Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

Accreditation assessment of the Royal New Zealand College of General Practitioners for vocational medical training and recertification

Date of assessment: 18 – 21 March 2024
Date of Council decision: 15 August 2024

Medical Council of New Zealand

Contents

Background

It is Te Kaunihera Rata o Aotearoa, Medical Council of New Zealand's (MCNZ) statutory role to monitor and promote medical education and training in Aotearoa New Zealand. To ensure that its standards for Aotearoa New Zealand-based vocational and prevocational training providers are met, MCNZ accredits training and recertification providers and their training programme or programmes.

The purpose of the accreditation process is to recognise vocational medical training and recertification programmes and their associated training providers that produce medical practitioners who:

- can practise unsupervised in the relevant vocational scope
- can provide comprehensive, safe and high-quality medical care that meets the needs of the Aotearoa New Zealand healthcare system
- are prepared to assess and maintain their competence and performance through recertification programmes, maintaining their skills and developing new skills.

The MCNZ accreditation process involves both accreditation (validating that standards are met) and peer review to promote high standards of medical education, stimulate self-analysis and assist the training provider to achieve its objectives. Accreditation is conducted in a collegial manner that includes consultation, advice and feedback to the training provider.

The MCNZ's accreditation of vocational medical training and recertification programmes and their associated training providers is intended to:

- provide an incentive for the organisation being accredited to review and to assess its own programme. The collegiate nature of accreditation should facilitate discussion and interaction with colleagues from other disciplines to benefit from their experience
- respect the autonomy of the training provider, and acknowledge the expertise in, and achievements of, the training provider and its programme
- support and foster educational initiatives
- assist the training provider by drawing attention in the accreditation report both to weaknesses of the organisation's education, training and professional development programmes and its strengths
- as a quality assurance mechanism, benefit prospective trainees, employers of the graduates of programmes and the Aotearoa New Zealand public by ensuring a highly skilled medical workforce.

Training providers are assessed against the MCNZ's *Accreditation standards for New Zealand training providers of vocational medical training and recertification programmes*.

The Medical Council of New Zealand's accreditation of the Royal New Zealand College of General Practitioners for vocational medical training

General information

Name of training provider:	The Royal New Zealand College of General Practitioners (RNZCGP)
Date of accreditation assessment:	18-21 March 2024
Accreditation assessment decision:	15 August 2024
Accreditation period granted:	31 August 2030
Date of last accreditation decision:	May 2014

Programme information

Scope:	General Practice Rural Hospital Medicine
Post fellowship awarded:	Fellowship of the Royal New Zealand College of General Practitioners (FRNZCGP) Fellowship of the Division of Rural Hospital Medicine New Zealand (FDRHMNZ)
Training programmes offered:	General Practice Education Programme (GPEP) Rural Hospital Medicine Training programme (RHMTP)

Fellowship and membership categories General Practice	**Number**
Membership:	**5818**
Associate in training:	**282**
Associate in practice:	**155**
Fellowship:	**4620**
Life membership or life fellowship:	**50**

Fellowship and membership categories Rural Hospital Medicine	**Number**
Membership:	**123**
Associate in training:	**49**
Fellowship:	**74**

Executive summary

An accreditation panel of Te Kaunihera Rata o Aotearoa, Medical Council of New Zealand (MCNZ) has assessed the Royal New Zealand College of General Practitioners (RNZCGP) and its vocational training and recertification programmes in general practice and rural hospital medicine against MCNZ's 2022 *Accreditation standards for New Zealand training providers of vocational medical training and recertification programmes.*

The RNZCGP was last accredited by MCNZ as a vocational training provider for general practice, in 2014, with the Division of Rural Hospital Medicine accredited as a vocational training provider for rural hospital medicine in 2018.

The accreditation panel is grateful to the fellows, trainees and staff of the RNZCGP for their thorough preparation for the accreditation process and for their active and willing engagement with the panel throughout the visit.

The accreditation panel recognises and acknowledges the RNZCGP's critical role in the training of, and maintaining the education of, the general practice workforce in Aotearoa New Zealand. The RNZCGP undertakes this in the face of major societal pressures including significant demographic changes, increasing expectations as to levels of care, evolving information technology (IT) and artificial intelligence (AI) capabilities, and cost of living issues. In addition, the RNZCGP continues to promote the standing of vocational registration in general practice in Aotearoa New Zealand, and is demonstrably cognisant of te Tiriti o Waitangi and the nation's aspirations and obligations in respect to it.

The MCNZ accreditation of the RNZCGP's training and recertification activities encompasses the two training programmes provided by the RNZCGP - that is the General Practice Education Programme (GPEP) and the Rural Hospital Medicine Training Programme (RHMTP). Within this report there is at times commentary specific to one or other of these programmes, however the RNZCGP's performance in meeting or otherwise each of the accreditation standards has been assessed in summation across the two programmes.

The accreditation panel has identified a number of areas where the RNZCGP is to be commended for the excellence of its endeavours in provision of certain aspects of its training programmes. Particularly noteworthy in this respect are the prominence given to its educational role and responsibilities in the governance structure, and the extent to which the RNZCGP embeds educational expertise in its governance and associated structures, drawing upon this expertise in discharging its training and education functions. The RNZCGP's strong commitment to equity is also evident, as exemplified by its support for Māori and Pasifika trainees through Te Pou Whirinaki, and by the cultural safety pou of the RNZCGP's recertification programme, Te Whanake.

Areas of vulnerability in provision of the RNZCGP's vocational training programme have also been identified with a number of required actions presented for the RNZCGP's attention. A number of recommendations for the RNZCGP's consideration, are also listed within the report.

While all required actions are seen as essential for the RNZCGP to fully meet the accreditation standards, the need to review the balance of teaching and learning activities across the *entire* GPEP, to ensure that trainees are appropriately supported to develop increasingly independent practice, is seen by the accreditation panel to be of paramount importance. There is also a pressing need for the RNZCGP to fully define its own accountabilities, and those of the New Zealand Society of Cosmetic Medicine (NZSCM), in respect to the NZSCM's training programme and its recertification programme.

The panel met with the various bodies contributing to governance at the RNZCGP. It was clear that the RNZCGP's educational purpose is strongly prioritised by these bodies, however the panel found that

concerns and issues raised by trainees were not sufficiently elevated at RNZCGP Board level and that there was no trainee participation at this level. Therefore, the RNZCGP must ensure that there is trainee representation at Board level to ensure the trainee voice is heard.

Concerning the Rural Hospital Medicine Training Programme (RHMTP), a significant area of concern identified by the panel was the viability of the RHMTP. The RNZCGP will need to consider the vulnerabilities within the six-factor framework for the RHMTP, with a strong focus on funding and resourcing of the training and education functions at a sustainable level.

The panel were impressed with the GPEP curriculum, which was extensively reviewed in 2021, however the RNZCGP's processes in place to regularly review its training and recertification programmes to ensure the programmes are continuing to meet changing needs are lacking. There is currently no evidence of a planned and systematic process to review the programmes which includes curriculum content, teaching and learning, supervision, assessment, and trainee progression.

Summary of findings

Overall, the Royal New Zealand College of General Practitioners has met 15 of the 35 sets of Council's 2022 *Accreditation standards for New Zealand training providers of vocational medical training and recertification programmes*.

25 required actions were identified, along with 27 recommendations and 15 commendations.

Standard		**2024 findings**	**No. of required actions**
1 – The context of training and education	1.1 Governance	substantially met	6
	1.2 Programme management	substantially met	
	1.3 Reconsideration, review and appeals processes	substantially met	
	1.4 Educational expertise and exchange	met	
	1.5 Educational resources	substantially met	
	1.6 Interaction with the health sector	substantially met	
	1.7 Continuous renewal	substantially met	
2 – The outcomes of vocational medical training	2.1 Educational purpose	met	0
	2.2 Programme outcomes	met	
	2.3 Graduate outcomes	met	
3 – The vocational medical training and education framework	3.1 Curriculum framework	met	2
	3.2 The content of the curriculum	substantially met	
	3.3 Continuum of training, education and practice	met	
	3.4 Structure of the curriculum	met	
4 – Teaching and learning	4.1 Teaching and learning approach	met	1
	4.2 Teaching and learning methods	substantially met	
5 – Assessment of learning	5.1 Assessment approach	substantially met	2
	5.2 Assessment methods	substantially met	
	5.3 Performance feedback	substantially met	
	5.4 Assessment quality	substantially met	
6 – Monitoring and evaluation	6.1 Monitoring	substantially met	3
	6.2 Evaluation	met	
	6.3 Feedback, reporting and action	met	
7 – Trainees	7.1 Admission policy and selection	met	4
	7.2 Trainee participation in training provider governance	substantially met	
	7.3 Communication with trainees	not met	
	7.4 Trainee wellbeing	substantially met	
	7.5 Resolution of training problems and disputes	not met	
8 – Implementing the programme: delivery of education and accreditation of training sites	8.1 Supervisory and educational roles	not met	6
	8.2 Training sites and posts	substantially met	
9 – Recertification programmes, further training and remediation	9.1 Recertification programmes	substantially met	1
	9.2 Further training of individual vocationally registered doctors	met	
	9.3 Remediation	met	
	10.1 Assessment framework	met	0

Standard		2024 findings	No. of required actions
10 – Assessment of specialist international medical graduates for the purpose of provisional vocational registration	10.2 Assessment methods	met	

Required actions	Standard
1. The RNZCGP must review the advisory status of the boards of studies with consideration of assigning decision-making responsibilities in relation to education and training.	**The context of training and education – Governance** **1.1.3** - The training provider's governance structures set out the composition, terms of reference, delegations and reporting relationships of each entity that contributes to governance, and allow all relevant groups to be represented in decision-making.
2. The RNZCGP must ensure the viability of the RHMTP, with a particular focus on funding and resourcing its training and education functions at a sustainable level.	**The context of training and education – Programme management** **1.2.1** - The training provider has structures with the responsibility, authority and capacity to direct the following key functions: • planning, implementing and evaluating the vocational medical programme(s) and curriculum, and setting relevant policy and procedures • setting and implementing policy on its recertification programme(s) and evaluating the effectiveness of recertification activities • setting, implementing and evaluating policy and procedures relating to the assessment of SIMGs • certifying successful completion of the training and education programmes • reporting on the six-factor framework on the viability of the vocational training provider as part of its accreditation process. **The context of training and education – Educational resources** **1.5.1** - The training provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions.

3. The RNZCGP must review and update its MoU with the NZSCM, including to: a) identify risks and issues that may not be currently satisfactorily managed; and b) clarify and fully define the accountabilities of both parties in respect of both the NZSCM's training programme and its recertification programme.	**The context of training and education – Programme management** **1.2.1** - The training provider has structures with the responsibility, authority and capacity to direct the following key functions: • planning, implementing and evaluating the vocational medical programme(s) and curriculum, and setting relevant policy and procedures • setting and implementing policy on its recertification programme(s) and evaluating the effectiveness of recertification activities • setting, implementing and evaluating policy and procedures relating to the assessment of SIMGs • certifying successful completion of the training and education programmes • reporting on the six-factor framework on the viability of the vocational training provider as part of its accreditation process.
4. The RNZCGP must develop a formal process for evaluating de-identified appeals and complaints.	**The context of training and education – Reconsideration, review and appeals processes** **1.3.2 -** The training provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.
5. The RNZCGP must develop, including at senior management level, enduring relationships with Māori health providers, in order to better understand their issues and challenges to inform and support further enhancement of its training and education programmes.	**The context of training and education – Interaction with the health sector** **1.6.4** - The training provider has effective partnerships with Māori health providers to support vocational medical training and education.
6. The RNZCGP must employ a planned and systematic review process to regularly review its training and recertification programmes to ensure the programmes are continuing to meet changing needs and best practice.	**The context of training and education – Continuous renewal** **1.7.1** - The training provider regularly reviews its structures and functions for and resource allocation to training and education functions to meet changing needs and evolving best practice. **Monitoring and evaluation – Monitoring** **6.1.1** - The training provider regularly reviews its training and education programmes. Its review processes address curriculum content, teaching and learning, supervision, assessment and trainee progress.

7. The RNZCGP must have formal learning opportunities for GPEP and RHM trainees in research methodology, critical appraisal of literature, scientific data, and evidence-based practice.	**The vocational medical training and education framework – The content of the curriculum** **3.2.8** - The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so that all trainees are research literate. The programme encourages trainees to participate in research, enables appropriate candidates to enter research training during vocational medical training and receive appropriate credit for this towards completion of vocational medical training.
8. The RNZCGP must ensure that the RHM curriculum enables development of a substantive understanding of the determinants of Māori health inequities, achieving Māori health equity and development of cultural safety.	**The vocational medical training and education framework – The content of the curriculum** **3.2.9** - The curriculum includes formal learning about and develops a substantive understanding of the determinants of Māori health inequities and achieving Māori health equity. The training programme should demonstrate that the training is producing doctors who engage in ongoing self-reflection and self-awareness and hold themselves accountable for their patients' cultural safety. The training programme should include formal components that contribute to the trainees' education and development in cultural safety. **Teaching and learning – Teaching and learning methods** **4.2.5** - The training provider has processes that ensure that trainees receive the supervision and opportunities to develop their cultural safety and reflect on their unconscious bias in order to deliver patient care in a culturally-safe manner.
9. The RNZCGP must ensure that the GPEP training and education processes facilitate trainees' development of an increasing degree of independent responsibility in a more graduated manner, in the more formal elements of the programme, including in the acquisition of procedural skills.	**Teaching and learning – Teaching and learning methods** **4.2.4** - The training and education process facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge, and experience grow.

