

Submission from CMDHB Allied Health Forum

1. Is the Act achieving its purpose? Please explain.

Yes agree it is mostly achieving its purpose of regulating health professions to protect public safety. The continuing competency program ensures that we are competent and fit to practise. The Act has provided more mechanisms in place for practitioners to prove competency

2. What evidence supports your answer?

Most Allied Health professions covered by the Act appear to have good understanding of competency requirements through their Boards' review and reporting processes.

Few complaints to the Health and Disability Commissioner and few if any disciplinary actions for Allied health professionals since the Act was passed. However the restrictions provided by the Act are a deterrence to others calling themselves 'Dietitian'; "Physiotherapist", "Psychologist" etc.

Here at CMDHB each profession reviews their practice more regularly because it is a requirement of the Act

Boards ensure those coming back into practice after a long break are competent as well as ensuring those who were trained a long time ago keep up competency.

3. What, if any, comments do you have on the adequacy of evidence available about the success of the Act and any changes needed – including, for example, any reporting requirements that might ensure more open access to evidence that the Act is being effective.

Nil

4. Are the provisions in section 7 of the Act operating in a way that ensures that non-qualified persons do not claim or imply to be qualified practitioners and what, if any, changes do you recommend (note that issues around enforcing breaches are dealt with in the section titled 'Enforcement of the Act' which is set out below)?

The provisions in Section 7 of the act are not operating in a way that ensures non-qualified persons do not claim or imply to be qualified practitioners.

Naturopaths, osteopaths, non registered nutritionists who do not hold suitable qualifications etc undermine what is being said by qualified practitioners.

For example an issue at CMDHB

There are instances of unqualified people working in areas covered by the dietitian's scope of practice without definition of appropriate and inappropriate functions. By default they are holding themselves out to be equivalent practitioners and the Act does not protect the public from these individuals. There is a risk, for example, of an under qualified/unregistered practitioner with no tertiary qualifications giving individual advice to a diabetic in a PHO clinic and not recognising a) the macrovascular risk a patient with type 2 diabetes is experiencing b) the risk of hypoglycaemia a patient with blood glucose lowering medication is exposed to when he or she changes their eating pattern or loses weight and this potential overmedication is not recognised.

This is also of concern because it could increase inequalities in health as well as imposing safety and quality issues and "a risk of harm to the public".

The problem arises when the following occur:

- 1) The current shortage of dietitians, particularly Maori and Pacific, results in difficulty filling some positions and, on occasions, someone with lesser qualifications and training being appointed. There is currently no identification of tasks which can appropriately be carried out by individuals with lesser training outside of the restricted activities listed in Section 9.*

An under qualified person (unregistered) is outside the framework of the Health Professional Competence Assurance Act and consequently there is no assessment of fitness to practice.

The long term solution is dietetic workforce development to ensure adequate number of qualified practitioners.

2) When both the organisation employing an under qualified practitioner and the practitioner his/herself do not acknowledge this skill and qualification deficit, competency and safety issues become paramount. There needs to be a quality assurance process and a clinical safety framework around such employment.

This could be addressed by specifying, for example in the dietitians scope of practice, what aspects of the application of nutrition to health and disease can only be addressed by a practitioner who is a New Zealand registered dietitian.

5. Are the provisions in section 8 operating effectively and what, if any, changes would you recommend?

Is working moderately effectively for most allied health professions, however several professions have expressed concern about general scopes and practice. Social work, Dietitians and Physiotherapy are looking at whether there is a need to develop several more specific scopes of practice

6. Are the provisions in section 9 and the current list of restricted activities operating effectively and what, if any, changes, amendments or additions would you recommend?

Working effectively and is useful in general however there is a view that the rules around restricted activities need to be tightened e.g. the management of enteral/parenteral nutrition

7. Is the Ministry approach to enforcement of the Act in keeping with the purpose of the Act and what, if any, changes would you recommend?

Nil

8. Are scopes of practice achieving their intent? Please explain.

Several professions have expressed concern about general scopes and practice. Social work, Dieticians and Physiotherapy are looking at whether there is a need to develop several more specific scopes of practice

9. What, if any, comments do you have on the operation of the powers that registration authorities hold to allow conditions or authorisations on individuals' scopes of practice?

