and processes in place.
2. To determine if the changes to prevocational medical training are operating effectively.
3. To determine if the changes to prevocational medical training have been accepted by users and stakeholders.

4. To highlight any challenges or barriers to the implementation of the changes to prevocational medical training that need to be resolved.

5. To recommend to Council possible solutions for any issues that are identified.

2.6 Out of scope for the review

This review will not include:

- The learning outcomes in the NZCF. The NZCF is scheduled for review in 2018.
- The requirements that have been set to achieve registration in a general scope of practice.
- A formal evaluation of the performance or outcomes of the changes to prevocational medical training. A formal external evaluation is scheduled for 2018.
- Community based clinical attachments as these will not be fully implemented until 2020.

2.7 Approach to the review

Dr Ken Clark, Chair of the National DHB CMO Group was appointed by Council as the Chair of the prevocational medical training review group (review group). The review group was established with membership from a broad range of stakeholders who have a strong interest in medical education. The terms of reference for the review group describes the scope of the review and approach taken (Appendix 1).

The outcomes and recommendations from the review group are provided in this report which will be presented to Council's Education Committee (the Committee) for feedback. This report and any feedback from the Committee will be provided to Council. Council will make the final decision on any actions to be taken in response to the recommendations.

2.8 Structure of the review

There are eight sections in this report that align with the changes implemented to prevocational medical training that are:

1. Attainment of the NZCF learning outcomes
2. Professional development plan (PDP)
3. Assessment of interns
4. Supervision
5. ePort
6. Advisory panel
7. Postgraduate year 2 (PGY2)
8. Accreditation for training providers and clinical attachments
9. General

2.9 Formal evaluation programme

Council contracted Malatest International to collect baseline data in November 2015. The report Medical Council of New Zealand: Establishing a prevocational training baseline March 2015 is available on the Medical Council website. This data will be used to evaluate the effectiveness of the changes made to prevocational medical training. The evaluation is planned for 2018 and will be undertaken by an external provider.

3. FINDINGS OF THE REVIEW

3.1 Attainment of NZCF Learning Outcomes

3.1.1 Background

The *New Zealand Curriculum Framework for Prevocational Medical Training* (NZCF) outlines the learning outcomes to be substantively completed by the end of PGY1 and PGY2. These outcomes are to be achieved through clinical attachments, educational programmes and individual learning, in order to promote safe quality healthcare. It is a high trust model and is a self-reflective tool.

The NZCF builds on the prior learning, experience, competencies, attitudes and behaviours acquired during medical school. A mix of clinical attachments, formal teaching programme and other educational support across PGY1 and PGY2 should ensure a breadth of exposure and opportunities to achieve the learning outcomes.

Interns record the attainment of their learning outcomes in ePort, the electronic portfolio for recording and tracking an intern's progress.

3.1.2 Discussion

The NZCF provides clarity to all involved in intern education about the areas that need to be focused on by interns and also by trainers. It makes it clear what interns should be able to do, or at least have knowledge about, and to know when to call for help. The NZCF has been criticised for having too many learning outcomes and it is scheduled for review in 2018. However in the meantime the NZCF is providing a structure that whilst not perfect, offers clarity of what needs to be achieved. Prior to its implementation in November 2014 a structure for the content of prevocational medical training did not exist. The benefits of the NZCF outweigh the challenges, even in its current form.

Prevocational educational supervisors and clinical supervisors report that interns are using ePort to record the attainment of their learning outcomes from the NZCF.

This is further demonstrated in the data extracted from ePort (see below). However interns are not recording the attainment in a consistent way, with some interns using it as a 'tick box' exercise and others using it as it was intended as a tool to reflect on their learnings. Most interns find ePort intuitive to use although when ePort was first implemented some interns avoided using it and needed encouragement from the prevocational educational supervisors, who provided support additional to that provided by the clinical supervisors.

The availability of ePort to all final year medical students has helped to create a better awareness and familiarity for interns.

Many medical students are recording learning outcomes and goals in their PDP prior to commencing their internship. This is of benefit to them and assists in the important transition between medical student and intern.

Some interns report that the need to record the attainment of such a large number (373) learning outcomes results in them feeling that this is something that must be done, rather than a quality reflective exercise. In response to feedback, Council has made changes in ePort that allow an intern to record a 'learning activity' and assign numerous learning outcomes to that one learning activity. This will reduce the number of entries an intern needs to make to record all of the learning outcomes and is designed to encourage them to spend longer on reflecting on what they have learnt. There has been positive feedback from intern groups when this new functionality has been demonstrated.

Not all learning outcomes can be attained in practice. For example, foreign body removal and anaphylactic shock may need to be incorporated into the formal teaching programme and this is appropriate.

The requirement of 'substantive attainment' of learning outcomes by the end of PGY1 led to confusion and anxiety about the 'right' number of learning outcomes. In response to numerous and persistent requests about the required number of learning outcomes that an intern needs to complete for substantive attainment, Council set the requirement that interns would need to record a minimum of 270 learning outcomes by the end of PGY1.

Some clinical supervisors do not understand the link between the learning outcomes and the accreditation of clinical attachments. Some are not aware of the information available to them in ePort about the specific learning outcomes that are linked to their clinical attachment. Although it is clear to all supervisors and interns which learning outcomes have been recorded overall, some are unaware of the ability to view what learning outcomes the intern has recorded on a specific clinical attachment.

3.1.3 ePort data

Data extracted from ePort at 7 October 2016 demonstrates PGY1 interns had recorded an average of 278 learning outcomes (table 1) which is approximately 75% of the total 373 learning outcomes. Of these PGY1 interns have linked an average of 24 learning outcomes to prior learning during their final year at medical school. PGY2 interns, had recorded an average of 328 learning outcomes (table 2) of which they have linked an average of 30 to prior learning. Over the two intern years interns have linked the attainment of an average of 256 learning outcomes to the work they have done on clinical attachments.

Data from ePort at 7 October 2016

Table 1: Recording of learning outcomes (PGY1s)

Average number of learning outcomes recorded per intern	278
Average number of learning outcomes by prior learning	24

Table 2: Recording of learning outcomes (PGY2s)

Average number of learning outcomes recorded per intern	328
Average number of learning outcomes by prior learning	30

Table 3: Learning outcomes attained on clinical attachments PGY1s and PGY2s

Average number of learning outcomes completed on an attachment	256

3.1.4 Findings

- **The NZCF is providing a structure that whilst not perfect, offers clarity of what needs to be achieved. The benefits of the NZCF outweigh the challenges, even in its current form.**
- **Informal reporting and data extracted from ePort indicates that interns are recording the appropriate number of learning outcomes in each of the two intern years.**
- **Progress with the attainment and recording of learning outcomes by each intern is clear and visible to interns, clinical supervisors and prevocational educational supervisors.**
- **Some clinical supervisors do not understand the link between the learning outcomes and the accreditation of clinical attachments. They are not aware of all the information available to them in ePort about the specific learning outcomes linked to their clinical attachment.**

- **Interns are finding the recording of learning outcomes onerous. The proposed changes in ePort that will allow an intern to record a 'learning activity' and assign numerous learning outcomes to that one learning activity will reduce the number of entries an intern needs to make to record all of the learning outcomes. This should encourage interns to reflect on what they have learnt rather than use it as a tick-box exercise.**
- **There is not a clear understanding by all involved that the NZCF is a high trust, self-reflection tool used as part of the formative assessment. Attainment of learning outcomes by interns may be recorded as complete whether the intern has demonstrated competence, or declared participation or knowledge of the learning outcome, or prior learning of it, however this is not widely understood. Formal (summative) assessment occurs as part of the mid and end of clinical attachment assessment meetings with clinical supervisors.**

3.1.5 Recommendations

1. A drop down box is inserted in the NZCF log in ePort to allow interns to record the manner in which they have attained a learning outcome. This will ensure clarity for all involved about the attainment of learning outcomes. The options in the drop down box should be:
   a. The intern has demonstrated competence in the learning outcome.
   b. The intern has participated in the learning outcome.
   c. The intern has knowledge of the learning outcome (either through self-directed learning or through formal or informal teaching).
   d. Attained as part of prior learning during the final year at medical school.
2. The various ways an intern can attain each learning outcome should be emphasised to interns, prevocational educational supervisors, clinical supervisors and all those involved in prevocational medical training.
3. The proposed changes in ePort that will allow an intern to record a 'learning activity' and assign numerous learning outcomes to that one learning activity should be implemented for the 2017 intern year.
4. Each intern should record a minimum of 270 learning outcomes by the end of PGY1 in order to be considered sufficient to apply for registration in a general scope of practice (with an endorsement).
5. Each intern should record the attainment of all 373 learning outcomes by the end of PGY2 in order to have the endorsement removed from their practicing certificate.
6. Training about functionality in ePort should continue to be included as part of ongoing clinical supervisor training workshops.

3.2 Professional development plan (PDP)

3.2.1 Background

All interns are required to develop and work towards goals in a PDP during PGY1 and PGY2. A PDP is a short planning document compiled by the intern, with input from their prevocational educational supervisor and the clinical supervisor for each clinical attachment. The goals should relate to what the intern needs to learn, what the intern needs to consolidate and what the intern wants to learn (for example for career development). The goals in the PDP must target areas for improvement identified through the previous End of clinical attachment assessment.

The PDP will assist the intern to reflect on achievements and help to identify what they need to do in order to substantively attain the learning outcomes in the NZCF. The PDP helps to structure and focus learning, strengthen existing skills, and develop new skills. The PDP can also help the intern to focus on their vocational aspirations.

For PGY2, the goals in the PDP should be targeted on:

- Outstanding learning outcomes from the NZCF not been completed in PGY.
- Learning outcomes from the NZCF that are stipulated for PGY2.
- Areas for improvement identified on previous clinical attachments.
- Community based experience.
- Vocational aspirations.

The PDP is regularly revisited, reviewed and updated throughout PGY1 and PGY2. Goals relating to PGY2 are endorsed as appropriate by the Advisory Panel at the end of PGY1 when it considers the intern's progress and whether to recommend registration in a general scope of practice.

3.2.2 Discussion

Informal feedback indicates that further clarity and guidance regarding appropriate goals for the PDP is required. Interns can find it hard to set 'SMART' goals (specific, measurable, attainable, realistic and time bound) when they cannot control what they are being asked to do, or what is available on a clinical attachment. Further support is needed for interns and supervisors about the setting of goals and what is appropriate.

Measurement and completion of goals is challenging and should not be the main aim of this part of ePort. This is because what is important may not be easily measurable and what is measurable may not be that important. The setting of goals may be sufficient to show awareness of a learning need. Interns are wanting guidance about the required number of goals that need to be set or completed. However, the number of goals set or achieved should not be taken as any indication of level of performance.

Given the importance of PGY1 and PGY2 in career development all interns should include a career goal in ePort. A separate place in ePort to capture career goals would be beneficial, especially if this was quite separate to the PDP. This could replace the current 'personal statement' on each intern's summary page.

As with other goal setting, a discussion between the intern and prevocational educational supervisor or clinical supervisor at the beginning and end of each clinical attachment about career goals is important.

Supervisors would benefit from specific support to assist them to have conversations with interns about career goals. There are ample resources with career information that the intern can be directed to and ePort does not need to duplicate these.

3.2.3 ePort data

Data extracted from the PDP section of ePort demonstrates that PGY1s have recorded an average of 18 goals and completed an average of 11 (Table 3). PGY2 interns have recorded an average of 23 goals and completed an average of 16.

Statistics from ePort at 7 October 2016

Table 3: Recording of PDP goals (PGY1s)

Average number of goals recorded per intern	18
Average number of goals completed per intern	11

Table 4: Recording of PDP goals (PGY2s)

Average number of goals recorded per intern	23
Average number of goals completed per intern	16

3.2.4 Findings

- **More clarity or guidance regarding appropriate goals and the number of goals to be recorded in the PDP section of ePort is needed. This should include examples of appropriate goals for interns and supervisors.**
- **Emphasis needs to be placed on clinical supervisors and prevocational educational supervisors discussing career goals with interns.**
- **The 'personal statement' on the intern summary page is being used in a number of ways but this might be better used for recording career goals instead.**

3.2.5 Recommendations

7. The requirement for interns to make their goals 'SMART' (specific, measurable, attainable, realistic and time bound) should be removed.
8. An exemplar list of appropriate goals needs to be developed and available within ePort as a resource to interns, clinical supervisors and prevocational educational supervisors.
9. Each training provider should include a session in their formal intern teaching programme, within the first month of the intern year, which focuses on goal setting in the PDP.
10. The role of the clinical supervisor in ensuring appropriate goals are set at the beginning of each clinical attachment needs to be emphasised and training providers will need to be involved in this process.
11. Each intern should set at least three goals for each clinical attachment, with a maximum of eight. The prevocational educational supervisor should encourage interns to set goals across more than one domain (from the NZCF) and a drop down box should be added to ePort under 'My goals' to facilitate choosing of the section headings from the NZCF. The goals should be focused on the current attachment, however some may be longer term.
12. A separate place should be made available in ePort for interns to record their career aspirations and related goals. The current "Personal statement" should be replaced with "Current/future career plans". Functionality to upload documents should be included to the career goals area. Exemplars of career goals and links to career sites should be included in a help button.

