



Report on the feedback and decisions following the consultation of:

A review of prevocational training requirements for doctors in New Zealand: Stage 2

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*

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Executive Summary

The Medical Council of New Zealand (Council) released the consultation paper *A review of prevocational training requirements for doctors in New Zealand: Stage 2* on 28 February 2013. The consultation paper described the background, issues, and objectives for prevocational training in New Zealand, and proposed a number of changes.

A comprehensive national road show took place during the months of March and April 2013 to discuss the proposed changes to prevocational training outlined in the consultation paper. The meetings were well attended, with a total of over 550 attendees, and the feedback has been very positive.

Council's Decisions

At its meeting on 10 July 2013 Council received the submissions and considered the key themes arising from the feedback received in response to the consultation.

Council made a number of final decisions in regard to the proposals raised in the consultation paper, taking into account the key themes highlighted in the feedback, and considered a plan for implementation of all of the changes.

Council made the following decisions and each of these is described in detail, along with the reasons for Council's decisions in the body of this paper.

1. Curriculum Framework

The *New Zealand Curriculum Framework for Prevocational Medical Training* will be implemented.

2. Standards for accreditation of clinical attachments

Standards for accreditation of clinical attachments will be developed and implemented, ensuring that each attachment provides a quality learning experience.

3. Professional development plan (PDP)

There will be a requirement for a professional development plan (PDP) that is to be completed during PGY2 (within the competence provisions of the HPCAA), and an endorsement to this effect will be made on the practising certificate.

4. Framework for assessment

The framework for assessment, as described in the consultation paper, will be implemented for the Intern years (PGY1 and PGY2). This will be a high trust model of assessment that does not require evidence of achievement of each and every skill or competency.

5. E-portfolio

A record of learning in the form of an e-portfolio, will be implemented, and this will ensure a nationally consistent means of tracking and recording skills and knowledge acquired during the Intern years (PGY1 and PGY2).

6. Multisource feedback

Multisource feedback will be used as an educational assessment tool during prevocational training. A working group will consider how multisource feedback is best implemented, and provide advice to Council about issues of the timing, frequency, and content of the tool.

7. Supervision reports

A working group will review the current supervision report form and provide advice to Council about format and content for a report form to be used by supervisors for feedback for each Intern for each clinical attachment, and what will constitute 'satisfactory' completion of a clinical attachment, taking into account:

- the focus of the assessment framework towards an assessment for learning, rather than an assessment of learning
- the importance of the trajectory of learning, the levels of supervision needed, and the move to increasingly independent practice
- the goals of the assessment framework, as defined in the consultation paper.

8. Training for supervisors

A framework for training of supervisors will be developed as one of the key priorities in preparation for implementation of the changes to prevocational training. Training will focus on the needs of both Intern Supervisors as well as supervisors of individual clinical attachments.

A review of the role and responsibilities of Intern Supervisors will be undertaken.

9. Community based experience

Interns will be required to spend at least 12.5% of their time over PGY1 and PGY2 in community based and outpatient settings. This is equivalent to completing one attachment over the 2 year period, or alternatively a selection of attachments, each of which has a portion of time allocated to the community or outpatient setting. This aspect will not be mandated until the last stage of implementation; however it will be made available as an option that can be implemented earlier, for those who wish to do so.

10. Gaining a general scope of practice

The following requirements will need to be met in order for an Intern to be approved a general scope of practice:

- The (satisfactory) completion of four accredited clinical attachments.
- The attainment of the learning outcomes outlined in the *New Zealand Curriculum Framework for Prevocational Medical Training* (prior learning from the trainee Intern year will be taken into account).
- Completion of a minimum of 10 weeks in each attachment.
- A recommendation for registration in a general scope of practice by an approved panel (to include the Intern Supervisor).
- Establishing an acceptable PDP for PGY2, which will be completed during PGY2.

11. Implementation plan (*Appendix 1*)

A transitional implementation plan will be developed to phase in changes, with the first changes taking effect in November 2014 and other changes taking effect in November 2015.

A number of small focused working groups will work on various work streams. Members will be drawn from the existing Prevocational Working Group, and the Stakeholder Advisory Group, as well as Council's Education Committee (*Appendix 1*).

The following are immediate priorities:

- Final agreement to curriculum framework.
- Developing the PDP.

- Developing the requirements for an e-portfolio and identifying and entering into an agreement with a provider to develop and administer the process.
- Developing a framework for training of Intern Supervisors and supervisors of clinical attachments.
- Developing standards for the accreditation of clinical attachments.

12. Implementation plan timeframes (*Appendix 1*)

To be implemented in November 2014:

- The curriculum framework.
- The PDP and e-portfolio for PGY 1.
- The framework for assessment.
- Training for supervisors.

To be implemented in November 2015:

- The accreditation standards for clinical attachments.
- Inclusion of time in a community based or outpatient setting to meet 12.5%.
- Changes to requirements for PGY2.
- Multisource feedback.

13. Evaluation

An evaluation programme will be developed to consider the effectiveness of the changes, and this will be informed by an expert advisory group.

14. Communications plan

A communication plan will be developed to ensure relevant stakeholders are informed of Council's decisions about changes to prevocational training, and to ensure ongoing communication during the design, development, and implementation period.

Introduction

At its meeting on 10 July 2013 Council received the submissions and considered the key themes arising from the feedback received in response to the recent consultation: *A review of prevocational training requirements for doctors in New Zealand: Stage 2*.

Council made final decisions in regard to the proposals raised in the consultation paper, taking into account the key themes highlighted in the feedback, and considered a plan for implementation of all of the changes.

Background

Council's medical education strategic direction

There have been numerous reports over recent years exploring medical education, training and workforce matters. Building on these reports, along with the information Council has gained through its hospital accreditation visits, Council identified a number of problems with the current prevocational training arrangements.

Stage 1 Consultation – May to August 2011

The first consultation process was undertaken in 2011. The consultation paper *Prevocational training requirements for doctors in New Zealand: a discussion paper on options for an enhanced training framework* primarily considered the structural issues of the prevocational framework and was intended to be the first stage of a review of prevocational training.

