New Zealand College
of Public Health Medicine

Tracking of Professional Standards (TOPS) Manual

2025-2027

Contents

Publishing Note

The Tracking of Professional Standards Manual was last updated by the New Zealand College of Public Health Medicine in 2025.

PART 1: Operation of the TOPS Programme

Summary

The Tracking of Professional Standards (TOPS) Programme provides a process to guide and monitor the continuing professional development (CPD) of Public Health Medicine Specialists (PHMS) and is accredited by the Medical Council of New Zealand (MCNZ) for this purpose.

The TOPS programme aims to reflect the diversity of public health medicine practice in New Zealand and recognises a range of activities in the following four areas:

1. Māori Health, Health Equity and Cultural Safety (to be reflected across all areas and filter through all TOPS activities)
2. Reviewing and reflecting on practice, including an Annual Conversation
3. Measuring and improving outcomes
4. Educational activities (continuing medical education, CME).

It is based on the Public Health Medicine competencies described in Appendix 1, and includes responsibilities under the Code of Health and Disability Services Consumers' Rights.

The TOPS programme runs on a calendar year (January to December) and includes both annual requirements and requirements over a three-year period (a triennium). The tracking mechanism involves self-reporting via entry of activities onto the TOPS database which is accessed through the College website (www.nzcphm.org.nz).

Doctors are required to complete a professional development plan and have an annual conversation about their progress and career plans with a colleague each year, as well as accumulate a minimum of 50 points in the year. They are also required to meet the minimum TOPS point requirements for the triennium. The triennium requirements are as follows: 200 points total, including a minimum of 30 points in the 'Māori health, health equity and cultural safety' category, 60 'reviewing and reflecting on practice' points, 30 'measuring and improving outcomes' points, and 30 points for 'educational activities'.

The College is required to report any doctor who does not comply with TOPS requirements to the MCNZ and the MCNZ may ask the College whether a doctor is complying with the TOPS requirements as part of its random audit process. In addition, the College audits 10% of all TOPS participants each year to verify activities recorded.

This document aims to provide College members and other relevant groups with detailed information on the use of TOPS. The College reserves the right to change any aspect of TOPS at its discretion at any time, including in response to altered MCNZ requirements or other considerations that the College considers justify such changes.

Aims, Context, and Key Features

Aims of the TOPS Programme

The College TOPS programme aims to:

- Encourage Public Health Medicine Specialists (PHMS) to undertake continuing professional development (CPD) through: developing culturally safe practice that contributes to Māori health and equity, reviewing and reflecting on practice, measuring and improving outcomes and undertaking educational activities.
- Provide PHMS with a mechanism for demonstrating to their peers, employers and the community that they are actively participating in CPD and quality assurance activities.
- Meet and exceed MCNZ recertification programme standards, encourage improvement in competence, and monitor recording of CPD activity by participants.
- Encourage PHMS to participate in activities that enhance the public health of New Zealand and contribute to the training, development and recognition of the public health workforce.
- Encourage participants to question why each activity has been chosen and aim for maximum impact.
- Ensure that PHMS who have difficulty in meeting the above objectives are provided with clear information about assistance and recertification options available to them.
- Be a fair and transparent process that balances compliance costs for participants with the requirement that they maintain professional expertise in the specialty.

Legislative Requirements

The MCNZ requires every vocationally registered medical practitioner who holds an annual practising certificate to participate in a Council-approved recertification programme.[1] The legislative basis is Section 41, Health Practitioners Competence Assurance Act 2003.[2]

The MCNZ's vision for recertification is that:

> Recertification should ensure that each doctor is supported by education that provides for their individual professional development needs and is delivered by effective, efficient and reflective mechanisms that support maintenance of high standards and continuing improvement in performance. [3]

The MCNZ's view is that quality recertification activities are:

- Evidence-based

[1] See Medical Council of New Zealand website for more details: https://www.mcnz.org.nz/registration/maintain-or-renew-registration/recertification-and-professional-development/recertification-requirements/recertification-for-doctors-on-a-vocational-scope-of-practice/

[2] A summary and details of the Act are available on the Manatū Hauora website. http://www.moh.govt.nz/hpca

[3] Medical Council of New Zealand. Recertification requirements for vocationally-registered doctors in New Zealand. MCNZ. Wellington: November, 2019 https://www.mcnz.org.nz/assets/Publications/Booklets/f7d4bc7fff/Strengthened-recertification-requirements-for-vocationally-registered-doctors-November-2019.pdf

- Those that inform ongoing learning and development[4]
- Informed by relevant data
- Based on the doctor's actual work and workplace setting
- Profession-led
- Directed to clinical competencies
- Directed to cultural safety
- Informed by and referenced to the New Zealand Code of Health and Disability Services Consumers' Rights
- Supported by employers

The MCNZ requires all recertification programmes to include the following core elements:[3,5]

1. Doctors must complete a mix of activities across three continuing professional development (CPD) categories:

   a. Reviewing and reflecting on practice
   b. Measuring and improving outcomes
   c. Educational activities (continuing medical education – CME)

2. Doctors must have a structured conversation with a peer, colleague or manager (at least annually) to discuss outcome data from activities already undertaken (e.g. CPD, educational activities, or other), the doctor's personal reflection on their practice, learning aspirations, professional development, wellbeing, and their career stage and intentions.

3. Doctors should use the information gathered from undertaking activities and from their structured conversation, to inform the development and ongoing maintenance of a professional development plan (PDP).

4. Cultural safety and a focus on health equity, in particular in relation to achieving best outcomes for Māori, must be embedded within all of the above activities.

Note to TOPS participants:

It is your responsibility to advise the MCNZ of your participation in the TOPS programme when applying for renewal of your Practising Certificate. It is also your responsibility to inform the MCNZ if you withdraw from the TOPS programme for any reason. The College will also report withdrawals from the TOPS programme to the MCNZ.

You may be audited by the MCNZ in their annual random audit process. The College may provide information about your compliance with TOPS programme requirements to the MCNZ in this process. [6]

[4] Medical Council of New Zealand. Recertification – evidence to support change. Wellington: MCNZ, 2017. https://www.mcnz.org.nz/assets/News-and-Publications/5cdb4f4b06/Recertification-Literature-Review-evidence-for-change.pdf

[5] Medical Council of New Zealand. He Ara Hauora Māori – a Pathway to Māori Health Equity. Wellington: MCNZ, 2019. https://www.mcnz.org.nz/assets/standards/6c2ece58e8/He-Ara-Hauora-Maori-A-Pathway-to-Maori-Health-Equity.pdf

[6] Medical Council of New Zealand. Audit requirements. https://www.mcnz.org.nz/maintain-registration/recertification-and-professional-development/recertification-audit/

Non-compliance with TOPS requirements may result in the MCNZ placing conditions on your scope of practice, altering your scope of practice or suspending your registration.

If at any stage you feel that you need additional support in maintaining your on-going competence in public health medicine, or in development in a particular area (for example, due to changes within the scope), or you are finding it difficult to meet TOPS requirements, you should contact the College. The Director of CPD will provide support to you in developing a professional development plan, and if appropriate, may be able to refer you to a senior Fellow who is willing to counsel and mentor you as appropriate.

TOPS requirements for doctors working internationally who continue to hold a New Zealand practicing certificate (or who have chosen to continue reporting TOPS) do not differ from those for doctors practicing in New Zealand. However, health equity issues will differ in different contexts, and activities should be chosen accordingly. It is still expected that you will keep abreast of developments in Māori health whilst abroad. If you have any issues completing this requirement, please contact the College office.

When selecting particular activities, it is useful to consider the aim of the activity by asking "why choose this activity?"

Features of the TOPS Programme

3.1 Features that are part of the TOPS programme

The TOPS Programme:

- Meets the MCNZ standard for recertification programmes.
- Adapts some clinical requirements for the public health medicine scope of practice.
- Is based on Public Health Medicine competencies.
- Acknowledges and reflects the diversity of public health medicine practice in New Zealand.
- Recognises continuing professional development activities relevant to public health medicine practice.
- Encourages participants to ensure that they are practicing in a manner consistent with te Tiriti o Waitangi.
- Enables participants to ensure that they are contributing to the Vision outlined in the College's He Rautaki Māori - Māori Health Strategy, i.e. practicing in a culturally safe, Tiriti compliant, pro-equity and anti-racist manner.
- Recognises public health outputs that are visible to colleagues and therefore amenable to quality assurance processes, including an Annual Conversation.
- Recognises regular participation in activities that involve peer review of the work of participants.
- Includes measures of cultural safety development and application to ensure continuous development.
- Encourages self-reflection and critical consciousness on styles of practice and power relationships in practice.
- Emphasises activities that are likely to influence learning and improve professional practice and outcomes.
- Requires the minimum possible time and cost from participants to report TOPS activities.

- Provides a means of recording CPD information.
- Recognises consumer rights.

3.2 Features that are not part of the TOPS programme

The TOPS Programme:

- Does not attempt to measure all aspects of good professional practice.
- Is not a substitute for the usual requirements for a doctor to perform competently as an employee or contractor and engage in performance and staff development programmes in such settings.
- Does not substitute for ethical and mandatory requirements for notification to the MCNZ about competence or health concerns.[7]
- Does not set differing requirements for PHMS in different employment and personal situations (e.g., those employed part-time). It is likely that some PHMS will need to devote more of their own time and resources to their CPD if they are in a work environment that provides fewer opportunities for professional development activities.

3.3 Māori health, health equity and cultural safety requirements

The **College's vision** set out in He Rautaki Māori - Māori Strategy,[8] is that by 2040, the College will be recognised as culturally safe, Tiriti compliant, pro-equity and anti-racist, and actively

He Rautaki Māori – Māori Strategy

We have a vision that by 2040, the New Zealand College of Public Health Medicine is recognised as:

Culturally Safe

- We are continuously examining ourselves and the potential impact of our own culture and bias on public health practice
- We are promoting and exemplifying cultural safety to the sector; and cultural safety as part of the leadership style of the College

Tiriti Compliant

- We are committed to Te Tiriti o Waitangi as a professional imperative and advance our organisation and professional practice through a Tiriti framework
- We challenge the New Zealand health system with its Te Tiriti o Waitangi obligations

Pro-equity

- We are driving, demonstrating and achieving equity within the College and what we can influence
- We will share power authentically and promote Māori leadership and self-determination

Anti-racist

- We actively oppose racism in our organisation and communities
- We hold free and frank discussions about racism, and colonialism, ensuring policy explicitly addresses racism

[7] Medical Council of New Zealand. What to do when you have concerns about a colleague. Wellington: MCNZ, 2012. http://www.mcnz.org.nz/assets/News-and-Publications/Statements/Concerns-about-a-colleague.pdf

[8] New Zealand College of Public Health Medicine. He Rautaki Māori – Māori Strategy. Wellington: NZCPHM, 2020. https://nzcphm.org.nz/Policy-Statements/10944/

contributing its expertise, knowledge and capability to supporting tangata whenua to achieve their maximum health and well-being.

Māori health, health equity and culturally safe practice are key components of the College TOPS programme, with 14 related competencies described in the Public Health Medicine competency list (see Appendix 1).

Activities related to Māori health, health equity and cultural safety must be reflected across recertification requirements and filter through all TOPS activities.[3,9]

The focus on **Māori health** recognises that Māori, as the indigenous people of Aotearoa New Zealand, have unique rights under te Tiriti o Waitangi (the Treaty of Waitangi) which include the right to self-determination and to monitor and evaluate the Crown. For Māori health, the Tiriti o Waitangi principles of tino rangatiratanga, partnership, protection, equity and options apply:

- Tino rangatiratanga, which provides for Māori self-determination and mana Motuhake in the design, delivery, and monitoring of health and disability services.
- Partnership establishes the relationship between Māori and the Crown. The Crown has the right to govern in exchange for tino rangatiratanga (autonomy) for Māori.
- Protection arises from the Crown's partnership responsibilities. The Crown has a responsibility to actively protect Māori health and wellbeing through provision of health services equitably to close gaps.
- Equity obliges the government to actively pursue equitable outcomes for Māori including measuring inequities.
- Options recognises the rights of Māori to determine their own social and cultural path, including Kaupapa Māori solutions to health services.[10]

Māori also have distinctive rights as Tangata Whenua under the United Nations Declaration on the Rights of Indigenous Peoples, including the right to be free from discrimination, the right to be respected as a distinct people and collective as well as individual rights.[11,12]

The College recommends that improving Māori health and achieving equity in health between Māori and non-Māori is prioritised as a focus for health policy and action by all health professionals and policy makers. The College recognises its own responsibilities for Māori health, including obligations in all of its work to prioritise Māori health and to achieve equity in health.[13]

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[9] Medical Council of New Zealand. Cultural Safety Baseline Data Report Release and Recommendations. Wellington: MCNZ, 2020. https://www.mcnz.org.nz/assets/Publications/Reports/f5c692d6b0/Cultural-Safety-Baseline-Data-Report-FINAL-September-2020.pdf

[10] Waitangi Tribunal. Hauora: Report on Stage One of the Health Services and Outcomes Inquiry. Waitangi Tribunal. 2019. https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_195476216/Hauora%202023%20W.pdf

[11] United Nations. Declaration of the Rights of Indigenous People. New York: UN, 2007. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

[12] New Zealand College of Public Health Medicine. Māori Health Policy Statement. Wellington: NZCPHM, 2015. https://nzcphm.org.nz/Policy-Statements/10944/

[13] New Zealand College of Public Health Medicine. Māori Health Policy Statement. Wellington: NZCPHM, 2015. https://nzcphm.org.nz/Policy-Statements/10944/

Health equity is defined by Manatū Hauora (the Ministry of Health) as:

> *In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.* [14]

The concept of health equity includes Māori health equity, Pacific health equity, and also applies to other ethnic groups and groups defined by gender, gender identity, age, disability, sexual orientation, religious and spiritual beliefs, socioeconomic status, occupation and lifestyle.

The College regards the achievement of health equity as a critical component of both the nation's overall health, and the principles and practice of public health medicine. [15]

Cultural safety requires healthcare professionals and healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This includes acknowledging and addressing personal biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. Cultural safety encompasses critical consciousness, where healthcare professionals engage in self-reflection and self-awareness and hold themselves accountable for providing culturally safe care as defined by the patient and their communities and as measured through progress toward achieving health equity.[16,17]

The TOPS programme requires the minimum completion of 30 points of activities relevant to Māori health, health equity and cultural safety over the course of the triennium, with at least five points annually in this category. There must be at least one activity in the triennium in each of the three areas, i.e., Māori health, health equity and cultural safety.

These requirements aim to strengthen Māori health, health equity and cultural safety practice in public health medicine in New Zealand.