10. The RNZCGP must develop a programme of assessment for each of GPEP and RHMTP which is mapped to the graduate outcomes and in which progression in performance expected at each stage of training is documented.	**Assessment of learning – Assessment approach** **5.1.1** - The training provider has a programme of assessment aligned to the outcomes and curriculum of the vocational medical training programme which enables progressive judgements to be made about trainees' preparedness for the vocational scope of practice. **Assessment of learning – Assessment methods** **5.2.2** - The training provider has a blueprint to guide assessment through each stage of the vocational medical training programme. **Assessment of learning – Assessment quality** **5.4.1** - The training provider regularly reviews the quality, consistency and fairness of assessment methods, their educational impact and their feasibility. The provider introduces new methods where required.
11. The RNZCGP must systematise and provide regular and timely feedback to trainees on their progress to guide learning.	**Assessment of learning – Performance feedback** **5.3.1** - The training provider facilitates regular and timely feedback to trainees on performance to guide learning.
12. The RNZCGP must ensure that supervisors can contribute to monitoring and programme development by systematically seeking, analysing and using supervisor feedback in the monitoring process.	**Monitoring and evaluation – Monitoring** **6.1.2** - Supervisors contribute to monitoring and to programme development. The training provider systematically seeks, analyses and uses supervisor feedback in the monitoring process.
13. The RNZCGP must ensure that there are adequate mechanisms for trainees to provide feedback at every level of supervision, and that feedback is handled sensitively to maintain or redirect training relationships.	**Monitoring and evaluation – Monitoring** **6.1.3** - Trainees contribute to monitoring and to programme development. The training provider systematically seeks, analyses and uses their confidential feedback on the quality of supervision, training and clinical experience in the monitoring process. Trainee feedback is specifically sought on proposed changes to the vocational medical training programme to ensure that existing trainees are not unfairly disadvantaged by such changes. **Implementing the programme: delivery of education and accreditation of training sites – Supervisory and educational roles** **8.1.4** - The training provider routinely evaluates supervisor effectiveness including feedback from trainees.

14. The RNZCGP must demonstrate how trainee input is used to improve the quality of supervision, training and clinical experience.	**Monitoring and evaluation – Monitoring** **6.1.3** - Trainees contribute to monitoring and to programme development. The training provider systematically seeks, analyses and uses their confidential feedback on the quality of supervision, training and clinical experience in the monitoring process. Trainee feedback is specifically sought on proposed changes to the vocational medical training programme to ensure that existing trainees are not unfairly disadvantaged by such changes.
15. The RNZCGP must ensure that there is trainee representation at Board level.	**The context of training and education – Governance** **1.1.3** - The training provider's governance structures set out the composition, terms of reference, delegations and reporting relationships of each entity that contributes to governance, and allow all relevant groups to be represented in decision-making. **Trainees – Trainee participation in training provider governance** **7.2.1** - The training provider has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.
16. The RNZCGP must develop comprehensive and diverse communications channels with trainees, including timely central support to disseminate information and answer queries. This must include communication with trainees about the current support services in place for trainees who are experiencing personal or professional difficulties including those experiencing issues with employers.	**Trainees – Communication with trainees** **7.3.3** - The training provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.
17. The RNZCGP must implement changes to better support trainees in the transition from GPEP1 to GPEP2 and 3 with focus on funding, support and mentoring, and preparation for fellowship training.	**The context of training and education – Educational resources** 1.5.1 The training provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions. **Trainees – Trainee wellbeing** **7.4.1** - The training provider promotes strategies to enable a supportive learning environment.

18. The RNZCGP must work collaboratively with trainees to develop a process that addresses problems with training supervision and requirements and the timely resolution of issues that arise between supervisors and trainees in the GPEP programme. Consideration should be given to cultural challenges, power imbalances and ongoing support of needs.	**Trainees – Resolution of training problems and disputes** **7.5.1** - The training provider supports trainees in addressing problems with training supervision and requirements, and other professional issues. The training provider's processes are transparent and timely, and safe and confidential for trainees. **7.5.2** - The training provider has clear impartial pathways for timely resolution of professional and/or training-related disputes between trainees and supervisors or trainees and the training provider.
19. The RNZCGP must refocus the accreditation and reaccreditation process for GPEP training sites on providing universal trainee clinical supervision in all circumstances.	**Implementing the programme: delivery of education and accreditation of training sites – Supervisory and educational roles** **8.1.1 -** The training provider ensures that there is an effective system of clinical supervision to support trainees to achieve the programme and graduate outcomes. **Implementing the programme: delivery of education and accreditation of training sites – Training sites and posts** **8.2.2** - The training provider's criteria or standards for accreditation of training sites link to the outcomes of the vocational medical training programme and: • promote the health, welfare and interests of trainees • ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner • support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provision of health care to Māori • ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment. • inform the MCNZ with reasonable notice of any intention to limit or withdraw the accreditation of any training site.

20. The RNZCGP must ensure that clinical supervisors for both GPEP and RHM trainees are provided with essential programme information to deliver robust supervision.	**Implementing the programme: delivery of education and accreditation of training sites – Supervisory and educational roles** **8.1.2** - The training provider has defined the responsibilities of hospital and community doctors who contribute to the delivery of the vocational medical training programme and the responsibilities of the training provider to these doctors. It communicates its programme and graduate outcomes to these doctors.
21. The RNZCGP must ensure that for both GPEP and RHM trainees, suitably qualified clinical supervision is available at all times and for GP practices, the expectation is that this clinical supervision would be provided by RNZCGP fellows working on site alongside the vocational trainee. Hospital supervision for RHM trainees may mean off-site clinical supervision at times, in line with supervision provided to all trainees working in specialty services.	**Implementing the programme: delivery of education and accreditation of training sites – Supervisory and educational roles** **8.1.3** - The training provider selects supervisors who have demonstrated appropriate capability for this role. It facilitates the training, support and professional development of supervisors.
22. The RNZCGP must review the GPEP training site accreditation process with a rural and diversity focus to increase opportunities in rural, remote and Māori communities and examine barriers to registrars taking up these posts.	**Implementing the programme: delivery of education and accreditation of training sites – Training sites and posts** **8.2.2** - The training provider's criteria or standards for accreditation of training sites link to the outcomes of the vocational medical training programme and: • promote the health, welfare and interests of trainees • ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner • support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provision of health care to Māori • ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment. • inform the MCNZ with reasonable notice of any intention to limit or withdraw the accreditation of any training site.

23. The RNZCGP must ensure that at secondary hospital training sites, accreditation processes for specialty training are reviewed to ensure that training needs of RHM trainees are being met and additional accreditation processes introduced where deficiencies are identified.	**Implementing the programme: delivery of education and accreditation of training sites – Training sites and posts** **8.2.2** - The training provider's criteria or standards for accreditation of training sites link to the outcomes of the vocational medical training programme and: • promote the health, welfare and interests of trainees • ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner • support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provision of health care to Māori • ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment. • inform the MCNZ with reasonable notice of any intention to limit or withdraw the accreditation of any training site.

24. The RNZCGP must review how both the GPEP and RHM training site accreditation processes map clearly to desired vocational programme outcomes.	**Implementing the programme: delivery of education and accreditation of training sites – Training sites and posts** **8.2.2** - The training provider's criteria or standards for accreditation of training sites link to the outcomes of the vocational medical training programme and: • promote the health, welfare and interests of trainees • ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner • support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provision of health care to Māori • ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment. • inform the MCNZ with reasonable notice of any intention to limit or withdraw the accreditation of any training site.
25. The RNZCGP must clearly allocate the responsibility for, and oversight of, recertification within its governance framework, and align recertification with its Learning section within the organisation, rather than solely with its Membership section.	**The context of training and education – Governance** **1.1.1** - The vocational medical training provider's (training provider's) corporate governance structures are appropriate for the delivery of vocational medical specialist programmes, recertification programmes and the assessment of specialist international medical graduates (SIMGs). **Recertification programmes, further training and remediation – Recertification programmes** **9.1.2** - The recertification programme provider determines its requirements in consultation with stakeholders and designs its recertification programme to meet Medical Council of New Zealand requirements and accreditation standards.

Accreditation decision

In August 2024, Te Rōpū Mātauranga | The Education Committee of Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand (Council) considered this report and resolved that:

- the overall outcome of the accreditation assessment of the RNZCGP is **'substantially met'**, and
- the RNZCGP's accreditation as a vocational medical training and recertification provider for the vocational scopes of general practice and rural hospital medicine, is extended to **31 August 2030**, subject to the following conditions:
  - the RNZCGP must provide progress reports that satisfy the Council that its required actions have been addressed, by the dates specified by the Council
  - the RNZCGP must provide annual reports for the period of its accreditation.

Accreditation standards

1 The context of training and education

1.1	Governance
1.1.1	The vocational medical training provider's (training provider's) corporate governance structures are appropriate for the delivery of vocational medical specialist programmes, recertification programmes and the assessment of international medical graduates (IMGs).
1.1.2	The training provider has structures and procedures for oversight of training and education functions which are understood by those delivering these functions. The governance structures should encompass the provider's relationships with internal units and external training providers where relevant.
1.1.3	The training provider's governance structures set out the composition, terms of reference, delegations and reporting relationships of each entity that contributes to governance, and allow all relevant groups to be represented in decision-making.
1.1.4	The training provider's governance structures give appropriate priority to its educational role relative to other activities, and this role is defined in relation to its corporate governance.
1.1.5	The training provider collaborates with relevant groups on key issues relating to its purpose, training and education functions, and educational governance.
1.1.6	The training provider has developed and follows procedures for identifying, managing and recording conflicts of interest in its training and education functions, governance and decision-making.

1.1 Governance	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The RNZCGP has a number of bodies contributing to governance, some having overlapping areas of interest, however, all bodies appear to serve a purpose and to interact reasonably effectively.

The governance structures appropriately deliver and support the relevant training programmes however there are issues around contribution and decision making highlighted further at standard 1.1.3 which warrant addressing.

The RNZCGP has structures and procedures for oversight of training and the education functions are generally understood by those delivering these functions, at least at a high level sufficient for initial engagement with the College or Division where needed. However, these structures are not necessarily well understood by trainees. Governance structures have appropriate coverage of internal and external relationships.

The RNZCGP governance documents appropriately cover composition, terms of reference, delegations and reporting relationships. All relevant groups contribute to decision-making, however, there are inefficiencies in the model around communication between contributing bodies and the RNZCGP Board. For example, the boards of studies for both programmes and the Academic Tāhuhu are advisory rather than empowered to make decisions, with the RNZCGP's chief executive appearing to have substantial practical power to influence the allocation of resources needed to enable initiatives to progress. This model risks disenfranchising Fellows who have contributed to proposals for positive change through the boards of studies, Academic Tāhuhu or National Advisory Committee (NAC). Although the various bodies provide advice and recommendations to the Board, these may not ultimately be acted upon due to limited funding and competing priorities and there appears to be dispersed and uncertain accountability.

Another notable exception is trainee contribution and decision making on the RNZCGP Board, this is indirect and through trainee representation on other governance bodies. The panel found that concerns and issues raised by trainees are not sufficiently elevated at RNZCGP Board level and acted upon, this is discussed further at standard 7.2.

The RNZCGP governance structures give appropriate priority to its educational role relative to other activities. In relation to its corporate governance, the educational role is prominent and heavily weighted. One qualification to this is that the NAC remit excludes trainee issues. During the visit the NAC provided the panel with valuable insight on fundamental issues regarding programme and graduate outcomes. Although the RNZCGP Board sources advice from its boards of studies and Academic Tāhuhu on training and education matters, it should consider how to give due weight to feedback provided by the NAC on education and training given the considerable practical experience of its members, collectively, in these areas.

The RNZCGP collaborates with relevant external groups on key issues relating to its purpose, training and education functions, and educational governance, with one exception. The RNZCGP should strengthen its engagement with the RNZCUC, as this was not at the level expected, especially given the degree of interface between urgent care and general practice and extent to which doctors might consider both vocational options in their training and professional development.

The RNZCGP has well documented procedures for managing conflicts of interest and there was a reasonable level of awareness of these as an issue to manage in the General Practice Education Programme (GPEP) context. However, there were some potential blind spots around recognising and managing conflicts of interest in the Rural Hospital Medicine Training Programme (RHMTP) context. The panel acknowledges the lesser degrees of separation given the smaller numbers in this division and this programme. Although some pragmatism is needed in managing conflicts, transparency around this is required.

Commendations:

- The RNZCGP is commended for the prominence given to the RNZCGP's educational role in the governance structure.

Recommendations:

- The RNZCGP should consider how to give due weight to feedback provided by the National Advisory Committee (NAC) on education and training given the considerable practical experience of its members, collectively, in these areas. (standard 1.1.4)
- The RNZCGP should consider the sufficiency of its engagement with the RNZCUC and if there are any other external groups where the level of collaboration could be improved. (standard 1.1.5)
- The RNZCGP should ensure conflict of interest issues and policies are well understood, managed and applied in the RHMTP. (standard 1.1.6)

Required actions:

1. The RNZCGP must review the advisory status of the boards of studies with consideration of assigning decision-making responsibilities in relation to education and training. (standard 1.1.3)

1.2 Programme management

1.2.1 The training provider has structures with the responsibility, authority and capacity to direct the following key functions:

- planning, implementing and evaluating the vocational medical programme(s) and curriculum, and setting relevant policy and procedures
- setting and implementing policy on its recertification programme(s) and evaluating the effectiveness of recertification activities
- setting, implementing and evaluating policy and procedures relating to the assessment of SIMGs

- certifying successful completion of the training and education programmes
- reporting on the six-factor framework on the viability of the vocational training provider as part of its accreditation process.

1.2 Programme management

	Met	Substantially met	Not met
Rating		X	

Summary of findings:

Regarding GPEP, the RNZCGP has structures with the responsibility, authority and capacity to direct the functions covered under this standard. However as evidenced by consideration of the six-factor framework, there are vulnerabilities in respect to the RHMTP. Although there is strong collegiality in the DRHM, and the RNZCGP did make a compelling case that this scope of medicine has long-term viability in Aotearoa New Zealand, the panel had significant concerns regarding the critical mass, sustainable base, infrastructure, and funding for rural hospital medicine programme. Concerning infrastructure within RNZCGP for the RHMTP, the human resources to administer the RHMTP appears insufficient, with high levels of turnover also impacting support for trainees. Further commentary on funding is at standard 1.5.1.