At its meeting on 13 December 2011, Council considered the feedback from the consultation along with recommendations from the Education Committee. Council made two key decisions about the structure of prevocational training:

- That the run length will remain at 3 months.
- That the length of the period of registration in a provisional general scope of practice will remain at 12 months.

Council also decided to take a number of actions, with the goal of improving the quality of prevocational training and thereby ensuring public safety and quality of care. Council's decision fell into a number of key areas including curriculum framework, assessment, supervision, structure of clinical attachments, and accreditation of training providers.

Early in 2012 a working group was established, comprising of members with experience and expertise in medical education, Intern training, medical regulation and service provision. The primary objective of the group was to develop a succinct draft curriculum framework document that could be used to engage further with stakeholders. The working group also considered elements of assessment and how assessment should take place.

Council considered the outcome of the working group and other broader issues pertaining to prevocational training at its meeting in December 2012 and agreed that a further consultation should take place with the profession and stakeholders.

Stage 2 Consultation – February to May 2013

The consultation paper *A review of prevocational training requirements for doctors in New Zealand: Stage 2* was released to stakeholders on 28 February 2013. The consultation paper describes the background, issues, and objectives for prevocational training in New Zealand.

The second stage of the review proposes changes to the following aspects of prevocational training, and explains the benefits and considerations for each proposal:

- Curriculum framework.
- Elements of assessment.
- Requirements for PGY2.
- Record of learning and e-portfolio.
- Required experience.
- Structure of clinical attachments and clinical settings.
- Requirements to gain a general scope of practice.

A national road show has taken place during the months of March and April 2013 to discuss the proposed changes to prevocational training. Meetings have been held at 15 DHBs. The meetings have been well attended, with a total of over 550 attendees, and the feedback has been very positive.

In conjunction with the road show meetings, meetings have also been held with many of the members of DHB Executive Leadership teams (CEOs, COOs, CMOs) as well as Intern Supervisors.

Meetings have also been held with a number of other stakeholders to discuss Council's proposed changes to prevocational training.

Prevocational Training Advisory Group

Prior to release of the consultation document, a Prevocational Stakeholder Advisory Group was established comprising of representatives from a range of organisations with an interest in prevocational training, including the New Zealand Resident Doctors Association (NZRDA), Association of Salaried Medical Specialists (ASMS), the New Zealand Medical Association (NZMA) Doctors in Training Council (DiTC), the medical schools, Ministry of Health (MoH), Royal New Zealand College of General Practitioners (RNZCGP), Council of Medical Colleges (CMC), New Zealand Medical Students' Association (NZMSA), Health Workforce New Zealand (HWNZ), and the national DHB CEO, and CMO groups. The group considered the draft consultation document at its first meeting and feedback was very positive, with all attendees in agreement with the proposed changes.

A further meeting of the Prevocational Stakeholder Advisory Group was held after the close of the consultation process on 19 June 2013. There was general support provided by the group for the proposed changes. Two main issues were raised at the meeting. The first was in regard to implementation and how and when this would take place. The second issue was about the requirement, and process, for approval and sign-off of the professional development plan. These issues are both discussed under the relevant sections of this paper.

Prevocational Training Steering Group Meeting

A Prevocational Training Steering Committee has been established, comprising of representatives of Council and HWNZ (the regulator and the funder).

The HWNZ Board has expressed general support for the proposed changes to prevocational training, and there has been discussion about potential funding for some of the changes.

Feedback to Council's proposals on changes to prevocational training

The road show meetings generated robust discussion and feedback about the proposed changes to prevocational training. In addition to feedback at the meetings, 60 written submissions were received.

The feedback in general was very positive with widespread support for the proposed changes. Concerns raised, were in the most part about 'how' the changes would be implemented and the practical implications of any such changes.

The feedback to each proposal is discussed briefly in this paper. Council has made a number of high level decisions. It is recognised that much of the detail of the proposals will need to be worked through and to this end Council has agreed that a number of small focussed working groups will be established to provide advice to Council as various aspects of the changes are worked through. Furthermore, the Stakeholder Advisory Group will be asked to provide advice and feedback about the various components of the changes throughout the design, planning and implementation phases.

Proposal 1 – New Zealand Curriculum Framework for Prevocational Medical Training

The *New Zealand Curriculum Framework for Prevocational Medical Training* is implemented, to guide the continuum of learning through PGY1 and PGY2. The curriculum framework should not be viewed as an exhaustive list of skills and competencies that Interns need to achieve, but rather an indicative list to guide Interns and those involved in training.

Are there any significant changes that you think should be made to the draft *New Zealand Framework for Prevocational Medical Training*?

The Australian Curriculum Framework for Junior Doctors (ACF) was used as a basis to draft a curriculum framework focusing on the competencies required for medical practice in New Zealand.

The majority of feedback received indicated there was strong support for implementing the curriculum framework as an indicative list to guide Interns and those involved in training. Feedback also indicated that the implementation of a broad set of competencies is in line with the approach taken by the Medical Board of Australia, General Medical Council and Federation of State Medical Boards and should enable Interns to gain the necessary skills and experience to gain a general scope of practice.

"The framework is an excellent document in outlining the core skills and behavioural domains that should be obtained by RMOS across PGY1 and 2 years. It will provide a useful guide for Intern Supervisors as they develop their training programme for Interns".

"The trans-Tasman curriculum alignment for prevocational training is particularly important for training organisations such as the College which aims to provide consistent standards of learning and development to its trainee members in Australia and New Zealand".

However, the consultation feedback highlighted three common themes regarding the curriculum framework as outlined below.

i. Achieving the outcomes in the framework

Council proposed that the curriculum framework is used as an indicative list to guide Interns and those involved in training. However, some feedback questioned whether Interns would be able to gain access to the necessary attachments or be exposed to the required medical conditions to fulfil all of the

outcomes. Concern was also raised that the curriculum framework could result in a loss of flexibility, and become a 'tick-box' exercise with Interns becoming more concerned with meeting the competencies rather than focusing on the whole learning experience. Some submissions proposed a smaller set of core competencies be identified and mandated, and that doing this should ensure all Interns could comfortably meet the required learning outcomes. Some questioned what evidence would need to be provided that a skill or competency had been achieved.