Confidentiality

4.1 TOPS Activity Monitoring

All personal information collected by the College through the operation of TOPS and related activities are protected by the Privacy Act in New Zealand.[18] Records kept by the College pertaining to your involvement in TOPS are held in confidence and will not be provided to other participants. There are two exceptions to this principle:

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[14] Manatū Hauora. Achieving equity. Wellington: Manatū Hauora, 2019. https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity

[15] New Zealand College of Public Health Medicine Health Equity Policy Statement. Wellington: NZCPHM, 2021. https://nzcphm.org.nz/Policy-Statements/10944/

[16] Medical Council of New Zealand. Statement on cultural safety. Wellington: MCNZ, 2019. https://www.mcnz.org.nz/assets/standards/b71d139dca/Statement-on-cultural-safety.pdf

[17] Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine S-J, Reid P. Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. International Journal for Equity in Health, 2019, 18:174. https://d-nb.info/1206408979/34

[18] New Zealand Parliament. Privacy Act 1993. (Updated March 2020) http://www.legislation.govt.nz/act/public/1993/0028/latest/DLM296639.html

- Officers and staff of the College directly involved in the operation of TOPS have access to all information submitted to the TOPS database.
- The College may release information regarding satisfactory participation to the MCNZ for the purpose of reviewing, assessing, and auditing eligibility for recertification.

4.2 Protected Quality Assurance Activities

There is a mechanism for quality assurance activities (QAA) to be protected under the Health Practitioners Competence Assurance Act 2003. QAA activities include studies of the incidence of adverse patient outcomes, peer review activities to learn from colleagues, and systems review.

"A 'protected' QAA protects the confidentiality of:

- Information that becomes known solely as a result of such activities.
- Documents brought into existence solely for the purposes of such activities.

It also gives immunity from civil liability to persons who engage in such activities in good faith".[19]

The Minister of Health can declare a QAA to be 'protected' if they are satisfied that to do so is in the public interest. Manatū Hauora **does not** currently consider that it is appropriate to extend such protection to peer-review activities carried out as part of TOPS. However, note that the College is not a government body and is therefore not subject to the Official Information Act.

Management of TOPS

Day-to-day management of the recertification programme is the responsibility of the College office.

Professional aspects of TOPS and its longer-term management and development are the responsibility of the Director of Continuing Professional Development (Director of CPD). The Director of CPD reports professionally to the Chair of the Education and Training Committee who, in turn, reports to the President of the College.

The Education and Training Committee, and ultimately the College Council, has responsibility for setting and monitoring the professional standards for recertification. This responsibility includes decisions about whether specific activities submitted by participants do in fact meet TOPS requirements (usually in the context of the annual audit of TOPS records submitted by selected participants).

Minor changes to this Manual (such as clarification and updating) will be undertaken by College staff in consultation with the Director of CPD. Significant changes, including wider strategic development, require agreement of the Education and Training Committee and the College Council. You will receive at least four months' notice of important changes to TOPS.

[19] Manatū Hauora. Protected Quality Assurance Activities under the Health Practitioners Competence Assurance Act 2003. Updated July 2014. Wellington: Manatū Hauora, 2004. Protected quality assurance activities under the Health Practitioners Competence Assurance Act 2003 | Ministry of Health NZ

Continuous Quality Improvement of the TOPS Programme

Once every three years the TOPS programme is reviewed. As part of this process, the membership is surveyed to ensure the TOPS System is meeting their needs. Changes are recommended by the Education and Training Committee and approved by the College Council. Between major review dates, the Director of Continuing Professional Development and General Manager will attend to any minor changes needed.

Participation in the TOPS Programme

Who Participates in TOPS

7.1 Vocational scope of Public Health Medicine

All doctors registered and practicing in the vocational scope of Public Health Medicine must participate in TOPS or an alternative CPD programme accredited by the MCNZ. If you work part-time, you are required to meet TOPS requirements in the same way as a full-time PHMS.

If you are not currently practicing public health medicine in New Zealand (e.g., you are overseas or on leave) but wish to maintain a Practising Certificate as a vocationally registered PHMS, you are required to continue to be enrolled in TOPS or an alternative programme accredited by the MCNZ. Contact the College office if you are going overseas or planning to take leave.

If you are also vocationally registered in another vocational scope and you wish to participate in only one recertification programme, advice should be sought from both colleges. This may be permissible if the two scopes are closely related.

While you hold vocational registration in public health medicine, the College must be kept informed about where you are reporting your CPD.

7.2 Others

The TOPS programme is available to any doctor registered in the vocational scope of Public Health Medicine. Associate members who hold provisional vocational registration in public health medicine may choose to register for TOPS. Associate members who hold vocational registration in a different scope and who are not registered in the vocational scope of public health medicine will have other recertification requirements. However, if an Associate member would like to enrol in TOPS they should contact the College office to discuss their circumstances.

Enrolling in TOPS

8.1 Conditions of TOPS Enrolment

To enrol in the TOPS programme, you should:

- Notify the College Office of your intention to enrol in TOPS.
- Accept the conditions required of a participant.

Conditions of TOPS Enrolment:

- That the College may inform the MCNZ that I am participating in TOPS.
- That the College may inform the MCNZ as to whether or not I have met TOPS recertification requirements.
- That the staff and officers of the College and MCNZ may inspect the content of my submissions to the TOPS database for the purpose of reviewing, assessing and auditing my submission and eligibility for recertification.
- That I will keep the College informed, via www.nzcphm.org.nz, of my current postal and email address for correspondence and reporting purposes.
- That I will, to the best of my ability, ensure that all information I submit to TOPS is accurate and a fair reflection of the recertification activity undertaken.
- That I will retain evidence of participation in TOPS activities for a minimum of four years and make this evidence available on request to the College.
- That I accept the College has the right to change any aspect of TOPS at its discretion at any time, including in response to altered MCNZ requirements or other considerations that the College considers justify such changes.

8.2 Enrolling in TOPS part-way through a year

When you enrol in TOPS, your triennium requirements will be pro-rated based on the date of your enrolment in the programme. If more than three months of the year have elapsed when you join the programme, the annual requirements for that year of the programme will be waived.

TOPS Activities and Points

9.1 General Features of TOPS Activities

The range of activities included in TOPS (and their point allocation) is based on the following principles:

- Within the four broad categories, there should be a range of activities that can warrant recognition.
- The activity should contribute to your professional development i.e., go beyond routine operational work where significant new learning is unlikely.
- The activity must be measurable and auditable.
- Points are allocated on a time or activity basis, generally with one point equivalent to one hour of education time.
- Point thresholds should be attainable by all competent PHMS in active practice, who are taking reasonable steps to ensure their CPD.
- Some of these activities could be carried out as part of normal work for example acting as a trainer, and/or attending seminars. Others might need to be negotiated specifically for CPD, including conference and training course attendance, contributions to College processes, and possibly time for peer review group meetings if significant travel is required. By combining some activities, the time requirements could be minimised (e.g.,

presenting a paper at the conference you attended or by holding peer review meetings to coincide with lunchtime seminars).

- The College has avoided setting maximum points allocations, except where CPD activities clearly overlap extensively with usual work activities. This situation particularly applies to PHMS employed in academic positions. In these cases:
    - Teaching points are set to maximum of 20 points annually.
    - Supervision, training and mentoring points are set to a maximum of 20 points annually.
    - Book chapters are set to a maximum of 2 chapters (40 points) per book.
    - Media management to a maximum of 30 points annually.
- Activities should not be recorded or counted more than once. For example, if your peer review process is based on a colleague presenting to your group, followed by a critical review of that piece of work, then this cannot also be recorded as attending a seminar.
- Activities should be assigned to TOPS categories based on their main intent. For example, an activity would be recorded as an educational meeting **OR** a peer review meeting depending on the reason it was held.
- For a full list of the TOPS activities and points, please see the Detailed Description of TOPS Activities section of this document.

9.2 TOPS Points Requirements

The following table shows the annual minimum TOPS point requirements and the triennium requirement. As shown below, you are required to have an active Professional Development Plan and an Annual Conversation every year and achieve a minimum of five points for Māori health, health equity and cultural safety activities (30 points must be obtained in this category over the triennium, with at least some points in each sub-category). The overall minimum annual requirement is 50 points, and the minimum triennium requirement is 200 points.

Category	Annual Minimum Requirement	Triennium Minimum Requirement
Māori health, health equity and cultural safety*	5	30
Māori health	-	-
Health equity	-	-
Cultural safety	-	-
Reviewing and reflecting on practice	-	60
PDP and Annual Conversation	10	(30)
Measuring and improving outcomes	-	30
Educational activities (CME)	-	30
Overall Total Minimum Requirement	**50**	**200**

* These points may be claimed within each of the other three categories but are not double counted towards that category.

There is no reduction in the TOPS point requirements if you are in part-time practice. This policy is set by the MCNZ.

Retired Fellows who are involved in education processes and who wish to continue to report TOPS should get in contact with the College (TOPS@nzcphm.org.nz).

Recording Activities on TOPS

You are required to record your activities on the TOPS database which is accessed via the Members Section of the College website (www.nzcphm.org.nz).

You may:

- Enter CPD activities - the TOPS points are calculated for you automatically
- Edit previous entries for the current year
- View summary reports and detailed reports of entered activities and resulting points
- View your current status in terms of meeting recertification requirements
- View approved TOPS leave and adjusted points requirements

You are responsible for the accuracy and appropriateness of entries recorded in the TOPS system. If the administrative staff are entering or editing records for you, you must check the accuracy of these entries.

The College recommends that you record all activities that attract TOPS points rather than just the minimum amount required. You should also keep a file of evidence for each activity entered for **four years** for audit purposes (see Detailed Description of TOPS Activities). Evidence of activities undertaken may be uploaded directly to the TOPS system.

The deadline for submission of points in any one year is **31 January** of the following year. The policy for late entry of TOPS points is described in the next section (see Late Entry of TOPS Activities).

10.1 Editing and Deleting TOPS Activity Records

TOPS activities can be edited or deleted via the Members Section of the website under 'Record an activity'. It is only possible to edit entries from the current year. Contact the College office (tops@nzcphm.org.nz) if you have any questions in this regard.

10.2 Recording an Active Professional Development Plan

Annual Professional Development Plans are compulsory and must be recorded in the TOPS database but do not need to be submitted to the College Office unless required as part of an audit of TOPS entries. ***Please note that it is important to enter your active plan into the online system during the year for which it was active. For example, if the plan is for 2025, then it should be entered between 1 January 2025 and 31 December 2025, even if it is reviewed in January 2026.***

Deadline for Entry of TOPS Activities

The deadline for the entry of TOPS activities into the database is **31 January** in the year following that in which the activity was undertaken.

11.1 Late Entry of TOPS Activities

If you do not meet the 31 January deadline, the College office may be requested to make arrangements to enter your TOPS points on your behalf. You will be charged a Late Fee and you will be selected for audit of the year's entries. The Late Fee is set annually by the College Council.

11.2 Exceptional Circumstances

If you are unable to meet the 31 January deadline because of exceptional circumstances, you should contact the College office. If deemed appropriate, the General Manager and Director of CPD may waive the Late Fee and/or the audit requirement. Arrangements will be made to enter your TOPS points on your behalf. The College will work with you to meet TOPS requirements if necessary.

Process if TOPS Requirements are Not Met

The College is required to notify MCNZ of participants who fail and continue to fail to meet TOPS requirements, and also to provide information to MCNZ for its regular audits. If you are not actively participating in an accredited CPD programme, you risk losing your practising certificate and/or face legal action for false declaration on your practicing certificate application.

12.1 Failure to Meet Annual Requirements

If no activities or insufficient activities are submitted for the year, you will be deemed to have 'not met annual TOPS requirements'. Additional reporting requirements will be set for the following TOPS year, and achievement will be monitored. If you fail to meet these reporting requirements, the College must report this to MCNZ.

12.2 Special Consideration for not meeting Annual Requirements

There may be a valid reason why you have not been able to meet annual TOPS requirements. If you have experienced, and can provide evidence of, significantly reduced opportunity to undertake regular TOPS activities during the year, your annual TOPS requirements may be reduced at the discretion of the General Manager and the Director of CPD.

Reasons may include responding to a national or local public health emergency or experiencing on-going ill-health. If you think that there should be special consideration of your situation, you should contact the College office as early as possible, and by 31 January of the following year at the latest.

12.3 Failure to Meet Triennium Requirements

If no activities or insufficient activities are submitted for the triennium, you will be deemed to have 'not met TOPS requirements' and the College will report this to MCNZ.

12.4 Remedial Process for Not Meeting TOPS Requirements

All MCNZ approved recertification programmes are required to have a remedial process for participants who have not met requirements. The TOPS process is as follows:

1. If triennium requirements are not met (taking into account any reductions for leave or special consideration) you will undergo annual monitoring by the College. Annual

monitoring will involve the application of annual requirements for each category: 20 'reviewing and reflecting on practice' points, 10 'measuring and improving outcomes' points, 10 'educational activities' points, and 10 points in the 'Māori health, health equity and cultural safety' category (a total of 50 points for the year).

2. You are also required to complete your Professional Development Plan and Annual Conversation each year and to submit it to the College office for each year that you are on the annual monitoring programme.
3. Annual monitoring will continue until you demonstrate that you are meeting the additional annual requirements for one year, after which you will return to normal annual requirements.

Disputes and Appeals

If you disagree with any aspect of the recertification process, or how it has been applied to you, you should raise your concerns in the first instance with the College Office (tops@nzcphm.org.nz). Such concerns will be followed-up by the General Manager and the Director of CPD. If the concern cannot be resolved at this level, it will be discussed with the Chair of the Education and Training Committee.

If you remain unsatisfied with the outcome, then you can request a formal 'reconsideration' or 'review'. The process for managing such concerns is explained in the College Reconsideration and Review Policy and Procedure which can be found in the Members Section of the College website (https://nzcphm.org.nz/).

Auditing of TOPS Entries

Audit of TOPS Entries

The MCNZ requires that the College audits a minimum of 10% of recertification returns each year to ensure that TOPS participants have undertaken their stated activities and have evidence to support this. It is therefore an audit of activities recorded rather than of practice. This audit requires selected participants to upload verifying documentation for each TOPS activity claimed.

Where evidence has not been directly uploaded to the TOPS system, it is your responsibility to keep supporting evidence of TOPS activities for at least four years. Evidence should ideally provide independent verification that an activity took place. Diary entries are not generally sufficient evidence for audit purposes.

If you cannot participate due to exceptional circumstances, postponement may be granted at the discretion of the General Manager and Director of CPD.

If you are selected for audit and do not participate you will not be regarded as having met the requirements for the year of the audit.

14.1 The audit will include the following steps:

1. Following the final date for TOPS entries (31 January), a 10% sample of TOPS participants will be selected both randomly and by a targeted process.

2. Selected participants will be informed of the audit and the requirements for evidence by email. A reasonable timeframe will be given to allow the necessary collation and uploading of evidence. Extra time may be granted in some circumstances.
3. The College Office should be notified once all evidence has been uploaded. The evidence required is outlined under the Detailed Description of TOPS Activities.
4. Following the audit of a participant's points, the College Office may request further evidence for some activities if the supplied evidence is not sufficient.
5. The result of the audit is finalised and the participant is informed of any changes that need to be made to their recorded points.
6. Participants who cannot produce acceptable evidence within a reasonable period of time may have the relevant points removed from the TOPS database.