Further progress could be made to remove barriers to registration of appropriately qualified and experienced overseas clinicians

Registration Boards frequently do not support individual, limited scopes of practice which would facilitate employment in certain sectors

10. Is the process for developing scopes of practice operating well (eg, are there suitable mechanisms for ensuring scopes of practice reflect service need) and what, if any, changes would you recommend?

There has been a move from generalist to specialist work in some large hospitals and there are few mechanisms developed by Registration Authorities to ensure scopes of practice meet service need. The Boards need to be audited to assess if it has consulted the profession for their feedback on this.

11. Do prescribed qualifications reflect scopes of practice? Please explain with reference to particular scopes of practice and considering whether a) the levels of qualification are too low or too high when considering their purpose of assuring public safety, and b) whether they meet the requirements of section 13.

In general this is not being met because it is inconsistently applied amongst the different professions for example there are exams to sit for some overseas professionals to register in NZ but not for others who go through an assessment procedure.

12. With regard to their purpose of assuring the competence of registered professionals, how well are the current recertification regimes working (where possible refer to particular professions)?

Working reasonably well in most professions. There are inconsistent applications e.g for some it is self-assessed based on a yearly development plan for others it is a complex process.

It is costly for part-time clinicians and some may resign rather than go through the audit process.

There is a perception (maybe unfounded) that it is a barrier to return to work.

13. What changes, if any, are needed to improve the evidence available to answer the previous question?

Evidence provided may need to be more objective – maybe a one-on-one personal audit every 3 years

Clinical supervision may need to be mandatory

Include client satisfaction surveys show are based on patient outcomes or client benefit

Supervision should be made compulsory especially for new graduates, small workplaces and isolated areas

14. Where recertification arrangements are in place, what issues arise and what changes, if any, would you suggest (eg, in respect of the nature of the programmes, the level of compliance, monitoring practitioners' compliance, the costs and other impacts on practitioners employers etc)?

Compliance costs for part-timers are huge – women who make up the bulk of the allied health professions also need time out for parenting and returning to work may initially be part-time until the children are of school age.

It would be shame if the compliance costs of continuing competency results in a loss to the profession when we already have recruitment & retention issues

Better buy-in by employers to continuing competency programmes and costs for example such as for the doctors who have \$8000 plus 10days study leave/year (accumulating)

Major issue is the time required to produce evidence for CCP programme resulting in less time for patients. At CMDHB we already have credentialing in place so Board could accept sign off from the Professional Leader

15. Where recertification programmes have not been introduced how do the authorities assure competence, and are there ways that these processes could be improved?

Nil

16. What would be the gains or problems associated with requiring all authorities to institute recertification programmes?

Equity should be spread across all professions

Would be good to establish consistency across professions

17. Registration authorities have to judge when a practitioner 'may pose a risk of harm to the public' and trigger notification: is this working effectively and what, if any, suggestions do you have to improve effectiveness?

CMDHB has "just culture policy" which provides staff with encouragement to report concerns

18. Is it appropriate that authorities must notify a particular set of agencies: what changes, if any, are needed?

Nil

19. At what times, if any, other than when there is a concern of a risk of harm to the public, should a registration authority exercise its power to review the competence of a health practitioner?

Nil

20. Is voluntary reporting by practitioners of possibly unfit practitioners working, on what do you base this opinion, and, in the light of experience, what are your views on making it a requirement to report concerns about a possibly unfit practitioner?

Don't make it mandatory, it is an ethical obligation

21. Is compulsory reporting by employers of possibly unfit practitioners working, on what do you base this opinion?

Nil

22. Are the interests of the public and of practitioners being balanced when dealing with the risk of harm from practitioners who are deemed to fail to meet required standards of competence? Please explain.

Emphasis on public safety is correct as profession is brought into disrepute if competence standards not met

23. In practice, do competence and recertification programmes differ, are both sets of provisions needed or should changes be made?

These programmes differ and both provisions are needed.

24. Should any other parties be obliged to inform the registrar of a practitioner's inability to perform their required functions because of a mental or physical condition?