"How do you allow for flexibility when it is primarily based on tick box type assessments"?

"As it stands, we believe that it will be impossible to learn all of the learning outcomes listed in the new curriculum framework, irrespective of whether this is over 1 or 2 years. We suggest the consideration of the development of a set of core learning outcomes that must be achieved while the remaining outcomes are optional".

"We appreciate the curriculum is a guide not a tick the box list, but still, how will MCNZ guarantee access? Regional anaesthesia is just one example – in the curriculum but an experience even anaesthetic trainees struggle to get. If the access issue is not resolved, the proposal seriously risks house officers being lost in the middle between MCNZ idealism and DHB practicalities".

"While the DHB will have to be accredited there may still be some difficulty in ensuring Interns gain the variety of workplace training desired. Flexibility should be built into the curriculum to allow for this".

However, the feedback from the recent Advisory Group meeting indicated that the view of the group was that the list of skills and competencies in the curriculum framework should be viewed as an achievable minimum list. Many saw this as a way of driving reconfiguration of clinical attachments to ensure quality learning in each attachment. How the curriculum framework would be implemented was the main concern raised by members of the group, and it was suggested to be most appropriate to charge the DHBs and the NZRDA with working out the best method way to complete the necessary work, to meet accreditation standards.

Some feedback indicated support for Council's approach to 'approved prior learning' and overlap with the undergraduate medical curriculum, viewing this as a way to ensure all competencies are covered, and learning from medical school is built upon.

"I have concerns however that it will be extremely difficult for a trainee to demonstrate competency in all of the areas in 1 or even 2 years post graduation although it may be possible if tightly coordinated with competencies achieved in undergraduate study".

ii. Assessing the curriculum framework

Council proposed to implement a curriculum framework to guide Interns, Intern Supervisors who may be setting up training programmes, and those involved in teaching. However, flexibility in 'how' the teaching will be delivered has been deliberately left to allow each DHB or each Regional Training Hub to determine the method they think is best for their Interns and particular region or DHB.

Some of the feedback suggested that some parts of the curriculum framework, such as the communication and professionalism sections, may be difficult to assess. There were also a number of suggestions about the type of assessments that could be used to assess various components of the curriculum framework. Some suggestions included e-modules, medical college short courses, simulation based skills testing, as well as the Intern teaching sessions.

"... the medical education literature is abundant with debate on the difficulties of truly assessing "competence" or "performance". At ADHB, we have mapped our current programme and experience

against the Australian Junior Doctor Curriculum Framework, and, like many hospitals in Australia, we find that there are significant gaps between what is experienced during 4x3 month runs in a tertiary hospital and that of the framework. Predominantly these lie in the areas of pediatrics, O+G and primary care but there is also a significant number in the area of “professionalism”. At our DHB we have attempted to fill those gaps through our specifically designed HO teaching programme as well as the development of some e-modules but it is still difficult to cover the full breath of the curriculum..... In addition..... ..on line assessments or simulation based skills testing could be included to assess for competency in ‘non standard’ or rare clinical presentations”.

“It is noted that many of the domains listed in the curriculum are behavioural and communication based and do not lend themselves easily to assessment. However the document stresses that assessment will be strengthened by the framework but without providing any detail about how this might be achieved. The document also mentions the use of a logbook and yet there is very little within the curriculum framework that lends itself to log book documentation. In summary the curriculum framework appears useful as a guide to the Intern Supervisors in setting up their training programme but also to clinical supervisors during performance appraisal and feedback sessions. However, the use of the curriculum framework for undertaking robust assessment will prove more difficult”.

The framework for assessment is discussed further under Proposal 3.

iii. Consistency of the framework of medical educational programmes

The issue has been raised about ‘international’ consistency of the framework of medical educational programmes. In particular, submissions have raised concerns that there is no alignment to the CanMEDS Framework and that the five sections outlined in the curriculum framework differ from the domains of competence set out in the *Good Medical Practice (GMP)*, and therefore different to the framework used by some Medical Colleges.

“...the breakdown into the five sections is not intuitive. Could we suggest also referencing the CanMEDS framework produced by the Royal College of Physicians and Surgeons of Canada”.

“Competencies as defined by CanMeds are widely accepted as the basis of the framework of medical educational programmes. These descriptors should be briefly described and utilised by MCNZ as the underlying basis of this frame work”.

“CMC notes that the five sections of the framework differ from those set out in the proposed version of Good Medical Practice (GMP) and this is different again to the framework used by many Colleges”.

Additions/amendments to the curriculum framework

A number of additions/amendments to the curriculum framework have been suggested, and these have been collated together.

In addition, some changes to the Australian Curriculum Framework (ACF) have been implemented following the 2012 review. The changes are mostly to do with structure and formatting, and include:

- significantly reducing the ‘Skills & Procedures’ list in line with the UK Foundation Programme
- including ‘Symptoms’ in the ‘Clinical Problems & Conditions’ section
- removing headings from both the above lists
- no longer identifying ‘advanced’ capabilities, all capabilities listed should be able to be attained within PGY1 or PGY2.

Consideration of whether any changes should be made to the *New Zealand Curriculum Framework for Prevocational Medical Training* is needed, given the amendments suggested in the submissions and the

recent changes to the ACF. Consideration also needed to be given to the frequency of future reviews of the framework.

Council's decision on the New Zealand Curriculum Framework for Prevocational Medical Training

Council resolved in principle to implement the *New Zealand Curriculum Framework for Prevocational Medical Training*. Implementation will be contingent on final approval of the detailed list of clinical problems and conditions, and procedures and interventions.