14.2 Circumstances where targeted audit may occur include:

- Where participants have entries that are not consistent with other information recorded on the TOPS database, incomplete entries or entries that contain obvious errors.
- Where TOPS records were audited in the previous year and found to contain a relatively high proportion of incorrect entries.
- To assess the uptake and interpretation of specific types of activities, particularly newly introduced options.
- Where a TOPS participant fails to meet the 31 January deadline and this was not due to exceptional circumstances.

Withdrawing From TOPS

Temporarily Withdrawing from TOPS

Continuing professional development and recertification are life-long requirements for working as a public health medicine specialist.

15.1 Leaving the workforce for periods of three months or more

If you plan to temporarily withdraw from the workforce for **three months or more** in any one calendar year, you may apply to withdraw from TOPS for the period you are not working. You should inform the MCNZ of your situation. While on leave, you must not undertake public health work in New Zealand. If you are working overseas in the field of public health medicine, you are expected to continue participating in TOPS or, on your return, to provide evidence to MCNZ of participation in an overseas equivalent. In addition, you must comply with the registration and reporting requirements of the country you are visiting.

Temporary leave from TOPS can be applied for via the College website. Information provided should include:

- the date that you intend to withdraw from the workforce,
- the intended date of return and,
- the reason(s) why you cannot continue participating in TOPS during the stated period.

For approved leave:

- The 50 points annual requirement, the Professional Development Plan and Annual Conversation will be waived for the calendar year in which the leave was taken.
- You must still meet the triennium requirements, which will have been prorated (both in total and by category) based on the length of leave. The College strongly recommends that you enter any CPD activities that you do complete so that these can count towards triennium point requirements.

If your approved leave extends over the duration of two consecutive calendar years but does not exceed three months in either year (e.g., two months in 2024 and one month of 2025), the annual and triennium point requirements will not be prorated; the leave must be three or more months within one calendar year.

Once your leave has been approved the College will provide an update of your point requirements.

You are required to continue to pay your Fellowship fees while on leave from TOPS. The 'rule of thumb' is that if you are in possession of a MCNZ Practising Certificate and intend to renew your Practising Certificate, then you need to continue to be enrolled in TOPS.

15.2 Leaving the workforce for periods of three years or more

If you have been out of the workforce for three years or more (i.e., have not held a Practising Certificate for that period), and subsequently wish to resume practising in public health medicine, you should contact the MCNZ. The MCNZ may set conditions on your return to practice, such as a period of supervision.

Permanently Withdrawing from TOPS

If you would like to withdraw from TOPS please contact the College Office (tops@nzcphm.org.nz). You should inform the MCNZ of your intention to withdraw from the programme; the College will also notify the MCNZ that you are no longer reporting TOPS to us. You may re-enrol in the TOPS programme at any stage.

Note that there is no difference in College annual subscription fees for those reporting or not reporting TOPS.

PART 2: Detailed Description of TOPS Activities

TOPS activities are based on the NZCPHM Public Health Medicine competencies for safe practice. Refer Appendix 1.

The New Zealand Code of Health and Disability Services Consumers' Rights includes a requirement for doctors (including public health medicine specialists) to take into account the patient's cultural, religious, and social needs, values, and beliefs.[20] This applies across multiple dimensions, including Indigenous status, age or generation, gender, gender identity, sexual orientation, socioeconomic status, ethnicity, religious or spiritual belief and disability. Refer Appendix 2.

Māori Health, Health Equity and Cultural Safety Activities

Points can be claimed towards Māori Health, Health Equity and Cultural Safety if the activity includes:

- Evidence of work done in accordance with te Tiriti o Waitangi obligations and to address health issues impacting on Māori;
- Evidence of work to achieve health equity; or
- Development of, and reflective practice, for cultural safety.

See Section 3.3 of this Manual for definitions of each of these categories. Some examples of activities which can be claimed in this category are listed in Appendix 3 and on the Cultural Safety and Health Equity learning resources webpage on the member website.

At least five points must be obtained annually, and a minimum of 30 points over the triennium, for activities related to Māori health, health equity and cultural safety. In addition, there must be at least one activity in the triennium in each of the three categories. The new 'Cultural Safety Reflection form (Appendix 4) can be used to gain these points.

Points for activities related to Māori Health, Health Equity and Cultural Safety can be claimed within any of the other three categories of TOPS activities (Reviewing and reflecting on practice; Measuring and improving outcomes; and Educational activities) but are not double counted towards that category. When entering an activity, you will be given an option to indicate what proportion of the points for the activity should be allocated to Māori health, health equity or cultural safety.

The Public Health Medicine competency list (Appendix 1) provides further information on the three sub-category areas. This information may be useful if you are unsure of which sub-category your activity relates to.

[20] Health and Disability Commission. Code of Health and Disability Services Consumers' Rights: Regulations 1996. HDC. Auckland: 1996. https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

17.1 Māori Health

Māori have a special status in New Zealand as tangata whenua and have unique rights under te Tiriti o Waitangi (the Treaty of Waitangi). Principles of te Tiriti o Waitangi which have been recognised by the Waitangi Tribunal as being of particular relevance to health include tino rangatiratanga, equity, active protection, options, and partnership,[10] with reciprocity, autonomy, mutual benefit, equal treatment and redress being other principles that have been accepted by the Tribunal.[21] The right to self-determination, freedom from discrimination, and the right to improvement of their economic and social conditions, including health, are also described in the United Nations Declaration on the Rights of Indigenous Peoples.[22]

A rights-based approach to health in New Zealand includes an understanding of the health impacts of colonisation and the role that Western health services have played in Māori health development on the Māori population, as well as the ongoing impact of institutional racism.

Māori health points are claimed for activities concerned with analysis, practice and advice related to improvements in Māori health and achievement of te Tiriti o Waitangi obligations.

Things to consider:

- How to honour Te Tiriti o Waitangi obligations in decision-taking processes
- Developing partnerships with Māori communities (i.e., whānau, hapū, iwi), and Māori health providers to design, implement and evaluate interventions with Māori
- Opportunities to advocate for Māori Health

Criteria	Points	Evidence Required
• Activities should focus on analysing and advising on public health issues affecting Māori and related practice. • They must relate to identifiable Māori health and te Tiriti competencies (see PHM Competencies List Appendix 1)	0.5 per half hour, or as per the normal category points allocation	Evidence of Māori Health and te Tiriti o Waitangi content in activities submitted in the categories of: • Reviewing and Reflecting on Practice (Category 18), • Measuring and Improving Outcomes (Category 19), and • Educational Activities (Category 20) Or, in the case of activities submitted directly into this category, title of article and evidence of authorship, or title

[21] Summarised in Reid P, Paine S-J, Curtis E, Jones R, Anderson A, Willing E and Harwood M. Achieving health equity in Aotearoa: strengthening responsiveness to Māori in health research. New Zealand Medical Journal, 2017, 130:1465. https://www.researchgate.net/publication/321366099_Achieving_health_equity_in_Aotearoa_strengthening_responsiveness_to_Maori_in_health_research

[22] United Nations. United Nations Declaration on the Rights of Indigenous Peoples, UN. 2008. United Nations: Geneva. (Endorsed by New Zealand in 2010.) https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

		of session, evidence of attendance, hours attended, and public health content, as appropriate.

Examples:

- Research and presentations on Māori health
- Working with a local Marae community on a health protection issue
- Developing a partnership with a local hapū or iwi to resolve a health-related issue
- Developing and presenting evidence for the Waitangi Tribunal on a health-related issue
- Teaching and mentoring on Māori health and Tiriti o Waitangi topics
- Learning activities focussed on Kaupapa Māori transformative praxis
- Development of understanding of Māori culture and society, including whānau, hapū and iwi structures, and te reo Māori

17.2 Health Equity

Material deprivation and related psychosocial impacts, as well as other social and economic determinants of health, result in different health outcomes for different social groups in New Zealand.[23] In particular,

- Māori experience significant inequities in health in New Zealand, including in their access to healthcare and quality of healthcare received. Māori also face inequities in their exposure to the adverse determinants of health, particularly through poverty and socioeconomic factors.
- in New Zealand, Pacific peoples experience poorer health status and life expectancy, and a disproportionate burden of communicable disease, non-communicable diseases and risk factors compared with non-Pacific peoples.[24]

Other groups who experience inequities in New Zealand may be defined by ethnicity, gender, gender identity, age, disability, sexual orientation, religious and spiritual beliefs, socioeconomic status, occupation, geographic region or lifestyle.

Activities focussed on the achievement of health equity for any group or 'culture' can be claimed in this category.

Criteria	Points	Evidence Required
• Activities should focus on analysing and advising on public health issues affecting health equity and related practice. • They must relate to identifiable health equity health competencies (see	0.5 per half hour, or as per the normal category points allocation	Evidence of health equity content in activities submitted in the categories of: • Reviewing and Reflecting on Practice (Category 18), • Measuring and Improving Outcomes (Category 19, and

[23] New Zealand College of Public Health Medicine. Health Equity Policy Statement. Wellington: NZCPHM, 2016. https://nzcphm.org.nz/Policy-Statements/10944/

[24] New Zealand College of Public Health Medicine. Pacific Peoples' Health Policy Statement. Wellington: NZCPHM, 2019. https://nzcphm.org.nz/Policy-Statements/10944/

PHM Competencies List Appendix 1).		• Educational Activities (Category 20) Or, in the case of activities submitted directly into this category, title of article and evidence of authorship, or title of session, evidence of attendance, hours attended, and public health content, as appropriate.

Examples:

- Collection, analysis and use of data to monitor health inequities
- Development of a strategy to address a local issue related to a socio-economic determinant of health
- Conducting an ethnicity audit of a health-related issue
- Development of understandings of different communities and 'cultures' in order to ensure equitable health services to those communities (for example, the LGTBI+ community; people living with disabilities)
- Planning for alternate ways of delivering services that prioritise elimination of health inequities

17.3 Cultural Safety

Cultural safety requires healthcare professionals and healthcare organisations to:

- examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.
- acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.
- develop critical consciousness involving self-reflection and self-awareness, and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress toward achieving health equity. [25,26,27]

Cultural safety points are claimed for activities concerned with the development of, application of, and reflective practice for culturally safe practice.

Criteria	Points	Evidence Required
• Activities should focus on developing and applying cultural safety.	0.5 per half hour, or as per the normal	Evidence of cultural safety content within activities submitted in the categories of:

[25] Medical Council of New Zealand, Statement on Cultural Safety, Wellington: MCNZ, 2019 https://www.mcnz.org.nz/assets/standards/b71d139dca/Statement-on-cultural-safety.pdf

[26] Medical Council of New Zealand, He Ara Hauora Māori – A Pathway to Health Equity, Wellington: MCNZ, 2019 https://www.mcnz.org.nz/assets/standards/6c2ece58e8/He-Ara-Hauora-Maori-A-Pathway-to-Maori-Health-Equity.pdf

[27] Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine S-J, Reid P. Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. International Journal for Equity in Health, 2019, 18:174. https://d-nb.info/1206408979/34

• They must relate to identifiable cultural safety competencies (see PHM Competencies List Appendix 1). • Activities may be part of a peer review process. • Activities may include reflection on cultural safety, and consideration of areas for further action	category points allocation Or 4 points for a completed Cultural Safety Reflection form (maximum one per year)	• Reviewing and Reflecting on Practice (Category 18) • Measuring and Improving Outcomes (Category 19), and • Educational Activities (Category 20). Or, in the case of activities submitted directly into this category, title of article and evidence of authorship, or title of session, evidence of attendance, hours attended, and public health content, as appropriate.
Examples: • Group peer review session in which cultural safety development was a major focus for group discussion • Reflective activities focussed on the development of cultural safety (note that it is important to reflect on what you could have done better, and on what you are not doing, as well as on what you are doing) • Attending a workshop or seminar on the concept of cultural safety • Researching and / or developing materials to be used in cultural safety training • Leading training or other initiatives to develop cultural safety • Completion of the Cultural Safety Reflection Form (see Appendix 4)		

Reviewing and Reflecting on Practice

The 'Reviewing and Reflecting on Practice' category includes formal or informal practice review of individuals or groups of doctors with feedback based on actual work processes. This includes activities where doctors are reviewing, reflecting and learning about their practice with colleagues, peers, co-workers and/or patients. Peer review may also include processes that employers may advise or mandate.

You are required to achieve a total of 60 points from this category over a triennium.

18.1 Professional Development Plan and Annual Conversation

You are required to have a Professional Development Plan that is updated and reviewed each year. This should include a review of your current and desired level of performance using the identified set of public health medicine competencies (Appendix 1). More information about the Plan can be found in Appendix 5. The College has produced an optional Professional Development Plan template that can be found in the TOPS section of the College website (https://nzcphm.org.nz/).

You do not need to submit your Plan to the College unless your TOPS activities are audited or you are undergoing annual monitoring as a result of not meeting triennium requirements. However, your plan must be discussed with a peer review group or individual reviewer (this is your Annual Conversation).[28]

Criteria	Points	Evidence Required

• This plan should be prepared and reviewed with a colleague. This could be a colleague from your Peer Review Group or workplace[29], for example.
• It is not compulsory to use the College Professional Development Plan template. However, all Plans should include the following:
  • A summary of information sources used
  • A review of key issues and lessons from the previous year
  • A review of career goals
  • A reflection on what you could do differently in the year ahead to increase equity through your work
  • A review of public health medicine competencies that you intend to focus on in your professional development for the year, and the activities in each TOPS category that you will undertake to achieve this.
	10 per year (Required)	A record on the TOPS database of: date plan was prepared at the start of the year and the name of person who reviewed it. The plan should also be reviewed in retrospect at the end of the year, at the time of review of the following year's plan.
		
		Copy of the plan and completed self-assessment of competencies.
		
		Note:
		The plan must have been reviewed by a peer review group or individual reviewer, or as part of your annual conversation process.
		You should meet once per year to review the previous year and plan for the coming year.

[28] It is important to enter your active plan into the online system during the year for which it was active. For example, if the plan is for 2025, then it should be entered between 1 January 2025 and 31 December 2025, even if it is reviewed in January 2026.

[29] Workplace is defined as your immediate work context rather than the broader organisation of which your workplace is a part.

18.2 Annual Workplace Review

The Annual Workplace Review provides an opportunity to reflect on your development needs and goals for learning. As part of the Review, you will consider what has happened over the past year and what your intentions are for the coming year. It provides a structured process to reflect on job satisfaction and career goals, as well as self-care and health issues.

The Annual Workplace Review may include the discussion of your Annual Professional Plan (see 18.1 above).

The Review can be undertaken with a peer, colleague or manager. As part of a process with your manager, this is an opportunity to get constructive feedback and to set performance targets for the future. Guidelines for the Workplace Review can be found in Appendix 8 and a template for recording the Review can be found on the website (https://nzcphm.org.nz/).