The RNZCGP has a memorandum of understanding (MoU) with the New Zealand Society of Cosmetic Medicine (NZSCM). The panel was advised that the MoU includes support for the NZSCM's training programme and oversight of the NZSCM's CPD programme. The MoU has not been reviewed for many years (possibly over 20 years) and the RNZCGP oversight of these programme related activities is considered to be 'light touch'. There is interaction between the Society and the RNZCGP Censor-in-Chief where necessary around concerns about members of the NZSCM. However, systematic and regular oversight of the NZSCM's recertification programme does not appear to be occurring, or to be well described, within the RNZCGP's processes and its governance structure.

Required actions:

2. The RNZCGP must ensure the viability of the RHMTP, with a particular focus on funding and resourcing its training and education functions at a sustainable level. (standards 1.2.1 and 1.5.1)
3. The RNZCGP must review and update its MoU with the NZSCM, including to:
   a. identify risks and issues that may not be currently satisfactorily managed; and
   b. clarify and fully define the accountabilities of both parties in respect of both the NZSCM's training programme and its recertification programme. (standard 1.2.1)

1.3 Reconsideration, review and appeals processes

1.3.1 The training provider has reconsideration, review and appeals processes that provide for impartial review of decisions related to training and education functions. It makes information about these processes publicly available.

1.3.2 The training provider has a process for evaluating de-identified appeals and complaints to determine if there is a systems problem.

1.3 Reconsideration, review and appeals processes

	Met	Substantially met	Not met
Rating		X	

Summary of findings:

The RNZCGP has reconsideration, review and appeal processes that are well documented, accessible and sufficiently 'sign-posted' for those looking for them. There was some feedback from DRHM trainees that suggested a lack of awareness and understanding, and possibly a lack of transparency, as to these processes, especially around the aegrotat process. However there was no suggestion of lack of impartiality in relation to such reviews, and the panel did not get a sense that reconsiderations, reviews and appeals were a significant area of concern for trainees.

The RNZCGP does not have a formal process for evaluating de-identified appeals and complaints to determine if there is a systems problem, this is due to the low number of appeals, rather it deals with appeals and complaints in an ad hoc manner.

Recommendations:

- The RNZCGP should consider whether communication around the outcome of reconsideration, review and appeal processes could be enhanced, in order to build further confidence in such processes and their perceived transparency (standard 1.3.1).

Required action:

4. The RNZCGP must develop a formal process for evaluating de-identified appeals and complaints (standard 1.3.2).

1.4 Educational expertise and exchange

1.4.1 The training provider uses educational expertise in the development, management and continuous improvement of its training and education functions.

1.4.2 The training provider collaborates with other educational institutions and compares its curriculum, vocational medical training programme and assessment with that of other relevant programmes.

1.4 Educational expertise and exchange

	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

The RNZCGP's use of educational expertise in the development, management and continuous improvement of its training functions is well reflected in its governance structures, associated membership and documentation.

The RNZCGP compares its curriculum, training programme and assessment with that of other relevant programmes through collaboration with other educational institutions. It was evident that within the RNZCGP's collaboration with other educational institutions, the motivation is to share ideas for continuous improvement and not 'reinvent the wheel'.

Commendations:

- The RNZCGP is commended for embedding educational expertise in its governance and associated structures and for demonstrably drawing upon this expertise in discharging its training and education functions.

1.5 Educational resources

1.5.1 The training provider has the resources and management capacity to sustain and, where appropriate, deliver its training and education functions.

1.5.2 The training provider's training and education functions are supported by sufficient administrative and technical staff.

1.5 Educational resources

	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The RNZCGP has sufficient resources, management capacity, administrative and technical staff to sustain and deliver the GPEP training programme, under its current funding model and in the form it currently exists. However, aspects of funding for GPEP 2 and 3+ are not directly or fully funded by the government, rather factors such as assessments and examinations are largely funded by registrar learning fees. The panel heard from interviewees that funding for GPEP 2 and 3+ covers the bare minimum, with areas identified where funding was lacking being upskilling, mentor support for trainees, teaching and educational resources. As discussed later in the report, concerns were raised at the large drop off in

educational support from the RNZCGP after GPEP1, therefore the panel suggests that if at all possible, funding for GPEP 2 and 3+ is fundamentally changed and optimised to support these trainees.

The funding model for RHMTP is substantially different to that of the GPEP with no direct government funding for training. This effectively creates a barrier for trainees when undertaking the required attachment in general practice, and potentially attachments in rural hospitals. Furthermore, annual training fees charged to RHM trainees do not cover the full cost of delivering the programme, which is subsidised from general RNZCGP funds. Consequently, there are insufficient resources to sustain and deliver its training and education functions in respect of the RHMTP over the longer term. As an example, the panel heard that suggested academic initiatives for the RHMTP are regularly 'hamstrung' by funding constraints, with many discussions about what 'bucket' the funding could come from.

The administrative and technical support for GPEP is supported by sufficient staff, however the administrative and technical support for RHMTP is not sufficient with only 0.4 FTE provided for clinical leads (who appear to go 'above and beyond' to do full justice to the role), and 0.9 FTE for administrative support. This support is highly regarded, but also represents 'key person risk', especially if an individual was to go on extended leave.

RNZCGP staff expressed views that that RHMTP resourcing was sufficient relative to the numbers in the programme, and that there was adequate cover when the key administrative support person had taken leave. However, the panel considered there had been material drop-off in service in periods when the administrative support person has been on extended leave.

The panel also heard from those involved in supervision of RHM trainees that a lot of the work relies on voluntary input from some educational facilitators and supervisors in order to fully discharge their roles. Lack of support and insufficient FTE were raised as contributing factors. For these reasons the administrative and technical staffing for the RHMTP appears precarious and unsustainable at its current level.

Commendations:

- The RNZCGP is commended for the responsiveness of, and support provided by, the RHMTP administrative and technical staff.

Required actions:

- *See required action 2.*

1.6 Interaction with the health sector

1.6.1 The training provider seeks to maintain effective relationships with health-related sectors of society and government, and relevant organisations and communities to promote the training, education and continuing professional development of vocationally registered doctors through recertification.

1.6.2 The training provider works with training sites to enable clinicians to contribute to high-quality teaching and supervision, and to foster professional development.

1.6.3 The training provider works with training sites and jurisdictions on matters of mutual interest.

1.6.4 The training provider has effective partnerships with Māori health providers to support vocational medical training and education.

1.6 Interaction with the health sector

	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The RNZCGP's overall maintenance of effective external relationships was well documented and supported by interviews. One area of potential weakness is the extent to which the RNZCGP engages

with consumers and their representative organisations or communities, in order to understand and assess how well its programmes are meeting community expectations.

The RNZCGP's work with training sites to enable clinicians to contribute to high quality teaching and supervision, to foster professional development, and on matters of wider mutual interest, was evident and validated in panel interviews.

The RNZCGP has developed effective partnerships with Te Aka Whai Ora and Māori health providers. However it was clear that relationships with Māori health providers are held by individuals contracted to the RNZCGP rather than by the RNZCGP itself, these individuals being the Pou Whirinaki, lead medical educators and medical educators in each region.

Recommendations:

- The RNZCGP should identify and engage with representative groups of consumers and communities to fully inform and test its understanding of the extent to which programme outcomes are meeting community needs. (standard 1.6.1, 2.1.4, 6.2.1)

Required actions:

5. The RNZCGP must develop, including at senior management level, enduring relationships with Māori health providers, in order to better understand their issues and challenges to inform and support further enhancement of its training and education programmes (standard 1.6.4).

1.7 Continuous renewal

1.7.1 The training provider regularly reviews its structures and functions for and resource allocation to training and education functions to meet changing needs and evolving best practice.

1.7 Continuous renewal

	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The RNZCGP has undertaken reviews and made consequent changes in relation to training and education functions. However, these occur on a somewhat ad hoc or reactive basis as issues warranting review are identified and prioritised, rather than under a formal review cycle. This did not provide assurance that consideration is given on a sufficiently regular basis to whether a training programme or curriculum refresh or renewal is required to reflect changing needs or developments in health care delivery.

Required actions:

6. The RNZCGP must employ a planned and systematic review process to regularly review its training and recertification programmes to ensure the programmes are continuing to meet changing needs and best practice. (standards 1.7.1 and 6.1.1)

2 The outcomes of vocational medical training

2.1	Educational purpose
2.1.1	The training provider has defined its educational purpose which includes setting and promoting high standards of training, education, assessment, professional and medical practice, and continuing professional development through the recertification programme, within the context of its community responsibilities.
2.1.2	The training provider's purpose addresses Māori health.
2.1.3	The training provider's purpose addresses health equity.
2.1.4	In defining its educational purpose, the training provider has consulted internal and external stakeholders.

2.1 Educational purpose			
	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

The RNZCGP educational purpose is defined in its Te Rautaki: Statement of Strategic Intent 2019-2024. This document clearly outlines that the RNZCGP is committed to setting and promoting high standards of training, education, assessment, professional and medical practice and continuing professional development through its recertification programme. Furthermore, it states that it is committed to addressing these within the context of its community responsibilities.

The RNZCGP's educational purpose addresses Māori health and shows commitment to addressing health inequities in all communities. However, it was evident from the panel's interviews that for the RHMTP, these elements warrant being elevated and more priority given to them.

In defining its educational purpose, the RNZCGP has collaborated with stakeholders through its boards of studies and Academic Tāhuhu which are structured to have a range of stakeholders who provide broad consultation and collaboration to support the educational purpose. However, direct consultation with consumers appeared to be lacking. The RNZCGP has found it difficult to identify suitable consumer groups to engage with on its educational purpose and consideration of community needs was more inherent in, and reliant on, doctors' direct knowledge from engaging with their own patient cohort and living in their local community. The RNZCGP should identify avenues to see issues through the lens of the patient and hear directly from consumers about whether the RNZCGP's educational purpose is meeting community needs.

Commendations:

- The RNZCGP is commended for its strong commitment to equity.
- The RNZCGP is commended for its Māori strategy (He Ihu Waka, He Ihu Whenua, He Ihu Tangata 2022-2024).

Recommendations:

- *Standard 2.1.4 see recommendation under standard 1.6.*

2.2	Programme outcomes
2.2.1	The training provider develops and maintains a set of programme outcomes for each of its vocational medical programmes, including any subspecialty programmes that take account of community needs, and medical and health practice. The provider relates its training and education functions to the health care needs of the communities it serves and the achievement of health equity.
2.2.2	The programme outcomes are based on the role of the vocational scopes of practice and the role of the vocationally registered doctor in the delivery of health care.

2.2	Programme outcomes

	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

The GPEP and RHMTP programme outcomes, in terms of the expected skills and capabilities of doctors emerging from the programmes in each scope of practice, are well aligned with needs in the relevant communities, with achievement of health equity, and reflect the level of medical practice required in each scope.

The programme outcomes for GPEP and RHMTP are closely based on the role of the vocational scopes of practice and the role of the vocationally registered doctor in the delivery of health care.

2.3 Graduate outcomes

2.3.1 The training provider has defined graduate outcomes for each of its vocational medical training programmes including any sub-specialty disciplines or the recognition of advanced skills programmes. These outcomes are based on the vocational scope of practice and the vocationally registered doctor's role in the delivery of health care and describe the attributes and competencies required by the vocationally registered doctor in this role. The training provider makes information on graduate outcomes publicly available.

2.3 Graduate outcomes

	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

The RNZCGP has defined graduate outcomes for both the GPEP and RHMTP, these outcomes are based on the vocational scope of practices and the vocationally registered doctor's role in the delivery of health care. The outcomes also describe the attributes and competencies required by vocationally registered general practitioners and rural hospital medicine specialists. The graduate outcomes are publicly available in the GPEP curriculum and RHM curriculum on the RNZCGP website.

3 The vocational medical training and education framework

3.1 Curriculum framework

3.1.1 For each of its vocational medical training programmes, the training provider has a framework for the curriculum organised according to the defined programme and graduate outcomes. The framework is publicly available.

3.1 Curriculum framework

	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

For both the GPEP and RHMTP, there is a framework for the curricula organised according to the defined programme and graduate outcomes which appear in public documents. These define the broad generalist base of each programme to meet the differing contexts of practice.

The domains are:

GPEP	**RHMTP**
1. Te Tiriti o Waitangi	
2. Equity	1. Rural hospital context
3. Communication	2. Communication
4. Clinical Expertise	3. Clinical expertise
5. Professionalism	4. Professionalism
6. Scholarship	5. Scholarship
7. Leadership and management	6. Leadership and management

3.2 The content of the curriculum

3.2.1 The curriculum content aligns with all of the vocational medical training programme and graduate outcomes.

3.2.2 The curriculum includes the scientific foundations of the specialty to develop skills in evidence-based practice and the scholarly development and maintenance of vocational trainees' knowledge.

3.2.3 The curriculum builds on communication, cultural, clinical, diagnostic, management and procedural skills to enable safe patient care.

3.2.4 The curriculum prepares vocational trainees to protect and advance the health and wellbeing of individuals through patient-centred and goal-orientated care. This practice advances the wellbeing of communities and populations, and demonstrates recognition of the shared role of the patient/carer in clinical decision-making.

3.2.5 The curriculum prepares vocational trainees for their ongoing roles as professionals and leaders.

3.2.6 The curriculum prepares vocational trainees to contribute to the effectiveness and efficiency of the health care system, through knowledge and understanding of the issues associated with the delivery of safe, high-quality, equitable and cost-effective health care across a range of health settings within the New Zealand health systems.

3.2.7 The curriculum prepares vocational trainees for the role of being a teacher and supervisor of students, junior medical staff, trainees, and other health professionals.

3.2.8 The curriculum includes formal learning about research methodology, critical appraisal of literature, scientific data and evidence-based practice, so that all trainees are research literate.

The programme encourages trainees to participate in research, enables appropriate candidates to enter research training during vocational medical training and receive appropriate credit for this towards completion of vocational medical training.

3.2.9 The curriculum includes formal learning about and develops a substantive understanding of the determinants of Māori health inequities and achieving Māori health equity. The training programme should demonstrate that the training is producing doctors who engage in ongoing self-reflection and self-awareness and hold themselves accountable for their patients' cultural safety. The training programme should include formal components that contribute to the trainees' education and development in cultural safety.