Council further resolved to:

- Work with DHBs to ensure that any system of approving placements and clinical attachments takes into account the global learning needs of Interns as well as each Intern's professional development plan (PDP).
- Ensure the framework allows the capacity to recognise prior learning achieved in the trainee Intern year, allowing an Intern to identify what has been previously learnt, what the gaps are, and to build on the education and training from medical school.
- Implement a high trust model that does not require evidence of achievement of each and every skill or competency.
- Make clear that the curriculum framework it is an achievable minimum list of skills and competencies.
- Note the concerns that had been raised about consistency between the curriculum framework, *Good Medical Practice*, and CanMEDS and agree that consideration of this issue should be delayed until the next planned review of *Good Medical Practice*.
- Request a small subgroup of the Prevocational Working Group is formed to:
 - consider the amendments proposed in the submissions
 - consider the changes made to the ACF
 - provide advice and recommendations to Council about the life cycle of the *New Zealand Curriculum Framework for Prevocational Medical Training* and the frequency for review
 - make a recommendation to the Education Committee and Council, for a curriculum framework that can be finalised and approved by Council for implementation.

Reasons:

- A curriculum framework that outlines learning outcomes required during the two prevocational years will improve the quality of learning for Interns and will ensure that there are clear expectations for all involved in prevocational training.
- A curriculum framework will consolidate and further develop the clinical and professional skills gained through the undergraduate years. It will also provide a more cohesive link to vocational training.
- Specific attachment standards, linked to the learning outcomes in the curriculum framework will allow for a clear and common understanding of what needs to be achieved and assessed.
- The curriculum framework allows for flexibility for learning outcomes to be achieved through the completion of clinical attachments, educational programmes and individual learning.

Proposal 2 – PGY2 and the Professional Development Plan

The Council proposes that an Intern must have a Professional Development Plan approved (to be completed during PGY2) at the time of applying for a general scope of practice. Council also proposes that an endorsement be placed on the practising certificates of PGY2s indicating that a Professional Development Plan is being completed.

What do you perceive to be the advantages and disadvantages to Interns completing a Professional Development Plan during PGY2?

There was strong support for all Interns to be required to complete a Professional Development Plan (PDP). Feedback specifically supported Council's proposal that an Intern must have a PDP approved (to be completed during PGY2) at the time of applying for a general scope of practice. Some feedback indicated a common view that a PDP will enable more personalised learning, direction, and focus, and will promote lifelong learning.

"We recognise that there is no formal requirement for formal training for doctors during their second postgraduate year (PGY2). We share the Medical Council's concerns about a lack of structure and quality of learning for PGY2. The College therefore welcomes the proposal that Interns provide the Medical Council with a structured learning plan for PGY2..."

Whilst the feedback very much supported the introduction of a PDP, concerns were raised about the need for flexibility to be retained. A number of submissions emphasised that a PDP must allow flexibility to allow Interns to be able to change employment, change clinical attachments, travel, gain overseas medical experience, work part time, or to take a break for whatever reason. It was suggested that this is particularly important during PGY2.

"It is important that the PDP has sufficient flexibility to incorporate changes to rotations during the year given that employment arrangements may change through the course of a year".

"I would strongly encourage medical council to include flexibility in the design of PDP – a greater number of junior doctors are no longer willing to delay other life plans for their medical careers. Already it is difficult to accommodate Interns part-time during internship to undertake care e.g. of a child. Not only are female doctors, in my opinion, taking time off work, but at our DHB, male doctors are increasingly taking time off for paternity leave or also want part-time work. Some doctors during the PGY-2 year may provide locum work for Accident and Emergency centres after hours (whilst employed for the DHB for example). Is it possible that flexibility exists in the PDP that will allow flow between public and private sectors"?

Although it is Council's intention to allow this sort of flexibility, it has been suggested that the language being used does not always reflect this. A greater emphasis will be placed on the type of language used, as the changes to prevocational training are further developed.

Some concerns were raised around a PDP placing additional pressure on Interns who have not yet decided on a vocation. The intention is for the PDP to enable the Intern to plan and target their learning around meeting the learning outcomes described in the *New Zealand Curriculum Framework for Prevocational Medical Training*. The PDP may also assist those who have decided upon their desired vocation, however those who have not yet decided will also be assisted by the PDP, which will provide them a greater direction and focus for their learning.

The feedback raised the potential for duplication between the PDP and the HWNZ Career plan. Council are liaising closely with HWNZ on this matter and HWNZ have agreed that the career plan could be

replaced by the PDP. The PDP will be regularly reviewed, and adapted to the needs of each Intern, and will remain with them throughout their lifelong learning experience.

Questions were raised about the consequence of not completing the PDP and whether the requirement would roll on to the next year. Some feedback emphasised that there needs to be consequences for non completion and endorsed the need for formal sign-off. Some raised the question as to who would oversee PGY2s, with a number of Intern Supervisors commenting that they already feel stretched. Despite this, oversight of PGY2s was viewed as an important component of improving the quality of PGY2.

Conversely, at the Advisory Group meeting, a concern was raised that the process for approval and sign-off of the PDP is treating the Interns as students and does not fall within the principles of adult learning. It was suggested that the use of mentors who could provide guidance would be more appropriate and useful.

The oversight of PGY2s is an issue that Council will need to consider. Intern Supervisors are appointed and act as Council agents, overseeing PGY1s. Council will need to consider whether to appoint a specific role to oversee the framework for PGY2s. An alternative would be to consider the use of mentors.

Council's decisions on PGY2 and the Professional Development Plan

Council resolved to:

- **Implement the requirement for a PDP that is to be completed during PGY2 (within the competence provisions of the HPCAA), and that an endorsement to this effect will be made on the practising certificates of PGY2s.**
- **Seek guidance from the Prevocational Working Group about an appropriate and simple framework for a PDP that will provide guidance to Interns and Intern Supervisors, but will not be onerous to complete.**
- **Seek advice from members of the Prevocational Working Group and engage further with the relevant stakeholders, before Council makes a final decision about:**
 - **the approval and sign-off of the PDP for PGY2s, and**
 - **the options for who should provide oversight of the PGY2 year.**

Reasons:

- **The use of a PDP during PGY2 will provide greater structure, with a focus on current and future learning needs, and this will help to ensure ongoing quality learning.**
- **The principles of lifelong learning will be established early in the Intern's career.**
- **The PDP will allow an Intern to focus on their career plan and intention for vocational training.**

Proposal 3 – Framework for assessment

The Council proposes to implement the framework for assessment, as described in the consultation paper, for the Intern years (PGY1 and PGY2).