Criteria	Points	Evidence Required
• The Review should be informed by your Professional Development Plan, your work over the past year, your professional development activities over the past year, and any Multi Source Feedback results that you may have. • It is not compulsory to use the College template.	5 points per year	**A record on TOPS system of date and person involved in the Annual Workplace Review.** **Notes of the discussion, e.g., completed College template.**

A Workplace Annual Performance Review may be considered an acceptable alternative to an Annual Workplace Review if it includes the elements listed below:

1. Highlights and challenges in past year
2. CPD activities over last year
3. Value of those CPD activities to work practice
4. Contribution of practice and CPD to cultural safety and health equity
5. Future work plan
6. Future CPD activities to support that work plan
7. Career direction
8. Health and wellbeing

18.3 Group Peer Review

Participating in regular meetings with an established peer review group – see Appendix 9: Guidelines for Peer Review Groups and Appendix 3: Improving Cultural Safety of Public Health Medicine Specialists.

Peer review groups are an excellent opportunity to examine culturally safe practice.

Criteria	Points	Evidence Required
• Group size should be 4 – 12 of which at least three members should be public health professionals (at least one of whom must be another PHMS), from at least two workplaces;[29] exemptions may be granted by the Director of CPD. • College Office should be advised about each peer review group, including its contact person, membership, and whether it is accepting new members. • Members are **required** to present examples of their own work for review. This should be recorded as 'Group Peer Review of own work' on the TOPS database (at least one presentation per member annually). Note that 'presentation' may be verbal or written. • Must be discrete from other meetings, i.e. it cannot occur as part of a meeting called for a different purpose, though it may follow on from such a meeting. • Meetings should be established as an on-going process, held regularly and distributed throughout the year. The interval between meetings should generally be at least four weeks.	1 per half hour	A record on the TOPS database of: • Attendance • Duration • Attendees • Areas reviewed • Name of presenter Note: You should record when review of your own work occurred as 'Group Peer Review of own work' on the TOPS database. It is important to record an accurate date and list all attendees on the TOPS database; this information is used as the basis for auditing attendance at such meetings. This information may be uploaded to the TOPS system as a 'supporting document' when you enter your peer review points.

• Groups should discuss and have explicit, ideally written, ground rules – see Appendix 9: Guidelines for Peer Review Groups. • Participants can be a member of two or more separate peer-review groups.		
Examples of work for review: • Your management of an outbreak that was particularly challenging • How you led the development of a new strategy for your DHB • How you managed a public consultation for an unpopular public health action • Critically reflective activities in relation to Māori e.g., local press audit, research into land/whenua of local health facility • Consideration of issues related to culturally safe practice and unconscious bias		

18.4 Individual Peer Review

Participating in a meeting/s with an individual peer reviewer. For use in situations where participation in a peer review group is difficult or impossible (for example, if you are working in an isolated location) or to address a particular area of practice.

Criteria	Points	Evidence Required
• The peer reviewer must be a PHMS from a different workplace[29] to the PHMS being reviewed.[30] • The peer reviewer cannot be someone that the PHMS is currently (or has recently been) reviewing, supervising, or mentoring. The reviewer should record this activity in the category: Supervision, training, mentoring, peer reviewing. • The meeting should be organised for peer review purposes (i.e., avoid having a reviewer who is also a project collaborator). • The meeting may be ad hoc or regular, but should include a critical examination of the public health work and outputs	1 per half hour	Record on system of: • Peer reviewer • Number of meetings • Duration of meetings • Topics / areas reviewed Note that the peer reviewer should also record details of the session in the category: Supervision, training, mentoring, peer reviewing.

[30] In the case of TOPS participants who are based overseas, the peer reviewer may be from a different medical scope, and can be in the same workplace, with the approval of the Director of CPD.

of the PHMS being reviewed. Both the reviewer and doctor reviewed may claim points for the interaction.		

Examples:

- A collaboration between a Māori and a non-Māori Fellow on a Māori health issue.
- A collaboration with a clinical support person.

18.5 The College Multisource Feedback process

This activity category is for reporting participation in the College Multisource Feedback review process. The process is designed to:

(1) collate assessments of your performance as a public health professional as well as aspects of your probity and health
(2) offer analysis and feedback to support you in improving your practise i.e., formative assessment

Instructions for completing the College Multisource Feedback review process are attached as Appendix 10, along with the Multisource Feedback Questionnaire and Related PHMS Competencies.

The College Multisource Feedback review can be completed once per triennium.

Criteria	Points	Evidence Required
• A minimum of 10 respondent questionnaires and one self-assessment questionnaire are required for assessment.	12 points per MSF process Maximum of 12 points per triennium	Copy of Multisource Feedback review report

18.6 Completing a 360° type survey or credentialing process

Completing a 360° type survey, credentialing or comparable review process.
This activity category covers structured review processes (other than the College Multisource Feedback review) that:

(1) gathers systematic information on the performance of the participant based on review or feedback from peers, colleagues or clients, combined with
(2) provides analysis and feedback to the participant in a way that supports them improving their performance

Criteria	Points	Evidence Required
• A minimum of 10 respondents is required for a 360° process.	6 per 360° process Maximum of 6 points per year	Copy of the report of the 360° or credentialing process, or other acceptable evidence that it was carried out

18.7 Collegial Practice Visit

The purpose of the Collegial Practice Visit is to provide a process to aid a Fellow with a specific area of their practice. It is a collegial, formative quality improvement process which provides an opportunity to reflect, review and take stock of practice and gives an independent view of practice. The learning results from peer review and input to a specific "real world problem". See the Guidelines for the Collegial Practice Visit in Appendix 12.

The Collegial Practice Visit may be undertaken up to once per triennium. It is optional at the discretion of the practitioner.

Criteria	Points	Evidence Required
This activity category is a formative process but aims to: • maintain and improve standards of the profession. • be profession-led. • provide learning on real world here and now problems. • give both affirmation and reassurance on practice and identify areas in which practice can improve.	10 points per triennium for the participant 5 points per triennium for the visitor	Report of the visit as described in Appendix 13

18.8 Reflection on Action and Practice

The Reflection on Action and Practice category allows Fellows to claim points for reflections on critical incidents and experiences, including engagement with colleagues on difficult issues.

You do not need to submit your completed Reflection form to the College unless your TOPS activities are audited or you are undergoing annual monitoring as a result of not meeting triennium requirements, in which case all identifying details and other personal information should be redacted.

Criteria	Points	Evidence Required
• The reflection may be on a positive incident in which your contribution was well-received, or on an incident in which you felt you were not successful.	2 points per reflection	A record on the TOPS database of: • date reflection form was completed • topic of reflection

• The reflection should identify learnings that can be applied in similar situations in the future.		Completed reflection form (Appendix 14)
Examples of incidents for reflection: • Engagement with a colleague about a cultural safety issue in their practice • Feedback received from a colleague about an aspect of your practice		

Measuring and Improving outcomes

The Medical Council of New Zealand describes activities in the Measuring and Improving Outcomes category as "a quality improvement process that includes review (internal or external) of a doctor's everyday work and resultant patient/health outcomes. The doctor can then analyse, reflect on and use the information gathered to develop their practice and identify professional development needs, with a view to improving patient care and health outcomes".[31]

Activities that inform and improve public health are included in this category. These activities:

- must be outputs that are visible to other public health medicine specialists, or related workers, and therefore be amenable to quality assurance processes
- should be regarded as end-results (as opposed to preparation work)
- should be counted only once in any given year, even if repeated in the same or similar form during that year
- should ideally enhance the public health of New Zealanders and contribute to the training, development and recognition of the public health workforce
- should recognise the additional effort required to conduct original research (based on analysis of primary or secondary data) compared with editorial comment or review

You are required to achieve a total of 30 points from this category over a triennium.

[31] Medical Council of New Zealand. Recertification requirements for vocationally registered doctors in New Zealand. MCNZ. Wellington: November 2019 https://www.mcnz.org.nz/assets/Publications/Booklets/f7d4bc7fff/Strengthened-recertification-requirements-for-vocationally-registered-doctors-November-2019.pdf

19.1 Peer Reviewed Conference Presentation

Presenting a peer reviewed paper or poster at a conference or scientific meeting.

Criteria	Points	Evidence Required
• Acceptance must be based on a peer-reviewed abstract or invited key-note address. • The paper must have a public health focus. • An oral presentation should be at least 10 minutes excluding questions. • Do not record essentially the same presentation more than once per year even if given multiple times. • Do not count presentations given entirely to an internal audience, i.e., in-house presentations.	10 per oral presentation **or** 10 per poster **and** +5 if original research +5 if first author	Evidence of: • Presentation, such as a copy of the programme • Public health content of the presentation, such as the paper abstract • Peer review, such as a link to the conference website

Examples:

- Oral Presentation
- Poster

19.2 Other Presentation

Presenting to other audiences with a public health focus.

Criteria	Points	Evidence Required
• Presentation must have a public health focus. • Oral presentation should be at least 10 minutes excluding questions. • Do not record essentially the same presentation more than once per year even if given multiple times.	5 per presentation **and** +5 if original research	Evidence of: • Presentation, such as a copy of the programme • Public health content, such as a presentation summary / PowerPoint hand-out

Examples

- Presenting to stakeholders
- Development of an online learning resource
- Presentation to co-workers to increase their understanding of public health topics

19.3 Media Management of Public Health Issue

Proactive media campaign or reactive media management of a public health issue.

Criteria	Points	Evidence Required
• Must have developed or contributed to a workplace[29] development of, a media release on a public health issue. *and/or* • Must have developed media communications strategy with messages intended to achieve public health objectives. • Do not record interviews on essentially the same topic more than once per year. • Do not record brief, opportunistic interviews and those simply concerned with providing an update or routine release of information.	1 per release or 5 per campaign Maximum 30 points annually	Evidence of: • Media outputs, such as a press release, newspaper cuttings, interview transcripts, or electronic copy of interview • Media management strategy, such as a copy of the media strategy document a document that demonstrates media strategy, notes or press release • Evidence of involvement in meetings at which the media strategy and outputs were discussed • Public health content

Examples:

- Substantial contribution to a press release subsequently covered by a daily or weekly newspaper or magazine
- Contribution towards the development of a media campaign for a New Zealand health organisation

19.4 Expert Advice on Public Health Issues

Provision of an expert opinion or advice by way of a written report and/or presentation, or substantial verbal input to an organisational process.

Criteria	Points	Evidence Required
• Analysis of data, evidence or other public health intelligence resulting in the provision of a written opinion or oral advice. Or • Use of expert knowledge to identify system gaps and assist others	5 points per report or presentation Or 1 point per piece of substantial verbal advice given	Evidence of • Public health content • Agenda at which the work is to be presented or advice given If points are claimed for a report or presentation, • The report title and date and a statement of authorship

• Points cannot be claimed for activities claimed elsewhere.		• Evidence of presentation given, such as name on agenda
Examples: • Advice given to a management team, governance board based on data, evidence or other public health intelligence. • Advice provided by a Māori Fellow in a meeting relating to Māori health equity or organisational cultural safety		

19.5 Journal Paper or Book

Writing a journal paper or book (indexed in Medline or Embase) on a public health topic.

Criteria	Points	Evidence Required
• The journal article must be published in a Medline or Embase indexed journal. • Do not include monthly and quarterly reports, surveillance newsletters, and letters to the editor of medical journals (see next section). • The book must have an ISBN.	20 per paper or chapter of a book **or** 20 per book edited **and** +10 if original research +10 if first author The maximum number of chapters you may claim points for is 2 chapters per book.	Evidence of • Authorship • Public health content • Publication For example: • For journal article or book chapter: A copy of the complete piece of work • For book written or edited: A copy of the title and contents pages • List of authors, or an acknowledgements section that makes authorship role clear

19.6 Published Report, Article, Letter, Plan or Blog Post

Writing a published report, article, letter or plan on a public health or health service topic.

Criteria	Points	Evidence Required
Examples: • Published report. • Article in a non-indexed journal (e.g., The New Zealand Public Health Surveillance Report). • Newspaper feature. • Substantial letter to the editor of a medical journal.	10 per publication **and** +5 if original research +5 if first author	Evidence of: • Authorship • Public health content • Publication For example: • Copy of the complete piece of work

• Substantial information feature on a website (at least 1000 words). • Health service reports and plans, including: Health needs assessment; Programme or service evaluation; Service development plan; Quality improvement plan.		• For published report: A copy of the title and contents pages • List of authors, or acknowledgements section that makes authorship role clear, or some other evidence of contribution Note: Health service reports and plans do not necessarily require publication if the content is considered sensitive. In such circumstances the documentation would need to be available for confidential review by a person nominated by the NZCPHM (if required)
Examples: • Drafting a new College policy document • Newspaper article		

19.7 Public Health Policy Submission

Preparing and delivering a substantial written or oral policy submission on a public health topic.

Criteria	Points	Evidence Required
• Must be of substantial length, i.e., at least 1000 words (written) or 10 minutes excluding questions (oral). Must include a clearly argued public health case for the position taken, and supporting evidence such as references or primary data. • Must have provided substantial input to the process of submission preparation, if others were involved also in development of the submission.	5 per submission	Evidence of: • Public health content • Participant's contribution For example: • Copy of written submission or presentation notes • Evidence of contribution by the author
Examples: • Submission on a Manatū Hauora, Te Aka Whai Ora or Te Whatu Ora discussion document, submissions on legislation to a select Committee		

- Compiling a submission document on behalf of the College
- Providing substantial internal feedback on a Manatū Hauora, Te Aka Whai Ora or Te Whatu Ora policy document prior to release

19.8 Formal Review of Public Health Documents

Formal review of papers, proposals, reports and theses concerned with public health.

Criteria	Points	Evidence Required
• Must be as part of a formal peer review or marking process. • Document must be concerned with public health.	5 per publication, grant or project **or** 10 per Master of Public Health dissertation/thesis or registrar Assessed Written Report **or** 20 per PhD thesis	Evidence of: • Review • Public health content For example: • Copy of title page of document reviewed • Letter, or other evidence, confirming that the review was done

Examples:

- Review of a paper for publication
- Review of a grant application
- Marking of a PHM registrar project e.g., an Assessed Written Report (AWR)
- Examination of a PhD thesis, MPH dissertation or MPH thesis
- Review of a College policy document

19.9 Advisory Committee and Board Membership

Membership of an Advisory Committee or Board concerned with public health or health services.

Criteria	Points	Evidence Required
• Must be a committee / Board outside the TOPS participant's immediate workplace.[29] • Must be a member of committee / Board rather than attending as an official or to make a submission. • Must be participating because of their public health expertise rather than just a governance role.	1 per hour	Evidence of: • Duration • Public health content For example: • Agenda and/or minutes of meeting showing date, duration, and attendees

• Do not count committees or working groups mainly carrying out administrative or organising tasks.		
Examples: • Health Quality & Safety Committee (HQSC) Mortality Review Committee • Ethics Committee • Independent Practitioners Association Council, Non-Government Organisation or Community Organisation board, or other similar Boards and committees • Health Research Council committee		

19.10 College Committee Membership

Membership of a New Zealand College of Public Health Medicine committee or working group.