3.2.10 The curriculum develops an understanding of the relationship between culture and health. Vocational trainees and doctors are expected to be aware of their own cultural values, beliefs, and assumptions and to be able to interact with each individual in a manner appropriate to that person's culture.

3.2 The content of the curriculum

	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The panel was assured that the programmes' curricula are ultimately delivering the desired graduate outcomes in the form of doctors who are fit for purpose at the expected level. The panel heard heartening comments about the RHMTP and how far it had come in meeting original aims and expectations, in terms of the calibre of doctors emerging from the programme. Furthermore, there was genuine pride expressed in the specialist general practitioners emerging from the GPEP programme, with those getting through to fellowship practising at a good level.

All stakeholders that the panel engaged with, including trainees, agreed that the RNZCGP's training programmes produce practitioners who are well-prepared for clinical practice. For both programmes, curriculum content is a mix of formally described and delivered material, supplemented by informal learning based on practice, and from self-identified learning needs. Both programmes support trainees to adapt and expand their practice.

Both programmes have outlined in detail their educational content within the curricula. It is less clear where in the programmes trainees may expect to cover the content. Some of the content in the courses is mapped to the graduate domains; for example, in GPEP, there is a compulsory activity, Te Ahunga, at the start of GPEP1, but limited learning on Te Tiriti and equity after that.

The content of the RHM is largely delivered through 7 core university papers. Most trainees and supervisors felt these provide a satisfactory framework and strong basis for RHM training and practice.

There were some areas in which several groups felt more formal education was needed, these were:

- GPEP trainees felt they needed more information around the various aspects of owning and managing a practice. This is discussed further under standard 7.4.
- Rural hospital medicine trainees reported being expected to do even more than their training prepared them for, and for which they may not always feel or be equipped. While the RHM trainee response numbers in the survey were relatively small, 50% of RHM trainees expected there would be major gaps in their training that will need to be addressed, particularly in the performance of procedural skills. Reasons for this were cited as time pressure on supervisors in general practice, as well as trainees having to be very self-motivated to seek out more specialised skills e.g. in airway management, minor surgery, anaesthesia, or insertion of a LARC.
- Furthermore, it was noted there does not seem to be any formal teaching in either programme on teaching or supervision.
- The programme outcomes for each of GPEP and RHMTP include a Scholarship domain, with an accompanying list of core competencies. Yet trainees did not feel they received sufficient formal

education in research methods. There seemed little formal recognition of research projects or research degree other than PhD.

- The panel heard from trainees, training site representatives and several RNZCGP groups that Hauora Māori, health equity and cultural safety do not feature as prominently in the RHM curriculum. The Division spoke to this becoming a focus shortly but had not begun in any substantive way.

Commendations:

- The RNZCGP is commended for the GPEP curriculum which was extensively reviewed in 2021 and which is presented in a comprehensive and clear curriculum document.

Required actions:

7. The RNZCGP must have formal learning opportunities for GPEP and RHM trainees in research methodology, critical appraisal of literature, scientific data, and evidence-based practice. (standard 3.2.8)
8. The RNZCGP must ensure that the RHM curriculum enables development of a substantive understanding of the determinants of Māori health inequities, achieving Māori health equity and development of cultural safety. (standard 3.2.9 and standard 4.2.5).

3.3 Continuum of training, education and practice

3.3.1 There is evidence of purposeful curriculum design which demonstrates horizontal and vertical integration, including undergraduate and prevocational education and continuing professional development through the recertification programme.

3.3.2 The vocational medical training programme allows for recognition of prior learning and appropriate credit towards completion of the programme.

3.3 Continuum of training, education and practice

	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

Although the 2021 GPEP curriculum review showed evidence of purposeful curriculum design which demonstrated vertical and horizontal integration as well as providing the spiral curriculum model to support the learning environment for general practice, concerns were raised around the rapid change in pedagogy from GPEP1 to GPEP2. GPEP1 is an intensive education programme with one day per week dedicated to formal learning and allows time for assessments, which in themselves will be educational. Trainees meet with their medical educator (ME) weekly. Thereafter, in GPEP2 and 3 there are learning groups and less contact with a GPEP2/3 educator. After completing the programme assessments and time, which in many cases is longer than two years, trainees may apply for a Fellowship assessment.

The rapid change in pedagogy, from formal to largely self-directed, and the large drop off in educational support from the RNZCGP after GPEP1 have been noted as issues for many years. They were prominent in the Te Whatu Ora commissioned Malatest Review of the General Practice Training Programme (2022) and were reported to the panel as significant issues by educators and trainees. The Malatest report recommended expanding the educational component of GPEP2 and deferring the clinical exam until GPEP2.

As will be discussed further in standards 4 and 5, it is not clear how the trainee builds their knowledge, skills and behaviours towards the graduate outcomes and into practice. The curriculum domains do not feature prominently and there is little systemic mapping.

The RHMTP structure was well-regarded by most stakeholders. The academic component of the programme is met primarily via completion of 7 post graduate University papers. The papers can be completed in as little as two years, but this would be a very heavy workload, and the papers are usually spread over three or four years. It is recommended to take the relevant course at the same time as the related clinical run to achieve the best learning outcome.

There are six domains clearly signalled in the RHM handbook and elsewhere, but what is less clear is how these are used explicitly in the design of the first two years of university papers, and in the later years of the programme, and into CME. Following on from required action 8 above, having a more explicit domain of Māori Health might assist in integrating across learning activities and years of the programme.

There is an appropriate and effective process for recognition of prior learning.

Recommendations:

- The RNZCGP should overtly use the domains as an organising mechanism in the curriculum and its assessment (standard 3.3.1).

3.4	**Structure of the curriculum**

3.4.1 The curriculum articulates what is expected of trainees at each stage of the vocational medical training programme.

3.4.2 The duration of the vocational medical training programme relates to the optimal time required to achieve the programme and graduate outcomes. The duration is able to be altered in a flexible manner according to the trainee's ability to achieve those outcomes.

3.4.3 The vocational medical training programme allows for part-time, interrupted and other flexible forms of training.

3.4.4 The vocational medical training programme provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes.

3.4	**Structure of the curriculum**		
	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

The curricula documents articulate what is expected at each stage of the programme in terms of learning, clinical runs and assessments. Based on the trainee survey data, around 7% of RNZCGP trainees are training in the RHMTP and another 7% dual training (general practice and rural hospital medicine).

For GPEP this is organised by GPEP1 and GPEP 2/3; for RHMTP this is largely Year 1/2, and Year 3/4. What is less clear is where in the GPEP programme the content in the curriculum might be obtained and how the content builds towards the Fellowship assessment visit and the graduate outcomes.

Time requirements for GPEP, RHMTP and dual are clearly spelled out. The GPEP minimum time is four tenths. The panel heard there may be a need to re-define 0.4 FTE, as four clinical sessions generate between 2 to 8 hours of unpaid medical administration, making it more like 0.5 to 0.6.

The total clinical time required on the RHMTP is 48 months' full-time equivalent. The compulsory runs are articulated clearly. This is a minimum requirement, and many trainees take five years or longer, sometimes due to availability of core runs or supervisors. 1 FTE is calculated as 8/10ths or more clinical workload. The maximum period that a trainee can remain on the RHMTP or dual programmes is eight years. Any time on hold is not counted in this equation.

Trainees who undertake dual training in RHM and general practice must be independently accepted to each training programme and can only be active in one programme at a time, that is, they need to put GPEP on hold while active in the RHMTP. Dual trainees may claim up to 18 months against the RHM's clinical experience requirements for general practice experience gained on GPEP, provided that at least six months of GPEP training is undertaken in rural general practice. The same amount of time in rural training is recognised towards the general practice programme.

A one-tenth concession for a full-time equivalent year during GPEP Years 2 and 3 may be granted approval by the RNZCGP to trainees involved in childcare and/or caring for a live-in disabled family member. The maximum concession that may be granted is 3 months.

The panel was satisfied that the RNZCGP provides flexibility for trainees to pursue studies of choice that promote breadth and diversity of experience, consistent with the defined outcomes.

Commendations:

- The GPEP and RHMTP are commended for their flexibility in terms of opportunities for part time and interrupted training, and scope for breadth in experience. (standard 3.4.3)

Recommendations:

- The RNZCGP should consider if there are other situations, such as long term cultural duties or leadership/educational roles where there may be a discount on length of training. (standard 3.4.2)

4 Teaching and learning

4.1	Teaching and learning approach
4.1.1	The vocational medical training programme employs a range of teaching and learning approaches, mapped to the curriculum content to meet the programme and graduate outcomes.

4.1 Teaching and learning approach			
	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

Both GPEP and the RHM training programmes employ a range of appropriate teaching and learning approaches which are mapped to curriculum content to meet the programme and graduate outcomes.

In GPEP, this can be seen in the spiral curriculum approach and the detailed mapping of learning opportunities to each course (subject area) in the Curriculum for General Practice 2022.

For each course, the GPEP curriculum also sets out the key skills and knowledge, the content to be covered, the learning outcomes for each course, and the formative and summative assessments which also provide a variety of ways to develop knowledge and skills in the subject area.

The RHMTP takes a different approach. The RHM Core Curriculum Statement identifies six domains and 16 curriculum area statements. The curriculum employs a range of teaching and learning opportunities, and maps domain core capabilities and assessment methods to key performance areas.

Commendations:

- The RNZCGP is commended on the comprehensive mapping of learning opportunities within the GPEP curriculum document.

4.2	Teaching and learning methods
4.2.1	The training is practice-based, involving the trainees' personal participation in appropriate aspects of health service, including supervised direct patient care, where relevant.
4.2.2	The vocational medical training programme includes appropriate adjuncts to learning in a clinical setting.
4.2.3	The vocational medical training programme encourages trainee learning through a range of teaching and learning methods including, but not limited to: self-directed learning; peer-to-peer learning; role modelling; and working with interdisciplinary and interprofessional teams.
4.2.4	The training and education process facilitates trainees' development of an increasing degree of independent responsibility as skills, knowledge, and experience grow.
4.2.5	The training provider has processes that ensure that trainees receive the supervision and opportunities to develop their cultural safety and reflect on their unconscious bias in order to deliver patient care in a culturally-safe manner.

4.2 Teaching and learning methods			
	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

Training in both programmes is practice-based and undertaken in relevant settings. The trainees are required to actively participate in service delivery including supervised direct patient care.

Seminar groups, study days, peer-to-peer learning and self-directed study are included in both programmes. However, the spread of these learning methods is uneven, with both GPEP and RHM trainees gaining the majority of the formal learning/study days towards the front-end of the programme.

The majority of the RHM content is provided through 7 core university papers. Following completion of these papers there is very limited formal teaching.

The GPEP1 seminars include a wide range of medical educator and trainee-led learning activities. The extent of trainee-led activities, whilst each activity is valuable, may put additional unnecessary load onto trainees who are new to practising in the general practice context and coping with a steep learning curve.

As trainees progress from GPEP1 to GPEP2, the level of supervision falls away suddenly and trainees are required to move to a much more independent way of working. They have a sudden enforced increase in responsibility and self-sufficiency as they work to independently apply the knowledge and skills developed in GPEP1. While some trainees rise to this challenge, many trainees find this transition difficult. This may result in the delivery of sub-optimal patient care, and adverse effects on trainee well-being, such as stress and loss of confidence.

In GPEP2/3, trainees receive an annual in-practice visit and meet four times a year with a learning group that is facilitated by a medical educator. While these visits and groups are appreciated by the trainees, there is no formal education programme and, overall, a lack of teaching and learning input into GPEP2/3. The teaching and learning that is delivered in practices is generally low, depending on the practice setting and access to on-site supervision and support.

Furthermore, GPEP 2 and 3 trainees are self-initiating and self-funding their learning to pick up procedural skills in some areas not readily available in their workplace. This was mentioned by several groups as an area for attention in the programmes. There is no formal training for practical skills eg speculum exams, incision and drainage, suturing or other acute procedural or emergency issues. Skills acquisition may be practice or site dependent. The RNZCGP might consider ways to strengthen the acquisition of procedural skills.

GPEP strongly encourages trainees to develop their cultural safety, and this is supported from the commencement of the programme by the Te Ahunga activity. In the RHMTP, cultural safety development is not sufficiently integrated at present, although the Division and RHM Board of Studies (BOS) have indicated it will have more emphasis when they come to review their curriculum.

Required actions:

9. The RNZCGP must ensure that the GPEP training and education processes facilitate trainees' development of an increasing degree of independent responsibility in a more graduated manner, in the more formal elements of the programme, including in the acquisition of procedural skills. (standard 4.2.4)

- *See required action 8.*

5 Assessment of learning

5.1	Assessment approach
5.1.1	The training provider has a programme of assessment aligned to the outcomes and curriculum of the vocational medical training programme which enables progressive judgements to be made about trainees' preparedness for the vocational scope of practice.
5.1.2	The training provider clearly documents its assessment and completion requirements. All documents explaining these requirements are accessible to all staff, supervisors and trainees.
5.1.3	The training provider has policies relating to special consideration in assessment.

5.1 Assessment approach	Met	Substantially met	Not met
Rating		X	

Summary of findings:

Both GPEP and RHMTP have a range of formative activities and assessments and several summative ones.

The summative requirements for both programmes include a required number of clinical hours and a final step which is the Fellowship assessment visit. This can only be undertaken once other requirements are met. The assessor evaluates the trainee's portfolio of progress and observes practice to ensure it is safe, competent and meets the standards for Fellowship.

Other requirements are:

- GPEP: written and clinical exams in GPEP1
- RHMTP: compulsory runs, seven academic papers, and the StAMPs assessment

Finally, trainees in both programmes are required to hold a current certificate in Advanced Cardiac Life Support (ACLS). Trainees in rural hospitals are also required to hold a current certificate in Advanced Paediatric Life Support (APLS) and Early Management of Severe Trauma (EMST).

The requirements for each summative assessment are clearly outlined in documents available to staff, supervisors and trainees, as are the criteria for special consideration. Among these are a GPEP Practice Based Alternative Assessment (PBAA) for trainees who have failed the GPEP 1 exams three times.

However, neither programme has a sufficiently clear programme of assessment aligned to the outcomes and curriculum of the vocational medical training programme which enables progressive judgements to be made about trainees' preparedness for the vocational scope of practice.