The individual's medical practitioner should be required to report to the registration board – this would avoid bias or personality clashes

25. Are the interests of the public and of practitioners being balanced when dealing with fitness to practise issues? Please explain.

Yes

26. Are protected QAAs operating in areas you are familiar with: are they valuable, are there any problems, are the reporting requirements appropriate, should there be any changes to the QAA arrangements, should QAAs continue? Please explain.

QAAs shouldn't need to be reported on, just specified

27. Are PCCs being used by the registration authorities you are familiar with, how often and for what reasons?
28. To what extent is the suspension of an annual practising certificate and referral of a practitioner to the HPDT effective in protecting the public?
29. What, if any, additional steps should be taken into account when determining to suspend an annual practising certificate?
None
30. What, if any, benefits or problems have arisen from having a single tribunal for all regulated professions and what, if any, changes would you recommend?
31. Is the current membership structure of the HPDT operating and are there any changes you would recommend (for example, the mix, the selection and appointment processes, training of members)?
32. Is there a need for the HPDT to have the capacity to deal with multi-practitioner/ team-based disciplinary matters and, if so, how should this be organised?
Yes this would be a fairer process that separate hearings which may leave important anomalies and outcomes.
33. Are the current arrangements for financing and supporting the HPDT, appropriate and what, if any, changes would you recommend (including the costs of taking cases to the tribunal and sustaining the operation of the tribunal)?
34. Are the appeal provisions operating well and what, if any, changes would you recommend?
35. How do you think the current number and mix of professions and authorities is operating and what, if any, changes do you think should be made?
For a small number of professions there are a large number of authorities with quite different requirements
If authorities were to combine they could share administration costs and there would be more consistency around the interpretation of the act
36. Are the provisions for adding new professions or health services working and what, if any, changes would you make?
Nutritionists need to be regulated
Speech language therapy need regulation

37. Are the current membership and appointment provisions working (eg, is the size and mix right, are people with the best skills being appointed, should the power to hold elections be retained and/or used, are lay and professional members appropriately trained and supported) and what changes, if any, would you recommend?

It needs to be more transparent about how Board members are selected

Democratic principles should apply, perhaps a mix of elected and appointed members would be appropriate as is the case in Social Work

38. What deletions, amendments or additions, if any, do you recommend to the list of functions – and why?

39. How well are authorities carrying out their functions and what changes, if any, do you recommend?

Slow to move and make changes but some progress.

Not monitoring education and training sufficiently against workplace requirements

Because the Dietitians Board has approved only one training school they are not carrying out their function of promoting education and training well. Additional training institutions need to be investigated particularly to provide a North Island institution to train more Maori and Pacific dietitians.

There is not sufficient connection between academia and the workplace or integration between dietetic training and the medical school/ health sciences

40. Are there any specific legislative requirements that regulatory authorities are currently subject to that they should not be? Please explain.

41. Are there any specific legislative requirements that regulatory authorities should be subject to that they are currently not? Please explain.

Should be subject to the Official Information Act to ensure more open and transparent access to information by the profession

Dieticians have expressed concerns within the profession about the influence of the training school in Dietitians Board business. This is also the case in Physiotherapy.

42. To what extent are the current powers of the Minister of Health appropriate to the purpose and effectiveness of the Act and what changes, if any, do you recommend?

43. What changes, if any, do you recommend to matters covered by the provisions of Part 7 of the Act?

44. What changes, if any, do you recommend to specific wording in the Act in order to clarify or address technical issues not otherwise covered already?

Supervision means the monitoring of, and reporting on, the performance of a health practitioner by a professional peer

This above definition of supervision in the HPCA Act is not appropriate and does not align with commonly accepted definitions in the literature.

Suggested definition: Supervision is a process in which one worker is given the responsibility to work with another in order to meet organisational, professional and personal objectives. The objectives relate to competence, accountable performance, continuing professional development and personal support

Morrison, T. (2001). Staff supervision in social care. Brighton: Pavilion.

45. What, if any, other matters are you aware of in respect of the operation of the Act and what changes do you recommend?

The need for compliance reduces patient contact time

The Act does not fit well with the Careers Framework as it keeps professions in silos.

Needs some flexibility in the Act to allow people to be trained in supervised activities e.g health care assistants