Criteria	Points	Evidence Required
Any of the following: • College Council, Education and Training Committee, Policy Committee, or Finance and Risk Committee. • Examination panel. • Mock oral examination panel organised by College. • Assessment Panel, Selection Panel, ASM Organising Committee or other group established by the College and approved for points.	1 per hour	A record on TOPS system of meeting dates and times No other evidence required as College has documentation of attendance

Educational Activities (CME)

Continuing education activities must address one or more of the defined competencies for public health medicine training and practice. Participating in such activities may include attending suitable events or use of distance education media such as the internet, teleconference or videoconference.

You are required to achieve a minimum of 30 points from this category over a triennium.

20.1 Conference Attendance

Participating in New Zealand or international conferences with an emphasis on public health.

Criteria	Points	Evidence Required
• Must address at least one of the defined competencies for public health medicine training and practice.	0.5 per half hour	Evidence of: • Attendance • Hours attended • Public health content For example: • Registration form and receipt, certificate of attendance, or printed list of conference members • Copy of the programme with period of attendance clearly marked

Examples:

- Annual Scientific Meeting of the College
- Te Ora Scientific Conference
- Pacific Medical Association Conference
- Public Health Association Annual Conference
- Australasian Epidemiological Association Annual Scientific Meeting
- Pacific Region Indigenous Doctors' Congress (PRIDoC)
- Leaders in Indigenous Medical Education (LIME) Conference

20.2 Other Educational Meeting Attendance

Attending a seminar, lecture or grand-round with a public health focus.

Criteria	Points	Evidence Required
• Must address at least one of the defined competencies for public health medicine training and practice. • Primary intent of meeting must be educational. • Do not count courses here (see next section).	0.5 per half hour	Evidence of: • Attendance • Hours attended • Public health content For example: • Copy of programme or other details which show length of event • List of sessions attended

		• Names of presenters, and dates

20.3 Course Attendance

Participation in a public health training course.

Criteria	Points	Evidence Required
• Must address at least one of the defined competencies for public health medicine training and practice. • CPR Training (recommended): the College recommends Certificate of Resuscitation and Emergency Care (CORE) Immediate, but Fellows are advised to attend the level that best meets their needs. **Please note that for some employment roles CORE Advanced certification may be required.** • All Fellows (including those not employed by a DHB) may wish to consider regularly attending first aid training. • Training in emergency response and communicable disease management skills is recommended.	0.5 per half hour **or** 400 per year of full-time study **or** 200 per semester of full-time study **or** 50 per course (part-time study)	Evidence of: • Attendance • Hours attended • Public health content For example: • Registration form and receipt • Documentation of course completion • Course outline with hours of attendance clearly marked

Examples:

- Training days organised by the College
- Courses to develop supervision or mentoring skills
- Pandemic planning training using an external source
- Degrees, summer schools and papers on public health topics offered by universities in NZ and overseas
- Structured distance learning courses in public health
- CPR / First aid course attendance

20.4 Self-directed learning

Participation in webinars and online conference sessions, listening to podcasts, reading journals and online public health material.

Criteria	Points	Evidence Required
• Must address at least one of the defined competencies for	0.5 per half hour	The following must be entered to the TOPS system: • Title of session / article

public health medicine training and practice.		• Web link, reference or screenshot • Hours attended • Public health content • Notes of key themes covered • Reflection on how the session is relevant to and can be applied to your practice

20.5 Journal Club & Study Group Attendance

Attending a regular group meeting to review published public health material.

Criteria	Points	Evidence Required
• Must address at least one of the defined competencies for public health medicine training and practice. • Must be an established journal club or study group that meets regularly • Group structure to consist of at least three health professionals.	0.5 per half hour	Evidence of: • Attendance • Hours attended • Public health content • Attendees For example: • Record of meeting dates, locations and names of attendees at each meeting • Brief details about each session - such as a list of topics covered or papers reviewed - uploaded into the TOPS database

20.6 Supervision, Training, Mentoring, Peer Reviewing

Supervision, training, mentoring, or peer reviewing a colleague, registrar or student in public health.

Criteria	Points	Evidence Required
• Must go beyond a staff management or project management role. • Must include a training function directed at improving the professional development of the recipient.	1 per person per month Maximum 20 points per year	Entered to TOPS system: • Name of person supervised • Type of supervision • Period of supervision (record of start and end date of period of supervision)

Examples:

- Mentor or Trainer of a PHM registrar
- Training Programme Supervisor
- Supervision of Masters or PhD student on a public health topic
- Mentor of a junior colleague in public health practice
- Providing formal, general oversight of a PHMS or formal supervision of an international medical graduate[32]
- Acting as the reviewer for a PHMS peer (see section on Individual Peer Review)

20.7 Teaching

Teaching students, PHMS, registrars, and other health professionals, and tutoring and coaching of groups.

Criteria	Points	Evidence Required
• Must have a public health focus. • Do not record essentially the same presentation more than once per year even if given multiple times.	1 per half hour teaching time Maximum 20 points per year	Evidence of: • Teaching hours • Public health content Examples: • Copy of teaching timetable with contribution clearly marked • Letters or emails from the organisers (if given outside of an institutional setting) confirming the teaching session and its length

[32] As defined by the MCNZ

LIST OF APPENDICES

Appendix 1: Competencies List

The Public Health Medicine competency list includes 116 competencies grouped into 15 areas. The list is reproduced below. Further detail on each of the competencies can be found in the NZCPHM Competencies for CPD document available on the TOPS section of the College members website (https://nzcphm.org.nz/).

Professional development and self-management competencies

1.1 Ability and commitment to manage one's own training and continuing professional development
1.2 Ability to establish and maintain career direction and motivation
1.3 Ability to manage time and workload to achieve organisational and professional goals
1.4 Ability to optimise one's personal health
1.5 Ability and commitment to practise in a safe manner
1.6 Ability and commitment to work in an ethically sound manner
1.7 Ability and commitment to advocate for timely effective action in response to important threats to public health
1.8 Ability and commitment to practise in a manner that promotes a sustainable physical and social environment
1.9 Ability and commitment to use evidence as the basis for public health practice
1.10 Ability to provide effective first aid in emergency situations

Communication, leadership and teamwork competencies

2.1 Ability and commitment to establish highly effective working relationships with colleagues
2.2 Ability to lead and influence effectively
2.3 Ability and commitment to contribute effectively to multidisciplinary teams
2.4 Ability to contribute effectively to organisational processes
2.5 Ability to support the professional development of colleagues and more junior staff
2.6 Ability to manage projects effectively
2.7 Ability and commitment to consult effectively with others in a range of settings
2.8 Ability to communicate effectively using written and electronic media
2.9 Ability to communicate effectively through oral discussion and presentations
2.10 Ability to communicate effectively using the mass media

Māori health and te Tiriti o Waitangi competencies

3.1 Ability to advise on the public health issues affecting Māori
3.2 Ability to analyse public health issues from a Tiriti o Waitangi perspective
3.3 Ability and commitment to share power authentically and work in partnership with Māori
3.4 Ability and commitment to promote Māori leadership and self-determination
3.5 Ability to challenge organisations and individuals in the New Zealand health system on their achievement of te Tiriti o Waitangi obligations

Health equity competencies

4.1 Ability to advise on the public health issues affecting groups who experience inequities in New Zealand
4.2 Ability to communicate effectively with people of all 'cultures'
4.3 Ability to contribute effectively to culturally diverse teams in order to achieve health equity
4.4 Ability and commitment to establish effective partnerships with groups who experience inequities to achieve improved public health outcomes
4.5 Ability to plan, analyse, research, and evaluate public health issues from a health equity lens in order to achieve health equity

Note that culture is broadly defined and includes groups defined by ethnicity, gender, gender identity, age, disability, sexual orientation, religious and spiritual beliefs, socioeconomic status, occupation, geographic region or lifestyle.

Culturally safe practice competencies

5.1 Ability and commitment to manage one's own development of culturally safe practice
5.2 Ability to continuously examine the potential impact of one's own culture and bias on own practice
5.3 Ability and commitment to take patient and community feedback into account to ensure culturally safe practice
5.4 Ability to develop and implement policy, proposals and programmes from a pro-equity and anti-racist perspective

Public health information and critical appraisal competencies

6.1 Ability to plan and deliver effective analyses of public health issues
6.2 Ability to rapidly assess and respond to urgent public health questions
6.3 Ability to store and swiftly access essential public health information
6.4 Ability to conduct effective literature reviews
6.5 Ability to critically assess published literature and other evidence
6.6 Ability to use suitable information sources to describe the health of populations
6.7 Ability to analyse and communicate the risk of adverse events in a meaningful way
6.8 Ability to advise on health and public health information systems
6.9 Ability to design and evaluate disease and hazard surveillance systems
6.10 Ability to design and evaluate screening programmes
6.11 Ability to advise on major public health determinants and inequalities
6.12 Ability to advise on the public health issues affecting age and gender groups
6.13 Ability to advise on the optimal public health response to specific health issues
6.14 Ability to advise on the implications of international events for public health

Public health research and teaching competencies

7.1 Ability to design and conduct effective research studies
7.2 Ability to design sound observational epidemiological studies
7.3 Ability to advise on trials to measure the effectiveness of interventions
7.4 Ability to design and manage data collection for studies

7.5 Ability to perform suitable epidemiological analyses
7.6 Ability to analyse and interpret the spatial distribution of health-related events
7.7 Ability to analyse alternative disease prevention and control strategies in a quantitative manner
7.8 Ability to use qualitative methods to investigate public health issues
7.9 Ability to teach effectively
7.10 Ability to support an effective research base for public health

Health care and public health programme evaluation competencies

8.1 Ability to evaluate health services and public health programmes
8.2 Ability to implement the results of evaluations to improve health services and public health programmes
8.3 Ability to evaluate health technologies and interventions
8.4 Ability to monitor access to and use of health technologies and interventions

Policy analysis, development and planning competencies

9.1 Ability to develop and influence policy to improve public health and reduce inequalities
9.2 Ability to conduct health needs assessments to inform policy
9.3 Ability to conduct health impact assessments
9.4 Ability to conduct priority setting processes to inform policy
9.5 Ability to develop and use goals, targets and indicators
9.6 Ability to manage policy implementation effectively
9.7 Ability to analyse policy and proposals from an economic perspective
9.8 Ability to analyse policy and proposals from an equity perspective
9.9 Ability to analyse policy and proposals from an ethical perspective

Health promotion and community development competencies

10.1 Ability to apply a health promotion approach to analysing public health problems
10.2 Ability to develop health promotion programmes in response to public health problems
10.3 Ability and commitment to enable individual and community participation in health promotion
10.4 Ability to establish effective partnerships and inter-sectoral action to achieve improved public health outcomes
10.5 Ability to advocate for action to respond to public health problems
10.6 Ability to advise on development of health educational material

Health protection and risk management competencies

11.1 Ability to advise on the public health management of environmental health risks
11.2 Ability to analyse surveillance data to support the management of environmental health risks
11.3 Ability to use regulatory measures to protect and promote health
11.4 Ability to use regional and local planning processes to protect and promote health

11.5 Ability to advise on protecting and promoting health in important settings
11.6 Ability to work with other agencies to manage imported hazards
11.7 Ability to manage public health emergencies (arising from natural disasters or environmental means)
11.8 Ability to investigate and manage clusters of non-infectious disease cases
11.9 Ability to conduct environmental health risk assessments
11.10 Ability to manage environmental health risks
11.11 Ability to communicate environmental health risk information effectively to the public and other groups

Infectious disease prevention and control competencies

12.1 Ability to advise on the public health management of infectious diseases
12.2 Ability to analyse surveillance data to support prevention and control of infectious diseases
12.3 Ability to manage infectious disease control measures
12.4 Ability to investigate and manage infectious disease outbreaks
12.5 Ability to develop and implement effective inter-sectoral strategies for prevention of infectious diseases

Chronic disease, mental illness and injury prevention competencies

13.1 Ability to advise on the public health management of chronic diseases, mental illness and injury
13.2 Ability to advise on the determinants of chronic disease, mental illness and injury and their public health management
13.3 Ability to analyse surveillance data to support the management of chronic diseases, mental illness and injury
13.4 Ability to advise on the public health response to alcohol, tobacco and other drugs
13.5 Ability to advise on the public health implications of genetic factors and technologies
13.6 Ability to develop and implement effective inter-sectoral strategies for prevention of chronic diseases, mental illness

Health sector development competencies

14.1 Ability to promote a population health approach within the health and disability care sector
14.2 Ability to influence clinical staff to adopt a population health approach
14.3 Ability to produce and implement best practice guidelines for the clinical and public health sectors practice
14.4 Ability to advise on optimal development and operation of the primary health care sector
14.5 Ability to advise on optimal development and operation of secondary and tertiary health services
14.6 Ability to plan developments or changes to health services
14.7 Ability to advise on health service needs of rural and remote areas
14.8 Ability to advise on health sector workforce planning

14.9 Ability to manage contracting processes for purchase or provision of services
14.10 Ability to develop and implement quality improvement programmes for health services
14.11 Ability to investigate and manage serious adverse events and complaints about health services, programmes, and practitioners
14.12 Ability to advise on strategies to address disability

Organisational management competencies

15.1 Ability to apply effective management principles to public health and other relevant organisations
15.2 Ability to advise on organisational governance issues
15.3 Ability to facilitate strategic and business planning
15.4 Ability to manage staff
15.5 Ability to manage budgets
15.6 Ability to manage organisational changes
15.7 Ability to manage an organisation, health service or business unit

Appendix 2: Code of Health and Disability Services Consumers' Rights[33]

Consumers have Rights and Providers have Duties:

1) Every consumer has the rights in this Code.

2) Every provider is subject to the duties in this Code.

3) Every provider must take action to -

a) Inform consumers of their rights; and

b) Enable consumers to exercise their rights.

Rights of Consumers:

The rights of consumers under this Code are as follows:

Right 1: The right to be treated with respect

Right 2: The right to freedom from discrimination, coercion, harassment, and exploitation

Right 3: The right to dignity and independence

Right 4: The right to services of an appropriate standard

Right 5: The right to effective communication

Right 6: The right to be fully informed

Right 7: The right to make an informed choice and give informed consent

Right 8: The right to support

Right 9: Rights in respect of teaching or research

Right 10: The right to complain

[33] Health and Disability Commissioner. Code of Health and Disability Services Consumers' Rights Regulations. Wellington:1996. https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

Appendix 3: Māori health, health equity and cultural safety resources

Guiding questions to reflect on Māori health, health equity and cultural safety

The guiding questions below are intended for use by public health medicine specialists in critical reflection on their practice, to employ during research and presentations and to discuss with their peer review group. Not all questions will be relevant to every scenario, and the questions are not exhaustive.

Awareness

- Are there any inequities in health outcome in this topic area?
- How could colonialism, power imbalance and racism, including ongoing institutionalized racism, have contributed to the inequity? How does this relate to me personally?
- What are my own cultural beliefs, assumptions and values in relation to this work? What unconscious attitudes may affect these?