The RNZCGP has already identified assessment in both programmes as a priority project, yet the panel found no firm plans or timeline for this, nor which group would be responsible. The panel noted the range of internal and external bodies responsible for the assessments in GPEP and RHM programmes, with no one overall body responsible for the alignment of the assessments.

Both programmes have policies relating to special consideration in assessment.

Recommendation:

- The RNZCGP should consider the roles of the respective board of studies in alignment of the assessments in GPEP and RHMTP (standard 5.1.1).

Required actions:

10. The RNZCGP must develop a programme of assessment for each of GPEP and RHMTP which is mapped to the graduate outcomes and in which progression in performance expected at each stage of training is documented (standards 5.1.1, 5.2.2 and 5.4.1).

5.2	Assessment methods

5.2.1	The assessment programme contains a range of methods that are fit for purpose and include assessment of trainee performance in the workplace.
5.2.2	The training provider has a blueprint to guide assessment through each stage of the vocational medical training programme.
5.2.3	The training provider uses valid methods of standard setting for determining passing scores.

5.2 Assessment methods			
	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The panel was impressed by the commitment and experience of the various teams involved in the RNZCGP assessments.

The methods used in assessments in each programme are broad and appropriate, including a number of workplace-based assessments such as In Practice Visits (IPVs), mini CEXs, and the Fellowship Assessment.

Individually, the assessments in the programmes are acceptably robust, with the requirements clearly outlined. There is use of recognised standard setting methods and other methods to ensure reliability such as assessor training and calibration.

Over 30% of trainees indicated in response to the accreditation panel's trainee survey that it was not clear what was expected at each stage of training. GPEP trainees reported that the links between the standards expected in the IPVs and the Fellowship Assessment were not clear enough. Further, there were reports of conflicting or incorrect advice given about the IPV.

The panel saw a clear marking rubric for the Fellowship Assessment outlining the criteria for assessing trainees, however this did not appear to be used in the GPEP 1, 2 and 3 IPVs. Use of a similar marking rubric across all GPEP practice visits might be helpful to trainees in determining their progress.
Given it is such a high stakes formal assessment, the criteria of the Fellowship Assessment Visit might link more overtly to the graduate outcomes.

There needs to be more explicit horizontal and vertical linkages within and among the assessments to guide trainee development towards the graduate outcomes, and to satisfy external stakeholders that programme outcomes can be met.

The RNZCGP uses valid methods of standard setting for determining passing scores.

Required actions:

- *See required action 10.*

5.3 Performance feedback

5.3.1	The training provider facilitates regular and timely feedback to trainees on performance to guide learning.
5.3.2	The training provider informs its supervisors of the assessment performance of the trainees for whom they are responsible.
5.3.3	The training provider has processes for early identification of trainees who are not meeting the outcomes of the vocational medical training programme and implements appropriate measures in response.
5.3.4	The training provider has procedures to inform employers and, where appropriate, the regulators, where patient safety concerns arise in assessment.

5.3 Performance feedback			
	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

There is a lot of informal and formative feedback, however formal feedback processes to trainees and supervisors are not systematic and may vary by region. There is a large responsibility on the GPEP 2/3 educators and the clinical leads (CLs) in the RHMTP to identify trainees needing remediation and/or provide constructive feedback on progression. The results of the accreditation panel's trainee survey yielded relatively high levels of disagreement that there is regular and timely feedback on performance to guide learning.

The panel were impressed with the GPEP Multi-Use Educator Team (MUE), which provides a range of services including registrar support, resource development and professional development. Referrals to the MUE team have helped to put supports in place for registrars in difficulty.

However, there did not seem to be adequate systems for tracking trainee progress at a College level in either programme to identify underperforming trainees, or to detect systematic issues affecting achievement.

Cases where patient safety concerns arise in assessment are handled on a case-by-case basis and the processes seem robust.

Commendations:

- The RNZCGP is commended for its Multi-Use Educator team, which supports trainees and educators across Aotearoa, it is highly valued.

Required actions:

11. The RNZCGP must systematise and provide regular and timely feedback to trainees on their progress to guide learning (standard 5.3.1).

5.4 Assessment quality

5.4.1 The training provider regularly reviews the quality, consistency and fairness of assessment methods, their educational impact and their feasibility. The provider introduces new methods where required.

5.4.2 The training provider maintains comparability in the scope and application of the assessment practices and standards across its training sites.

5.4 Assessment quality

	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

There was evidence that the RNZCGP reviews assessment and introduces new content or methods as appropriate. Examples include changes to StAMPs, which is now conducted fully online and is in the process of introducing more material relevant to Aotearoa New Zealand; the introduction of DOPS assessments; and enhanced presence of hauora Māori, equity principles, and cultural safety in the GPEP1 and Fellowship assessments.

The assessments that are done individually seem robust, yet, as mentioned above in Standards 5.1 and 5.2 and in Standard 3, it is not explicit enough how learning and assessment map to the graduate outcomes. This is mapping is necessary to show skills progression, but also to identify where under- or over-assessment may be occurring. Further, as there is no systematic tracking, it is difficult to compare equivalence of outcome across sites/regions.

An observation is that the GPEP1 examination, IPVs and Fellowship Assessments are resource-intensive in terms of assessor, administrator and trainee time, as well as in costs such as venue hire for the clinical examinations. Assessor availability may be magnified as an issue as trainee numbers grow. Consideration of the feasibility of the assessments might be taken into account in the review of assessment.

Recommendations:

- The RNZCGP should, in the review of assessments, consider the feasibility and sustainability of the assessment program. (standard 5.4.1)

Required actions:

- *See required action 10.*

6 Monitoring and evaluation

6.1	Monitoring
6.1.1	The training provider regularly reviews its training and education programmes. Its review processes address curriculum content, teaching and learning, supervision, assessment and trainee progress.
6.1.2	Supervisors contribute to monitoring and to programme development. The training provider systematically seeks, analyses and uses supervisor feedback in the monitoring process.
6.1.3	Trainees contribute to monitoring and to programme development. The training provider systematically seeks, analyses and uses their confidential feedback on the quality of supervision, training and clinical experience in the monitoring process. Trainee feedback is specifically sought on proposed changes to the vocational medical training programme to ensure that existing trainees are not unfairly disadvantaged by such changes.

6.1 Monitoring

	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The RNZCGP has reviewed aspects of the training and education programmes in recent years. This includes a curriculum review and the design and implementation of a purpose-built recertification and professional development programme launched in 2023.

However, there is no evidence of a planned programme of review for the new recertification programme and the current training and education programmes. The panel noted that a programme development and review policy effective in September 2020 is in place, but found that there was no evidence that this is being used. The RNZCGP must employ a planned and systematic process to regularly review its training and education programmes and its newly developed recertification programme. This should include the ability to feed into curriculum content, teaching and learning, supervision, assessment and trainee progression. Stakeholders should have an opportunity to feed into systematic and regular review processes.

The RNZCGP manages concerns about, or risks to, the quality of its training and education programmes, however onsite supervisors and trainees are not formally involved in monitoring and evaluation. Formally including their input would assist the RNZCGP to manage concerns more effectively and in a timely manner.

Required actions:

- *See required action 6.*

12. The RNZCGP must ensure that supervisors can contribute to monitoring and programme development by systematically seeking, analysing and using supervisor feedback in the monitoring process. (standard 6.1.2)
13. The RNZCGP must ensure that there are adequate mechanisms for trainees to provide feedback at every level of supervision, and that feedback is handled sensitively to maintain or redirect training relationships. (standard 6.1.3 and 8.1.4)
14. The RNZCGP must demonstrate how trainee input is used to improve the quality of supervision, training and clinical experience. (standard 6.1.3)

6.2	Evaluation
6.2.1	The training provider develops standards against which its programme and graduate outcomes are evaluated. These programme and graduate outcomes incorporate the needs of both graduates and stakeholders and reflect community needs, and medical and health practice.

6.2.2 The training provider collects, maintains and analyses both qualitative and quantitative data on its programme and graduate outcomes.

6.2.3 Stakeholders contribute to evaluation of programme and graduate outcomes.

6.2 Evaluation			
	Met	Substantially met	Not met
Rating	X		

Summary of findings:

The RNZCGP has a number of stakeholder relationships. Of note is its collaborative relationship with the Royal Australian College of General Practitioners (RACGP) during the recent curriculum review and further collaboration around expertise and support about CPD, examinations, Covid-19 and governance.

It was not clear how stakeholders contribute to the evaluation of programme and graduate outcomes and how stakeholder needs are incorporated in these outcomes. Therefore, evidence of broader stakeholder participation in regular review and evaluation processes is recommended, such as medical schools, primary health organisations and others with an interest in the education of general practitioners. In the case of medical schools, a memorandum of understanding or similar mechanism may help place these conversations into a regular timeframe.

Another area of enhancement for the RNZCGP would be to regularly test that programme outcomes are continuing to meet evolving community needs by finding suitable ways to engage directly with consumer representatives on this.

The RNZCGP self-evaluation and interview feedback systems provide evidence of wide-ranging data collection including participant surveys and an information collection function within the college. This data collection is both qualitative and quantitative and covers the training programme and recertification. It is recommended that the RNZCGP considers how the data it collects is evaluated, reported to governance, fellows, trainees and stakeholders and used for improvement initiatives and programme development.

Commendations:

- The RNZCGP is commended for seeking feedback from the RACGP in the recent curriculum review.

Recommendations:

- The RNZCGP should regularly test that graduate outcomes are continuing to meet evolving community needs by finding suitable ways to engage directly with consumer representatives on this. (standard 6.2.1)
- The RNZCGP should consider how the data it collects is evaluated, reported to governance, fellows, trainees and stakeholders and used for improvement initiatives and programme development. (standard 6.2.2)
- The RNZCGP should consider how stakeholders can feed into systematic and regular review processes. (standard 6.2.3)

6.3 Feedback, reporting and action

6.3.1 The training provider reports the results of monitoring and evaluation through its governance and administrative structures.

6.3.2 The training provider makes evaluation results available to stakeholders with an interest in programme and graduate outcomes, and considers their views in continuous renewal of its programme(s).

6.3.3 The training provider manages concerns about, or risks to, the quality of any aspect of its training and education programmes effectively and in a timely manner.

6.3 Feedback, reporting and action			
	Met	Substantially met	Not met
Rating	X		

Summary of findings:

The RNZCGP reports the results of monitoring and evaluation through its governance structures. An example of this was in the early stages of the implementation of the CPD programme, the effectiveness of the CPD programme (Te Whanake) and early indications as to the effectiveness of the CPD programme were made available to the Board.

The panel encourages the RNZCGP to go further and evaluate and use the feedback from both GP and the RHM fellows for improvement initiatives.

Although the RNZCGP shares summarised examination results with some stakeholders ie the College Board and lead medical educators, it does not include stakeholders in considering evaluation results of its programme and graduate outcomes. The RNZCGP should consider how to disseminate its programme and graduate outcomes and engage in a dialogue with stakeholders. There should be evidence that stakeholder views are considered in continuous renewal of the education programme(s). Doing so may provide an additional level of useful engagement and insight into improvements within the training programme.

Recommendations:

- The RNZCGP should consider making evaluation results available to stakeholders with an interest in the programme, including on graduate outcomes (standard 6.3.2).

7 Trainees

7.1	Admission policy and selection
7.1.1	The training provider has clear, documented selection policies and principles that can be implemented and sustained in practice. The policies and principles support merit-based selection and can be consistently applied. These policies are publicly available.
7.1.2	The processes for selection into the vocational medical training programme: • use the published criteria and weightings (if relevant) based on the training provider's selection principles • are evaluated with respect to validity, reliability, feasibility • are transparent, rigorous and fair • are free from discrimination and bias • are capable of standing up to external scrutiny • include a process for formal review of decisions in relation to selection which is outlined to candidates prior to the selection process.
7.1.3	The training provider ensures equitable recruitment and selection of trainees who identify as Māori.
7.1.4	The training provider publishes the mandatory requirements of the vocational medical training programme, such as periods of rural training, and/or for rotation through a range of training sites so that trainees are aware of these requirements prior to selection. The criteria and process for seeking exemption from such requirements are made clear.
7.1.5	The training provider monitors the consistent application of selection policies across training sites and/or regions.

7.1 Admission policy and selection			
	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

The admission policy and selection of trainees to both GPEP and the RHMTP is a strength of RNZCGP. The RNZCGP publishes the mandatory requirements of the programme and trainees were aware of these requirements including the requirements around seeking exemption. The panel were impressed at the efforts made by the RNZCGP towards ensuring equitable recruitment and selection of Māori trainees. Feedback from trainees also supported this.

Although the RNZCGP monitors application of selection policies, some practices, notably in hard to staff rural/regional areas, highlighted the difficulties in attracting trainees to their centres. Trainees highlighted an increased number of barriers around participation in face-to-face training when based in more remote and rural centres, such as the difficulties in attending required teaching. The RNZCGP should consider further monitoring and support for both trainees and training sites in these areas.

Commendations:

- The RNZCGP is commended for its proactive strategies to increase recruitment of Māori trainees.

Recommendations:

- The RNZCGP should consider a mechanism for monitoring and improving the ability of practices in regional, rural and hard to staff areas to employ and support trainees at GPEP 1-3.

7.2	Trainee participation in training provider governance
7.2.1	The training provider has formal processes and structures that facilitate and support the involvement of trainees in the governance of their training.

7.2 Trainee participation in training provider governance			
	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The RNZCGP provides insufficient opportunities for trainee participation at governance level. As noted under standard 1, although the RNZCGP has trainee representation on committees such as the Board of Studies. Trainees are not represented on the College Board. Given the significant size and importance of the trainee cohort there must be trainee representation at this level.

The panel observed that the representatives and trainees involved in the registrar chapter are passionate and actively involved in collaborating with the wider body of trainees across Aotearoa New Zealand. Despite their resource constraints they appear to be excelling in providing a trainee voice.

Trainee representation is also missing on the research and education committee. Given the concerns voiced around the lack of trainee insight and involvement in relation to this committee, the RNZCGP should consider reviewing this to further strengthen trainee participation.