3.3 Assessment of interns

3.3.1 Background

Each intern has a record of learning maintained in ePort, which provides a nationally consistent means of tracking progress and recording skills and knowledge acquired during PGY1 and PGY2. The ePort is owned by the intern but is accessible to the prevocational educational supervisor and the clinical supervisor.

The assessment framework for PGY1 and PGY2 provides regular, formal and documented feedback to interns on their performance within each clinical attachment. ePort facilitates the recording of meetings between the intern and clinical supervisor at the beginning, middle and end of each clinical attachment and for the prevocational educational supervisor at the beginning of the year and at the end of each clinical attachment. ePort also allows additional meetings to be recorded when necessary.

The clinical supervisor makes a summative assessment of the performance of each intern they have supervised at the end of each clinical attachment. The clinical supervisor will consult with the healthcare team to inform their assessment. They must also identify areas of the intern's strengths and areas for improvement. Using all of the information available to them, they complete an *End of Clinical Attachment Assessment* and must rate the overall performance on each clinical attachment as either:

- Unsatisfactory.
- Marginal (conditional pass).
- Meets expectation.
- Exceeds expectation or exceptional.

Where there has been a marginal performance on the previous clinical attachment improvement must be observed for the marginal to count as a 'satisfactory' clinical attachment. It is considered a conditional pass.

An *End of Clinical Attachment Assessment* that is marked as marginal will require identified improvement goals to be detailed in the PDP. The goals in the PDP must be agreed to by the prevocational educational supervisor, clinical supervisor, and the intern. Improvement must be observed on the next clinical attachment, with satisfactory performance in all aspects of performance, to allow the marginal attachment to be considered satisfactory.

Since the middle of 2015, functionality in ePort has allowed RMO unit staff and prevocational educational supervisors to send meeting reminders to both interns and their clinical supervisors about due and overdue meetings and assessments.

3.3.2 Discussion

Informal feedback as well as data extracted from ePort indicates that ePort is working effectively with the recording of meetings held between the clinical supervisor, prevocational educational supervisor and intern.

Prevocational educational supervisors and clinical supervisors appreciate being able to view an intern's complete progress, including previous supervision reports, learning outcomes attained and the goals in the PDP.

There continues to be an embedded culture with many clinical supervisors believing that to provide an unsatisfactory rating will affect an intern's career in the long term. Clinical supervisors also appear reluctant to use the marginal pass rating. This is demonstrated in the data extracted from ePort. There could be a number of reasons for this and the language used is one of these. The use of the wording 'marginal pass' could be replaced with 'conditional pass' which is more encouraging, and better reflects that the pass is conditional upon specific improvements being made on the next clinical attachment.

> **When an intern receives a marginal or conditional pass then more focus needs to be placed on the setting of specific goals which need to be achieved by the intern on the next clinical attachment.**

The goals need to be explicit and relate to the reasons for the marginal or conditional rating. A further wording change from 'areas to focus on for improvement' to 'areas to focus on for further development' would also be viewed as more encouraging. Both of these wording changes are designed to encourage clinical supervisors to have open and honest conversations with their clinical supervisors and to encourage the use of the conditional rating when appropriate.

The system for escalation of any immediate concerns regarding the performance of an intern from clinical supervisor to prevocational educational supervisor and when needed, to the CMO or delegate, is working effectively.

The reminder notification system with ePort managed by each training provider is assisting the timeliness of meetings between interns and clinical supervisors as well as prevocational educational supervisors.

Interns who are working on relief attachments often do not meet their clinical supervisor until the end of the attachment. Missing the mid meeting with the clinical supervisor means that the intern does not receive feedback mid-attachment about areas that need to be focused on for improvement before the end of the clinical attachment. Therefore the intern is unable to rectify any deficiencies. Prevocational educational supervisors think that this contributes to marginal and unsatisfactory outcomes occurring more often on relief attachments.

3.3.3 ePort data

Data regarding the occurrence and timeliness of meetings between interns and their clinical supervisors have been extracted from ePort. The data demonstrate that beginning, middle and end meetings have largely been recorded within appropriate timeframes since the implementation of ePort in November 2014.

> **The number of start, middle and end meeting meetings recorded between PGY1 interns and clinical supervisors during 2015 increased for each quarter through the year, and the timeliness of meetings also improved over the course of the year.**

Table 6 includes meetings for PGY1 and PGY2 interns in 2016. Potential reasons for the slight decrease in the number of interns having meetings in 2016 include that this is the first year that PGY2 have been part of formal prevocational medical training and clinical supervisors are adjusting to the need to meet with each PGY2. An additional reason may be that for the first year of implementation Council staff were following up with each DHB each quarter to ensure all meetings were recorded and this responsibility has been passed back to the DHBs in 2016 as business as usual.

The data for quarter 4 in 2016 are not yet available because the quarter was still in progress at the time of the writing of this report.

Beginning meeting (Should occur between 1 -21 days)	Mid meeting (Should occur around 45 days into attachment)	End meeting (Should occur around 91 days into attachment)

Table 5: Meetings between interns and clinical supervisors 2015 – PGY1s

Quarter	Number of interns	No. of start meetings	Start meeting average	No. of mid meetings	Mid meeting average	No. of end meetings	End meeting average
1	402	344	51 days	338	73 days	402	97 days
2	418	405	29 days	398	58 days	417	91 days
3	444	429	34 days	415	63 days	443	92 days
4	448	442	23 days	440	48 days	444	92 days

Table 6: Meetings between interns and clinical supervisors 2016 – PGY1s and PGY2s

	Quarter	Number of interns	No. of start meetings	Start meeting average	No. of mid meetings	Mid meet average	No. of end meetings	End meeting average
PGY1	1	424	415	40 days	397	77 days	421	103 days
PGY2	1	397	377	57 days	359	84 days	390	108 days
PGY1	2	440	436	32 days	416	71 days	439	101 days
PGY2	2	386	356	43 days	338	75 days	366	103 days
PGY1	3	475	462	37 days	445	74 days	371	102 days
PGY2	3	379	342	45 days	322	76 days	336	104 days
PGY1	4	477	424	30 days	N/A	N/A	N/A	N/A
PGY2	4	375	243	32 days	N/A	N/A	N/A	N/A

Table 7 demonstrates the number of marginal outcomes for *End of clinical attachment assessments* completed by clinical supervisors during 2015 and 2016. The number of marginal outcomes is low with 11 being recorded in 2015 and 10 being recorded in the first three quarters of 2016.

Table 7: Marginal outcomes recorded

2015	No. of marginal outcomes	2016	No. of marginal outcomes
Q1	3	Q1	4
Q2	2	Q2	3
Q3	3	Q3	3
Q4	3	Q4	Not available
Totals	11	Totals	10

Table 8 demonstrates the number of unsatisfactory outcomes for *End of clinical attachment assessments* completed by clinical supervisors during 2015 and 2016. The number of unsatisfactory outcomes is very low on the whole and may reflect clinical supervisors' hesitance to fail an intern.

Table 8: Unsatisfactory outcomes recorded

2015	No. of unsatisfactory outcomes	2016	No. of unsatisfactory outcomes
Q1	1	Q1	0
Q2	1	Q2	0
Q3	0	Q3	5
Q4	2	Q4	Not available
Totals	4	Totals	5

3.3.4 Findings

- **The recording of end of clinical attachment assessments and timeliness of meetings is improved by the ePort system.**
- **The reminder system in ePort is helping training providers to follow up on meetings that have not occurred.**
- **The ability to view previous supervision reports assists clinical supervisors and prevocational educational supervisors to gain a sound understanding of each intern's overall progress.**
- **Marginal and unsatisfactory outcomes are more commonly seen on relief clinical attachments.**
- **Interns on relief attachments are frequently not able to meet with the clinical supervisor and this may be contributing to a higher number of marginal ratings.**
- **The system for escalation of any immediate concerns regarding the performance of an intern from clinical supervisor to prevocational educational supervisor and when needed to the CMO or delegate is working effectively.**
- **The 'Areas that intern should focus on for improvement' is viewed by some clinical supervisors as a negative, rather than encouraging interns to further develop their skills.**

3.3.5 Recommendations

13. Further guidance needs to be developed about supervision for relief clinical attachments to ensure interns are provided quality supervision and feedback.

14. The wording of 'marginal pass' should change to 'conditional pass' to encourage clinical supervisors to use this rating when appropriate. The wording change will better reflect that the pass is conditional upon specific improvements being made on the next clinical attachment.

15. The wording 'areas to focus on for improvement' should change to 'areas to focus on for further development'. This features in both the end of clinical attachment assessment and in the PDP section in ePort.

3.4 Supervision

3.4.1 Background

Prevocational medical training for interns is based on the apprenticeship model of 'learning on the job' as part of a team. Senior doctors supervise and assess each intern's performance, providing ongoing feedback, gradually increasing the interns' responsibilities according to their abilities.

Prevocational educational supervisor role

Interns have a designated prevocational educational supervisor to offer support and provide feedback over the course of the year in PGY1 and PGY2. A prevocational educational supervisor is a Council appointed vocationally registered doctor who has oversight of the overall educational experience of a group of PGY1 and PGY2 doctors as part of the intern training programme.

Each training provider (DHB) needs to ensure that there is one prevocational educational supervisor appointed for up to every 10 interns. New prevocational educational supervisors were appointed in all DHBs prior to the changes taking effect for PGY2s in November 2015. There are now 95 prevocational educational supervisors ensuring cover for all PGY1s and PGY2s.

Prevocational educational supervisors are required to meet with their interns at:

- The beginning of PGY1 to discuss:
  - ePort and how to use it as a self-reflective and educational tool
  - the intern's upcoming clinical attachment
  - recording of the learning outcomes in the NZCF including those attained through prior learning at medical school, through completion of clinical attachments and through the teaching programme
  - setting goals in the PDP.

- The end of each clinical attachment to discuss the intern's performance on the clinical attachment and review progress being made with learning outcomes and goals in the PDP. If there are any concerns about the intern's performance the prevocational educational supervisor should work with the intern to develop goals for the intern to focus on for the next clinical attachment. Performance concerns should be discussed with the clinical supervisor of the next clinical attachment.
- Towards the end of PGY1 to assist the intern in developing an appropriate PDP for PGY2 and to discuss the intern's vocational aspirations and review the mix of clinical attachments for the next year.
- At the end of PGY2 to review progress made by the intern over the year and consider if the intern has met requirements, enabling the intern to apply to have the endorsement removed from their practising certificate.

3.4.2 Discussion

Prevocational educational supervisors play a crucial role in the education and training of interns.

Overall prevocational educational supervisors enjoy their role and are providing excellent support to interns.

However the amount of support interns receive from their prevocational educational supervisors can vary, especially in PGY2.

When Council is accrediting a training provider the level of support provided by prevocational educational supervisors is reviewed. Feedback is sought from interns in writing via a survey and also at a face to face meeting. The issues raised through this process has identified that not all PGY2 interns have had adequate contact with their prevocational educational supervisor.

Interns moving to different sites

There is a variance across the country in relation to prevocational educational supervisors and their PGY2 cohort. In the Auckland metropolitan area interns and some prevocational educational supervisors reported that there was very little contact in PGY2. This is partly due to interns in PGY2 in the three Auckland metropolitan DHBs moving around each quarter. The three DHBs have decided that interns should keep the same prevocational educational supervisor through PGY2 if staying within the region. This means that the prevocational educational supervisors are often not working at the same location or DHB as their PGY2 intern. This causes additional challenges for prevocational educational supervisors to meet their interns. These challenges are unique to the Auckland DHBs. In the Wellington region when interns in PGY2 move between the three DHBs (Wellington Hospital, Kenepuru Hospital, Hutt Hospital and Masterton Hospital) the prevocational educational supervisor is changed to ensure the intern and prevocational educational supervisor are both at the same site. If offsite supervision is to occur for interns and prevocational educational supervisors, then clear requirements should be put in place to ensure meetings take place and interns have appropriate support.

