



REPORT ON PROGRESS OF STRATEGIC DIRECTIONS – 12-MONTH REPORT

This report outlines progress with Council's strategic directions and initiatives for the 12-month period 1 July 2015 to 30 June 2016.



**TE KAUNIHERA RATA O AOTEAROA
MEDICAL COUNCIL OF NEW ZEALAND**

Protecting the public, promoting good medical practice

Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

COUNCIL'S STRATEGIC GOALS

■ GOAL ONE

Optimise mechanisms to ensure doctors are competent and fit to practise.

■ GOAL TWO

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

■ GOAL THREE

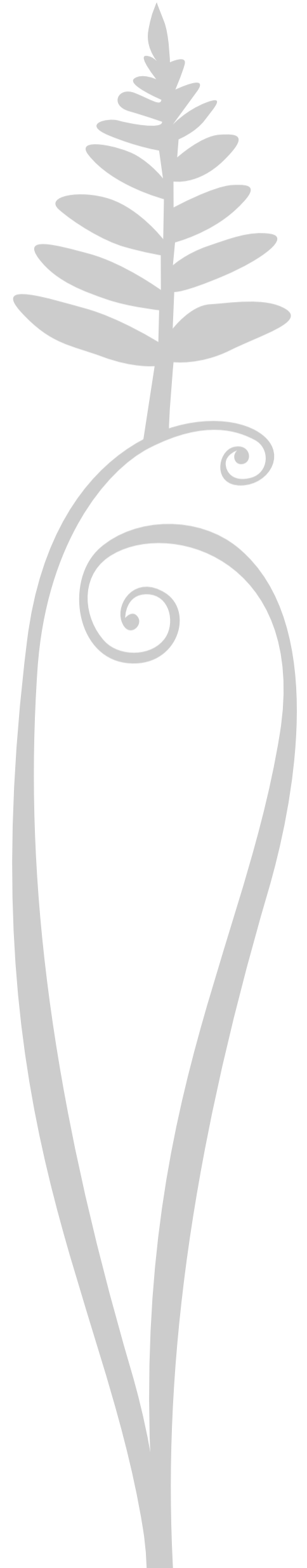
Promote good regulation of the medical profession by providing standards of clinical competence, cultural competence and ethical conduct and ensuring that the standards reflect the expectations of the public, the profession and stakeholders.

■ GOAL FOUR

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

■ GOAL FIVE

Promote good medical education and learning environments throughout the undergraduate/postgraduate continuum to help ensure all doctors have achieved the necessary standards for their practice.



THE COUNCIL'S STRATEGIC DIRECTIONS

In 2007/08, Council established four strategic directions:

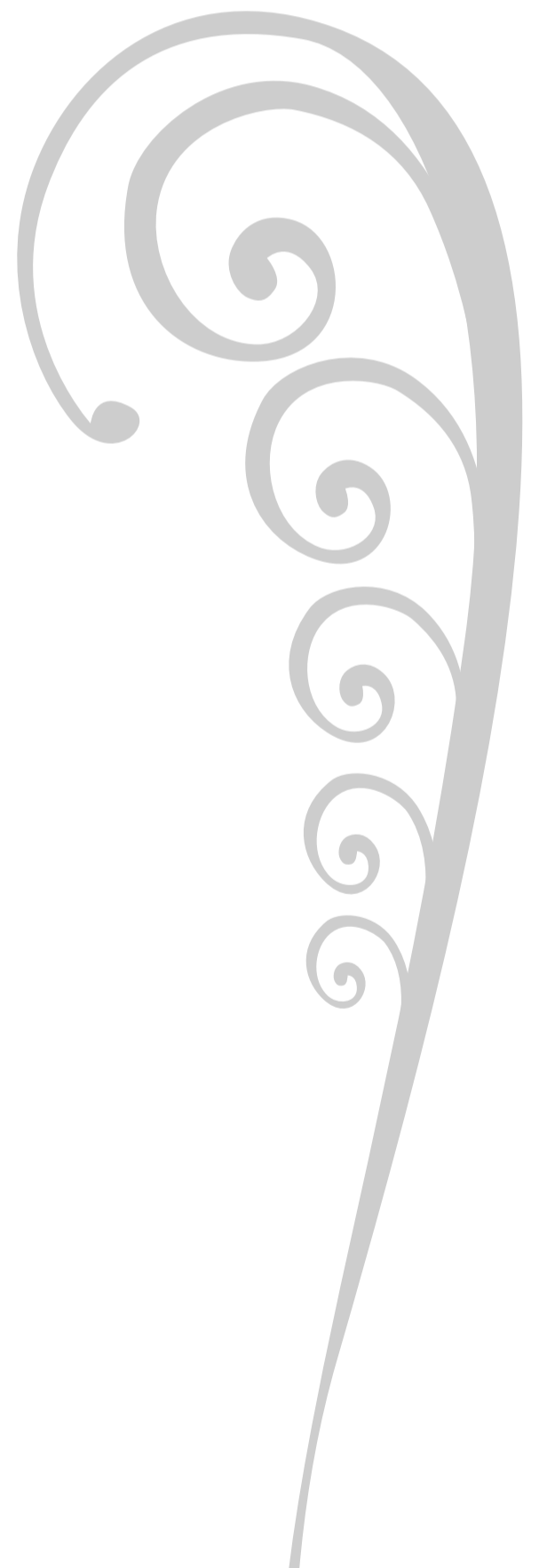
- Fitness to practise.
- Medical workforce.
- Medical education.
- Accountability to the public and stakeholders.

DIRECTION ONE – FITNESS TO PRACTISE

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

Recertification programme for doctors in a general scope of practice

The 2015/16 year was the 4th year of the *Inpractice* programme. Membership has decreased from 1,973 to around 1,700 doctors, with approximately 25 percent of these doctors working in general practice, 18 percent in general medical and surgical



hospital attachments and the rest working in District Health Boards, spread across a range of areas of medicine.

Of interest is the decrease in membership in the December 2015 to January 2016 period. This is traditionally the period of greatest flux as doctors leave to begin their vocational training and a large cohort of new doctors joins as they receive general registration at the end of their postgraduate year 1 (PGY1).

This year, there was no influx of postgraduate year 2 (PGY2) doctors because that they are now required to remain in the prevocational medical training programme. The effect of this change will largely be limited to the 2016 year, with numbers rebounding as the current cohort of PGY2 doctors complete prevocational medical training and move on to either Inpractice or vocational training programmes.

bpac^{nz} has a robust monitoring system in place to ensure collegial relationship meetings take place and that doctors meet Council's requirements. Council receives regular notifications from bpac^{nz} about doctors who are not meeting requirements, and an approved escalation process is followed by Council's office. If doctors do not engage in the process, a referral to Council is triggered.

bpac^{nz} has referred 181 doctors to Council for unsatisfactory participation and a further 15 for non-participation in continuing professional development activities in the last 12 months (down from 61 the previous year). Of the 15 cases, five were resolved before being referred to Council, as the doctors agreed to meet Council's recertification requirements.

A priority over the 2016/17 year will be to review the effectiveness of the collegial relationships within the recertification programme for doctors registered in a general scope of practice.

Regular practice review (RPR)

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

RPR for general scope doctors

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



RPR visits are now well established in the *Inpractice* recertification programme, with a total of 168 visits being completed in the last year. These have primarily been for doctors practising in secondary care (109). The first nine hospital-based RPR visits have now also been completed. Altogether, 530 RPR visits have been completed for doctors registered in a general scope of practice through the *Inpractice* programme over the last 3 years.

Over the past year, bpac^{nz} has focused on recruiting secondary care reviewers. This has been very successful in terms of the quality of the people it has been able to attract but unsuccessful in terms of the number of reviewers, and this is the key issue it faces with respect to maintaining its programme of RPR visits.

Some RPR visits where issues are identified result in an action plan being implemented following recommendations from the *Inpractice* medical adviser. Adherence to these plans is closely monitored over the following 12 months.