Knowledge

- Have I researched what may contribute to any inequities? What have I found?
- How have I listened to what the groups most affected have to say?
- How have I considered te Tiriti o Waitangi issues in my analysis? How have I incorporated the Tiriti principles of partnership, protection, equity and options in this work?

Skills

- How am I involving the people who are most affected by the inequity? Have I created a partnership that is meaningful?
- Do I introduce myself, explain who I am and where I come from, and offer to provide feedback? Can I do this in a way that is appropriate and courteous to the particular person/group?
- What did I learn and what will I do differently in the future?

Additional Resources[34]

The section below lists some resources for the development of cultural safety and competency and guidance available to health practitioners in Aotearoa New Zealand. See also the Cultural Safety and Health Equity Learning Resources webpage on the member website.

1. Te Ohu Rata o Aotearoa (Te ORA) & Te Kaunihera o Ngā Kāreti Rata o Aotearoa – Council of Medical Colleges (CMC) New Zealand Cultural Safety Training Plan for Vocational Medicine in Aotearoa

[34] The resources and readings list will be continually updated. Please visit the website for the latest version of this document.

(https://www.cmc.org.nz/media/4xmpx1dz/cultural-safety-training-plan-for-vocational-medicine-in-aotearoa.pdf)

2. Manatū Hauora - Ministry of Health: Learn Online Free courses on cultural competency, Hauora Māori governance and understanding bias in healthcare (https://learnonline.health.nz/)
3. Mauriora Foundation Course in Cultural Competency Māori (https://members.mauriora.co.nz/course/foundation-course-in-cultural-competency-maori/)
4. Diversity Works New Zealand Introduction to Unconscious Bias Workshop (https://diversityworksnz.org.nz/events-training/)
5. Dr Heather Came and Associates Pursuing Racial Justice. Public Courses. (https://www.heathercameassociates.com/general-clean)
6. Te Pumaomao Indigenous Nationhood Building Course (https://takawai.com/)
7. Network Waitangi (https://nwo.org.nz/)
8. Treaty Resource Centre He Puna Mātauranga o te Tiriti (https://www.trc.org.nz/educational-resources)
9. TUHA-NZ A Treaty Understanding of Hauora in Aotearoa-New Zealand – The Health Promotion Forum Runanga Whakapiki ake i te Hauora o Aotearoa (https://hauora.co.nz/tuhanz-treaty-understanding-of-hauora-in-aotearoa-new-zealand/)
10. Te Tiriti o Waitangi-based Practice in Health Promotion - STIR: Stop Institutional Racism Aotearoa-NZ (https://trc.org.nz/sites/trc.org.nz/files/ToW%20practice%20in%20HP%20online.pdf)

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Waitangi Tribunal. Hauora Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry Wai 2575. Lower Hutt: Waitangi Tribunal, 2019. (https://www.health.govt.nz/maori-health/wai-2575-health-services-and-outcomes-inquiry)

Appendix 4: Cultural Safety Reflection form

Cultural Safety Reflection form

This Cultural Safety Reflection Form is developed from the Te ORA / Council of Medical College's Cultural Safety Framework.[35] The Framework identifies cultural safety as one of the three dimensions of vocational medical education that contribute to optimal Māori health: cultural safety, cultural competence and Hauora Māori (see Figure 1 below).

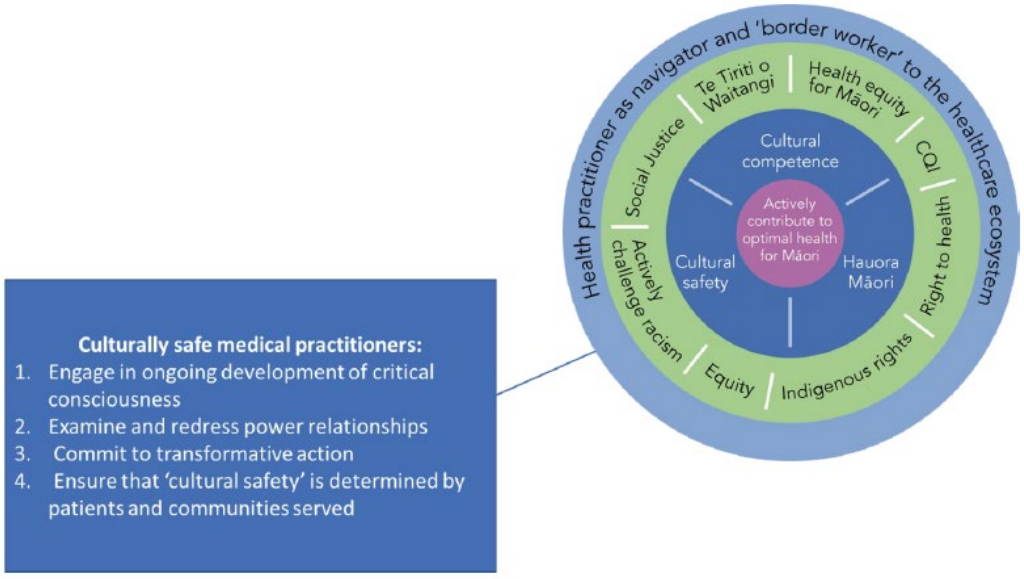


Figure 1: Conceptual framework for optimal health for Māori in Aotearoa, with cultural safety key proficiencies[1]

The Framework describes the components that support the development of a culturally safe medical practitioner by identifying four 'key proficiencies' of cultural safety, as shown in the figure above. Each key proficiency has five enabling proficiencies. These are shown in the table below and can be used as a tool for reflection and self-assessment.

To complete this form, take a moment to reflect on how you can demonstrate the ways in which you've achieved each of these proficiencies.

By reflecting on these proficiencies, you'll be able to recognise areas where you can improve. A self-assessment rating tool is provided at the end of the document.

[35] Te ORA | Council of Medical Colleges. Cultural safety training plan for vocational medicine in Aotearoa. Wellington: Council of Medical Colleges. January 2023. (https://www.cmc.org.nz/resources/publications)

Cultural Safety Reflection form
Proficiency 1. Culturally safe medical practitioners engage in ongoing development of critical consciousness
1.1 Demonstrate understanding of your own cultural heritage, values, and history. **1.2** Identify and address your own biases, attitudes, assumptions, stereotypes, prejudices, privileges, and characteristics that may affect the quality of healthcare you provide. **1.3** Engage in ongoing self-reflection and self-awareness of own conduct and interactions to identify and remedy oppressive practices in interactions with patients, whānau and communities. **1.4** Engage in ongoing self-reflection and self-awareness of own conduct and interactions with colleagues in the workforce to uphold culturally safe spaces. **1.5** Commit to transformative change and identify and implement alternative personal practices that contribute to equity and ongoing progression towards optimal health for Māori.
Summary of development and achievement of this skill (note areas for further development):
Proficiency 2. Culturally safe medical practitioners examine and redress power relationships
2.1 Recognise and advocate for the rights of patients, whānau, communities and tangata whenua. **2.2** Examine and redress power imbalances between yourself and patients, whānau, the community, and tangata whenua. **2.3** Relinquish and leverage your own power to develop reciprocal relationships with patients and their whānau to foster shared decision making and informed consent throughout treatment. **2.4** Examine and redress power imbalances within the healthcare profession and workforce. **2.5** Examine and influence power imbalances in the institution or organisation you work for, and the wider healthcare ecosystem.
Summary of development and achievement of this skill (note areas for further development):
Proficiency 3. Culturally safe medical practitioners commit to transformative action
3.1 Analyse and critique the healthcare ecosystems and its structures and processes that reinforce health advantage and disadvantage. **3.2** Identify structural barriers to equitable, culturally safe care within the institution or entity you are employed by. **3.3** Analyse and critique the culture and relationships amongst colleagues in your workplace and identify oppressive elements in workplace culture, and support colleagues on the journey of cultural safety. **3.4** Examine health outcomes for Māori patients in clinical audit and case reviews, and identify interventions to eliminate inequities, and progress towards optimal health. **3.5** Identify solutions to structural and institutional barriers, and contribute to, implement, and embed transformative change.
Summary of development and achievement of this skill (note areas for further development):

Proficiency 4. Culturally safe medical practitioners ensure that 'safety' is determined by patients & communities
4.1 Make provision for regular feedback and input from patients, whānau and communities on the cultural safety of the healthcare environment, interactions and care provided. **4.2** Advocate for your workplace to ensure regular feedback and input from tangata whenua/mana whenua on the cultural safety of the healthcare environment and interactions. **4.3** Implement recommendations from patients, whānau, and communities, and tangata whenua, in personal practice. **4.4** Identify and critique research and information that draws on a diverse range of patient perspectives and experiences, to shape policy, practice, and healthcare interactions. **4.5** Identify kaupapa Māori research that represents tangata whenua perspectives and experiences, to shape policy, practice, and healthcare interactions
Summary of development and achievement of this skill (note areas for further development):

Self-assessment rating tool

I'M AWAKE TO THIS	I'M INTO THIS	I'VE GOT THIS
This signifies an awakening or raising of awareness and understanding, and early stages of the development of knowledge and skills, and of identifying transformative changes needed.	This indicates deeper understanding and the beginning of transformative action, putting into practice behaviours and actions that support and promote cultural safety.	This signifies normalising and habitualising practices that promote cultural safety, and that these practices have become embedded. It does not signal an 'end point' but indicates the continuing pursuit of advancement and growth.
Practices observed at this stage of development include: - Developing critical analysis skills - Recognising and identifying where change is needed (internal, interpersonal, structural).	Practices observed at this stage of development include: - Acting on opportunities to create change (internal, interpersonal, structural) - Initiating and contributing to transformative change	Practices observed at this stage of development include: - Embedding transformative change as normalised practice (internal, interpersonal, structural) - Regularly reflecting on, reviewing and refining practices

Appendix 5: Guidelines for the Professional Development Plan

1. Aims of the Professional Development Plan (PDP)

1. To help you clarify your career direction, reflect on feedback you have received, and identify the competencies you need to develop.
2. To help you plan work and educational activities to develop the competencies you need to meet your TOPS requirements.
3. To help you reflect on cultural safety, self-awareness, critical consciousness.
4. To provide a basis for you to obtain effective input from your peers through individual and group peer review processes.
5. Plan to meet your recertification requirements.

2. Process for Completing the PDP

The College proposes that you prepare and fully review your PDP each year using the annual planning cycle shown in *Figure 1.* The suggested steps in this planning cycle are: (a) plan professional development, (b) implement plan, (c) monitor progress and review performance, and (d) TOPS reporting.

(a) Plan Professional Development

Complete the PDP template[36] (or relevant alternative) at the start/end of each year. The process involves the following three steps:

1. Review the previous year and set direction

- Summarise the range of information sources being used (section 3) of the template.
- Summarise key feedback and lessons learned from the previous year, including barriers that prevented the completion of the previous plan (section 4)
- Review career goals (section 5)
- Review competencies needing development (section 6). This step would be supported by the separate document *Competencies for public health medicine training and practice in New Zealand.*[37]
- Review the four TOPS categorical point requirements and ascertain areas needing attention to meet triennium requirements.

2. Plan for the coming year

- Plan to undertake high impact activities. Ask "why am I planning to do this activity and what will be the impact on my practice?"
- Ask "what am I not doing, particularly in relation to advocating for Māori and unconscious bias?"
- Record planned activities for developing competencies in the current year, notably education activities and specific work outputs (section 10)
- Plan training and work to develop cultural safety and health equity (section 7)

[36] The PDP Template can be found on the member section of the College website: https://nzcphm.org.nz

[37] Competencies for public health medicine training and practice in New Zealand can be found on the College website at: https://nzcphm.org.nz

- Plan work to measure and improve public health outcomes, using TOPS categories (section 9)
- Plan reflective practice activities (section 8)
- Plan work towards successful completion of TOPS categorical points requirements before the close of the triennium.

3. Discuss with usual peer review group or individual reviewer

Discuss with usual peer review group or individual reviewer and record date and name of review group or reviewer (section 2). If using your peer review group, this process may be best done using a single member of the peer review group.

It is useful to consider what you are not doing or what could be done, or what could be done differently to greater effect.

(b) Implement plan

Implement agreed continuing education, cultural safety and health equity, measuring and improving outcomes and reviewing and reflecting on practice. This is a living document to be revisited regularly and progress checked.

(c) Monitor progress and review performance

Monitor progress and seek feedback during the year, particularly from

- Clients and Chief Executives (employers)
- Community and Consumers, particularly Māori Consumers
- Co-workers
- Colleagues through peer review group or individual peer-reviewer

(d) Record activities

Record activities on TOPS database and monitor progress towards TOPS targets during the year.

Review the PDP (or appropriate alternative) at the end of each year to assess what was achieved and what lessons were learned. Progress should be discussed with your usual peer review group or individual reviewer. Record date and name of review group or reviewer (section 2)

The final step is to consider input into next year's PDP.