Some training providers provide opportunities for interns to provide feedback (via surveys or other feedback mechanisms) about their prevocational educational supervisors and RMO units and others involved in intern education. This should be encouraged. Feedback from these mechanisms provide an excellent opportunity to identify areas for quality improvement.

Role and responsibility

Prevocational educational supervisors hold a contract with Council. The contract is linked to the prevocational educational supervisor guide, which outlines their role and responsibility in detail. One requirement is to attend one of the Council annual prevocational educational supervisor meetings each year. These meetings are held towards the end of the intern year and provide time to discuss highlights and challenges from the year, updates from Council and additional training focussed on supervision and providing feedback. The annual meetings also provide prevocational educational supervisors the opportunity to network with colleagues from other training providers. Prevocational educational supervisors report that these meetings are highly valued.

In addition to the annual meetings that prevocational educational supervisors attend, Council holds virtual training sessions. These sessions cover ePort functionality and the role and responsibilities of the prevocational educational supervisor. The training utilises an online tool designed for sharing screens. Eight sessions have been held in 2016, with a further two scheduled in 2016. Sixty prevocational educational supervisors have attended these sessions. Virtual training sessions are held regularly to ensure those new to the role have the appropriate training early on in their role. Prevocational educational supervisors have reported that the training provided through the virtual training sessions have helped them to use ePort more effectively to support interns.

Prevocational educational supervisor ratio

The ratio of one prevocational educational supervisor for up to ten interns has been implemented well. However specific circumstances may necessitate a slight variance. This seems appropriate, taking into account that PGY2 supervision requirements may be slightly less and most prevocational educational supervisors have a mix of both PGY1 and PGY2 interns. The number of prevocational educational supervisors has increased significantly over the past year and those with more experience are providing mentoring and support to new prevocational educational supervisors at their DHB. In some DHBs the more experienced prevocational educational supervisors are supervising the PGY1s as this work can often be more challenging than supervision of PGY2s.

3.4.3 Findings

- **Overall prevocational educational supervisors are providing excellent support to interns.**
- **Prevocational educational supervisors play a crucial role in the education and training of interns.**
- **There are some mechanisms in place to ensure adequate support is being provided by prevocational educational supervisors to interns, however these could be strengthened.**
- **The annual prevocational educational supervisor meetings provide opportunity for training, sharing information and networking with colleagues, these meetings are highly valued by prevocational educational supervisors.**
- **Prevocational educational supervisors have reported that the training provided through the virtual training sessions have helped them to use ePort more effectively to support interns.**
- **The ratio of one prevocational educational supervisor for up to ten interns is working well, however specific circumstances may necessitate a variance with this which is appropriate.**

3.4.4 Recommendations

16. The prevocational educational supervisor whenever possible should be the same person for the entire year.

17. If an intern is working across multiple sites within the same DHB they should continue with the same prevocational educational supervisor if at all possible.

18. If an intern moves to another DHB they must have a prevocational educational supervisor at that DHB. However interns in the Wellington or Auckland region may have a prevocational educational supervisor located in one of the other DHBs within the same region. The following conditions apply:

    - Quarterly meetings occur. These may be by telephone (if in person is not practical) but only if the prevocational educational supervisor and the intern have held their first meeting in person.
    - If the intern has been identified as needing additional support, then ideally a prevocational educational supervisor should be appointed who is at the same site as the intern. Alternatively, a shared care system including support from a local onsite prevocational educational supervisor should be put in place. The role of the local onsite prevocational educational supervisor is to provide immediate support to the intern and assistance with communication with clinical supervisors if needed. If an additional local onsite prevocational educational supervisor is used, then they should also be involved in review of the intern's progress with the Advisory Panel at the end of PGY1 and at the end of PGY2.

19. If an intern has more than one prevocational educational supervisor over the course of the year:

    - A verbal handover should occur between the prevocational educational supervisors to discuss the intern's progress and any concerns.
    - A meeting should be held between the intern and new prevocational educational supervisor as soon as the change occurs to form the supervisory relationship.

20. Further opportunities for interns to provide feedback about their prevocational educational supervisors, RMO units, and others involved in intern education should be explored by training providers.

Clinical supervisor role

On each 13-week clinical attachment the intern will be under the supervision of one or more clinical supervisors named as part of the accreditation of that particular clinical attachment. Clinical supervisors must be registered in the vocational scope relevant to the clinical attachment and be in good standing with the Council. Clinical supervisors are responsible for ensuring a quality learning experience for interns.

The clinical supervisor meets with the intern at three points throughout the 13 week clinical attachment; the beginning, middle and end of the attachment. The clinical supervisor can delegate day-to-day supervision however they are required to seek feedback on the intern's performance from members of the healthcare team to inform the meetings with the intern.

Training for clinical supervisors

High quality supervision and assessment are crucial to the success of the changes being made to prevocational medical training.

Therefore a focus was placed on ensuring those providing supervision have the relevant skills to do so. A framework for training supervisors of interns was developed and a programme of workshops have been held.

Council contracted Connect Communications to co-facilitate the workshops with senior staff from Council. The objectives of the workshops are to assist supervisors to be able to:

- Confidently identify and appropriately manage situations in which interns require support, including management of those who are struggling or performing poorly.
- Understand and demonstrate different methods of providing feedback.
- Understand and prioritise the supervisory role as strong and primary advocates of patient safety.
- Understand the supervisory relationship, including handling authority and recognising one's own bias.
- Confidently identify and manage the intern who may have health problems balancing the dual requirements of support and boundaries.
- Understand Council's processes and requirements for supervision of interns.

Council has held 10 training workshops for clinical supervisors in 2014, 11 in 2015 and four in 2016. A further four workshops are scheduled early in 2017.

- 668 clinical supervisors have attended training workshops.
- Evaluation forms have been completed by over 80% of attendees.
- Feedback has indicated that clinical supervisors find the training valuable.
- 98% of the attendees who completed evaluation forms said they would recommend the workshops to a colleague.

3.4.5 Discussion

The ePort system is beneficial in providing a framework for clinical supervisors to support the formal supervision of interns. As an electronic record, ePort provides the opportunity to easily collect qualitative data regarding the timeliness of the beginning, middle and end of clinical attachment meetings and grading data entered by clinical supervisors.

An absence or very significant delays in meetings may indicate either a problem with clinical supervision or a lack of engagement of the clinical supervisor with ePort. This may be because the clinical supervisor has not been trained in using ePort or has simply "lost their password" but could also reflect a lack of engagement with the overall process due to other reasons.

The Council-led training for clinical supervisors has been effective with well over 600 clinical supervisors having attended training.

The half day training sessions are providing very good training with a balance between Council requirements and supervisory skills including those needed to provide effective feedback to interns.

The workshops for supervisors of interns are more effective than written documentation and guides as many clinical supervisors do not tend to read information provided, although they are readily available from within the ePort system.

Supervision training needs to continue to ensure new clinical supervisors moving into this role are trained. Training should be made available locally and regionally (using local and regional trainers) and this needs to be enabled by training providers. There is a limit to how sustainable it is for Council to continue to lead the training for clinical supervisors.

Other supervisor training is also available through medical colleges and medical schools.

Some medical colleges have started training registrars in supervisory skills before gaining vocational registration and this is a positive step.

Training providers need to support their clinical supervisors with the role by recognising its value and importance, having services allocate dedicated time for supervision, and offer leave to attend training workshops about supervision and mentoring. This needs to be included in job sizing.

The development of clinical supervisors should occur through the annual review or appraisal process. The review process should include providing feedback to the clinical supervisor on the quality of their feedback to interns and their supervision of interns

The comments recorded in ePort on an intern's performance can be viewed by prevocational educational supervisors and Advisory Panel members and any concerns regarding the quality of that feedback should be escalated to the CMO. Collated anonymous feedback by interns should also be provided to the clinical supervisor. Training providers should be encouraged to provide this in the annual review or appraisal process.

Council needs to continue to communicate the importance of the supervisory role to ensure clinical supervisors truly feel valued.

3.4.6 Findings

- **The ePort system is beneficial in providing a framework for clinical supervisors to support the formal supervision of interns.**
- **The Council-led training for clinical supervisors has been very effective in upskilling clinical supervisors in both Council requirements and supervisory skills including those needed to provide effective feedback to interns.**

3.4.7 Recommendations

21. Training providers should hold regular appraisal meetings with clinical supervisors and prevocational educational supervisors for quality assurance and quality improvement processes.

22. Training for clinical supervisors is important and needs to continue and should be made available locally and regionally (using local and regional trainers) and this needs to be enabled by training providers.

3.5 ePort

3.5.1 Background

ePort is an electronic portfolio for recording and tracking an intern's progress. It is a system administrated by bpacnz and has been in place since November 2014. ePort is utilised by different user groups in different ways.

ePort provides an individual record of learning for interns that allows them to:

- record the learning outcomes from the NZCF that have been attained
- create and update goals in their PDP
- record professional development activities
- view feedback and *End of clinical attachment assessments* from clinical supervisors
- apply for general registration once recommended by the Advisory Panel.

All year 6 medical students can now access ePort. They have limited functionality to allow them to record the attainment of the NZCF learning outcomes and to set goals in their PDP. This is being integrated in different ways by each medical school.

Prevocational educational supervisors access the ePort of interns they supervise to record feedback and provide educational support. They also use ePort to access reports about their group of interns and progress of interns overall at their DHB.

Clinical supervisors access ePort to complete the *End of clinical attachment assessment.* Clinical supervisors also use ePort to review each interns PDP goals and learning outcomes. Clinical supervisors have access to all previous End of clinical attachment assessments and all other information recorded in the intern's ePort for the duration of the clinical attachment.

Training provider RMO units use ePort to undertake a range of administration duties including assigning interns to clinical attachments, creating clinical attachments, monitoring intern's progress and managing Advisory Panels. The Advisory Panel uses the information stored in the intern's ePort to review each intern's overall progress in PGY1 to inform their recommendation for registration in a general scope practice.

Council use ePort to process and approve accreditation of clinical attachments. Council also uses ePort to access reports about progress being made by training providers. Benchmarking reports are sent to CMOs, clinical directors of training, prevocational educational supervisors and RMO unit staff at the end of each quarter to help inform training providers on the progress of its interns. Live data about progress by interns at each DHB are also accessible to each of these groups directly from ePort should they wish to view individual intern or overall training provider progress at any stage.

3.5.2 Discussion

Very good support has been provided to all user groups about ePort and there is ongoing regular communication. The prevocational medical training helpline and the generic prevocational email address have provided effective and efficient assistance to those requiring help.

ePort is an effective and valuable tool that is fit for purpose, with only slight 'tweaking' needed in areas. It has placed a spotlight on intern education and contributed to a culture change to how medical education for interns is viewed.

Interns are familiar with using technology and are comfortable using ePort to capture learning. Prevocational educational supervisors, clinical supervisors and interns all appreciate the visual overview of individual progress, particularly seen on the summary page of each intern's ePort.

In response to interns wanting to share information from their ePort, they are now

able to request a 'VP link' from Council which can be shared with anyone outside of ePort. This link enables the recipient of the link to view but not edit the intern's ePort profile for a limited period of time. There is concern however, that this will create pressure for interns to share information when they do not wish to.

The initial rollout of ePort in November 2014 resulted in additional work for RMO units and others at training providers. The ongoing workload to maintain the smooth running of ePort and to ensure the system is up to date needs to be acknowledged and monitored now it has been imbedded. However much of this was required before the implementation of ePort but was not always being done. ePort provides more visibility when things are not done and therefore training providers are being held more accountable by Council, in particular through accreditation processes.

It is important that employer and human resource issues are kept separate from ePort. ePort is designed to be used as an educational tool and records about employment issues must not be entered into ePort.

Intern feedback

There is currently no system to allow interns to provide anonymous feedback about their educational experience on each clinical attachment. Before ePort was implemented there was a feedback form (RP7) available for interns to provide feedback, which was collated by the training provider.

Regular feedback from interns about each clinical attachment provides a model of continuous monitoring and allows for early identification of issues within the learning environment of a clinical attachment. This feedback should be sought by both PGY1 and PGY2 interns.

Intern feedback about the educational experience on each clinical attachment would be useful to ensure good quality attachments. This is important to both training providers for quality improvement and to Council for quality assurance in ensuring that each intern has a positive and safe learning experience on each attachment.

There is the potential to build an electronic feedback form into ePort and ideally the same tool would be used on a national basis by all training providers. The feedback would be accessed by the training provider and used to identify problems early and to target continuous quality improvement and feedback to clinical supervisors and clinical services. Council would request a collation of the results (annual data to give longitudinal perspectives) and reports demonstrating what changes, if any, had occurred as a result of the feedback. Council would use this information at the time of training provider accreditation.