Commendations:

- The RNZCGP is commended for its registrar chapter which has been effective in collecting and collating the views of the wider trainee group even though it is a diverse and widely spread group.

Recommendations:

- The RNZCGP should consider further involvement of trainees in the research and education committee. (standard 7.2.1)

Required actions:

15. The RNZCGP must ensure that there is trainee representation at Board level. (standard 1.1.3 and 7.2.1)

7.3 Communication with trainees

7.3.1 The training provider has mechanisms to inform trainees in a timely manner about the activities of its decision-making structures, in addition to communication from the trainee organisation or trainee representatives.

7.3.2 The training provider provides clear and easily accessible information about the vocational medical training programme(s), costs and requirements, and any proposed changes.

7.3.3 The training provider provides timely and correct information to trainees about their training status to facilitate their progress through training requirements.

7.3 Communication with trainees

	Met	Substantially met	Not met
Rating			**X**

Summary of findings:

The panel observed a high level of variability reported regarding the standard of communication between the RNZCGP and trainees. A recurring theme were the concerns about the reliance on very responsive individual staff members rather than a systematic method.

In some areas, such as the RHMTP, this proved effective for the trainees who would only need to liaise with one person for a wide range and variety of issues. Trainees viewed this as a clear and easily accessible way to communicate issues and receive necessary information pertinent to their training. Unfortunately, the vulnerability of this reliance on a single staff member was highlighted when the key staff member became temporarily unavailable.

In GPEP, concerns were raised around the RNZCGP's ability to communicate in a timely manner which were exacerbated by delays when an individual staff member was no longer available.

Specifically, concerns were raised around confidentiality and lack of notification for trainees struggling to meet the requirements of the training programme.

Trainees voiced that delays in the communication can reach several months in some cases and this understandably adds to stress and impacts on the ability of trainees to progress through their requirements.

Trainees reported efforts have been made by them to seek clarity around a lack of transparency in costs related to their training with insufficient responses given. They also highlighted there has been a lack of notice given to them with recent increases in training fees.

Required actions:

16. The RNZCGP must develop comprehensive and diverse communication channels with trainees, including timely central support to disseminate information and answer queries. This must include communication with trainees about the current support services in place for trainees who are experiencing personal or professional difficulties including those experiencing issues with employers. (standard 7.3.3)

7.4 Trainee wellbeing

7.4.1 The training provider promotes strategies to enable a supportive learning environment.

7.4.2 The training provider collaborates with other stakeholders, especially employers, to identify and support trainees who are experiencing personal and/or professional difficulties that may affect their training. It publishes information on the services available.

7.4.3 The training provider ensures a culturally-safe environment for all trainees, including those who identify as Māori.

7.4.4 The training provider recognises that trainees who identify as Māori may have additional cultural obligations, and has flexible processes to enable those obligations to be met.

7.4 Trainee wellbeing

	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

The RHMTP and GPEP 1 were generally described as having supportive learning environments. In GPEP 2 and beyond, significant concerns were raised about a lack of support for trainees. Trainees expressed that pastoral care and training provider input is minimal beyond GPEP1. Their role was predominantly viewed as service delivery for their employers.

There is a high level of variability of experiences for GPEP 2+ trainees and collaboration with their practices/employers was reported as minimal. Trainees shared reports of struggles in their training and seeking additional support from the RNZCGP was viewed as difficult to access. Their employer varied in the support offered. Any systemised learning support system should consider mixed methods of attendance at training sessions and national conference to account for cost of travel, distance to travel for those in rural, regional, or hard to staff areas.

Trainees spoke of a lack of support to understand the business aspects of a practice. There is room for further collaboration with stakeholders to strengthen their training in this area. This will enable trainees to feel equipped to work as a self-employed doctor (if contracting) and understand their role in the context of a GP practice.

Trainees who experienced failure in their training reported additional struggles. They expressed there was minimal additional support or input given to them by the RNZCGP after experiencing failure and conveyed that more could be done in this area. We acknowledge that the RNZCGP is undertaking ongoing work, to address such issues.

Cultural support for Māori trainees is a strength of both training programmes. Namely the significant work done by Te Akoranga a Māui, Pou Wirinaki, using Tuakana Teina methods. There remains further work to be done in cultural safety with acknowledgement of the cultural loading experienced by Māori

trainees. There were reports of racism experienced by trainees from supervisors and the difficulties encountered by trainees to address these issues. The deficiencies in pastoral support and collaboration with employers for GPEP 2 + trainees added to the complexity of resolving these issues.

The RNZCGP has evidently worked hard to systematically put in place mechanisms to support Māori and Pacifica trainees. Feedback from trainees has been excellent regarding equity support, Te Akoranga a Māui, Pou Wirinaki, Tuakana Teina methods at chapter and advisory committees.

Commendations:

- The RNZCGP is commended for its visibility of Māori and Pasifika culture, knowledge, and education at the College. This includes improvements in the RNZCGP ceremony, conference, and communications.
- The RNZCGP is commended for its significant support, input and oversight given to GPEP1 trainees.

Recommendations:

- The RNZCGP should consider a systemised learning support system to support trainees more holistically. (standard 7.4.2)
- The RNZCGP should consider assisting trainees with information to build their knowledge of primary care business practice (self-employment, taxation knowledge, contracting, practice methods) as a way of building their knowledge and confidence about the setting they are working in. (standard 7.4.2)
- The RNZCGP should develop a clear pathway for trainees to raise issues regarding racism and cultural loading experienced at their training sites. (standard 7.4.3)

Required actions:

17. The RNZCGP must implement changes to better support trainees in the transition from GPEP1 to GPEP2 and 3 with focus on funding, support and mentoring and preparation for the fellowship training (standard 7.4.1 and 1.5.1).

7.5 Resolution of training problems and disputes

7.5.1 The training provider supports trainees in addressing problems with training supervision and requirements, and other professional issues. The training provider's processes are transparent and timely, and safe and confidential for trainees.

7.5.2 The training provider has clear impartial pathways for timely resolution of professional and/or training-related disputes between trainees and supervisors or trainees and the training provider.

7.5 Resolution of training problems and disputes

	Met	Substantially met	Not met
Rating			**X**

Summary of findings:

Trainees acknowledged that there is a diverse range of working environments within their cohort and as expected there is a high level of variability in experiences. A common theme echoed by several trainees was the insufficient support available in resolving issues between trainees and supervisors.

As discussed in section 7.3, the RNZCGP's processes for resolving training problems and disputes are not transparent, timely, safe, and confidential for trainees. The recent issues around high staff turnover at all levels of the RNZCGP and reliance on individual staff members to co-ordinate the resolution of issues was a reported area of concern.

Issues were raised by trainees predominantly in GPEP 2+ of training around the support available to address issues regarding supervision. Trainees shared the implications of breaches of confidentiality and the lack of timely engagement on their training. The panel acknowledge the current model of employment for these trainees adds further complexity in the resolution of these issues.

Although pathways exist, these do not appear to be operating in manner where they are achieving adequate/timely resolution of disputes. Individual trainee experiences reported were concerning in this regard and there was a sense of helplessness and vulnerability conveyed by trainees in GPEP2+.

GPEP1 and RHM trainees generally reported better experiences in the resolution of problems and disputes, however they also highlighted issues with the current processes in place.

The RHM trainees reported that there are limited formal supports, and that the main strength of the programme was the cultivation of relationships with educational facilitators who follow trainees through their training. These relationships enable concerns to be raised separate from immediate colleagues and supervisors.

Required actions:

18. The RNZCGP must work collaboratively with trainees to develop a process that addresses problems with training supervision and requirements and the timely resolution of issues that arise between supervisors and trainees in the GPEP program. Consideration should be given to cultural challenges, power imbalances and ongoing support of needs. (standard 7.5.1 and 7.5.2)

8 Implementing the programme: delivery of education and accreditation of training sites

8.1	Supervisory and educational roles
8.1.1	The training provider ensures that there is an effective system of clinical supervision to support trainees to achieve the programme and graduate outcomes.
8.1.2	The training provider has defined the responsibilities of hospital and community doctors who contribute to the delivery of the vocational medical training programme and the responsibilities of the training provider to these doctors. It communicates its programme and graduate outcomes to these doctors.
8.1.3	The training provider selects supervisors who have demonstrated appropriate capability for this role. It facilitates the training, support and professional development of supervisors.
8.1.4	The training provider routinely evaluates supervisor effectiveness including feedback from trainees.
8.1.5	The training provider selects assessors in written, oral and performance-based assessments who have demonstrated appropriate capabilities for this role. It provides training, support and professional development opportunities relevant to this educational role.
8.1.6	The training provider routinely evaluates the effectiveness of its assessors including feedback from trainees.

8.1 Supervisory and educational roles	Met	Substantially met	Not met
Rating			**X**

Summary of findings:

GPEP and RHM trainees find their own training sites which are approved by the RNZCGP. There are multilayered supervision opportunities for trainees on both training programmes.

For GPEP trainees, supervision by RNZCGP fellows in GPEP1 is well structured and consistent and the majority of trainees reported that this was satisfactory. The consistency of supervision deteriorated across GPEP2 and GPEP3. Reduced appointment times and a shift towards service provision has limited opportunities for supervision. Across all years including GPEP1, trainees described instances when they were working in practices with no RNZGCP fellow on site to provide immediate supervision. Trainees described instances when only telephone support was provided and instances when no supervision was available at all, and the advice was to consult Health Pathways.

For RHM trainees, clinical supervision is provided by rotational supervisors who are vocationally registered specialists working in the relevant service. Trainees reported satisfactory clinical supervision and no instances where supervision was not provided.

GPEP trainees reported that clarity around the training programme requirement was satisfactory in GPEP1 however this was less robust in GPEP2 and 3 with fragmentation of the supervisor role and engagement with the training programme requirements.

RHM trainees reported that direction was often needed for rotational supervisors as they had no direct communication with the RNZCGP and were not cognisant of the training programme requirements. This was more evident in large tertiary centres with rotational supervisors in regional centres being more attuned to the RHM programme and trainees reported that there was a trend towards increasing awareness of the RHM programme.

The RNZCGP does not appear to have a mechanism in place for communicating graduate outcomes to doctors contributing to supervision of GPEP and RHMTP trainees.

Clinical supervision for GPEP trainees is provided by fellows of the RNZCGP who have undertaken initial teacher training. Supervision is supported by additional teaching provided by medical educators, coordinated by lead medical educators.

GPEP trainees are placed by the RNZCGP into GP practices meeting the college's Foundation Standard or with Cornerstone accreditation. Training sites will allocate the trainee to a RNZCGP fellow who has teacher status. The RNZCGP provides educational opportunities to achieve and maintain teacher status. Medical educators are assigned by the RNZCGP.

There is no allocation by the RNZCGP to rotational supervisors for RHM trainees, instead, supervisors are selected by trainees rather than the College. There is an assumption that accredited specialty services will amalgamate RHM trainees into the larger trainee pool and that RHM trainees will be allocated to clinical supervisors in the same way that specialty trainees are allocated. The assumption is that there is reciprocal suitability by way of these supervisors meeting specialty registrar supervision requirements.

In the rural hospital medicine training programme, rotational supervisors are not given any training or support and are predominantly directed by trainees regarding training requirements. Resources may be available from the RNZCGP however there is no formal facilitation by the RNZCGP of training support or professional development for rotational supervisors. Educational facilitators are selected by the RNZCGP and clinical leads provide national support to trainees. Rotational supervisors and educational facilitators have no FTE allocated to their roles.

There is no structured, consistent feedback mechanism for trainees to raise concerns about supervisors in either training programme. GPEP trainees have reported instances where feedback has not been handled sensitively by the RNZCGP and has adversely affected training relationships. Annual in-practice visits offer further opportunities for GPEP trainees to provide feedback. RHM trainees have opportunities to provide feedback at the end of attachments. In addition, regular meetings with educational facilitators and annual meetings with the clinical leads, whilst not formalised, provide additional feedback options.

For GPEP, assessors are selected by interview and receive robust training which is based on an observership model which ends with the assessor being observed by a senior assessor. A similar process exists for examiners. Training is provided by the RNZCGP, including unconscious bias awareness; there are biannual assessor meetings which include peer review and there is a process to ensure a standardised approach to marking examinations.

For RHM assessors it is recognised that this is a smaller group of four assessors including a chief assessor who is available to discuss assessments and share decision making. Assessors are trained under an observership model however it did not appear that assessors were consistently observed by an experienced assessor when performing their first fellowship assessment.

Trainees in both GPEP and RHMTP are given an opportunity to provide immediate feedback to their fellowship assessors after the assessment. There is no formal process for trainees to provide anonymised feedback on assessors at another time-point.

Commendations:

- The RNZCGP is commended for its robust GPEP assessor selection, training and professional support processes.

Recommendations:

- The RNZCGP should consider enhanced support for rotational supervisors and education facilitators for the RHMTP including training opportunities. The RNZCGP should also consider supporting education facilitators to have this role recognised within their FTE. (standard 8.1.3)

- The RNZCGP should consider a mechanism to allow anonymised assessor feedback for all trainees in addition to the ability to provide immediate feedback on the day of assessment. (standard 8.1.6)
- The RNZCGP should explore ways to recruit and diversify the assessor and educator pools. (standard 8.1.3)
- The RNZCGP should improve the pathway for Māori and Pasifika fellows into in practice visits (IPV) and assessor roles to enable support in language of origin and in language in which consultations take place. (standard 8.1.5)

Required actions:

19. The RNZCGP must refocus the accreditation and reaccreditation process for GPEP training sites on providing universal trainee clinical supervision in all circumstances. (standard 8.1.1 and 8.2.2)
20. The RNZCGP must ensure that clinical supervisors for both GPEP and RHM trainees are provided with essential programme information to deliver robust supervision. (standard 8.1.2)
21. The RNZCGP must ensure that for both GPEP and RHM trainees, suitably qualified clinical supervision is available at all times and for GP practices, the expectation is that this clinical supervision would be provided by RNZCGP fellows working on site alongside the vocational trainee. Hospital supervision for RHM trainees may mean off-site clinical supervision at times, in line with supervision provided to all trainees working in specialty services. (standard 8.1.3)

- *See required action 13.*

8.2 Training sites and posts

8.2.1 The training provider has a clear process and criteria to assess, accredit and monitor facilities and posts as training sites. The training provider:
- applies its published accreditation criteria when assessing, accrediting and monitoring training sites
- makes publicly available the accreditation criteria and the accreditation procedures
- is transparent and consistent in applying the accreditation process.