Sources of input for reviewing and planning PDP

You are encouraged to use a wide range of inputs to guide your PDP planning and reviewing. The following list, the Eight "Cs", includes sources that will be relevant for most Fellows:

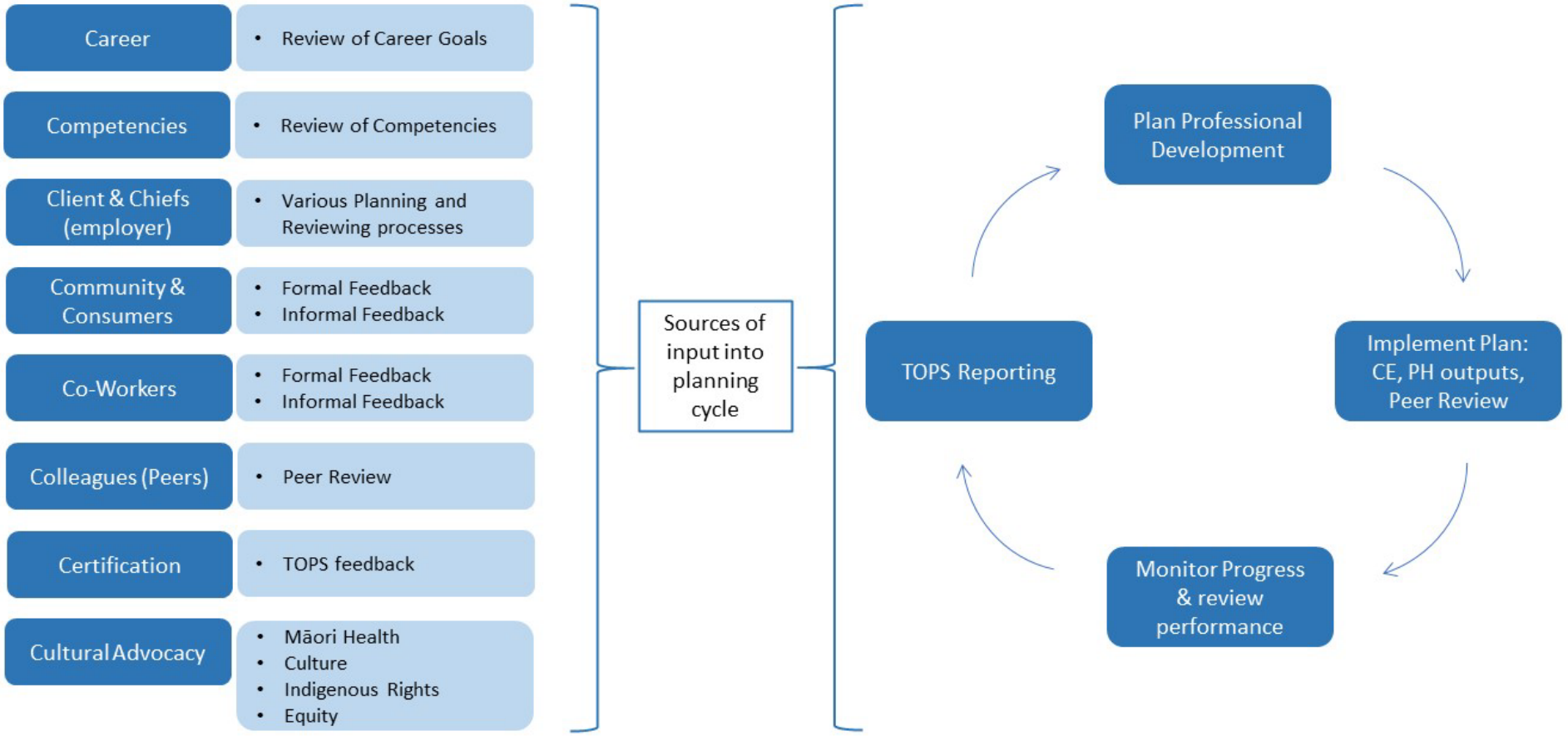
Career	Where you are going, including consideration of your personal goals and input from your wider network of family and friends
Competencies	The skills you need to achieve your professional goals
Clients and Chief Executives	Input and expectations from your clients and chief executives (employers)
Co-workers	Input from other team members

Community and Consumers	Input from the communities and people who use the services and outputs you produce
Colleagues	Input from your peers
Certification	Requirements from the Medical Council of New Zealand to demonstrate CPD, notably through TOPS
Cultural Advisor	Input from Māori advisors

Relationship to Workplace PDP

The College acknowledges that you may undertake similar professional development planning processes as part of your annual performance appraisal as an employee. You are encouraged to minimise duplication and use one process to cover both TOPS and appraisal where possible.

Figure 1. PDP for public health medicine specialists: Sources of input and planning cycle



Appendix 6: Template for the Professional Development Plan

Professional Development Plan Template for Public Health Medicine Specialists

1. Personal Details

Full name: Click or tap here to enter text.

Current work position(s): Click or tap here to enter text.

2. Plan Preparation and Review (for TOPS record)

Year plan relates to: Click or tap here to enter text.

Date plan prepared and reviewed (start of year): Click or tap here to enter text.

Name of reviewer (start of year): Click or tap here to enter text.

Date progress reviewed (end of year): Click or tap here to enter text.

Name of reviewer (end of year): Click or tap here to enter text.

3. Information Sources Referred to in Preparing this Plan

Information source	Used
Career (identified career goals, see section 5)	☐
Competencies (review of PHMS competencies checklist, see section 6 and 7)	☐
Clients & Chiefs (review of input & expectations of employers/clients)	☐
Co-workers (review of input from other team members)	☐
Community & Consumers (review of input from community & consumers of your work)	☐
Colleagues (review of input from peer review group or individual peer reviewer)	☐
Cultural Advisor (consideration of discussion/s with a cultural advisor)	☐
Certification (review of TOPS progress & MCNZ requirements)	☐
Other review process (specify below)	☐

Click or tap here to enter text.

4. Reflect on the previous year to identify any practice issues or knowledge gaps

For example: An incident occurred which indicates I need to improve my communication skills.

Consider also what changes you have made to your practice to increase your cultural safety, improve Māori health and address equity in health outcomes over the past year, and what you could have done differently.

Click or tap here to enter text.

5. Identified Career Goals

Consider your career goals and how these might inform your TOPS activities for the coming years.

For example: In one year's time I want to be working with Manatū Hauora in the area of infectious disease control. In five years' time I want to be in charge of the people doing the role I started out in. In ten years, I want to be in charge of infectious disease control nationally and possibly also throughout the Pacific. Now: what things do I need to do/knowledge do I need to have to achieve these?

Click or tap here to enter text.

6. Health equity

What will you do differently this year to increase equity through your work?

- Think about ways you can partner with groups who experience inequities to achieve improved public health outcomes
- Think about how to include a health equity lens in your public health analyses and practice

Click or tap here to enter text.

7. Planned activities for the year ahead

Identify competencies required for your planned professional activities and those requiring further development from the *Competencies for public health medicine training and practice in New Zealand.*

7.1 Cultural Safety, Māori health and health equity

Competency	TOPS activities planned for the current year	Achieved Yes/ In progress/ No

7.2 Reflection on Practice

Competency	TOPS activities planned for the current year	Achieved Yes/ In progress/ No

7.3 Measuring and Improving Outcomes

Competency	TOPS activities planned for the current year	Achieved Yes/ In progress/ No

7.4 Educational Activities

Competency	TOPS activities planned for the current year	Achieved Yes/ In progress/ No

Appendix 7: Guidelines for the Annual Workplace Review

Background and process

An Annual Workplace Review is a structured conversation with a peer, colleague or employer about professional practice. Its objectives are:

1. to provide time for reflection on professional practice over the last year;
2. consider how your Continuing Professional Development (CPD) activities have informed that practice;
3. contemplate what professional practice will be taken in the next year; and
4. identify developmental needs and competencies required for that practice.

It is a time to reflect on the highlights and challenges of the past year. It also allows an opportunity to receive constructive feedback using a constructive CRC (Commend, Recommend, Commend) process that leads to constructive planning for both work practice and professional development in the coming year.

When considering CPD activities it is useful to ask "Why am I planning to do" that activity (or in review, "Why did I do that activity")? That helps to choose high value CPD activities. It is useful to consider cultural safety and health equity when choosing CPD activities so that these can be integrated into practice.

In the Review the practitioner can reflect on their satisfaction in their current role, career direction to date and discuss their career aspirations. If a change in career has been identified, this can be discussed with your colleague.

If any health or wellbeing issues have arisen, it is a time to work out how these can be addressed and how work practices might be adjusted to mitigate them.

At the end of the Review the work programme and performance targets for the coming year can be set along with the Continuing Professional Development activities to support that work. If a change in career direction has been identified, support can be given to pursue that.

Complete the template before your Annual Workplace Review meeting so that this can provide a basis for the discussion. Afterwards, record what was discussed and keep this for your records.

Outcome of the Annual Workplace Review

- Learning requirements going forward
- Work programme for the next year
- Professional Development Plan updated for coming year
- Career development plan

Documentation used to inform the Annual Workplace Review

- Work programme or job description
- Review of work over the year (informal Annual Report)
- TOPS activities for past year
- Multi Source Feedback Report
- TOPS Manual
- Completed Public Health Medicine Competencies checklist
- Professional Development Plan

Documentation of the Annual Workplace Review

It is useful to document the Review under the headings:

1. Highlights and challenges in past year
2. CPD activities over last year
3. Value of those CPD activities to work practice
4. Contribution of practice and CPD to cultural safety, health equity and Māori health
5. Future work plan
6. Future CPD activities to support that work plan
7. Career direction
8. Health and wellbeing

A suggested template for the Annual Workplace Review discussion is provided in Appendix 8

A record of the Review, including the elements listed above, should be kept in case of audit.

Appendix 8: Template for the Annual Workplace Review

Annual Workplace Review Template for Public Health Medicine Specialists

Guidelines for conducting the Annual Workplace Review are available in the TOPS Manual.

Note: to 'tick' the boxes, double click on the box and select *checked* from the pop-up menu.

1. Details	
Date:	
Time:	
Location:	

2. Doctor Details	
Full Name:	
Employer:	
Current work position(s):	
Length of employment:	
Address:	
Email:	
Phone:	

3. Peer Details	
Full Name:	
Employer:	
Current work position(s):	
Address:	
Email:	
Phone:	

4. Documentation required prior to Review

Doctor to supply documents	Provided	Not provided
Work programme or job description	☐	☐
Review of work over the past year	☐	☐
TOPS activities for the past year	☐	☐
Multi Source Feedback report (MSF)	☐	☐
TOPS Manual	☐	☐
Completed Public Health Medicine Competencies checklist	☐	☐
Professional Development Plan (PDP)	☐	☐
Any other documentation (please specify):	☐	☐

5. Highlights and challenges over the past year

What aspects of your work achieved the best outcomes? Why were they successful? What can you take from these learnings to build into your work practices next year? What aspect of your work this year did not go as well as hoped? Why did this happen? What are the opportunities for improvement or changes in your practice that you can make in response to these learnings for next year?

6. TOPS activities over the past year

Why did you choose to do those activities? What was the value of these TOPS activities to your work practice?

7. Contribution of practice and TOPS activities to Māori health, health equity and cultural safety

How have your practice and TOPS activities contributed to Māori health and promoted health equity? How have your practice and TOPS activities increased your own cultural safety and cultural safety in your workplace?

8. Future work plans

What are your plans for the coming year?

9. Future TOPS activities to support that work plan

Is there any training or education you require to achieve the activities outlined in your future work plan?

10. Career direction

What are your career goals and is there anything you specifically need to do to get there?

11. Health and wellbeing

What will you do to ensure your own health and wellbeing are looked after?

Appendix 9: Guidelines for Peer Review Groups

The following guidelines may assist Peer Review Groups with managing and administrating the group.

Administration and ground rules

Group membership:

- Group size should be 4-12; exemptions may be granted by the Director of CPD
- The College office maintains a register of peer review groups, please notify the College office of any changes to your peer review group membership by emailing tops@nzcphm.org.nz
- We encourage participants to have the majority of meetings with the same peer review group

Administration:

- Date of meeting e.g., 3rd Friday in the month
- Time of meeting e.g., Start at 2pm (1.5 -2 hours)
- Contact person for the group whose name will be listed on the Peer Review Group list and who may be contacted by the College
- Physical arrangements (e.g., face to face / face to face with 1-2 participants phoning in / virtual / audio. If virtual, who will initiate call)
- Contact person / convenor will email a reminder to all members within one week prior to meeting, asking for an indication of attendance, and confirming any formal presenters
- Contact person / convenor will keep a note of attendances and topics covered and will circulate this for TOPS recording
- Determine a process for nominating convenor for each meeting

Meeting process:

- Each peer review session will have a convenor, whose role is to support robust group processes including keeping time, assisting discussion, and maintaining a focus on reflection and constructive criticism of practice
- Aim to have at least two topics discussed at each meeting (adapt as required)
- Meetings start with a brief update from each participant
- Where appropriate have the group reflect on cultural safety, Māori culture and health equity
- Meetings finish with a brief review of topics covered and any learnings / insights / changes to practice as a result of the meeting
- Consider how the discussion contributes to a 'shift in attitude' of the participants positively

Ground rules:

- The purpose of the group is for members to be able to present aspects of their work for reflection, review and constructive criticism
- All participants are required to present examples of their own work for review by the group at least once per year
- Groups should aim to have an open and supportive environment in which members feel safe to present their work, including any difficulties, honestly
- Any conflicts of interest with other group members must be declared
- If there is a conflict of interest, the individuals should resolve including how such a conflict can be managed: this may mean some topics are off limits
- Discussions are confidential
- Members will attempt to attend each session
- Feedback is thoughtful and constructive

- Decision to accept a new member is by consensus (keeping in mind the potential for conflict of interest as well as the need for a variety of perspectives)
- Members of the group will be available to review each other's Professional Development Plans
- In the unlikely event that serious concerns about a colleague (ethical, health, competence) are identified through the peer review group process, these will be raised with the colleague first, and support offered. If it is necessary to take the concern beyond the group, the colleague will be informed.

Information to provide to the College

Please inform the College Office (tops@nzcphm.org.nz) of any new Peer Review Groups. We ask that you provide the following information:

- Name of group
- Name of contact person
- List group members' names with contact information (contact information of members will not be posted online)
- Meeting times and physical arrangements
- Whether or not the group is open or closed for new members

Please also notify the College of any updates/changes to a Peer Review Group.

Template for Meeting Dates and Record

Name of group:

Contact person:

Peer review group meetings (Year):

Updated (date) by contact person:

Meeting date	Duration	Attendees	Presenter, practice issue discussed

The College encourages all participants to keep upload hardcopy evidence (i.e., printed version of emails) of peer review group meeting dates and times, attendance and discussions to produce in the event of an audit.

Appendix 10: Instructions for NZCPHM Multisource Feedback Tool

The College is required by the Medical Council of New Zealand to provide Multisource Feedback (MSF) process in the TOPS programme. The College provides an MSF review process specifically created for the public health medicine specialist (PHMS) scope of practice for TOPS participants.

The NZCPHM MSF process strengthens the 'reviewing and reflecting on practice' TOPS category by providing evidence about your practice to inform your professional development.

1. Background

The MSF process in brief is as follows:

- Find a professional mentor who can guide you through the process. Your mentor should ideally, but not necessarily, be a Public Health Medicine Specialist.
- Nominate a number of respondents who agree to comment on your practice who will be sent a standardised electronic questionnaire
- Information from respondents is collated and anonymised electronically
- Participants fill in the self-evaluation page of the MSF Reflection Form
- Collated feedback is sent to the participant and their mentor
- Feedback includes a comparison of results with norms for PHMS

The MSF process encourages feedback from a variety of respondents including colleagues and 'end-users' and includes a template to help the participant reflect and act on the findings.

2. Find a Mentor

Find a professional mentor who can guide you in the process and with whom you can discuss and reflect on the feedback received. This mentor can be the same colleague who reviews your PDP but should not participate as a respondent in the survey.

3. Selecting respondents

We recommend that you discuss the selection of respondents with your nominated mentor. You should choose respondents who have sufficient knowledge of your professional practice to make a meaningful assessment.

We suggest choosing at least five colleagues and at least five end-users (who are somewhat equivalent to the 'patient group' who are a feature of MSF evaluations used by clinicians). Choose people from a range of perspectives, both colleagues and end-users. Examples of these include:

Colleagues: Where your work relationship is predominantly peer-to-peer:

- Public health medicine specialist colleague in your workplace
- Non-public health medicine specialist colleague in your workplace
- Public health medicine specialist colleague at a different workplace[38]
- Non-public health medicine specialist colleague at a different workplace
- Member of your Peer Review Group
- Person with another professional relationship with you

[38] Different workplaces will usually be based at different organisations. However, for some large organisations like DHBs, different workplaces could be within the same organisation. For example, a 'funding and planning' unit would be a different workplace to a 'public health service'.