The working group considered a number of feedback tools including the following:

- Postgraduate Hospital Educational Environment Measure (PHEEM)
- Cleveland Clinic Teaching Effectiveness Instrument (CCTEI).
- Medical University of South Carolina Graduate Medical Education Committee Resident to Resident Assessment Form.
- MUSC College of Medicine Office of Graduate Medical Education Resident Evaluation of Faculty Teaching Skills.

The PHEEM tool was considered the most appropriate option as it is already successfully embedded at Canterbury and Waikato DHBs. Changes may need to be made to ensure the PHEEM tool is appropriate for use in New Zealand. Information gathered using the PHEEM tool will supplement other monitoring

tools used by training providers to inform quality improvement. A copy of the PHEEM Feedback Tool is found in Appendix 2. The important features of, and case for, PHEEM are outlined in Appendix 3.

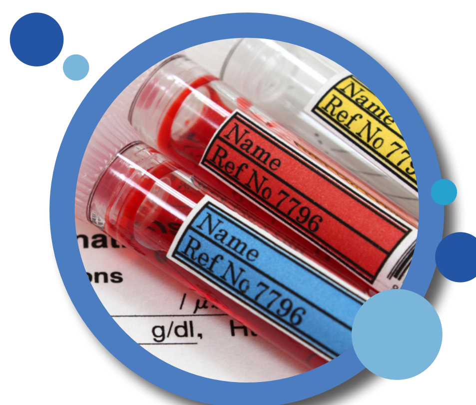
3.5.3 Findings

- **ePort is an effective and valuable tool that is fit for purpose.**
- **The prevocational medical training helpline and the generic prevocational email address have provided effective and efficient assistance to those requiring help.**
- **The front page of each intern's ePort provides a valuable colour coded summary of each intern's progress.**
- **All final year medical students can now access ePort. However this functionality is not being utilised well.**
- **The rollout of ePort caused a lot of additional work for RMO units and others at training providers and the ongoing workload needs to be monitored now it is imbedded, in particular in regard to RMO unit staff.**
- **ePort is creating a culture change about how medical education for interns is viewed and delivered.**
- **ePort is intuitive to use and interns are comfortable with using the online tool.**
- **Employer and human resource issues need to be dealt with separately from ePort. ePort is an educational tool, not an employment record and needs to be kept quite separate from human resource processes.**
- **An intern can share their information in ePort via a VP link issued by Council.**
- **Feedback about the learning environment during each clinical attachment is important for the training provider for quality improvement and to Council as quality assurance.**

3.5.4 Recommendations

23. Regular feedback should be sought from interns about their educational experience on each clinical attachment. This allows training providers to identify problems within the learning environment early and provides opportunity for continuous quality improvement. It is recommended that the Postgraduate Hospital Educational Environment Measure (PHEEM) questionnaire is implemented in the ePort system as the tool used nationally by all training providers. Council will not have access to feedback from interns but will request a collation of the results (annual data to give longitudinal perspectives) and reports demonstrating what changes, if any, training providers have made as a result of the feedback. Council will use this information at the time of training provider accreditation.

24. Further collaboration needs to occur with the universities to ensure medical students in their final year fully utilise the ePort functionality available to them including attainment of NZCF learning outcomes and the setting and completion of goals in the PDP. Use of ePort by medical students must be encouraged.



3.6 Advisory Panel

3.6.1 Background

All training providers have established Advisory Panels. The primary role of the Advisory Panel is to review the overall progress and performance of each intern at the end of PGY1. The Advisory Panel makes a recommendation to Council about whether each intern has met requirements and should be approved registration in a general scope of practice. Council is the final decision maker. The Advisory Panel also holds the responsibility for endorsing each intern's PDP as acceptable for PGY2.

Each training provider has Advisory Panels comprising of the following four members:

- the CMO or delegate
- 2 x prevocational educational supervisors (one must be the intern's own)
- one lay person.

ePort allows the Advisory Panel to consider each intern electronically without the panel members needing to be in the same room. The Advisory Panel reviews each intern's progress taking into account that the intern:

- is actively engaged in ongoing learning and is responding to feedback
- has addressed sufficiently all issues arising from the 'requires development' sections of the *End of Clinical Attachment Assessments,* particularly those that have any implications on safety to practice
- has met a substantive proportion of the learning outcomes in the NZCF
- is making progress to meet all the learning outcomes in the NZCF.

An Advisory Panel guide which includes an ePort guide is designed to be used as a reference tool by all members of the Advisory Panel and the RMO unit staff.

3.6.2 Discussion

Each of the training providers established Advisory Panels with appropriate membership at the end of the 2015 intern year. Every intern who had completed the PGY1 year by the end of November 2015 had their progress reviewed by an Advisory Panel.

Feedback has been received through accreditation visits and prevocational educational supervisor meetings and informally through the established DHB national groups and by the working group members. Advisory Panel members, training providers and prevocational educational supervisors report that the process of having an Advisory Panel review each intern's progress has provided an additional level of rigour to the decision making process. The process is viewed as being robust, fair and transparent. The CMOs and Clinical Directors of Training who chaired the DHB Advisory Panels valued the part they played in the process and took their roles very seriously. The addition of a lay member to the Advisory Panels was viewed as beneficial particularly in regard to the communication and professionalism areas of the assessments. Prevocational educational supervisors report they feel better supported, and appreciate no longer being placed in the role of advocate and support person as well as judge.

Advisory Panel members, training providers and prevocational educational supervisors report that the process of having an Advisory Panel review each intern's progress has provided an additional level of rigour to the decision making process. The process is viewed as being robust, fair and transparent.

Advisory Panels preferred to hold meetings in person, rather than virtual electronic meetings, in particular at the time when the Advisory Panel was reviewing the majority of the PGY1 cohort (at the mid-point of

quarter 4). For those PGY1s who are out of sequence, some Advisory Panels continue to meet in person however they also appreciate the flexibility at being able to hold virtual electronic meetings if they wish to. Interns who have completed their intern year outside of the usual cohort have had their progress reviewed appropriately.

For many interns the Advisory Panel function occurs behind the scenes and some interns were unaware of the process. Despite numerous email communications some interns were not aware of the need to apply for general registration through ePort following the Advisory Panel decision.

Advisory Panels are typically established and monitored by RMO unit administration staff. It is important that the RMO units have the appropriate resources to be able to do this. There is new additional functionality for RMO unit staff to allow them to monitor the Advisory Panels more efficiently.

3.6.3 Findings

- **The Advisory Panel process for reviewing progress of each intern at the end of PGY1 is robust, fair and transparent and is more rigorous than the previous system of the prevocational educational supervisor undertaking the assessment alone.**
- **The addition of the lay person to the Advisory Panel is beneficial particularly in regard to the communication and professionalism areas of the assessments.**
- **Advisory Panels prefer face-to-face meetings but appreciate the flexibility in being able to also hold virtual electronic meetings.**
- **It is important that the RMO unit staff have appropriate resource to manage the Advisory Panel process.**

3.6.4 Recommendations

Nil.

3.7 Changes to PGY2 requirements

3.7.1 Background

In November 2015 the changes for PGY2 interns were implemented. PGY2 interns now must satisfactorily complete four accredited clinical attachments, complete the remainder of their learning outcomes and maintain their PDP in ePort.

There is flexibility to allow PGY2s to enter into vocational training programmes or to work overseas. When an intern is approved registration in a general scope of practice an endorsement related to completing a PDP will be included on their practising certificate for the PGY2 year, under the competence provision of the HPCAA.

At the end of PGY2, interns must demonstrate through the information in their ePort that they have met the prevocational medical training requirements and achieved their PDP goals. If the requirements have not been satisfactorily completed at that time, then the endorsement will remain on the interns practising certificate.

3.7.2 Discussion

The requirements for PGY2 are still being bedded in and are not yet fully understood by those involved in prevocational medical training. Although Council has communicated extensively about these changes, it was realised early on that many clinical supervisors did not understand what their role entailed following the change in PGY2 requirements. This became particularly apparent when some interns chose to enter a vocational training programme as an alternative to participating in accredited clinical attachments. From this, interns and supervisors had assumed that they were no longer required to participate in ePort at all but instead participate in the vocational training programme alone. PGY2 interns who enter a vocational training programme must still record attainment of NZCF learning outcomes and continue to record progress

in their PDP. Many did not understand that interns must complete 12 months as a PGY2. If an intern takes time out for any reason this must be made up in order to meet the PGY2 requirements.

Despite the challenges of the transition of PGY2 into the formal intern period, there is recognition that the additional structure provided by the accredited clinical attachments, clinical supervisor feedback and ongoing engagement with ePort is providing an improved educational experience.

The flexibility to enter vocational training at an early stage has been appreciated by interns and most parties agree that this option should remain. However, prevocational educational supervisors, clinical directors of training among others, believe these interns should continue to be under the supervision of a prevocational educational supervisor and work within a more structured learning environment. Currently, if an intern joins a vocational training programme in PGY2, they will work under the supervision of the college training programme, rather than the clinical supervisors through the ePort system.

Feedback from prevocational educational supervisors indicates a need for these interns to remain within the ePort, with appointed clinical supervisors to ensure their ongoing progress. There is a widely held perception that interns are enrolling in a vocational training programme as it is seen as an easier option.

There have been some concerns about the use of annual leave and the hesitance of interns to take sick or maternity leave because of the continued 10 week time requirement in each clinical attachment. It is thought that this will improve over time with some further education and communication as this is the first transitional year and it was expected that there would be some misunderstanding around this. For the most part these concerns have been able to be alleviated by contact with Council office or the prevocational educational supervisor.

3.7.3 Findings

- **The requirements for PGY2 are still being bedded in and are not yet fully understood by those involved in prevocational medical training.**
- **The additional structure provided by the accredited clinical attachments, clinical supervisor feedback and ongoing engagement with ePort is providing an improved educational experience for PGY2s.**
- **Some interns are entering vocational training in PGY2 as they view this as an easy option.**

3.7.4 Recommendations

25. The new requirements for PGY2 should continue to be promulgated to all those involved in intern education.

26. Interns may continue to enter vocational training in PGY2, however they will still be required to record their learning in ePort, including clinical supervisor *End of clinical attachment assessments*, prevocational educational supervisor meetings, NZCF learning outcomes and goals in their PDP.

27. An intern should complete their PGY2 year prior to being appointed to a registrar position that is not undertaking vocational training.

3.8 Accreditation

3.8.1 Background

The purpose of accreditation of training providers for prevocational medical training is to ensure that standards have been met for the provision of education and training for interns. Under the Health Practitioners Competence Assurance Act 2003 (HPCAA) the Council is required to accredit and monitor educational institutions that deliver medical training for doctors and to promote medical education and training in New Zealand.

Accreditation for training providers

Accreditation is granted to those training providers who have:

- structures and systems in place to enable interns to meet the learning outcomes of the NZCF
- an integrated system of education, support and supervision for interns
- individual clinical attachments to provide a high quality learning experience.

The Council has set *Accreditation standards for training providers* which Council approved Accreditation Team assess each training provider against.

The process of assessment for the accreditation of a DHB as a training provider of prevocational medical training involves:

- A self-assessment undertaken by the training provider, with documentation provided to Council.
- Interns being invited to complete a questionnaire about their educational experience at the training provider.
- A site visit by a Council approved accreditation team that includes meetings with key personnel and interns.
- Assessment by the accreditation team of the training provider's intern training programme against the Council's *Accreditation standards for training providers.*

The draft report is considered by the training provider and Council. The report is then published on Council's website 30 days after the final report is released to the training provider.

Thirteen training providers have undergone an accreditation process in 2015 and 2016. The remainder will be completed through 2017.

Accreditation for clinical attachments

Clinical attachments must meet Council's *Accreditation standards for clinical attachments.* The standards ensure every clinical attachment provides a quality educational experience with appropriate supervision and a breadth of experience with appropriate opportunity to achieve the NZCF learning outcomes.

A clinical attachment spans 13 weeks (or 14 weeks maximum). At least one (and up to four) named clinical supervisors registered in the relevant vocational scope of practice will be responsible for meeting with the intern (beginning, mid and end of the attachment) to provide formal feedback on the intern's progress and performance. The standards for accreditation of a clinical attachment include explicit requirements regarding the structure of the clinical attachment and supervision.

3.8.2 Discussion

Accreditation of training providers

The *Accreditation standards for training providers* and the new accreditation process are still relatively new for both Council and training providers and requires further time to imbed fully. However, early feedback of the process has been mostly positive, even those who have experienced a difficult accreditation visit reporting that they have found the

process to be fair and transparent. Council has deliberately kept the pool of accreditation team members narrow to ensure consistent quality.