Are there any changes you think could be made to improve the framework for assessment?

The framework for assessment focuses on nurturing a culture of learning, whilst ensuring defined generic skills such as professionalism and communication, as well as specific skills in procedures and interventions are attained. The process focuses on encouraging ongoing improvement over the course of the year, with each clinical attachment building on the learning and identified gaps from the last attachment.

There was general support for the framework for assessment. There was a consensus from the Advisory Group meeting that the approach for assessment is appropriate. However the feedback also highlights a number of areas where further work is required before successful implementation could occur.

Supervision and support for supervisors

Much of the feedback emphasised the importance of high quality supervision and assessment to the success of any changes to prevocational training. A key theme in the feedback was that those assessing and supervising need to have the relevant skills to do so, with a number of submissions focusing largely on ensuring supervisors were adequately trained to undertake assessment. It was pointed out that training is required for both Intern Supervisors and supervisors on individual clinical attachments.

Many submissions suggested that the proposed framework for assessment would impact on SMO time, which is already under pressure with increasing clinical workloads. Questions were raised about both the funding and human resource available to support the model.

Some proposed that a change in culture at DHBs is necessary, with a greater focus on training and supervision. Engaging with key clinical leaders to champion the changes was seen as key.

“The success of the new framework largely depends on engagement with the relevant services, and their subsequent support for the necessary changes, including:

- *Employers releasing the necessary amount of time for supervisors/directors of training to fulfill the supervision requirements.*
- *Clinical leaders and service managers championing the cooperation/involvement of senior clinicians.*
- *Additional training requirements for supervisors to ensure the necessary skill sets are in place, and that ongoing support is available”.*

“...it is clear that this will require greater levels of supervision and assessment from Intern Supervisors and clinical supervisors attached to specific runs, and will greatly increase costs incurred by DHBs. The impact of these proposals on SMO time and availability and the cost to DHBs has not been accounted for and needs to be assessed in great detail”.

It was emphasised that consideration needs to be given to the extra workload on the Intern Supervisors and how this will be resourced, especially if it is extended to incorporate oversight of PGY2s. It was also proposed that a written resource for Intern Supervisors is developed, clearly setting out the expectations and requirements of them.

A number of mechanisms will need to be used to bring about the necessary change in culture to ensure a greater focus on quality training during PGY1 and PGY2.

HWNZ have indicated that they are in support of providing funding for training of supervisors, however further discussion needs to take place. The intention is to establish a framework for training early in the implementation phase. Training will not only up skill the supervisors, but will also ensure that a spotlight is placed on the role of the supervisor, and the importance of supervisors making time for assessment and feedback.

Further discussion is also needed with the leadership groups of DHBs, in particular the CEO and CMO groups, to ensure that supervisory responsibilities and accountabilities are included in DHB job descriptions, and are viewed as being a fundamental aspect of employment. In particular, time is needed to be made available for supervisors to undertake their role. Although much work has been done in recent years to ensure Intern Supervisors are trained and get access to the required time, the supervisors

of each clinical attachment also need to gain the necessary skills and have the time available to undertake their role.

“There will need to be some negotiation with employers/CEO's regarding how supervisors will be freed up from clinical time to learn the supervisor components and undertake supervision responsibilities”.

Managing poor performance

One of the areas of feedback on the framework for assessment is around managing poor performance and ensuring Intern's progress adequately. The feedback suggests a process needs to be developed to identify and support Interns not progressing adequately, to ensure standardisation. The availability of resources to implement any required remediation plan for individual Interns who are struggling was highlighted as an issue that needs to be addressed.

“...there will also need to be dedicated resources available for remedial training. Increased supervision, supplementary training, communication skills, performance assessments and supernumerary experience all require additional resources that are not now nor have ever been available in the Auckland region. For this reason, most trainees in difficulty receive variable low level support often based on the good will and dedication of some outstanding committed individuals”.

“One of the major challenges of a PDP is to deal with the non-performing doctor should the PDP goals not be met. This issue has to be addressed at the start otherwise the concept of PDP at best is formative and at worst has no authority and would not be able to be implemented in a meaningful way. It is suggested that the Council look at some of the College processes in dealing with failure to achieve the necessary requirements”.

It was also suggested at times language used can be seen as negative and not the appropriate language for an outcomes-based framework. For example a suggested phrase to use for those who do not progress was 'outcomes not yet achieved'.

The assessment framework is designed to assist in identifying poor performance early, and the PDP will assist in some way to help address areas of deficiency. However, the detail of any remediation plan, if required, may be best left to the individual DHB, or regional training hub to determine.

Council's decisions on the framework for assessment and supervision

Council resolved to:

- **Implement the framework for assessment, as described in the consultation paper, for the Intern years (PGY1 and PGY2).**
- **Continue discussion with HWNZ, seeking a commitment about funding for the training of supervisors.**
- **Establish a framework for training of supervisors as one of the key priorities in preparation for implementation of the changes to prevocational training. Training will focus on the needs of Intern Supervisors as well as supervisors of individual clinical attachments.**
- **To undertake a review of the role and responsibility of Intern Supervisors.**

Reasons:

The framework for assessment will:

- **Nurture a culture of learning, focusing on improvement over the course of the year.**
- **Ensure defined skills are attained at a defined level.**
- **Identify and assist those who are not ready to proceed to the next level of training.**

- Provide a natural fit with workplace learning and preparation for lifelong CPD.
- Ensure that learning is tailored to identify learning needs.

Proposal 4a – E-portfolio

The Council proposes that a record of learning, in the form of an e-portfolio, is implemented to ensure a national consistent means of tracking and recording skills and knowledge acquired during the Intern years (PGY1 and PGY2). This will better aid doctors' transition along the continuum of learning.