In the 12 months to July 2016, a total of 61 plans have been implemented for reasons of:

- inadequate patient notes
- inadequate clinical knowledge or skills
- failure to undertake patient or multisource feedback
- professional isolation.

If there are serious concerns about a doctor's practice following an RPR visit, bpac^{nz} refers the doctor to Council. A doctor referred in this way would go through the usual Council review process for consideration of a performance assessment.

Three training days for reviewers have been held over the last 12 months, with all reviewers attending at least one training day. In addition, six members of the faculty of musculoskeletal medicine attended training in June 2016 as bpac^{nz} works with them to initiate and support a comprehensive programme of RPR for their vocationally registered members. One of Council's medical advisers has attended each of the reviewer training sessions.

Evaluation of RPR

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



The evaluation findings are based on self-reported changes and interviews. Data is being collected 2 weeks after receipt of the RPR report by online survey, with opportunity to have in-depth interviews, and 12 months after the RPR.

The Evaluation report – 12 month report, February 2016:

Evaluation of the regular practice review programme includes results from 194 doctors and survey results from 41 reviewers about their role as well as results from 39 post-RPR interviews and six interviews completed 12 months after RPR.

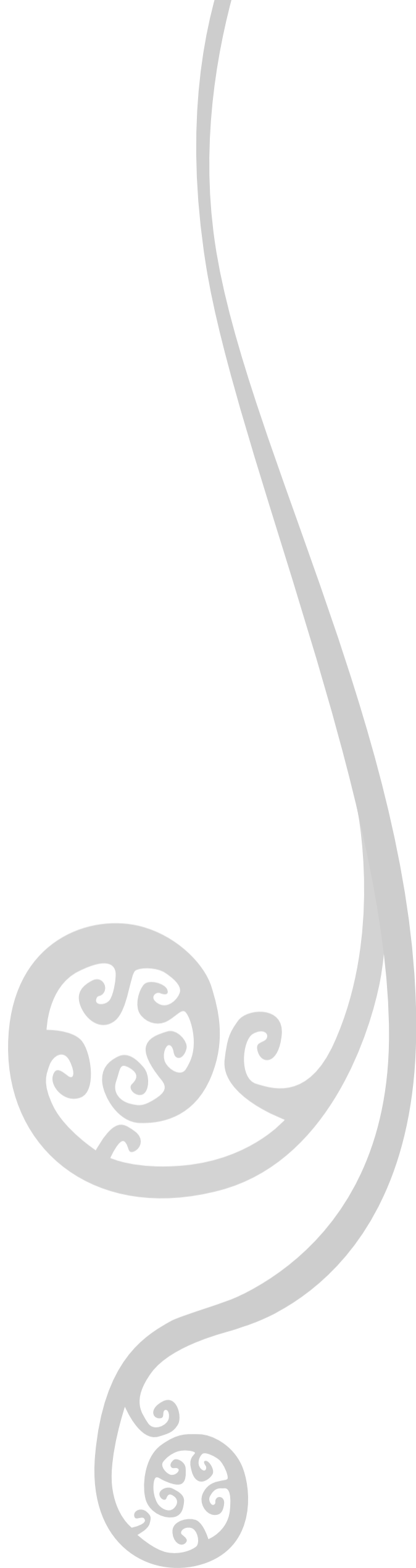
Nearly half (48 percent) of the doctors who completed the post-RPR survey said they had already made changes to their practice as a result of participating in RPR, and a further 13 percent intended to make changes. Around half of the post-RPR survey participants agreed that participating in RPR had improved the care they deliver to their patients and improved their practice in other ways. Examples of changes reported included:

- improvements in consultation style
- interaction with patients, improvements to note taking, habits in prescribing and ordering tests and better use of resources.

Council of Medical Colleges (CMC) project – *A Best-Practice Guide for Continuous Practice Improvement*

Senior Council staff have been involved in a project being undertaken by the Council of Medical Colleges, in partnership with the Ministry of Health, National District Health Board Chief Medical Officers group, Royal New Zealand College of General Practitioners and Council, looking at links between various tools used in the assessment of doctors, with a focus on continuous practice improvement.