The new accreditation process and the publishing of accreditation reports on Council's website provides leverage to ensure that the standards are being implemented and that the resources and facilities meet Council's requirements. The publication of the accreditation report on Council's website means that training providers are now more engaged due to the public transparency of the process. However, feedback from some interns (who had been present at a training providers undergoing the accreditation process) indicates that the Council's accreditation reports and findings are not been disseminated to those involved in the process and not all were aware the reports were publically available.

A more stringent process of accreditation of clinical attachments was implemented through the ePort system at the end of 2015. Many clinical attachments fell short of Council's standards, and were approved on an interim basis subject to specific issues being addressed within timeframes by each training provider. Since then a review of all clinical attachments has been completed and each training provider has needed to address the identified issues. This has resulted in an increased workload falling mostly on RMO units. Despite the challenges, almost all clinical attachments now hold final approval, and any remaining will be finalised prior to the new intern year.

Accreditation of clinical attachments

The clinical attachment accreditation application form includes a section on the NZCF learning outcomes. Each clinical attachment needs to have identified learning outcomes that will generally be available on the clinical attachment.

It took a long time for users to understand how the learning outcomes should be associated with each clinical attachment and the need to only have a realistic number for each attachment rather than selecting every possible learning outcome that an intern might achieve in the course of completing the attachment.

The clinical attachment accreditation application in ePort allows for additional information about the clinical attachment to be uploaded and this information is then available for the prevocational educational supervisors, clinical supervisors and interns when they are assigned to the clinical attachment. Many training providers had used this functionality to upload additional information, however it was clear that not all are aware of this functionality.

ePort allows training providers to name up to four clinical supervisors on each clinical attachment. This restriction on the number of clinical supervisors who can be named on an attachment has worked well, however at some training providers, specific departments have indicated it would be easier for them if they would be able to name more than four clinical supervisors.

For interns to more easily identify the clinical supervisor on a clinical attachment, feedback indicated the number of named clinical supervisors on an attachment should remain at four.

The introduction of ePort as a tool for recording and monitoring intern progress means there is much more quantitative data available to inform accreditation assessments. The data available in ePort about the occurrence and timeliness of beginning, mid and end of clinical attachment meetings is

provided to accreditation teams ahead of the accreditation visit. Other data provided includes interns' progress at attaining the learning outcomes in the NZCF and the average number of goals created and achieved in PDPs.

Relief attachments

The accreditation standards for clinical attachments are specific about requirements for relief attachments stating there must be *"comparable supervision for their clinical work and appropriate support for an intern to achieve their training goals."* However clinical supervision of relief attachments remains an issue. Unlike other clinical attachments the clinical supervisor is usually not working directly with the intern. To provide feedback and complete the intern's assessment the clinical supervisor needs to seek feedback from those who have worked with the intern over the course of the clinical attachment including consultants, registrars and nurses amongst others. Some training providers use a log book system that that captures the intern's working location/s within the hospital for the period of the clinical attachment. The interns get the logbook signed and brief comments are recorded about their progress from those who are working directly with them and provided to the clinical supervisor. Many prevocational educational supervisors are currently covering the supervision shortfall for those interns working on relief attachments.

3.8.3 Findings

- **The *Accreditation standards for training providers* and the tightened accreditation process is still a new process for both Council and training providers.**
- **The new accreditation process provides leverage to ensure that the standards are implemented and that the resources and facilities meet Council's requirements.**
- **Training providers are more engaged now due to the public transparency with the accreditation reports being published on Council's website. It is an appropriately rigorous process that does a thorough job.**
- **The narrow pool of accreditation team members is ensuring consistent quality.**
- **The introduction of ePort as a tool for recording and monitoring intern progress means there is much more quantitative data available to inform accreditation assessments.**
- **It is not clear to all involved that there is the functionality to upload documents, such as position descriptions in the clinical attachment application for accreditation.**
- **Clinical supervision on relief attachments is an issue. To provide feedback and complete the intern's assessment the clinical supervisor of a relief attachment needs to seek feedback from those who have worked with the intern over the course of the clinical attachment including consultants, registrars and nurses amongst others. Some training providers utilise a log book system to help facilitate this.**

3.8.4 Recommendations

28. The maximum number of clinical supervisors per clinical attachment should remain at four.
29. Each training provider must appoint a small group of relief attachment clinical supervisors. The relief attachment clinical supervisor will require additional support to ensure they understand the different nature of their role and how to be effective when providing support to interns they are not directly working with.
30. To provide feedback and complete the intern's assessment the clinical supervisor of a relief attachment needs to seek feedback from those who have worked with the intern over the course of the clinical attachment including consultants, registrars and nurses amongst others.
31. Accreditation visits should place particular focus on ensuring interns on relief attachments are appropriately supported and receiving feedback.
32. Training providers should be encouraged to upload additional information, for example objectives for the clinical attachments into the clinical attachment accreditation application.
33. Training providers should make interns and all those involved in intern education aware of accreditation reports being publically available on Council's website.

3.9 General

There is a wealth of experience and knowledge about prevocational medical training throughout all of the DHBs. Some of the larger DHBs have medical education and training units and access to more resources than smaller DHBs.

Sharing ideas and knowledge about things such as how to best prepare for an accreditation visit and sharing resources such as policies and protocols would be of much benefit. There needs to be encouragement for resources and knowledge to be shared across DHB and regional boundaries.

3.9.1 Recommendations

34. Training providers should be encouraged to share resources and knowledge about prevocational medical training, including those relating to accreditation processes as well as policies and protocols, across DHB and regional boundaries.
35. A review should take place 12 months from the date of this report reviewing the extent to which the recommendations in this report have been implemented. Ideally this should be undertaken by the members of the Implementation Review Group.

APPENDICES

APPENDIX 1 - Terms of Reference

Terms of Reference – Prevocational Medical Training Training

Implementation Review

Project Lead: Dr Kenneth Clark (Chair of working group)
National DHB CMO group Chair
Project Sponsor: Prof John Nacey
Medical Council of New Zealand (Council's) Education Committee Chair
Project start date: May 2016
Version status: Final
Project end date: November 2016
Version number: 1.0

Context

Council's strategic direction in medical education has focused on issues relating to prevocational medical training since 2010. The key outcome has been to improve the quality of education and training for interns, thereby contributing to the quality of care for patients and enhancing public safety. Decisions made in 2013 led to a number of key changes to prevocational medical training. A transitional implementation plan was developed to phase in these changes, with the first changes taking effect in November 2014 and others in November 2015.

Rationale and purpose

The changes to prevocational training are now 18 months into their implementation and as such Council considers this an appropriate time for a review. The purpose of this review is to consider key questions regarding the process, structures and outputs of the prevocational medical training changes to date. The results of this review will be used to inform any further changes to the strategic programme of the project by the end of 2017.

Background information

It is Council's responsibility to ensure that the satisfactory completion of requirements set for New Zealand or Australian medical graduates to gain a general scope of practice (during their provisional period), provides assurance of their competence to practice within that scope. Council achieves this by setting the training and education requirements to be satisfactorily completed for the provisional period, ensuring that these provide an opportunity for Interns to further learn, develop and demonstrate clinical and professional skills, under the supervision of senior doctors and through an exposure to differing clinical settings.

Council commenced a review of prevocational training in late 2010, focusing on the issues relating to the education and training of doctors during the first 2 years following graduation from medical school. The review was undertaken by Council with support from Health Workforce New Zealand (HWNZ).

Over recent years there have been numerous reports that have resulted from reviews of medical education, training and workforce matters. Building on these reports, along with the information Council received through its hospital accreditation visits, Council identified a number of aspects of the prevocational medical training arrangements that required improvement. These included the requirement:

- to balance increasing service demand with increasing training requirements
- to obtain broad based core competencies
- for better vertical integration on the continuum of training
- for training to be less hospital focused
- to remove the hiatus in training

- for greater accountability by services training providers
- to meet safety concerns related to PGY2s working in locum positions.

In February 2013 Council released the consultation paper *A review of prevocational training requirements for doctors in New Zealand: Stage 2*. The consultation paper described the background, issues, and objectives for prevocational medical training in New Zealand, and proposed a number of changes. At its meeting 10 July 2013, Council considered the feedback from the consultation and made a number of decisions. A report outlining the feedback and decisions is available on Council's website https://www.mcnz.org.nz/news-and-publications/mediareleases/prevocational-training-requirements-for-doctors-in-new-zealand/.

To date the following initiatives have been implemented:

- New Zealand Curriculum Framework for Prevocational Medical Training (NZCF).
- Training for supervisors of interns – 21 workshops held across the country.
- ePort – an electronic record of learning for interns in PGY1 and PGY2.
- Professional development plan (PDP) for all interns in PGY1 and PGY2.
- The framework for continued structured training and education in PGY2.
- The extension of the educational supervisory role to provide oversight of PGY2.
- Commencement of the implementation of community based clinical attachments.
- New accreditation standards and processes for approval of training providers.
- Accreditation standards and processes for approval of clinical attachments.
- Introduction of Advisory Panels to review progress at the end of PGY1 and make recommendations.
- Baseline data collected to inform future evaluation of the changes.

The following initiatives will continue to be implemented in 2016:

- Multi Source Feedback (MSF).
- Training for accreditation team members.
- Completion of the accreditation of clinical attachments.
- Consideration of a national Intern survey to collect feedback about educational experience at the end of each clinical attachment.
- The implementation of community based clinical attachments.
- Introduction of an "App" for ePort users.

Objectives of the review

The objectives for this review include the following:

1. To determine if the changes to prevocational medical training have been widely implemented with appropriate systems and processes in place.
2. To determine if the changes to prevocational medical training are operating effectively.
3. To determine if the changes to prevocational medical training have been accepted by users and stakeholders.
4. To highlight any issues that currently exist from the changes to prevocational medical training that need resolving prior to the end of the strategic project.
5. To provide possible solutions for any unresolved issues.

Scope of this review:

The review will focus on the period of the implementation to date, that is, November 2014 – May 2016. Involved in the review are members of stakeholder groups affected by the prevocational medical training changes.

The review will focus on the following prevocational changes:

- Use of the NZCF (please note that the NZCF itself is out of scope at this stage as that is scheduled for review 3 years from when first implemented – in 2018).

- Assessment framework:
  - the beginning, mid and end of clinical attachment meetings with clinical supervisors and the quality of supervision and feedback
  - the use of the PDP, and the setting and achievement of intern focussed goals
  - the use of the "marginal" rating at the end of the clinical attachment assessment
  - prevocational educational supervisor's role including their meetings with interns at the end of each clinical attachment.
- Use of ePort – strengths and areas of concern.
- Advisory Panels to review progress of each intern and the end of PGY1.
- New requirements for PGY2.
- The extension of the prevocational educational supervisory role to PGY2.
- Training and support for clinical supervisors.
- Process of accreditation of clinical attachments.
- Process of accreditation of training providers.

For more specific information on each prevocational medical training changes included in this review **see Appendix 1.**

Out of scope for this review:

Please note that the following changes are OUT of scope for this review. The review will NOT include:

- Content and details of the:
  - learning outcomes outlined in the NZCF
  - *Accreditation standards for training providers*
  - *Accreditation standards for clinical attachments* and the *Additional accreditation standards for community based attachments*
  - requirements for registration in a general scope of practice.
- Performance or outcomes of the changes to prevocational medical training. A formal evaluation is scheduled for 2018 to consider whether the programme changes have achieved the outcomes sought. This evaluation will use the baseline data Malatest International captured at the start of the project in February 2015. The report *Medical Council of New Zealand: Establishing a prevocational training baseline March 2015* is available on Council's website https://www.mcnz.org.nz/news-and-publications/media-releases/evaluation-of-changes-to-prevocational-training/
- Multisource feedback which is being implemented later in 2016.
- Community based clinical attachments whereby every intern will be required to complete one clinical attachment in a community based setting over the course of the intern training programme. Council approved a staged transition, with a goal of 10% of interns completing a community based clinical attachment in the year commencing November 2015 and working towards 100% compliance by November 2020. Training providers will need to demonstrate progress over this period. This change is therefore not fully implemented yet and has the oversight from a Governance Group chaired by Mr Andrew Connolly, Chair of Council.

Methodology

This review is a short term project that is due for completion by November 2016 and will involve approximately 3 meetings of the working group, of which the first face to face meeting is scheduled for 19 May 2016. Any further meetings are likely to be held by teleconference.