Do you agree with the concept of a nationally consistent record of learning in the form of an e-portfolio?
Are there any further considerations that need to be incorporated?

There was strong support for implementing a nationally consistent record of learning in the form of an e-portfolio which is owned by the Intern. The feedback highlighted the importance of using an electronic model which is easy to access, not onerous, and incorporates the PDP. It was emphasised that there needs to be compatibility across multi operating systems.

"In principle e-portfolios are seen to be very useful as a means of tracking progress and performance of trainees. They have the advantage of being portable and owned by the trainees so that they can take their e-portfolios to different DHBs throughout their training".

"Yes this is a must. This will make their learning record more visible, portable and accessible".

"The software should have an underlying architecture permitting its wide integration with that used in all DHBs".

Security and privacy were raised as issues that would need further consideration.

Whilst there was strong support one concern raised was around the cost for implementing and managing an e-portfolio system, and who would be responsible for meeting that cost.

Some were concerned that an e-portfolio could be more time consuming for Interns and supervisors. However, the e-portfolio should provide some efficiency and allow for Interns and supervisors to record information in real time rather than have to retain information which they manually document at a later stage. An e-portfolio will ensure that supervisors are more aware of the learning needs of each Intern, and this will allow quality learning to take place from the beginning of each clinical attachment.

"We applaud the introduction of an e-portfolio to serve as a record of learning for Interns. This is likely to be very useful for Interns and should minimise the administrative burdens they face in tracking and documenting the learning activities in which they participate".

Of note, the Confederation of Postgraduate Medical Education Council (CPMEC) is currently developing an 'App' for the ACF for smart phones that will make recording of skills and competencies even more accessible.

Council has recently gained experience in implementing the recertification programme for general registrants which uses a secure web based model. This experience will inform the development of e-portfolios for Interns. The intention is that Interns would own their own e-portfolio which would be designed to be portable and compatible with other platforms used in medical schools and postgraduate Medical Colleges. The issue of access rights to the e-portfolio will need careful consideration, but the intention is that Intern Supervisors as well as the supervisor of a current clinical attachment would have

access to an Intern's e-portfolio. It is not intended that Council would have access rights to individual e-portfolios.

Council's decision on implementing an e-portfolio

Council resolved in principle to implement a record of learning, in the form of an e-portfolio, to ensure a national consistent means of tracking and recording skills and knowledge acquired during the Intern years (PGY1 and PGY2).

Council further resolved to:

- **Continue discussions with HWNZ, seeking a commitment about funding for developing and maintain e-portfolios.**
- **Liaise with the medical schools to ensure that any e-portfolio will be consistent with their future needs.**
- **Explore via a competitive process, providers and systems for developing and maintaining an e-portfolio platform for prevocational training. This will only proceed once funding has been established.**

Reasons:

- **A record of learning, maintained in an e-portfolio will help to track the progress made in each attachment, and will also capture overall learning.**
- **The evidence maintained in the e-portfolio will help to identify future learning needs, and will aid a doctor's transition along the continuum of learning.**
- **An e-portfolio will decrease the bureaucratic burden for both Interns and supervisors.**

Proposal 4b – Multisource feedback

The Council proposes that a formal multisource feedback process is used to assess communication and professionalism.

What are the benefits and challenges that you think would arise from the use of a multisource feedback tool?

The feedback did not indicate a strong view on the use of multisource feedback. Whilst some submissions supported the use of multisource feedback some also highlight a number of challenges. These included the cost of such a system, the logistics for implementing it, the success and validity of the feedback especially given the duration of attachments (3 months) and getting buy-in. The issue around the potential for bias from those providing feedback and the frequency at which it could be expected that multisource feedback would take place was also raised.

Despite the challenges, many pointed out the importance of seeking feedback from the interdisciplinary team, as well as from patients. Many agreed that multisource feedback will provide valuable feedback to Interns, in particular about communication and professionalism.

“The benefits are that the RMO will gain far more useful feedback from those with whom they interact on a daily basis, rather than simply from one supervisor who may not get the opportunity to observe their communication and professionalism in all aspects of their work”.

“All professionals working in health and social care, including doctors, will require the skills of caring, compassion and effective communication. In addition if the needs of patients are constantly changing, then they need to be integral to the education process with the focus on improving patient care.”

At the Advisory Group meeting it was suggested that success of the use of multisource feedback tools depends on the maturity of the system and those providing feedback. However the meeting was informed that the health workforce in general is being exposed to multisource feedback more regularly and people will become accustomed to it and develop their skills in providing mature feedback. Following general discussion there was agreement by the group that undertaking multisource feedback is useful and can result in change in behaviour and practice.

Council’s decision on the use of multisource feedback

Council resolved in principle that multisource feedback should be used as an educational assessment tool during prevocational training.

Council further resolved that a working group will consider how multisource feedback is best implemented, and provide advice to Council about issues of the timing, frequency and content of the tool.

Reasons:

Multisource feedback allows a colleague or patient’s view of skills, behaviour and performance to be systematically collected to:

- **identify strengths and areas for improvement to inform professional development, and**
- **provide reliable feedback on important qualities of a doctor that are difficult to get by other means, including communication skills, professionalism, cultural competence, and interpersonal skills, assessed in the context of day to day practise.**

Proposal 5a – Standards for clinical attachments

The Council proposes to no longer require specific attachments (category A and B runs) to be completed during the provisional general period. Instead Council proposes to set robust processes in place for setting standards and accrediting individual attachments for PGY1 and PGY2, ensuring that each attachment provides quality learning experience.

Do you support the proposal to set standards and accredit individual attachments? What benefits and challenges do you think may arise from this change?

Most submissions were in support of this proposal. Some suggested it will drive quality in the learning environment, and will help to focus DHBs on education. Many see it as an opportunity to refocus the medical workforce from being predominantly focused on service to one with greater emphasis on Intern training. One of the key benefits highlighted in the submissions is the greater flexibility and freedom the proposed change would provide for PGY1s, while still ensuring that the Interns obtain good broad-based competencies. However, some concern was raised about current practice, with administrators allocating clinical attachments, and the need for this to change to allow greater flexibility.