A Best-Practice Guide for Continuous Practice Improvement was published in February 2016. This guide is a framework for use when developing or reviewing programmes set up to demonstrate the competence and performance of medical specialists.



Council's visions and principles for recertification

A consultation with stakeholders was undertaken on Council's vision and principles for recertification in August 2015. Council approved the final *Vision and principles for recertification for doctors in New Zealand* in February 2016. This has been published on Council's website and circulated to stakeholders.

A review of Council's current recertification requirements to ensure they align with the *Vision and principles for recertification for doctors in New Zealand* is a priority for the 2016/17 year.



DIRECTION TWO – MEDICAL WORKFORCE

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

The New Zealand medical workforce is heavily reliant on international medical graduates, with 41 percent of doctors practising in New Zealand holding a primary medical qualification from overseas, although this figure reduces to around 26 percent if those doctors with a New Zealand or Australasian postgraduate medical qualification are removed from the calculation. The Council registers up to 1,200 international medical graduates every year.

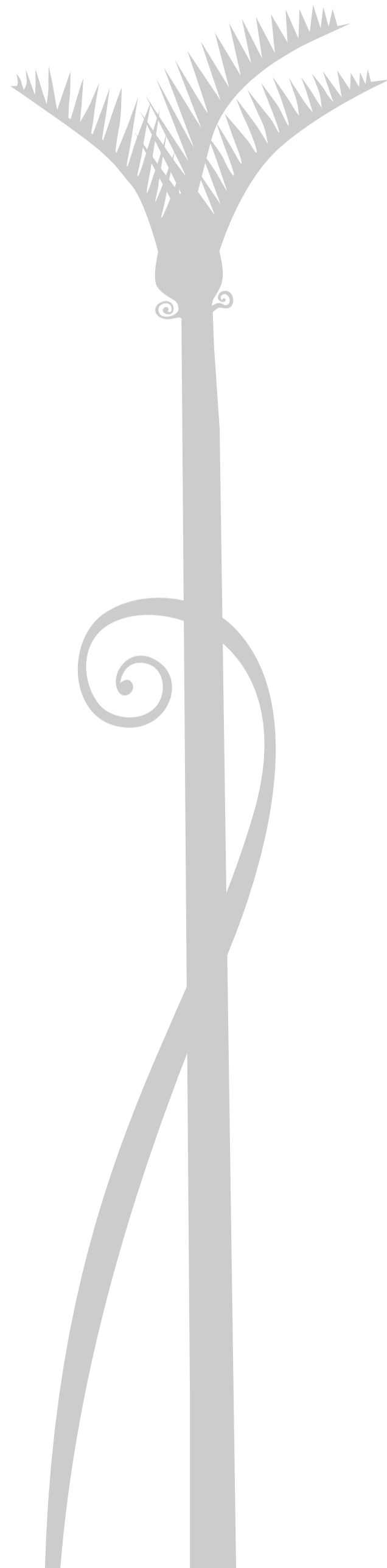
The key outcome of this strategic direction is to assist all doctors, including international medical graduates, to integrate safely and successfully into the New Zealand medical workforce.

Collaborative work with medical colleges to ensure consistent advice regarding international medical graduates

The Memorandum of Understanding with medical colleges was signed by all but one of the medical colleges. Over the 2016/17 year, Council staff will work closely with all colleges to amend and improve resources to ensure the consistency of advice received by Council.

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

Over the 2015/16 year, the Physicians Information Exchange Working Group of IAMRA has been completing a project to establish a portal for members to proactively share and access



information held internationally about doctors who work across multiple jurisdictions and may pose a risk of harm to the public.

The group has agreed that it is not feasible for regulators to upload all fitness to practise or disciplinary actions in relation to doctors that pose an immediate threat to the public. The group has proposed to limit alerts to doctors that pose an immediate threat to the public in another jurisdiction because:

- they have attempted to register with fraudulent documents
- action has been taken against them and they are thought to pose a flight risk to a jurisdiction in which they already have registration or a licence to practice, noting that this should not deter regulators from communicating with each other directly
- action has been taken against them and they are thought likely to seek registration or licensure with another regulator.