8.2.2 The training provider's criteria or standards for accreditation of training sites link to the outcomes of the vocational medical training programme and:
- promote the health, welfare and interests of trainees
- ensure trainees receive the supervision and opportunities to develop the appropriate knowledge and skills to deliver high-quality and safe patient care, in a culturally safe manner
- support training and education opportunities in diverse settings aligned to the curriculum requirements including rural and regional locations, and settings which provide experience of the provisions of health care to Māori
- ensure trainees have access to educational resources, including information communication technology applications, required to facilitate their learning in the clinical environment.
- inform the MCNZ with reasonable notice of any intention to limit or withdraw the accreditation of any training site.

8.2.3 The training provider works with health care providers to effectively use the capacity of the health care system for work-based training, and to give trainees experience of the breadth of the discipline.

8.2.4 The training provider actively engages with other training providers to support common accreditation approaches and sharing of relevant information.

8.2 Training sites and posts

	Met	Substantially met	Not met
Rating		**X**	

Summary of findings:

GPEP training sites must at a minimum be Foundation Standard certified and be Cornerstone accredited/working towards to have a trainee placed. There is a robust process around Foundation Standard certification, conducted by qualified assessors. In-practice annual visits with the trainees

provide an opportunity to review how the accredited site is performing in relation to facilities, process and trainee support.

RHM training sites in rural hospitals undergo a formal accreditation process every three years using predefined criteria which is conducted by Division fellows. Monitoring relies on trainee feedback at the end of attachments. There is no additional accreditation process for attachments to specialties in secondary or tertiary hospital locations which have accreditation from the specialty accrediting college.

The Foundation Standard certification and Cornerstone accreditation criteria for GPEP practices are sufficient, when implemented effectively, to protect trainee interests and provide an excellent training environment. It is not clear however that the accreditation process for GPEP practices is linked to desired vocational programme outcomes.

The accreditation process for GPEP supervisors is not meeting standard 8.1.1. It has not resulted in universal supervision standards across all sites and GPEP training years, and gaps in minimum standards of supervision are occurring.

The accreditation process for GPEP trainees is not promoting support for training and education in remote, diverse and rural locations where a high proportion of Māori healthcare is delivered. Trainees in these sites may be disadvantaged in several ways, for example, having to travel long distances and pay accommodation costs to attend teaching sessions at times that do not take this commitment into account.

Many GPEP trainees have extremely limited access to publications, research literature, search engines and best evidence resources. Conducting literature reviews, preparing for quality improvement projects or research is not possible for many trainees, nor is consultation of the literature to inform best evidence practice. There are also issues with access to relevant curriculum resources to support self-directed learning, for example Te Ara, the learning platform, is not particularly easy to navigate.

Although the process around rural hospital accreditation appears robust it is not clearly linked to vocational programme outcomes. Variance in volume of work and patient demographics at different sites has not been given sufficient attention and this may lead to a high degree of variation in training opportunities. Whilst reliance on college accreditation standards at secondary sites reduces duplication and is sufficient to ensure a standard of supervision, the specific training needs of RHM trainees are not being met.

The RNZCGP should consider how it can work better with Māori health care providers to effectively use the capacity of the health care system for work-based training, and to give trainees experience of the breadth of the discipline. Especially as both the GPEP and RHMTP extend across all aspects of community based, secondary and tertiary hospital care and dual trainees will experience the full breadth.

There is an assumption that specialty accredited secondary and tertiary hospital sites provide suitable locations for RHM trainees. However, there may be specific nuances in the needs of RHM trainees that require further consideration. The RNZCGP should consider further formal engagement with accrediting specialist colleges to support common accreditation approaches and sharing of relevant information.

Recommendations:

- The RNZCGP should consider how rural hospital training site accreditation can include an assessment of variability in work volume and patient demographic to recognise and address variation in training opportunities at different sites. (standard 8.2.2)
- The RNZCGP should consider the potential for Māori health providers to add to the health-care training capacity, where these training sites are able to meet accreditation standards. (standard 8.2.3)

- The RNZCGP should consider engagement with other specialty colleges to ensure that its site accreditation processes map to the vocational training programme outcomes for the RHMTP. (standard 8.2.4)

Required actions:

22. The RNZCGP must review the GPEP training site accreditation process with a rural and diversity focus to increase opportunities in rural, remote and Māori communities and examine barriers to registrars taking up these posts. (standard 8.2.2)
23. The RNZCGP must ensure that at secondary hospital training sites, accreditation processes for specialty training are reviewed to ensure that training needs of RHM trainees are being met and additional accreditation processes introduced where deficiencies are identified. (standard 8.2.2)
24. The RNZCGP must review how both the GPEP and RHM training site accreditation processes map clearly to desired vocational programme outcomes. (standard 8.2.2)

- *See required action 19.*

9 Recertification programmes, further training and remediation

9.1	Recertification programmes
9.1.1	The recertification programme provider provides a recertification programme(s) that is available to all vocationally registered doctors within the scope(s) of practice, including those who are not fellows. The training provider publishes its recertification programme requirements and offers a system for participants to document their recertification programme activity.
9.1.2	The recertification programme provider determines its requirements in consultation with stakeholders and designs its recertification programme to meet Medical Council of New Zealand requirements and accreditation standards.
9.1.3	The recertification programme provider's recertification programme(s) requirements define the required participation in activities that maintain and develop the knowledge, skills and performance required for safe and appropriate practice in the relevant scope(s) of practice, this must include the areas of cultural safety, professionalism and ethics.
9.1.4	The recertification programme provider determines the appropriate type of activities under each continuing professional development (CPD) category. It assigns greater weight to activities that evidence shows are most effective in improving a doctor's performance.
9.1.5	The recertification programme provider ensures that in each cycle, participants are required to undertake a mix of activities across all three CPD categories: I. Reviewing and reflecting on practice II. Measuring and improving outcomes III. Educational activities (continuing medical education - CME).
9.1.6	The recertification programme requires participants to undertake a structured conversation, at least annually, with a peer, colleague or employer. Providers must offer a process and guidance to support this activity to ensure the greatest benefit is gained from this process.
9.1.7	The recertification programme requires participants to develop and maintain a professional development plan.
9.1.8	The recertification programme provider ensures that cultural safety and a focus on health equity are embedded within and across all of the three CPD categories and all other core elements of the recertification programme. The recertification programme must support participants to meet cultural safety standards.
9.1.9	The recertification programme provider makes available a multisource feedback process for participants to voluntarily undertake, should they wish to do so.
9.1.10	The recertification programme provider makes available a process for collegial practice visits (sometimes referred to as Regular Practice Review) for participants to voluntarily participate in, should they wish to do so.
9.1.11	The recertification programme provider has a documented process for recognising and crediting appropriate and high-quality recertification activities that are undertaken through another organisation.
9.1.12	The recertification programme provider ensures there is a method by which review, and continuous quality improvement of the recertification programme occurs.
9.1.13	The recertification programme provider has a process in place for monitoring participation and reviewing whether participants are meeting recertification requirements. The provider defines the categories of participants (for example Fellows/associates/members) and the number of participants undertaking the recertification programme.
9.1.14	The recertification programme provider regularly audits the records of programme participants, including completeness of evidence and educational quality. The provider has a process to address participants' failure to satisfy programme requirements. This must include action taken by the provider to encourage compliance/re-engagement, and the threshold and process for reporting continuing non-participation to the Medical Council of New Zealand.

9.1.15 The recertification programme provider reports to the Medical Council of New Zealand as soon as practicable when a participant fails to re-engage and satisfy programme requirements and gives immediate notification of any participant who withdraws from their programme.

9.1 Recertification programmes			
	Met	Substantially met	Not met
Rating		X	

Summary of findings:

The RNZCGP provides a recertification programme (Te Whanake) that is available to all vocationally registered doctors within the scopes of practice of general practice and rural hospital medicine. There are few doctors outside of the fellowship of the RNZCGP that fit into this category, but there are arrangements whereby they can access the recertification programme. The programme offers a functional system for participants to document their recertification programme activity.

The RNZCGP recertification programme, Te Whanake, is designed and constructed to meet the requirements of the Medical Council of New Zealand. It reached its current configuration in consultation with appropriate stakeholders to ensure it was member-centric and fit-for-purpose.

The RNZCGP recertification programme satisfactorily defines the required participation of members in activities across the range of skills, and the necessary knowledge and performance required for a general practitioner to practice safely and appropriately in their scope of practice. There is evidence that the programme genuinely includes the areas of cultural safety as well as professionalism and ethics. Particular note needs to be made of the CPD category - the pou - that specifically addresses cultural safety. This work was informed by the *Cultural Safety Training Plan for Vocational Medicine* produced by the Council of Medical Colleges (CMC) in 2023. The contents of this category are both innovative and in keeping with Medical Council expectations. There is also evidence that participation in this aspect of recertification is at a high level and is increasing.

Vocationally-registered rural hospital medicine specialists are required to fulfil all aspects of the RNZCGP recertification programme, and in addition are required to have currency of ACLS certification and satisfy a requirement of 120 clinical attachment hours. For the programme to fully reflect the scope of practice of RHM doctors, further additions, specific to the RHM context, have been discussed by the Division but have yet to be put in place.

Vocationally-registered GPs, who are also members of the New Zealand Society of Cosmetic Medicine (NZSCM), are required to maintain compliance with the RNZCGP recertification programme, Te Whanake. In addition, they are required to comply with the CPD requirements of the NZSCM, which include maintaining current ACLS certification and the completion of triennial practice visits to a satisfactory standard.

As discussed under standard 1.1, whilst the NZSCM reports to the RNZCGP as to the recertification activities of its members, the RNZCGP oversight of these activities is considered to be “light touch”. There is interaction of the NZSCM with the Censor-in-Chief of the RNZCCGP where necessary, if there are any particular concerns about members of the Society. However, systematic and regular oversight of the Society's recertification programme does not appear to be occurring, or to be well described, within the RNZCGP's processes and its governance structure.

The RNZCGP recertification programme clearly determines the appropriate types of activities under each of the four CPD categories described within the CPD framework. The programme satisfactorily assigns extra weight to activities where there is evidence that such activities are more effective in improving a doctor's performance.

The RNZCGP recertification programme ensures, that in each recertification cycle, participants undertake a mix of activities across all three of the Council's CPD categories. And, in addition, within the cultural safety category (pou).

The RNZCGP recertification programme requires participants to undertake a structured conversation on an annual basis with a peer, colleague or employer. For those needing additional support, conversation guides for doctors and facilitators involved in the annual conversation are available via the College's website.

The RNZCGP recertification programme requires participants to fully engage in the generating and maintenance of a professional development plan on an annual basis. "Setting Goals" is the name used by the RNZCGP for developing and maintaining a professional development plan. Goals can be informed by the previous year's annual conversation and can be carried on from one year to the next if appropriate.

The RNZCGP recertification programme ensures that cultural safety, and a focus on health equity, are embedded across the CPD categories and all other core elements of the recertification programme. The cultural safety category or pou is a feature of the programme, and the RNZCGP is to be commended on its place in the continuing professional development of general practitioners and the clear emphasis within the programme on the development of skills and attitudes contributing to cultural safety of all participants. Te Akoranga ā Māui indicates its strong support for this Pou, and its place in the structure and design of the CPD programme.

The RNZCGP recertification programme makes available a multisource feedback process that participants can undertake if they so wish. It appears that it is fit for purpose and uses the *Better Practice Patient Questionnaire* (BPPQ) and links members to further multisource feedback providers, should they wish to complete these.

The RNZCGP recertification programme offers a process for collegial practice visits/regular practice reviews. Such visits are available for participants to use if they so wish. This tool is fit for purpose with the RNZCGP having significant experience in the promulgation of regular practice review. There are helpful resources and guidance to assist with the visit for both the member and the reviewer.
The RNZCGP recertification programme has a clearly documented process for recognising and accrediting, appropriate and high-quality certification activities that are undertaken through other organisations. The functionality and flexibility inherent in this process and policy is confirmed by fellows and other parties involved with, and highly familiar with, the programme.

The RNZCGP recertification programme has some methods for review and continuous quality improvement of the recertification programme. However, these are somewhat 'ad hoc' and there is some lack of clarity as to where the responsibility for such review and continuous quality improvement should be considered and be promulgated from. Whilst the recertification team within the RNZCGP staff have some cognisance of this matter, governance relating to continuing professional development is not clearly represented or articulated within the broader governance functions of the college. High level and major changes or additions to the CPD programme have been, and are, considered at Board level, but there is no clear allocation of responsibility and oversight at other levels, including whether the respective boards of study, should have a place in these processes.

The RNZCGP recertification programme has comprehensive processes in place for monitoring participation in the programme and review of whether participants are meeting the recertification requirements.

The RNZCGP recertification programme regularly audits the records of programme participants to an appropriate standard. Equally, the College has satisfactory processes to address participants failing to satisfy programme requirements, including means and methods to encourage compliance and re-

engagement. There are clear thresholds and processes for reporting ongoing non-participation to the Medical Council of New Zealand.

The RNZCGP recertification programme reports to the Medical Council of New Zealand in a timely fashion in respect to participants who fail to re-engage or satisfy programme requirements.

Commendations:

- The cultural safety category (or pou) is a feature of the recertification programme, and the RNZCGP is to be commended on its place in the continuing professional development of general practitioners - and the clear emphasis within the programme on the development of skills and attitudes contributing to cultural safety of all participants.

Recommendations:

- The RNZCGP should explore, in addition to the recertification requirements for fellows of the DRHM, further tailored requirements that fully reflect the scope of practice of such doctors (standard 9.1.3).

Required actions:

25. The RNZCGP must clearly allocate the responsibility for, and oversight of, recertification within its governance framework, and align recertification with its Learning section within the organisation, rather than solely with its Membership section (standard 9.1.2 and 1.1.1).