It is expected that the working group will follow the below methodology:

Prior to the first meeting:	• Read the Terms of Reference (TOR) – *Prevocational Medical Training Implementation Review* and supporting documents. • Engage with a broad range of stakeholders including those from each member's DHB and region as well as each member's national work group to seek feedback on the questions of this review.

First Meeting:	• Agree to the plan and process for the review and TOR. • Participate in discussion and provide feedback to the working group. • Determine key issues that may require actions outside of the working group meeting. • Determine deliverables and timelines. • Set the next meeting.
Second Meeting:	• Review of feedback collated so far. • Further discussion. • Review deliverables and timelines. • Set the next meeting.
Third Meeting:	• Agreement of findings and recommendations for the written report. • Wrap up.

The review will use a participatory approach. It is not anticipated that all DHBs and all individuals of various roles will have input into the review. Rather it is expected that members on the working group informally consult with a cross reference of stakeholders within their respective DHBs and regions and report views and comments back to the working group. The approach taken will ensure that a broad cross section of feedback from all regions and all roles involved are incorporated and considered into the review.

The project manager will collate content from the meeting discussions for the written report. After the last meeting the final review document will be sent to all members of the working group to check that the draft findings and recommendations are representative of the stakeholder views.

Management and governance

A list of members in the working group is provided in **Appendix 2.**

The working group will operate within the Council's decision making principles as outlined in **Appendix 3**, and will be guided by this TOR. Consensus will be the preferred form of decision making. Final decisions of the working group will remain the responsibility of the working group Chair.

The outcomes and recommendations from the working group will be provided to the Education Committee for feedback, prior to consideration by Council for final approval and sign-off.

Outputs and reporting requirements

The final output required from this review is a comprehensive written report that addresses the following:

1. **Answers the specific questions as outlined in the chart below for various aspects of prevocational medical training. The closed questions below are only a guide. Appropriate information should be provided in response to each question.**

Prevocational Change	Specific Questions
Recording the attainment of learning outcomes from the NZCF	1) Are interns using ePort as a tool to record the attainment of learning outcomes from the NZCF? 2) Are clinical supervisors reviewing the intern's attainment of learning outcomes on each clinical attachment as recorded in ePort? 3) Are educational supervisors regularly reviewing the attainment of learning outcomes for each intern? 4) Have interns substantively attained the learning outcomes by the end of PGY1?
Assessment	5) Are clinical supervisors providing constructive and useful feedback when recording the beginning, mid and end of clinical attachment meetings in the ePort?

	6) Are prevocational educational supervisors reviewing clinical supervisor feedback and recording their comments at the end of each clinical attachment? 7) Are meetings and assessments completed in a timely manner?
PDP	8) Are interns setting goals and recording the attainment of goals in the ePort? 9) Are the goals SMART? 10) Are clinical supervisors reviewing each interns PDP at the beginning, mid and end of clinical attachment meetings?
Clinical supervisor role	11) Has Council provided enough guidance about the role of the clinical supervisor? Is the written guidance document useful?
End of Clinical Attachment Assessment	12) Are clinical supervisors utilising the marginal pass option at the end of clinical attachments? If so, is this being used appropriately? 13) Are areas to focus on for improvement being identified and documented by clinical supervisors in the end of clinical attachment assessment? 14) Has Council provided enough guidance around making an overall assessment at the end of each clinical attachment?
Prevocational educational supervisor role	15) Do interns receive appropriate support from their prevocational educational supervisors? 16) Has Council provided enough guidance, training and support for prevocational educational supervisors 17) Have the online tutorials for educational supervisors been useful? 18) Is the written guidance document useful?
ePort	19) Has an appropriate level of support been provided to users and user groups? 20) Has the 0800 number and generic email address been effective in answering queries? 21) Have iterative changes made to ePort in response to feedback made appropriate improvements? 22) Are interns using the ePort to track their overall progress and learning in ePort? 23) Are DHB RMO units using the ePort effectively to monitor progress made by PGY1 and PGY2 interns? 24) Do DHB RMO units and educational supervisors use the electronic reminder system to remind interns and clinical supervisors of required actions? 25) Are there any areas of concern? 26) What are the main strengths of ePort?
Advisory panel	27) Are DHB Advisory Panels using the information recorded in ePort to make accurate assessments when considering an intern's eligibility for general registration? 28) Are DHB Advisory Panels providing appropriate support and feedback to each intern in their assessments? 29) Is the Advisory Panel process easy to access and administer?
Prevocational educational	30) Has the ratio of one prevocational educational supervisor for up to 10

supervisor role for PGY2	interns been implemented? 31) Are PGY2 interns provided with the same or similar level of feedback and meetings as PGY1 interns?
Changes to PGY2 requirements	32) Are all interns working only in accredited clinical attachments? 33) Were the communications around the changes for PGY2 clear and easily understood?
Training clinical supervisors	34) Are Council-led workshops effective in supporting and training clinical supervisors? 35) Are Council-led workshops promoted and advertised appropriately?
Accreditation standards for training providers	36) Are the accreditation standards understood? 37) Do training providers understand what information they need to provide to Council prior to an accreditation visit? 38) Are Council's processes clear and effective? 39) Are Council's accreditation reports for training providers clear and informative?
Accreditation standards for clinical attachments	40) Are Council's processes clear, effective and easy to use? 41) Is this process being driven by the appropriate staff at the DHB? 42) Are clinical supervisors completing the clinical supervisor forms in full? If not, how are these being managed? 43) Are clinical attachment applications completed to a satisfactory standard?

2. **Answers the structural and process questions as outlined in the chart below regarding the changes overall:**

STRUCTURE AND PROCESS QUESTIONS: Considering the changes to prevocational medical training as a whole, please answer the following questions:	
1.	Are the individual changes coordinated to facilitate ease of use and effective functioning of the system as a whole?
2.	Is there a system of checks and balances so that problems can be picked up easily?
3.	Can progress be monitored and evaluated along the way?
4.	Is there balanced authority for users in regards to autonomy versus control?
5.	Are there clearly defined roles, lines of communication and accountability?
6.	Is the system resourced with quality information and people support?
7.	Do the changes provide output data of value? (ePort only)
8.	Are the changes easy enough to understand without unnecessary complexity?
9.	Are the changes simple enough to use without specific tools or special requirements?
10.	Are the changes robust enough to cater for various conditions and individual circumstances?
11.	Are the changes controlled and managed for consistent execution and outputs?
12.	Have the changes been communicated to users in a way so that expectations are understood and the ability to self-manage the process is self-driven?
13.	Is the input relative to the output i.e. time spent recording things in ePort compared to the record of learning it provides at the end of training? Is the time and effort spent using the system relative compared to the end of system result?
14.	Is the system supported by clearly and concisely documented guidelines and support? Supported by help when needed.

3. **Reviews how effectively the changes are operating to meet the needs of the following users: interns, clinical supervisors, prevocational educational supervisors, clinical directors or training, resident medical officer unit managers, chief medical officers and others.**

4. **Provides a list of the strengths and weaknesses of the changes to prevocational medical training.**

5. **Identifies any outstanding issues in relation to the changes implemented that need to be resolved.**

6. **Supplies a list of possible solutions for any unresolved issues identified together with recommendations on any preferred solutions.**

7. **Specifies as a group if the changes have been accepted generally by users and stakeholders and identify any outstanding barriers to acceptance.**

Appendix 1 – Information on specific prevocational medical training changes in the review

New Zealand Curriculum Framework for prevocational medical training (NZCF)

The NZCF was developed with the aim to:

- build on undergraduate education by guiding recently graduated doctors to develop and consolidate the attributes needed for professionalism, communication and patient care
- guide generic training that ensures PGY1 and PGY2 doctors develop and demonstrate a range of essential interpersonal and clinical skills for managing patients with both acute and long-term conditions, regardless of the specialty
- guide the seeking of opportunities to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to begin to make independent clinical decisions with appropriate support
- guide decisions on career choice and vocational aspirations.

The NZCF incorporates a total of 373 learning outcomes that an intern is expected to achieve during their two postgraduate years as a PGY1 & PGY2. These learning outcomes are to be achieved through clinical attachments, formal educational programmes and individual learning, in order to promote safe quality healthcare.

The NZCF is split into five sections: Professionalism, Communication, Clinical management, Clinical problems and conditions, Procedures and interventions. The learning outcomes within each of the sections are broken into:

- a list of core competencies a doctor must substantively attain by the end of PGY1
- competencies that a doctor should develop and consolidate by the end of PGY2. Competencies should be extended with the acquisition of new skills, including those relevant to future vocational training.

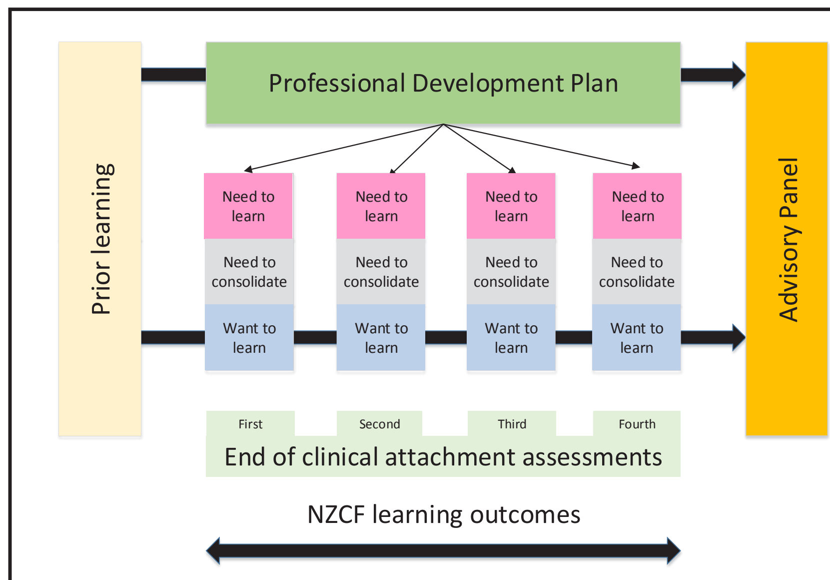
ePort

ePort is an electronic portfolio for recording and tracking an intern's progress. It is a system administrated by bpac^{nz}. It went live in November 2014. ePort is utilised in a variety of ways:

- Every intern has their own record of learning in ePort that allows them to:
  - record the learning outcomes from the NZCF that have been attained
  - create and update goals their PDP
  - record professional development activities
  - view feedback and *End of clinical attachment assessments* from supervisors
  - apply for general registration once recommended by the Advisory Panel.
- Prevocational educational supervisors access the ePort of the interns they supervise to record feedback and provide educational support.
- Clinical supervisors access ePort to complete the *End of clinical attachment assessment* of the interns they supervise, for the duration of the clinical attachment and provide feedback.
- Clinical supervisors also use ePort to review goals in each interns PDP and review the learning outcomes they have attained.
- Clinical supervisors have access to all previous *End of clinical attachment assessments* for the duration of the clinical attachment.
- DHB RMO units use ePort for the process of assigning their interns to clinical attachments, creating and modifying clinical attachments, monitoring intern's progress and following up with interns and clinical supervisors.
- Council use ePort to process and approve accreditation of clinical attachments. Council also uses ePort to gain various statistics about DHBs.
- The Advisory Panel uses the information stored in the intern's ePort to review their progress to inform their recommendation for registration in a general scope practice.

- All year 6 medical students can now access ePort. They have limited functionality to allow them to record the attainment of the NZCF learning outcomes and to set goals in their PDP. This is being integrated in different ways by each medical school.

PDP



All interns are required to develop and complete a PDP during PGY1 and PGY2. A PDP is a short planning document compiled by the intern, with input from their prevocational educational supervisor and the clinical supervisor on each attachment. The goals in the PDP must target areas for improvement identified through the previous *End of clinical attachment assessment*.

The PDP will assist the intern to reflect on achievements to date and identify what they need to learn, what they want to learn and need to consolidate in order to substantively attain the learning outcomes in the NZCF. It helps to structure and focus learning, strengthen existing skills, and develop new skills. The PDP can also help the intern to focus on their vocational aspirations.

The PDP is regularly reviewed and updated throughout PGY1 and PGY2. Goals relating to PGY2 are endorsed by the Advisory Panel at the time that it decides whether to recommend registration in a general scope of practice.

Clinical supervisor role

On each 13-week clinical attachment the intern will be under the supervision of one or more clinical supervisors named as part of the accreditation of that particular clinical attachment. Clinical supervisors must be registered in the vocational scope relevant to the clinical attachment and be in good standing with the Council. Clinical supervisors are responsible for ensuring a quality learning experience for interns.