End-users: Where your work relationship is predominantly based on you providing them with definable public health medicine specialist services:

- Manager or supervisor you report to
- Person you manage or supervise[39]
- End-user of papers, reports, presentations, advice you produce
- Chair or member of an advisory group or board you are on
- Representative of an organisation you work with
- Representative of a community group you work with
- Journalist you provide information and comment to

4. How it works

You will be asked to nominate respondents: contact at least 10 respondents (we recommend you ask more) who are willing and able to provide feedback on your practice are approached. A maximum of 50 respondents can be nominated; the more questionnaires that are completed the more reliable the feedback and the less impact any outlier scores will have.

The respondents you nominate will be sent an email asking them to complete an online questionnaire which assesses your public health knowledge, communication and organisational skills as well as aspects of your probity and health.

All individual responses are anonymous.

If your nominated respondents fail to respond within a reasonable time, you may nominate additional respondents. You are not required to have responses from all your nominated respondents to complete the assessment phase, just a minimum of 5.

Once the process is initiated, you will have one month to complete it.

When at least 5 respondents have completed the questionnaire, you may opt to close off the assessment phase (or you may choose to wait until more questionnaires have been completed before you close off).

Once the assessment phase is closed, a report will be generated and posted in your profile. This report will contain the aggregated results of the completed questionnaires. The report will also be emailed to your nominated mentor.

Before opening the report from respondents, complete the self-evaluation page of the MSF Reflection Form.

5. Interpreting your report

Before obtaining your survey results, you should complete the self-evaluation page of the MSF Reflection Form (available on the College members website). This form asks you to rate yourself on the same questions as asked of your survey respondents and will allow you to compare your own perceptions with those of others.

[39] Most organisations have defined line-management relationships for key functions, such as periodic performance reviews. We suggest you try to include your main line-manager as an MSF respondent as well as one or more people you manage in this way. You may also want to include others where you have a supervisory relationship, particularly if you are not directly managing staff.

Take time to analyse your report with your nominated mentor using the MSF Reflection Form (https://nzcphm.org.nz/).

6. Acting on the results

Once you have had the opportunity to reflect on the report, and to discuss the results with your nominated mentor, you should consider what action if any you wish to take as a result of the feedback you have received.

It is recommended that any action you intend to take as a result of the feedback you have received should be incorporated into your Professional Development Plan as a specific goal/s.

7. Additional Support

If you would like to discuss your report, or obtain advice regarding the process, you can contact the Director of Continuing Professional Development (via the College office, tops@nzcphm.org.nz).

The NZCPHM MSF Questionnaire and Related PHMS Competencies

	MSF Questions for PHMS	PHMS Competencies
Please indicate how far you agree with the following statements: **Scale: Strongly disagree, Disagree, Neutral, Agree, Strongly agree, Don't know**		
	A. Self-management	
1	Recognises own strengths and weaknesses, and works within limitations	1.5
2	Reviews and reflects on own performance, open to feedback, acknowledges mistakes, seeks constant improvement	1.1, 1.2
3	Keeps knowledge and skills up to date	All
4	Documents and records work activities effectively	1.5
5	Manages time effectively including timely delivery of outputs	1.3, 2.6
	B. Communication, Teamwork and Leadership	
6	Uses effective written, oral, electronic and mass media communication	2.8, 2.9, 2.10, 7.9
7	Provides strategic leadership, including awareness of the bigger picture and goals, openness to new ideas, innovative, flexible	2.2
8	Leads and influences effectively, including inspiring others, acknowledging contributions	2.2
9	Manages projects effectively including coordination, prioritisation, delegation, problem solving, dealing with uncertainty, realistic expectations, accountability	2.6
10	Works effectively with colleagues, including respectful behaviour, fairness, kindness, effective listening, commitment to resolving interpersonal problems	2.1
11	Works effectively with multi-disciplinary teams and organisations, fosters an inclusive, open work environment	2.2, 2.3, 2,4
12	Supervises colleagues effectively and supports their professional development	2.5
	C. Cultural safety, health equity and Māori health	
13	Demonstrates cultural safety, establishes effective cross-cultural partnerships and acts on cultural bias when required	3.1, 3.2, 3.3, 3.4, 3.5, 3.6
14	Demonstrates commitment to working in accordance with te Tiriti o Waitangi and addressing public health issues affecting Māori	4.1, 4.2, 4.3
15	Demonstrates commitment to addressing health determinants and inequities	6.11, 9.1, 3.5, 4.1, 5.1
16	Consults effectively in a range of settings	2.7
	D. Public health knowledge and skills	
17	Has sufficient public health knowledge or accesses it when needed	All, 6.3, 6.4
18	Has sufficient public health analysis and research skills to investigate public health problems when needed	6.1, 6.2, 7.1, 8.1
19	Demonstrates sound public health decision making and use of evidence	1.9, 6.1-6.14
20	Identifies timely and effective interventions and policy responses to improve public health and reduce health inequities	1.7, 9.1, 10.1, 11.1, 12.1, 13.1, 14.1, 15.1
21	Can assist during public health emergencies when needed	6.2, 11.7
	E. Ethics, health, and overall	
22	Works in an ethically sound manner	1.6
23	Is honest and trustworthy	1.6
24	Would recommend for conducting public health medicine specialist work (within their sub-specialist role, if relevant)	All

25	Performance is not impaired by ill health	1.4
	Please comment on their workplace behaviour	
26	What aspects of this doctor's behaviour do you consider make them particularly effective as a public health medicine specialist, i.e., strengths to maintain or even develop further? (Please specify or state 'Nothing specific')	
27	What aspects of this doctor's behaviour do you consider reduce their effectiveness as a public health medicine specialist, i.e., weaknesses that could be improved? (Please specify or state 'Nothing specific')	

Appendix 11: Multisource Feedback Reflection Form

MSF Reflection Form for Public Health Medicine Specialists

This template must be completed to claim TOPS points for your MSF survey. The template does not need to be returned to the College, but the completed template should be discussed with your professional mentor.

1. Personal Details

Full name: Click or tap here to enter text.

Year MSF completed: Click or tap here to enter text.

2. Reviewing the responses

Once you have downloaded your MSF feedback, reflect on the issues below, and discuss with your mentor:

a. Respondent sample

How did you decide which respondents to nominate? Is there likely to have been any over / under representation of respondent groups in the sample?

Note that, ideally, feedback should have been provided by a balanced mix of medical and non-medical colleagues. Research shows colleagues in managerial or administrative roles, and health professionals in non-medical roles, tend to give more favourable feedback than medical colleagues. Colleagues with whom you have more frequent contact tend to give more favourable feedback.

Consider whether any of the above factors could have affected your results.

b. Distribution of responses

What is the spread or range of responses for each question? If there is a wide range, consider why there might be such disparate views among your colleagues.

c. Proportion of invalid responses

What proportions of the responses are invalid, i.e. the respondent picked the 'don't know' option or did not answer the question? A high proportion of invalid responses may suggest inappropriate respondent selection and will affect the usefulness of the results. In this instance you should consider repeating the process.

d. Identifying areas of strengths and weakness

Do the results show any obvious areas of strength and weakness?

How do these compare with your self-assessment? Are there areas of strength or weakness you were unaware of?

Appendix 12: Guidelines for the Collegial Practice Visit

Introduction and Purpose

The purpose of a Collegial Practice Visit is to provide a supportive and collegial process in which a doctor can get constructive feedback on a particular aspect of their practice. The process will help maintain and improve the standards of the profession and is an optional, profession-led, part of the Recertification requirements set by the College.

The goal is to help individual doctors identify areas where specific aspects of their practice could be improved. The process encourages self-reflection and critical consciousness on styles of practice and power relationships in practice. The visit can be used for consideration of how Māori health, health equity and cultural safety can be improved in practice.

The visit gives the visited doctor (the 'Practitioner') affirmation and reassurance regarding their practice, and also identifies areas where aspects of performance could be improved for the benefit of clients, the practitioner and the profession. The learning in this process is based on real world problems to improve skills, knowledge, attitudes and behaviours. It is an opportunity to discuss practice with a peer in a safe environment and to reflect, review and take stock of practice and gives an independent view on practice.[40]

Occasionally, areas of work that need significant improvement may be identified during a visit. If needed, the College will provide support to the Practitioner to address these issues. If the concerns are such that patient safety may be at risk, the College is required to report the matter to the Medical Council.

The Collegial Practice Visit is optional, rather than required. It is expected that it would occur at a maximum once per triennium.

Setting up the visit

The Visitor

The visit is undertaken by a peer (the "Visitor') in the same scope of practice and in the same general area of work as the Practitioner. The Visitor should be external to the Practitioner's place of work and is independent of their work. Both the Practitioner and the Visitor can benefit from the process. The Practitioner is the primary focus of the review, but the Visitor can gain insights into their own practice through observation of the Practitioner's practice.

You are welcome to approach a Fellow of your choosing to act as your Visitor. If necessary, the College can facilitate the process by suggesting possible reviewers to choose from. It is the responsibility of the Practitioner to organise the date and time of the review.

The Visitor should be someone working in a similar field, or someone who will have an understanding of the working situation or area of focus for the review, for instance: academia; policy

[40] Malatest International. Final evaluation report: Evaluation of the Regular Practice Review programme. Wellington: MCNZ, 2019. https://www.mcnz.org.nz/assets/Publications/Reports/a185d7b752/Evaluation-of-RPR-final-report-August-2019.pdf

/ government; Māori health; health promotion; disease prevention; and organisational development.

Preparation for the visit

The visit is informed by a portfolio of information provided by the Practitioner to the Visitor, ideally in advance of the visit. This may include (but is not limited to):

- Professional Development Plan (PDP)
- Multi Source Feedback (MSF) Report
- Annual Conversation notes
- A sample of work, or a specific piece of work that the doctor is working on
- Outline of portfolio responsibilities or work programme
- Suggested area for discussion

The programme for the day to be agreed between the Practitioner and the Visitor prior to the visit, as well as any areas of specific focus, if relevant, such as piece of work that is proving difficult.

The visit must include observation of the Practitioner in their normal practice situation. Virtual visits may not be used as a substitute. If the Practitioner is to be attending any meetings or group discussions on the day of the visit, arrangements must be made in advance to ensure that the Visitor can attend as an observer.

The visit

The visit process should include an initial discussion between the Visitor and the Practitioner to provide an orientation and necessary context and background to the Practitioner's work situation and responsibilities. Some time may then be provided for the Visitor to look over the documents that have been provided.

Observation of the Doctor's practice is an important part of the visit, and time should be set aside for this (this might include observing participation in a meeting or teaching session, for example).

If a specific piece of work is to be the focus of the visit then this is agreed and dissected looking at: nature of the work; progress to date; issues blocking progress; competency gaps and possible ways forward.

The visit should include a discussion about the Doctor's cultural safety and the impact of their work on Māori health and health equity.

The final component of the visit is a discussion between the Visitor and the Practitioner in which feedback is given in a constructive way using the Commend, Recommend, Commend method. The conversation should also be used to review the Practitioner's PDP and to identify competencies for professional development, taking onto account the Practitioner's career goals. Issues of self-care may also be discussed. Agreement should be reached on areas for focus in the period ahead.

Post visit

The Visitor makes notes on the visit for the Practitioner on their observations during the visit, their recommendations and the actions agreed during the visit.

The Practitioner reviews this report and makes any factual amendments if necessary, in consultation with the Visitor. The Practitioner then revises his / her PDP in line with the recommendations.

The Practitioner should retain the completed report with their professional development records and must produce it as evidence when audited.

Report of the Practice Visit

The visit report must include the name of the Visitor, and the date and location of the visit.

It should also include:

- Nature of the work observed or discussed
- Recommendations identified by the Visitor
- Any agreed actions with regard to competency gaps or self-care for inclusion in the PDP
- Any other suggestions for consideration, including ways to improve cultural safety, or address health equity and/ or Māori health

A template for the report is provided in Appendix 13

Note: Both the Practitioner and the Visitor are eligible for TOPS points when engaging in this process.

Appendix 13: Template for the Collegial Practice Visit

Collegial Practice Visit Template for Public Health Medicine Specialists

Guidelines for completing your Collegial Practice Visit are available in the TOPS Manual.

Note: to 'tick' the boxes, double click on the box and select *checked* from the pop-up menu.

1. Visit Details	
Date:	
Time:	
Location:	

2. Participant Details	
Full Name:	
Employer:	
Current work position(s):	
Length of employment:	
Address:	
Email:	
Phone:	

3. Reviewer Details	
Full Name:	
Employer:	
Current work position(s):	
Address:	
Email:	
Phone:	

4. Documentation required prior to visit

Candidate to supply documents	Provided	Not provided
Professional Development Plan	☐	☐
Multi Source Feedback report	☐	☐
Candidate's current work programme	☐	☐
College Competencies Self-evaluation	☐	☐
Suggested area for discussion	☐	☐

5. Meeting plan

Any organisational matters of significance to be noted at the beginning of the meeting.	
Agree on topic for discussion:	
Significant parts of Professional Development Plan relevant to the upcoming discussion:	
Significant parts of Multi Source Feedback report relevant to the upcoming discussion:	
Current work programme and how it relates to the topic for discussion:	
Aspects of relevance to the impact of work on Māori health, health equity and cultural safety:	

6. Record of meeting

Record details of the discussion here.	
Nature of work:	
Progress to date:	

Blocks/barriers to progress:
Competency gaps:
Ways forward to consider:
Review of Professional Development Plan and competency manual:
Competencies identified to develop:

7. Specific considerations for next Professional Development Plan

Specific considerations for next Professional Development Plan / Competencies to be developed

Appendix 14: Reflection on Action and Practice form

Reflection on Action and Practice Form

Use this form to reflect on critical incidents and experiences, including during participation in processes or meetings, or engagement with colleagues on difficult issues. The form is based on the Integrated Reflective Cycle described by Bassot, 2013.[41]

Full name:

Date:

EXPERIENCE
Describe the context or situation. Useful questions include: • What happened? • What were the contributing factors? • Who else was there? • What did I/others do?
REFLECTION ON ACTION
Identify what went well, and what could be improved. Consider your actions and the assumptions that led to your actions, or any unanticipated outcomes from your actions and the reasons for this. Useful questions include: • What was I trying to achieve? • Why did I act as I did? • What assumptions did I make? • Did my actions have the effect I intended? • What were the consequences for me and the other people involved? • How did I feel? • How did the other people feel and how could I tell?

[41] Bassot, B. (2013). The Reflective Journal. Basingstoke: Palgrave.
See also The University of Edinburgh Reflection Toolkit website: https://www.ed.ac.uk/reflection

THEORY
Think about the experience in larger context of professional literature and your own learning and personal experience. Useful questions include: • What has this experience contributed to my professional or theoretical knowledge? • What have I learned that I can apply to a similar situation in the future? • What have I learned in general?
PREPARATION
Use your reflection to prepare yourself for future experiences. Ask yourself: • What will I do next time in a similar situation? • How could I do better next time? • What will I now consider for next time? • What other strategies could I adopt to move forward?