9.2 Further training of individual vocationally registered doctors

9.2.1 The training provider has processes to respond to requests for further training of individual vocationally registered doctors in its vocational scope of practice(s).

9.2 Further training of individual vocationally registered doctors			
	Met	Substantially met	Not met
Rating	X		

Summary of findings:

The RNZCGP has processes to respond to requests for further training of individuals in the vocational scope of general practice, whether these requests come from doctors themselves, from employers or the Medical Council of New Zealand. The RNZCGP responds to member queries for further training by guiding them to an extensive array of information available as training options. The processes are satisfactory and appropriate to allow for practice re-entry and desired training in new scopes of practice for such doctors.

9.3 Remediation

9.3.1 The training provider has processes to respond to requests from MCNZ for remediation of vocationally registered doctors who have been identified as underperforming in a particular area.

9.3 Remediation			
	Met	Substantially met	Not met
Rating	X		

Summary of findings:

The RNZCGP has well-articulated processes to respond to requests from the Medical Council of New Zealand for remediation of vocationally registered general practitioners who have been identified as underperforming in any particular aspects of their practice. In such circumstances the RNZCGP will employ one or more of the following options with the practitioner:

- collaboration with the member's relevant Faculty, Te Akoranga a Māui, or Chapter as appropriate
- (including DRHM, Pasifika Chapter, and Rural GPs)
- collaboration with the member's registered peer group
- allocation of online learning courses
- enrolment in RNZCGP endorsed continuing medical education
- professional supervision
- mentorship by a peer actively engaged in the Te Whanake CPD programme
- collegial review

- referral to EAP.

10 Assessment of international medical graduates for the purpose of vocational registration

10.1	Assessment framework
10.1.1	The training provider has a process for assessing a specialist international medical graduate's (SIMG) qualifications, training and experience (QTE) which is designed to satisfy MCNZ's requirements.
10.1.2	The training provider bases its assessment on the comparability of an SIMG's QTE to a New Zealand vocationally trained doctor registered in the same vocational scope of practice, taking into account the vocational medical training programme outcomes.
10.1.3	The training provider provides advice to MCNZ within an agreed timeframe.

10.1 Assessment framework	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:

The RNZCGP has comprehensive and fit for purpose processes for assessing specialist international medical graduate (SIMG) qualifications, training and experience. These processes are designed to, and do satisfy, the Medical Council of New Zealand's requirements.

The RNZCGP demonstrably bases its assessment on the comparability of a SIMG's qualifications, training and experience, to those of a New Zealand trained doctor in the vocational scope of general practice. The RNZCGP provides advice to the Medical Council of New Zealand in a timely fashion and within agreed time frames.

The panel were uncertain about the development of an alternative practice assessment for general practitioners that will not lead to Fellowship. The Council already has a vocational practice assessment (VPA) as an assessment requirement for SIMGs. However, it has a long-standing agreement with the RNZCGP - that is, rather than Council undertaking a VPA, the RNZCGP would undertake its own practice assessment visit which would also lead to the award of Fellowship. If SIMGs are no longer going to be awarded Fellowship as they are no longer undertaking the RNZCGP practice assessment visit, then in line with Council's policy, the Council would require the SIMGs to undertake the Council's VPA.

Regarding rural hospital medicine, apart from doctors with fellowship of the Australian College of Rural and Remote Medicine, there are no overseas qualifications considered to be equivalent to that of the New Zealand Division of Rural Hospital Medicine. The pathway to vocational registration in rural hospital medicine for SIMGs is via progression to fellowship of the division (that is, it is a process of recognition of prior learning). The requirements for progression in such a manner is clearly described in the Prior Specialist Pathway and this pathway is seen to be functional and effective.

Recommendation:

- The RNZCGP should clarify and communicate its intentions in respect to vocational practice assessments for SIMGs to the Council. (standard 10.1.1)

10.2	Assessment methods
10.2.1	The methods of assessment of SIMGs, while they are practising under their provisional vocational registration, are fit for purpose.
10.2.2	The training provider has procedures to inform employers, and where appropriate the regulators, including the MCNZ, where patient safety concerns arise in assessment.

10.2 Assessment methods	Met	Substantially met	Not met
Rating	**X**		

Summary of findings:
The RNZCGP's methods of assessment of SIMGs practising under their provisional vocational scope of practice are fit for purpose, and have congruence, with the relevant methods of assessment within the GPEP training programme - and with more specific methods of assessment used more broadly across vocational providers for the assessment of SIMGs in Aotearoa New Zealand. The RNZCGP has appropriate procedures to inform employers, and if necessary, the Medical Council of New Zealand, if there have any patient safety concerns that arise in the assessment of an SIMG. There are a range of mechanisms in place to ensure patient safety and the notification of concerns. The processes used are consistent with those used in the GPEP. If on consideration there is not sufficient concern to make a notification, additional support may be put in place for the SIMG.

Appendix 1 – Membership of the 2024 accreditation panel

Dr Ken Clark (Chair of accreditation team)
Medical member

Prof Phillippa Poole
Medical member

Dr Adam Mullan
Medical member

Mr Simon Watt
Lay member

Dr Jibi Kunnethedam
Trainee member

Ms Kiri Rikihana
Senior staff member MCNZ

Ms Jane Dancer
Senior staff member MCNZ

Appendix 2 – RNZCGP key staff

Board President	Dr Samantha Murton
Division Chair	Dr Andrew Morgan
Acting Chief Executive	Mr Terry McCaul
Head of learning	Ms Victoria Harrison
Head of equity	Ms Julie McDonald
Head of membership	Ms Rachael Dippie
Trainee committee Chair	Dr James Enright
Rural hospital medicine representative on trainee committee	Dr Ben Brooker
GPEP clinical consultant	Dr Steven Lillis
GPEP clinical consultant	Dr Sally Carter
GPEP lead medical educator	Dr Deborah Mitchell
RHM clinical lead	Dr Chloe Horner
RHM clinical lead	Dr Marcus Walker
Academic Tāhuhu Chair	Dr Kerryn Lum
Te Akoranga a Māui Chair	Dr Jason Tuhoe
GPEP board of studies Chair	Dr David Henry
RHM board of studies Chair	Dr Munanga Mwandila
Pou Whirinaki	Dr Maia Melbourne-Wilcox
Chief examiner clinical	Dr Jethro Le Roy
National Advisory Committee Chair	Dr Stephanus Lombard

Appendix 3 – List of submissions on the RNZCGP

The University of Auckland
The University of Otago
Te Aka Whai Ora
Te Whatu Ora – Health New Zealand
The Royal Australian College of General Practitioners
The Royal New Zealand College of Urgent Care
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
The Australasian College of Emergency Medicine
The Rural Health Network
The New Zealand Medical Students Association
The Accident Compensation Corporation
Primary Health Organisations
GPEP and RHM training sites

Appendix 4 – Summary of the 2024 accreditation programme

18 March 2024 – in person and via Zoom	
Opening meeting with Board president and Senior Management	Board President – Samantha Murton Acting Chief Executive – Terry McCaul Head of Equity – Julie McDonald Head of Learning – Victoria Harrison Head of Membership services – Rachael Dippie Head of Corporate services – Terry McCaul
RNZCGP Board	Board President – Samantha Murton Te Akoranga a Māui representative – Kiriana Bird Elected College Fellows – Karl Cole Elected College Fellows – Caroline Christie Independent director – Susan Huria National Advisory Council Chair (ex officio) – Stephan Lombard Division of Rural Hospital Medicine Chair (ex officio) – Andrew Morgan **RNZCGP Staff** Acting Chief Executive – Terry McCaul Head of Learning – Victoria Harrison Head of Equity – Julie McDonald Head of Membership services – Rachael Dippie
The Division Council	Chair – Andrew Morgan Board of Studies representative – Munanga Mwandila Te Akoranga a Māui representative – Alex Mcleod Member – Dinesha Kumarawansa Member – Rosalie Evans Member – Andrew Laurenson **RNZCGP Staff** Acting Chief Executive – Terry McCaul Head of Membership services – Rachael Dippie
External stakeholder meetings	Auckland University Otago University Te Aka Whai Ora Te Whatu Ora Royal Australian College of General Practitioners Royal New Zealand College of Urgent Care Rural Health Network

19 March 2024 – in person and via Zoom	
Training sites – GPEP	
Training sites – RHM	
GPEP Registrar Committee	Chair – James Enright Treasurer – Ralston Craig D'Souza Secretary – Isabelle Lewis GPEP1 representative – Darren O'Gorman GPEP1 representative – Rex Liao GPEP2 representative – Ginette Musker GPEP2 representative – Darren O'Gorman GPEP3 representative – Mathanki Vivekananda Te Akoranga a Māui representative – Amanda Smith Pasifika representative – Leone Vadei Rural Hospital Medicine representative – Ben Booker
GPEP year 1 trainees	
RHM year 1 trainees	
GPEP year 2 and 3+ trainees	
RHM year 2 and 3+ trainees	
GPEP clinical consultants, lead medical educator and medical educators	Clinical consultant – Steven Lillis Clinical consultant – Sally Carter Lead Medical Educator – Deborah Mitchell Medical Educator – Frances Moon Medical Educator – Primla Khar GPEP2/3 Medical Educator – Ben Ng Wai Shing GPEP2/3 Medical Educator – Mohamed Bahr GPEP2/3 Medical Educator – Pat Hasilow
RHM clinical leads and educational facilitators	Clinical Leads – Chloe Horner Clinical Lead – Marcus Walker Educational Facilitator – Stephen Satish Ram Educational Facilitator – Margaret Ann Fielding Educational Facilitator – Stephen Withington
Academic Tāhuhu	Chair – Kerryn Lum Chair of GPEP Board of Studies – David Henry Chair of DRHM Board of Studies – Muna Mwandila Te Akoranga a Māui – Jason Tuhoe Te Akoranga a Māui – Rachel Thomson Independent educationalist – Jenny Poskitt College Board representative – Caroline Christie Staff representative – Victoria Harrison
GPEP Board of Studies	Chair – David Henry Registrar representative – Ralston Craig D'Souza Ex-officio member – Victoria Harrison Te Akoranga a Māui rep – Katrina Kirikino-Cox Member – Jethro Le Roy Te Akoranga a Māui rep – Maia Melbourne-Wilcox

DRHM Board of Studies	Chair – Munanga Mwandila Division Council chairperson – Andrew Morgan Staff Representative – Victoria Harrison Australian and New Zealand College of Anaesthetists representative – Graham Roper Te Akoranga a Māui Rep – Alexander Mcleod Assessor – Robyn Carey
20 March 2024 – in person and via Zoom	
Te Akoranga a Māui	Chair – Jason Tuhoe Deputy Chair – Nina Bevin Treasurer & Secretary – Amber-Lea Rerekura NAC Representative – Jordan Gibbs RHM & Rural Representative – Alexander McLeod Board representative – Kiriana Bird Registrar representative – Amanda Smith Registrar representative – Tawa Hunter Research and Education Committee representative – James Enright Research and Education Committee representative – Nina Bevin
Second meeting with Academic Tāhuhu	
Māori health provider and those who provide support to Māori registrars	Pou Whirinaki – Maia Melbourne-Wilcox Lead Medical Educator – Sean Hanna
External stakeholder meeting	Australian College of Rural and Remote Medicine
GP Fellows	
RHM Fellows	
GP CPD - staff involved in CPD support	Acting Manager MPD – Rachael Dippie Former manager MPD – Candice Beck Board President – Samantha Murton Academic Tāhuhu representative GPEP – Kerryn Lum
RHM CPD - staff involved in CPD support	Acting Manager MPD – Rachael Dippie Former manager MPD – Candice Beck Board President – Samantha Murton Academic Tāhuhu representative RHM – Muna Mwandila
Chief examiner, assessors and examiners	Chief Examiner Clinical – Jethro Le Roy Fellowship Assessor – Fiona Whitworth Fellowship Assessor – Heidi Mayer RHM Fellowship Assessor – Harpal Singh-Sandhu RHM Fellowship Assessor – Susan Weggery Senior Examiner Clinical – Jo Meyer Senior Examiner Clinical – Bryce Kihirini
New Zealand Society of Cosmetic Medicine	

GP Specialist International Medical Graduates (SIMG)	
Māori registrar group	
SIMG assessors and staff involved in supporting SIMG assessment	Manager Admissions – Peter Walton-Jones International Assessor – Jay Erickson International Assessor – Alistair Raiman IMG Assessor – Poornima Nair IMG Assessor – Andy von Biel
RNZCGP staff meeting	Head of Learning – Victoria Harrison Manager Advanced Delivery – Bianca Andrews Manager GPEP1 Delivery – Stefanie Joe Manager Academic Assurance – Jean Martin Manager Admissions and Registrar Support – Peter Walton-Jones Manager Quality Programmes – Sandy Bhawan
21 March 2024 – in person and via Zoom	
National Advisory Council	Chair – Stephanus Lombard NAC representative – Moira Chamberlain NAC representative – Patrick McHugh Member – Andrew Laurenson Member – Craig Pelvin Member – Dayna More Member – Dermot Coffey Member – Liza Lack Member – Mark Smith Member – Paul Nealis Member – Philippe Weeks Member – Sally Talbot Member – Sophie Ball Staff representative – Rachael Dippie Te Akoranga a Māui representative – Mel Wi Repa Te Akoranga a Māui representative – Jordan Gibbs Board representative – Daniel McIntosh Registrar representative – James Enright Pasifika representative – Vanisi Prescott
Senior leadership	Board President – Samantha Murton Acting Chief Executive – Terry McCaul Head of Equity – Julie McDonald Head of Learning – Victoria Harrison
Meeting with senior leadership and staff to feedback findings	Board President – Samantha Murton Acting Chief Executive – Terry McCaul Head of Equity – Julie McDonald Head of Learning – Victoria Harrison Head of Membership services – Rachael Dippie GPEP Board of Studies Chair – David Henry GPEP Censor-in-Chief – Kerryn Lum *(Board member, Chair Academic Tāhuhu)* The Division Council Chair – Andrew Morgan *(Board member)* DRHM Chief Assessor – Robyn Carey Division Board of Studies Chair – Munanga Mwandila