The clinical supervisor meets with the intern at:

- the beginning of the clinical attachment to discuss the learning opportunities available on the attachment and to assist the intern develop goals in their PDP
- mid-attachment to provide feedback on the intern's progress and performance and review and update the PDP. This is a crucial meeting and the intern should receive feedback on areas for improvement which they can focus on for the remainder of the attachment
- the end of clinical attachment to discuss the overall performance on the clinical attachment and review and update the PDP. This will inform the *End of Clinical Attachment Assessment* which the clinical supervisor is responsible for completing.

The clinical supervisor can delegate day-to-day supervision however they are required to seek feedback on the intern's performance from the healthcare team to inform the meetings with the intern.

End of Clinical Attachment Assessment

The clinical supervisor makes a summative assessment of the performance of each intern they have supervised for each clinical attachment. The clinical supervisor will consult with the healthcare team to inform their assessment. They must also identify three of the intern's strengths and areas for improvement.

Using all of the information available to them, they complete an *End of Clinical Attachment Assessment* and must rate the overall performance on each clinical attachment as either:

- Unsatisfactory.
- Marginal (conditional pass).
- Meets expectation.
- Exceeds expectation or exceptional.

Where there has been a marginal performance on the previous clinical attachment improvement must be observed for the marginal to count as a 'satisfactory' clinical attachment. It is considered a conditional pass. An *End of Clinical Attachment Assessment* that is marked as marginal will require identified improvement goals to be detailed in the PDP. The goals in the PDP must be agreed to by the prevocational educational supervisor, clinical supervisor, and the intern. Improvement must be observed on the next clinical attachment, with satisfactory performance in all aspects of performance, to allow the marginal attachment to be considered satisfactory.

If more than one marginal rating is received for consecutive clinical attachments, then the first clinical attachment with a marginal rating may not be counted as satisfactory, however the second marginal clinical attachment may be counted, as long as improvement is demonstrated on the attachment immediate following, as described in the process above.

Where there is uncertainty the clinical supervisor is encouraged to engage with the prevocational educational supervisor. If an agreement is not reached then the prevocational educational supervisor can engage with the CMO or delegate. In some circumstances the training provider may wish to convene the Advisory Panel.

Prevocational educational supervisor role

Interns have a designated prevocational educational supervisor to offer support and provide feedback over the course of PGY1 and PGY2. This could be the same person for PGY1 and PGY2 or a separate one for each. A prevocational educational supervisor is a Council appointed vocationally registered doctor who has oversight of the overall educational experience of a group of PGY1 and/or PGY2 doctors as part of the intern training programme.

Prevocational educational supervisors are required to meet with their interns at:

- The beginning of PGY1 to discuss the intern's ePort, mix of clinical attachments and the learning outcomes in the NZCF.
- Following each clinical attachment to discuss the intern's performance on the clinical attachment, review and update ePort, and offer support and guidance. They are also required to record comments in the *End of Clinical Attachment Assessment* form and where there are performance issues work with the intern and clinical supervisor to develop a performance management plan to be addressed on the next clinical attachment.
- Towards the end of PGY1 they need to assist the intern in developing an appropriate PDP for PGY2, review their mix of four clinical attachments for the year and discuss their vocational aspirations. The prevocational educational supervisor is also required to be part of the Advisory Panel that discuss the overall performance of each PGY1, assessing whether they have met the required standard to be registered in a general scope of practice and proceed to the next stage of training.
- At the end of PGY2 which is the stage where the interns PDP can be signed-off as complete by the prevocational educational supervisor, enabling the intern to apply to have the endorsement removed from their practicing certificate as part of the practicing certificate renewal process.

Advisory Panel

All training providers have established Advisory Panels. The primary role of the Advisory Panel is to review the overall performance of all interns at the end of PGY1 and decide whether to recommend to Council whether they have meet the requirements for registration in a general scope of practice. The Advisory

Panel also holds the responsibility for endorsing the PDP as acceptable for PGY2. The Advisory Panel will make a recommendation to Council, who as regulator is the decision maker.
Each training provider's Advisory Panel comprises of the following four members:

- a CMO or delegate
- 2 x prevocational educational supervisor (one must be the intern's own)
- a lay person.

The use of an Advisory Panel adds further robustness to the assessment of interns and ensures that prevocational educational supervisors are better supported, and not placed in the role of advocate and judge.

The recommendation of the Advisory Panel takes into account that the intern:

- is actively engaged in ongoing learning and is responding to feedback
- has addressed sufficiently all issues arising from the 'requires development' sections of the *End of Clinical Attachment Assessments*, particularly those that have any implications on safety to practice
- has met a substantive proportion of the learning outcomes in the NZCF
- is making progress to meet all the learning outcomes in the NZCF.

The first Advisory Panel assessments took place in late 2015. Early feedback indicates that both Advisory Panel members, training providers and interns have found that the process is robust and has been a positive experience. There have been areas for improvement noted and this learning will inform our processes for the year ahead.

Appointment of new additional prevocational educational supervisors for PGY2
To better support the prevocational medical training programme and to ensure that each DHB is within Council's ratio of one prevocational educational supervisor for up to every 10 interns, new prevocational educational supervisors were appointed in all DHBs. There are now 95 prevocational educational supervisors ensuring cover for all PGY1 and PGY2.

Changes to PGY2 requirements
In November 2015 the changes for PGY2 interns were implemented. PGY2 interns now must satisfactorily complete four accredited clinical attachments, complete the remainder of their learning outcomes and maintain their PDP.

There is flexibility to allow PGY2s to enter into vocational training programmes or to work overseas. When an intern is approved registration in a general scope of practice an endorsement related to completing a PDP will be included on their practising certificate for the PGY2 year, under the competence provision of the HPCAA.

At the end of PGY2, interns must demonstrate through the information in their ePort that they have met the prevocational medical training requirements and achieved their PDP goals. If the requirements have not been satisfactorily completed at that time, then the endorsement will remain.

Training for clinical supervisors
It was recognised that high quality supervision and assessment were crucial to the success of the changes being made to prevocational medical training. Therefore a focus was placed on ensuring those providing supervision have the relevant skills to do so. A framework for training supervisors of interns was developed.

Council contracted Connect Communications to co-facilitate the workshops with senior staff from Council. The objectives of the workshops are to assist supervisors to be able to:

- Confidently identify and appropriately manage situations in which interns require support, including management of those who are struggling or performing poorly.
- Understand and demonstrate different methods of providing feedback.

- Understand and prioritise the supervisory role as strong and primary advocates of patient safety.
- Understand the supervisory relationship, including handling authority and recognising one's own bias.
- Confidently identify and manage the intern who may have health problems balancing the dual requirements of support and boundaries.
- Understand Council's processes and requirements for supervision of interns.

Council held 10 workshops in 2014, and a further 11 workshops in 2015. Some key details:
- 522 clinical supervisors attended these workshops.
- 264 evaluation forms were collated and analysed from the 2015 workshops
- 98% of the attendees said they would recommend the workshops to a colleague

In addition to training for clinical supervisors, further training and support has been provided to prevocational educational supervisors. Three meetings with prevocational educational supervisors have been held between August and October 2015 with 70 attending.

A further 6 virtual training sessions have been held with a total of 55 prevocational educational supervisors attending.

Support during the implementation

As part of implementing the changes, Council has:
- Provided ePort demonstrations and training in 2014 at most DHBs further to the clinical supervisor workshops and the prevocational educational supervisor annual meetings.
- Further ePort demonstrations were held in 2015 with RMO unit and prevocational educational supervisors throughout 2015.
- Since November 2014, Council has provided ongoing support consisting of one-on-one telephone support plus regular virtual training meetings. bpac[nz] also provide an 0800 number for technical support.

Accreditation of training providers

The purpose of accreditation of training providers for prevocational medical training is to ensure that standards have been met for the provision of education and training for interns. Under the Health Practitioners Competence Assurance Act 2003 (HPCAA) the Council is required to accredit and monitor educational institutions that deliver medical training for doctors and to promote medical education and training in New Zealand.

Accreditation is granted to those training providers who have:
- structures and systems in place to enable interns to meet the learning outcomes of the NZCF
- an integrated system of education, support and supervision for interns
- individual clinical attachments to provide a high quality learning experience.

The Council has set *Accreditation standards of training providers* which the Council approved Accreditation Team assess each training provider against.

The process of assessment for the accreditation of a DHB as a training provider of prevocational medical training involves:
- A self-assessment undertaken by the DHB, with documentation provided to the Council.
- Interns being invited to complete a questionnaire about their educational experience at the training provider.
- A site visit by a Council approved Accreditation Team that includes meetings with key personnel and interns.
- Assessment by the Accreditation Team of the training provider's intern training programme against the Council's Accreditation standards for training providers.

The draft report is considered by training provider and Council, and then it is published on Council's website 30 days after the final report is released to each DHB.

Seven training providers have undergone an accreditation process in 2015 and 2016. These are Auckland, Canterbury, South Canterbury, Southern, Waitemata and Whanganui DHBs. Four more are scheduled for this financial year.

Accreditation of clinical attachments

Clinical attachments must meet Council's Accreditation standards for clinical attachments. The standards ensure every clinical attachment provides a quality educational experience with appropriate supervision and provide interns a breadth of experience with opportunity to achieve the learning outcomes in the NZCF.

A clinical attachment spans 13 weeks (or 14 weeks maximum) and have at least one (and up to four) named clinical supervisors registered in the relevant vocational scope of practice who will be responsible for meeting with the intern (beginning, mid and end of the attachment) to provide formal feedback on the intern's progress and performance.

The rest of the standards for accreditation of a clinical attachment include explicit requirements regarding:

- The structure of the clinical attachment to ensure there are clear lines of accountability, the intern is well supported and integrated as part of a the team, learning outcomes for the attachments are identified and clear, teaching time is provided and protected, and comprehensive orientation is provided to the intern.
- Supervision requirements to ensure that supervisors understand their roles and responsibilities, demonstrate a commitment to intern training, have relevant training in supervision, and are able to provide feedback. Also that supervision arrangements are clear, interns are supervised at an appropriate level, that there are clear lines of reporting, and that procedures are in place to immediately address any patient safety concerns.
- CPD activities to ensure the intern is aware of work-based teaching and educational opportunities available during the clinical attachment, and that there are systems in place to facilitate an intern's attendance at the intern formal teaching.

2015 was the first year that the clinical attachment accreditation process has been required through ePort instead of paper based. The majority of the clinical attachments have fallen short of Council's standards, and have only been approved on an interim basis subject to specific issues being addressed within timeframes. This means that there will need to be a thorough review of all clinical attachments later during the 2016 year. Each DHB will require a follow-up to ensure the issues identified have been addressed. This is currently in progress.

Appendix 2 – Composition of the review team

Group / Title:	Name & DHB	DHB	Speciality
Project sponsor	Prof John Nacey	N/A	Urology
Chairperson	Dr Ken Clark	MidCentral	Obstetrics & Gynaecology, Med. Admin
CMO member	Dr Martin Thomas	Lakes	Anaesthesia
CDT member	Dr Wayne de Beer	Waikato	Psychiatry
RMO unit manager	Irene Warren	Lakes	N/A
RMO unit manager	David Brandts-Giesen	Canterbury	N/A
RMO unit manager	Terina Davis	NRA Auckland	N/A
Prevocational Educational Supervisor	Dr Huib Buyck	Capital and Coast	Internal Medicine and Pathology
Prevocational Educational Supervisor	Dr Suzanne Busch	Nelson	Internal Medicine
Prevocational Educational Supervisor	Dr Jules Schofield	Waikato	Emergency Medicine
GMHR member	Pat Hartung	Northland	N/A
University member	Dr Philippa Poole	Auckland University	Internal Medicine
Intern member	Dr Sam Holford	NZRDA	General
Intern member	Dr Magnus Cheesman	NZMA DiTC	Provisional General
Council CEO	Philip Pigou	Council staff	N/A
Strategic programme manager	Joan Crawford	Council staff	N/A
Strategic project manager	Toni Gray	Council staff	N/A

Appendix 3 - Protocol for decision-making principles

Background

1 The Council's governance role is to establish the strategic direction of the Council consistent with its purpose of protecting the health and safety of the public by ensuring doctors are competent and fit to practise.

2 The Council has a quasi-judicial function that is distinct from its strategic governance role. This function must be exercised within the Council's powers and responsibilities under the Health Practitioners Competence Assurance Act 2003 (HPCAA). These functions relate mainly to the exercise of Council's powers of registration, competence, conduct and health in relation to a specifically identified doctor.