“NZMSA support the move to revise the current requirements for PGY1 attachments and to create more flexibility in the allocation of runs”.

“A major benefit is the re-focussing from a service-dominated culture, to a more balanced environment, where education gains greater emphasis. It will assist in creating a more agreeable “Learning Environment”.

“We fully support the proposal to set standards and accredit individual attachments. Descriptions of each attachment will need to be made public to all Interns and supervisors. The main benefit is the attachments are driven by the learning outcomes (similar to medical school)”.

The concerns raised were mainly to do with a lack of understanding as to how the accreditation of attachments will be carried out and implemented. This misunderstanding has contributed to an underlying concern that removing Category A and B attachments will lead to DHBs using Interns to fill service demands rather than placing Interns into attachments that would provide an educational medical and surgical experience. The other key concerns included:

- That the total pool of attachments for Interns will be decreased. However, the aim is to work with DHBs to improve the quality and learning experience for each clinical attachment, and ensure accreditation standards are met.
- That the change will result in an administrative burden on clinical supervisors and DHB administration staff to allocate appropriate attachments to meet the Interns learning needs.

Clear standards and criteria for how Council will accredit the attachments will be made available to DHBs, clinical supervisors and Interns. Council can draw on the work already completed by the Australian Medical Council, who has set standards for specific ‘terms’ for Interns.

For effective implementation the new standards for clinical attachments will need to be completed and made available to DHBs as early as possible in the planning and design phase, to allow DHBs maximum lead in time to reconfigure the clinical attachments. The accreditation of attachments will need to occur well before the Intern roster for the following year is completed by individual hospitals, to allow for clarity and transparency of the available accredited attachments.

Engagement with DHBs, the NZRDA and others involved in prevocational training will be crucial to the success of this aspect of the changes. At the Advisory Group meeting, it was agreed that once Council has set the standards for clinical attachments, then the DHBs are best placed to lead the work required to make the necessary changes.

Council’s decision about standards for clinical attachments

Council resolved to:

- **No longer require specific attachments (category A and B runs) to be completed during the provisional general period.**
- **Set robust processes in place for setting standards and accrediting individual clinical attachments including rotator and relief runs) for PGY1 and PGY2, ensuring that each attachment provides quality learning experience.**

Reasons:

- **Standards for accreditation that are linked to the learning outcomes in the curriculum framework will ensure that every clinical attachment provides a quality learning experience.**
- **Information about the particular clinical attachments that are accredited at each DHB and the learning outcomes available to be met on each particular clinical attachment will be made available allowing clarity and transparency.**

Proposal 5b – PGY2s working in accredited attachments

The Council proposes to no longer require specific attachments (category A and B runs) to be completed during the provisional general period. Instead Council proposes to set robust processes in place for setting standards and accrediting individual attachments for PGY1 and PGY2, ensuring that each attachment provides quality learning experience.

What will be the advantages to PGY2 Interns being required to work in clinical attachments that are accredited? Do you perceive any challenges to this proposal?

The majority of the feedback was in favour of PGY2s being required to work in accredited attachments, in the same way as the PGY1 Interns. This is seen as a way of ensuring that PGY2s are provided an educational learning experience. In general feedback indicated that accredited attachments for PGY2 s will help provide quality-based structured learning and may focus them towards vocational training.

It was suggested that some correlation between the standards Council sets for clinical attachments and the attachments that the Medical Colleges accredit for their vocational training programmes would be beneficial. Council may wish to explore how duplication and overlap of processes for accreditation for various bodies could be avoided.

“The RACP supports the accreditation of attachments that provide learning experiences. PGY2 trainees of the College undertake rotations in College-accredited hospitals. It is hoped that significant alignment can be established between RACP’s verifiable rotation types and those required for PGY2 under the MCNZ proposal”.

Council’s decisions on PGY2s being required to work in accredited attachments

Council resolved that PGY2s will be required to work in clinical attachments that are accredited.

Reason:

Working in accredited clinical attachments will provide an improved and quality based learning experience for PGY2s.

Proposal 6 – Community based settings

The Council proposes that Interns be required to spend at least 12.5% of their time over PGY1 and PGY2 in community based and outpatient settings. This is equivalent to completing one attachment over the two year period, or alternatively a selection of attachments, each of which has a portion of time allocated to the community or outpatient setting.

Do you support Council’s proposal to increase Intern experience in community based and outpatient settings to at least 12.5% over PGY1 and PGY2?

Those in favour of the proposal believe that time spent in the community or outpatient settings will expose the Intern to a broad range of generic skills and competencies that will equip them to better interface between primary and secondary care. Feedback highlighted that changing models of care would result in more care being provided in the community.

The community experience will be beneficial for all doctors even those who do not choose to undertake vocational training in general practice.

Some submissions strongly urged Council to increase the 12.5% requirement of an Intern's experience in community or outpatient settings to 50%, and believe this would be possible through a gradual implementation process. Others would prefer to see dedicated time in general practice if this was feasible.

"Ideally, the College would prefer to see all prevocational trainees undertake a dedicated full general practice attachment (rather than a wider community-based attachment) as this ensures exposure to the 'undifferentiated patient'. However, from a workforce, logistical and financial perspective we recognise that this poses challenges".

However, others raised concerns and highlighted challenges to this proposal and these include:

- Resource constraints and the need to backfill positions at hospitals when Interns are out in the community setting. It was suggested that this may require an overall increase in the number of Interns employed to meet inpatient needs, which could be a financial burden on the DHBs.
- The availability of community attachments for Interns as GPEP trainees and medical students are all competing for the same attachments.
- A need for 'community or outpatient settings' to be better defined, to avoid the following issues:
 - an Intern spending their 12.5% in an attachment with little educational value, such as pre-admission clinics
 - an Intern working out of their depth or level of experience, for example difficult on-call or home visits.
- Challenges about how supervision will be carried out and monitored in the community setting, as private practices may struggle to provide appropriate supervision needed for Interns.
- Interns may be unfairly penalised if they fail to meet the 12.5% requirement due to factors out of their control, for example an unsupportive workplace that occupies all the Interns time in inpatient work.
- The reimbursement of trainers in primary care - while the practice may gain some service delivery the trainers will lose time and money for their own consultations.
- Concerns about how Interns working in private general practices will be remunerated if they are employed by the DHBs but generating income for private practices.
- Concerns about facilities and availability of space for Interns in particular in general practice settings.