During the 2016/17 year, the group will be considering the feasibility of developing software that would allow jurisdictions to use a shared portal to upload disciplinary information about doctors considered to pose an immediate risk of harm and who are at high risk of moving across jurisdictions.

MedSys online capability

MedSys online (myMCNZ) allows doctors to be able to renew their practising certificates online. This system has been operating successfully for the 2015/16 year with a focus on minor fixes.

Online applications for new registrations will be the focus for online development over the 2016/17 year.

Review the time doctors can hold provisional general or provisional vocational registration

Options for time-limited registration of provisionally registered doctors were considered by Council. Council resolved not to proceed. This review is now complete.



DIRECTION THREE – MEDICAL EDUCATION

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

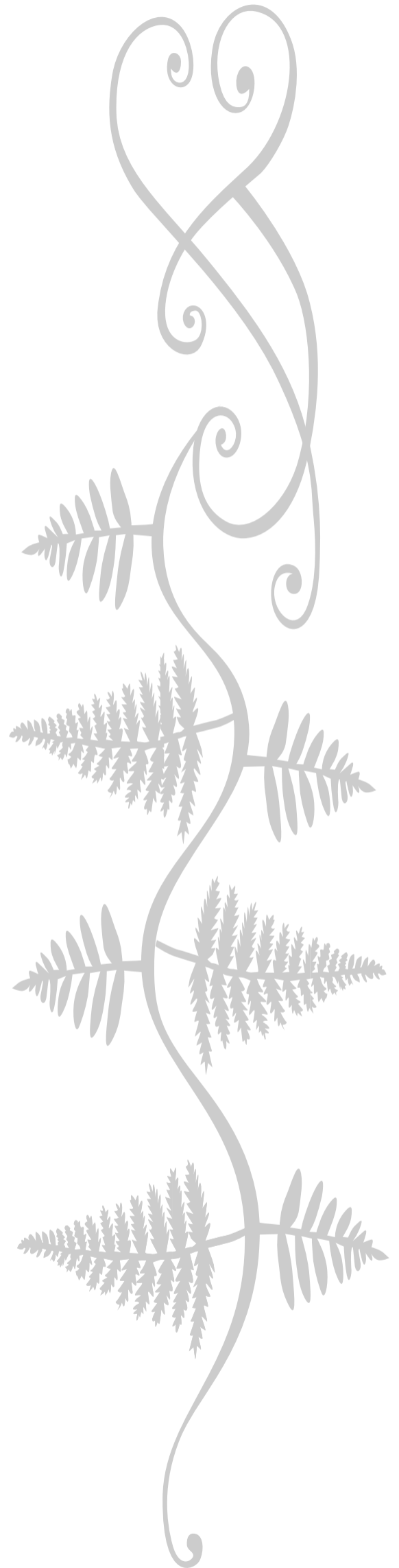
Review of prevocational training

The staged implementation of the changes to prevocational medical training commenced in November 2014 with further changes implemented in November 2015. Key achievements over the past year have been:

- accreditation of over 900 clinical attachments
- accreditation of 10 training providers (DHBs)
- development of community-based attachments – 35 community-based attachments have been accredited
- implementation of advisory panel functions
- holding 11 training workshops for clinical supervisors of interns – a total of 23 workshops have been held over the past 2 years
- holding three annual meetings for prevocational educational supervisors
- initiating a review of the implementation of the prevocational medical training programme
- ongoing refinement of ePort functionality.

The focus for the 2016/17 business year is:

- training for accreditation team members
- further development of community-based attachments
- completing the review of the implementation of the prevocational medical training programme
- implementation of a national tool to collect intern feedback about each clinical attachment



- implementation of a multisource feedback tool in ePort
- development of an app for ePort.

Accreditation of New Zealand specialist colleges

In May, a training workshop was attended by representatives of all New Zealand-based vocational training and recertification providers. Its purpose was to train the relevant institutions on preparing an application for accreditations against the new accreditation standards.