3 The Council's decision-making principles will need to reflect these differences in Council's roles. Although there are likely to be common principles for both roles, it is also likely that each role will have distinctly separate principles. The remainder of this protocol identifies common and separate principles, relevant to Council's roles.

Common principles – governance and quasi-judicial roles

- Accountability: Council is accountable for its decisions to the public, the Minister of Health and Parliament and, in relation to the efficient use of funds to achieve its purpose under the HPCAA, to the profession. This means that the Council will consider:
  - Whether the decision is consistent with its principal purpose – to protect the health and safety of the public.
  - Whether the decision is consistent with its functions under the HPCAA ie, setting standards, ensuring competence, promoting education and training, promoting public awareness, etc.
  - Whether the decision is consistent with its values and principles as expressed in the Business Plan.
  - Whether the decision is the most efficient means of meeting Council's obligations under the HPCAA.

- Trust: Council will consider trust in key relationships when deciding governance and quasi-judicial matters. The key relationships are:
  - Between the profession and the public.
  - Between the public and the Council.
  - Between the profession and the Council.

  Council will consider:
  - Would the decision improve the trust in one or more of these relationships?
  - What would be the impact on the other relationship(s)?

- Independence: The independence of Council members is important to ensure the integrity of Council decisions. The Council does not represent the profession and Members must be free from influence

from external bodies. Council will decide governance and quasi-judicial matters independently of any stakeholder interest, personal interest or relationship and professional interest or relationship. (Please also refer to Council's *Policy on conflict of interest*).

- Inquiry: Council will inquire into and assess all relevant and available information in deciding governance and quasi-judicial matters. This would include examining critically all assumptions to determine opinion and fact.

- Consistency: Council aims to ensure good decisions over time by giving consideration to earlier decisions when deciding governance and quasi-judicial matters. Council acknowledges that regulatory standards change over time and decisions will always be based on the standards existing at that time.

- Cultural competence: Council recognises that doctors in New Zealand work with a population that is culturally diverse and therefore cross-cultural doctor-patient and doctor-clinical team interactions are common. Council will itself demonstrate and continue to promote awareness amongst all doctors of cultural diversity and the ability to function effectively, and respectfully, when working with people of different cultural backgrounds.

Specific principles – governance roles

- Responsibility: Council, in relation to any regulatory intervention of a strategic or policy nature, has a responsibility to the profession to engage, consider comment and feedback fairly, and to make decisions that can be effectively implemented.

Specific principles – quasi-judicial roles

- HPCAA: The Council will always act consistent with the purpose, principles and specific enabling provisions of the HPCAA.

- Principles of natural justice:
  - The Council will apply the specific provisions of the HPCAA regarding providing relevant information and giving reasonable opportunity to make written submissions and be heard.
  - Proceedings of Council will be conducted so that they are fair to all parties.
  - The Council will only take into account relevant considerations and extenuating circumstances and ignore irrelevant considerations.
  - All members of Council should act without bias (refer to Council's *Policy on conflict of interest*) and act in good faith.

- Risk of harm and risk of serious harm: The Council, in considering individual cases, will expressly apply its definitions of risk of harm and risk of serious harm. The relevant definitions are:

  Risk of harm may be indicated by:
  - A pattern of practice over a period of time that suggests the doctor's practice of medicine may not meet the required standard of competence; or
  - A single incident that demonstrates a significant departure from accepted standards of medical practice; or
  - Recognised poor performance where local interventions have failed – this does not exclude notification of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern; or criminal offending.
  - Professional isolation with declining standards that become apparent.

  Risk of serious harm may be indicated when:
  - An individual patient may be seriously harmed by the doctor; or

- The doctor may pose a continued threat to more than one patient and as such, the harm is collectively considered 'serious'; or
- There is sufficient evidence to suggest that alleged criminal offending is of such a nature that the doctor poses a risk of serious harm to one or more members of the public.

Approved by Council: 13 May 2009
Amended by Council: 16 May 2012

APPENDIX 2 - The PHEEM Feedback Tool

Gender

- [ ] Male
- [ ] Female

Prevocational level

- [ ] PGY-1
- [ ] PGY-2
- [ ] PGY-3 and above

Vocational level

- [ ] Vocational registrar
- [ ] Non-training registrar

Hospital

- [ ] Waikato
- [ ] Thames
- [ ] Other

Ethnicity

- [ ] NZ European
- [ ] NZ Māori
- [ ] Pacific
- [ ] Asian
- [ ] Indian
- [ ] Other European
- [ ] African
- [ ] Other: _______________

Current Unit (Other)

- [ ] Psychiatry
- [ ] Paediatric
- [ ] Emergency
- [ ] Obs & Gynae
- [ ] Anaesthetics/ICU/Critical Care
- [ ] Other: _______________

Current Unit (Medical Spec.)

- [ ] Internal Medicine (GenMed)
- [ ] Renal
- [ ] Respiratory
- [ ] Cardiology
- [ ] Gastroenterology
- [ ] Oncology
- [ ] Haematology
- [ ] OPR&S
- [ ] Palliative Care
- [ ] Endocrinology/Diabetes
- [ ] Neurology
- [ ] Rheumatology
- [ ] Infectious Disease
- [ ] Dermatology
- [ ] Medical Reliever*

Current Unit (Surgical Spec.)

- [ ] General Surgery
- [ ] Neurosurgery
- [ ] Orthopaedics
- [ ] Plastics
- [ ] ENT
- [ ] Vascular
- [ ] Cardiothoracic
- [ ] Urology
- [ ] Paediatric Surgery
- [ ] Maxillo-facial
- [ ] Surgical Reliever*

Medical Degree Obtained

- [ ] New Zealand
- [ ] Overseas

***also** tick a specialty above which you wish to focus this evaluation on

Run (please circle)	1	Dec - Feb	2	March - May	3	June - August	4	Sept - Nov	Other	(state)

The following items all relate to your current training experience. Please read each statement and rate it as it applies to your own feelings about your present position in this hospital. It is about your personal perceptions of the current clinical attachment.
For administrative purposes, this survey uses assigned identification numbers known only to the researcher. However your responses will remain completely confidential and no identifying information will be provided to other parties.

Please circle ONE answer that most accurately reflects the extent to which you agree or disagree with each statement.

Statements:	**Strongly disagree**	**Slightly disagree**	**Neither agree nor disagree**	**Slightly agree**	**Strongly agree**
1. I have a contract of employment that provides information about hours of work	0	1	2	3	4
2. My clinical supervisor and I negotiate clear expectations	0	1	2	3	4
3. I have protected educational time in this clinical placement	0	1	2	3	4
4. I had an informative orientation programme	0	1	2	3	4
5. I have the appropriate level of responsibility in this clinical placement	0	1	2	3	4
6. I have good clinical supervision at all times	0	1	2	3	4
7. There is racism on this clinical placement	0	1	2	3	4
8. I have to perform inappropriate tasks	0	1	2	3	4
9. There is accurate, unit specific written information available	0	1	2	3	4
10. My clinical teachers have good communication skills	0	1	2	3	4
11. I am paged inappropriately	0	1	2	3	4
12. I am able to participate actively in educational events	0	1	2	3	4
13. There is sex discrimination in this clinical placement	0	1	2	3	4
14. There are clear clinical protocols in this clinical placement	0	1	2	3	4
15. My clinical teachers are enthusiastic	0	1	2	3	4
16. I have good collaboration with other junior doctors/registrars	0	1	2	3	4
17. My hours conform to the Resident Doctors Association and District Health Boards MECA Terms of Settlement	0	1	2	3	4
18. I have the opportunity to provide continuity of care	0	1	2	3	4
19. I have suitable access to careers advice	0	1	2	3	4
20. This hospital has good quality RMO facilities especially when on call	0	1	2	3	4

Postgraduate Hospital Educational Environment Measure (PHEEM)

Please circle ONE answer that most accurately reflects the extent to which you agree or disagree with each statement.

Statements:	Strongly disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Strongly agree
21. There is access to an educational programme relevant to my needs.	0	1	2	3	4
22. I get regular feedback from seniors	0	1	2	3	4
23. My clinical teachers are well organised	0	1	2	3	4
24. I feel physically safe within the hospital environment	0	1	2	3	4
25. There is a no blame culture in this clinical placement	0	1	2	3	4
26. There are adequate catering facilities when I am on call	0	1	2	3	4
27. I have enough clinical learning opportunities for my needs	0	1	2	3	4
28. My clinical teachers have good teaching skills	0	1	2	3	4
29. I feel part of a team working here	0	1	2	3	4
30. I have opportunities to acquire appropriate skills in practical procedures	0	1	2	3	4
31. My clinical teachers are accessible	0	1	2	3	4
32. My workload in this job is fine	0	1	2	3	4
33. Senior staff utilise learning opportunities effectively	0	1	2	3	4
34. The training in this clinical placement makes me feel ready for the next step	0	1	2	3	4
35. My clinical teachers have good mentoring skills	0	1	2	3	4
36. I get a lot of enjoyment out of my present job/clinical attachment	0	1	2	3	4
37. My clinical teachers encourage me to be an independent learner	0	1	2	3	4
38. There are good counselling opportunities for doctors who experience difficulty regarding their training in this clinical placement	0	1	2	3	4
39. The clinical teachers provide me with good feedback on my strengths and weaknesses	0	1	2	3	4
40. My clinical teachers promote an atmosphere of mutual respect	0	1	2	3	4

Please identify three positive aspects of your current experience within this specialty/clinical attachment:

Please identify three negative aspects of your current experience within this specialty/clinical attachment:

Please identify three ways this specialty/clinical attachment could have been improved from a training viewpoint:

Additional comments:

Thank you for your participation.

APPENDIX 3 - Features of the PHEEM Feedback Tool

1. To summarise important features of PHEEM:
   a. PHEEM is a scored 40-item questionnaire that was originally developed in the United Kingdom as a tool to measure hospital-based junior doctors' perception of their postgraduate learning environment.[1]
   b. Since its inception, the PHEEM has been validated and used in a number of international settings.[2 3 4].
   c. More recently, the PHEEM was implemented as a tool to evaluate the training environment for basic and advanced paediatric trainees in New Zealand.[5]

2. The Waikato DHB piloted a PHEEM survey amongst PGY1 interns in the 2014 academic year. The Clinical Education & training Unit (CETU) found the use of PHEEM to be a satisfactory measure. The PHEEM was then extended to survey all RMOs employed with the DHB for the 2015 academic year. All survey responses were recorded and analysed. Cronbach's Alpha was .943 which showed that the items had high internal consistency. This aligned well with validity ratings from other international studies.[1-3]

3. The PHEEM survey was aligned to local terminology. The original author was contacted, and the proposed changes were discussed and agreed upon. Statements were modified to fit with New Zealand standard terminology and language that is used both in the DHB's Position Description documents and in the Resident Doctors Association (RDA) and 20 District Health Boards Multi Employer Contract Agreement (MECA)[6].

4. Other changes included:
   a. Respondent ethnicity was included, as well as which hospital they were located at that time (the DHB has some RMOs situated outside of the main hospital campus, either based at rural hospital locations, or in community settings (for example general practice)).
   b. A category identifying which clinical attachment had been completed was added. Individual departments were listed under three groupings: 'Medical' (Cardiology, Renal etc.), 'Surgical' (Orthopaedics, Vascular etc.) and 'Other' (Psychiatry, Paediatrics), to allow for analysis and comparison of departmental differences.
   c. Changes to the Likert Scale. The PHEEM uses a 5-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. The original PHEEM authors used the following scoring: 4 = 'Strongly agree', 3 = 'Agree', 2 = 'Uncertain', 1 = 'Disagree' and 0 = 'Strongly Disagree'. However, recent literature suggests that the use of more sensitive side-points (for example 'slightly agree' in place of 'agree') is preferable[7]. We therefore changed the scoring scale to: 4 = 'strongly agree', 3 = 'slightly agree', 2 = 'neither agree nor disagree', 1 = 'slightly disagree', 0 = 'strongly disagree'. Four of the 40 items (Qu 7, 8, 11 and 13) are negative statements which are reverse scored, and this method was retained for the current study.
   d. Collection of qualitative comments. An additional modification included the opportunity to record qualitative comments. Respondents were asked to provide open-ended comments on the perceived strengths and weaknesses of the clinical attachment. A third category requested qualitative comments that asked RMO's to list suggestions for areas for improvement in training within the clinical attachment. The aim of this inclusion was to identify unprompted identification for each of these three categories. The addition of this section allowed for qualitative analysis of responses which could help to identify emerging predominant themes. This section appeared to have been well-received by the RMO cohort, with almost 83% of respondents providing at least one comment during the 2015 year.

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