Despite the concerns, the Advisory Group requested that feedback to Council emphasises the importance of this direction, and that Council needs to signal clearly that the requirement for 12.5% of time in a community setting is a minimum, and there is an expectation to go beyond this.

Council's decision on community based settings

Council resolved that Interns be required to spend at least 12.5% of their time over PGY1 and PGY2 in community based and outpatient settings. This is equivalent to completing one attachment over the two year period, or alternatively a selection of attachments, each of which has a portion of time allocated to the community or outpatient setting. Because of the complexity for implementation of the community based experience, this aspect will not be mandated until the last stage of implementation; however it will be an option that may be implemented earlier for those who wish to do so.

Council further resolved that a small working group with appropriate expertise is formed to develop this direction further, and to consider how to overcome implementation challenges. The group should also provide advice back to Council to help define the term 'community based experience' and where this may be completed, and whether time in an emergency department should be counted towards the community based experience.

Reason:

Changing models of care and a projected increase in the incidence of age-related and chronic conditions will result in a greater share of medical services needing to be provided in the community. Regardless of whether or not an Intern is planning to undertake vocational training in general practice, gaining some experience in a community setting will be of benefit. In particular it will ensure they are fit for purpose by providing the opportunity to:

- practise triaging skills
- work with degrees of uncertainty
- understand the systems beyond the hospital boundary and the integration between primary and secondary care.

Proposal 7a – requirements for gaining a general scope of practice

Taking into account the proposals discussed in this paper, the Council proposes that the following requirements will need to be met in order for an Intern to be approved a general scope of practice:

1. The (satisfactory) completion of four accredited clinical attachments.
2. The attainment of (all) learning outcomes outlined in the New Zealand Curriculum Framework for Prevocational Medical Training.
3. Completion of a minimum of 10 weeks in each attachment.
4. A recommendation for registration in a general scope of practice by an approved panel (to include the Intern Supervisor).
5. Approval of a PDP for PGY2, which will be completed during PGY2.

Any change to the existing requirements would be formally published by the Council as a change to the 'prescribed qualification' for registration in a general scope via the Australian/New Zealand Intern pathway 1.

Do you have any feedback about the requirements to gain general registration in a general scope of practice?

The majority of the feedback was in support of Council's requirements for a general scope of practice, and agreed with Council's decision that a general scope should be granted at the end of PGY1.

The few concerns raised relate to the following:

- meeting requirements for a general scope might become a 'tick box' exercise for some doctors, who are more interested in completing tasks rather than becoming insightful doctors with good communication and professional skills to be able to work independently
- the necessity of having a PDP approved at the end of PGY1 to gain a general scope especially if the doctor is moving overseas in PGY2
- potential for Intern Supervisors to be overburdened and under-resourced in having to nominate each Intern for a general scope.

Council's decision on requirements to gain a general scope of practice

Council resolved that the following requirements will need to be met in order for an Intern to be approved a general scope of practice:

1. The (satisfactory) completion of four accredited clinical attachments.

2. The attainment of the learning outcomes outlined in the *New Zealand Curriculum Framework for Prevocational Medical Training* (prior learning from the trainee Intern year will be taken into account).
3. Completion of a minimum of 10 weeks in each attachment.
4. A recommendation for registration in a general scope of practice by an approved panel (to include the Intern Supervisor).
5. Establishing an acceptable PDP for PGY2, to be completed during PGY2.

Council further resolved that a working group reviews the current supervision report form and provides advice about format and content for a report form to be used by supervisors for feedback about each clinical attachment, and what will constitute 'satisfactory' completion of a clinical attachment, taking into account:

- the focus of the assessment framework towards an assessment for learning, rather than an assessment of learning
- the importance of the trajectory of learning, the levels of supervision needed, and the move to increasingly independent practice
- the goals of the assessment framework, as defined in the consultation paper.

Reason:

Meeting these requirements will satisfy Council that a doctor is competent to practise within a general scope of practise, with a requirement to complete a PDP during the PGY2 year to guide ongoing learning.

Implementation

Council will work with key stakeholders and the Stakeholder Advisory Group throughout the planning and design phase, prior to implementation (*Appendix 1*).

1. A number of small focused sub-groups will work on various work streams.
2. A transitional implementation plan will be developed phasing in changes between November 2014 and November 2015.

The following will be immediate priorities:

- Final agreement to curriculum framework.
- Developing the PDP.
- Developing the requirements for an e-portfolio and identifying and entering into an agreement with a provider to develop and administer the process.
- Developing a framework for training and up skilling of Intern Supervisors and supervisors of clinical attachments.
- Developing standards for clinical attachments.

Implementation plan timeframes (*see Appendix 1*)

November 2014:

- The curriculum framework.
- The PDP and e-portfolio.

- The framework for assessment.
- Training for supervisors.

November 2015:

- Implementation of the accreditation standards for clinical attachments.
- Inclusion of time in a community based or outpatient setting to meet 12.5%.
- Changes to requirements for PGY2.
- Multisource feedback.

Evaluation of the effectiveness of the changes made to prevocational training

It is important that an evaluation programme is put in place to assess the effectiveness of the changes Council make to prevocational training.

An expert advisory group will be formed to provide advice to Council about how an evaluation programme to consider the effectiveness of the changes should be developed.

Communication plan

A communication plan will be developed to ensure relevant stakeholders are informed of Council's decisions about changes to prevocational training, and to ensure ongoing communication during the design, development, and implementation period.