DIRECTION FOUR – ACCOUNTABILITY TO THE PUBLIC AND STAKEHOLDERS

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

Consumer Advisory Group (CAG)

The purpose of using the CAG is to gain feedback on Council's strategic and policy development.

Items discussed were:

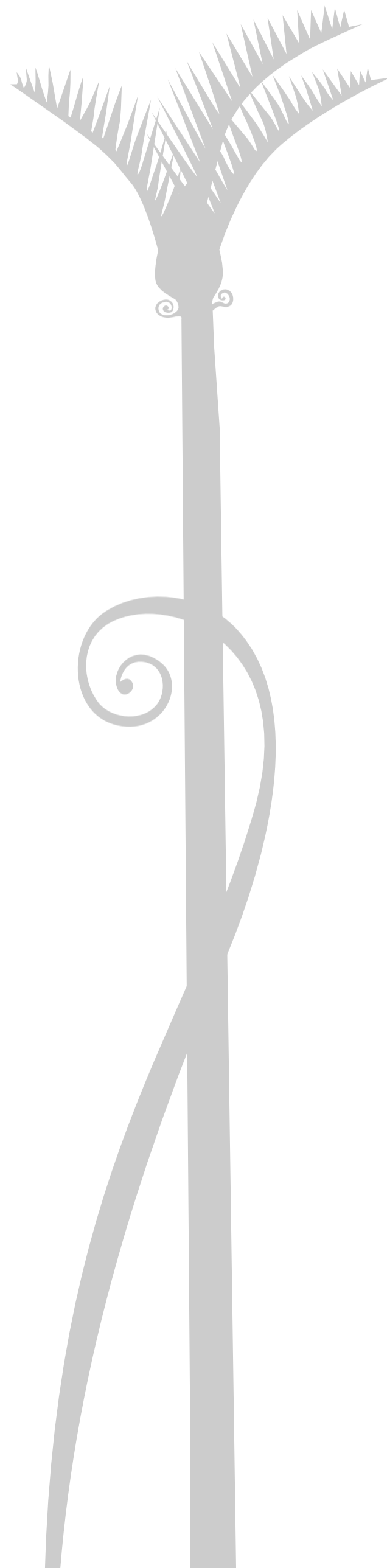
- the research findings of *Consumer Attitudes Towards and Experiences with Doctors in New Zealand*, which focused on the consumer experience
- *Choosing Wisely*
- Revision and feedback to Council's:
 - *Statement on telehealth*
 - *Statement on advertising*
 - *Statement on good prescribing practice*
 - *Statement on providing care to yourself and those close to you.*

MCNZ/DHB MoU oversight group

The MCNZ/DHB MoU oversight group has met three times during 2015. The meetings provide a forum for discussion about a range of operational issues and Council's strategic priorities.

Items discussed at the meetings included:

- changes to prevocational medical training
- requirements for PGY2



- ePort functionality updates
- accreditation of training providers
- accreditation of community-based attachments
- NZREX Clinical exams
- practising certificate reports
- registration of international medical graduates
- the review of the Memorandum of Understanding with District Health Boards.

Annual meeting of the medical colleges

The annual meeting of the medical colleges was held in August 2015 in Wellington. The meeting was attended by representatives from the colleges and some of their Australian counterparts including executives and fellows.

Topics included:

- cultural competence – eliminating inequity and health equity
- Council’s vision and principles for recertification
- risk factors (ageing doctors and doctors working in isolation)
- RPR evaluation programme
- Council of Medical Colleges A Best-Practice Guide for Continuous Practice Improvement
- college notifications and accreditation.

Executive officers of medical colleges meeting

The 2016 Executive Officers of medical colleges meeting was held at Council’s office in May 2016. The topics covered on the agenda included:

- an overview of Council’s strategic and business initiatives for 2016/17
- an update on Council’s vision and principles for recertification
- health, competence and conduct, college leadership and involvement.



MoU with New Zealand Police

At its June meeting, Council approved the MoU between the Council and New Zealand Police. It is expected that the agreement will be signed in July 2016.



