

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

The act provides a reasonable framework for professions to develop competence and fitness to practice processes. It is the interpretation of the act at the authority level that has proven to be more difficult with regard to compliance, cost and processing of applications for review or registration. Given the wide aim of the act it is difficult to see how one would assess achievement other than in review of outcomes for clients and there are multiple processes for that.

2. What evidence supports your answer?

The growth in uptake of PG education by nurses strongly supports the focus on continued competence.

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.

While it has been three years since that act was fully enacted this is not a long time given the complexity of the changes required of authorities who had to significantly restructure and develop new processes around competence to practice. I think the review period is too short.

Protection of the public is a large undertaking and involves not only credentialing and competence maintenance but the infrastructures in practice to support these, such as peer review, audit and supervision. I think the beginnings are established but there is still ongoing work which has barely begun in this time span.

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)?

I think the provisions are good but there are always difficulties in policing these in everyday relationships, especially for nurses who I think are sometimes confused with carers and home assistants by the recipients of care.

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

No changes suggested at the legislative level but perhaps some in the processes at authority level that take so much time.

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?

The list seems generally reasonable for 'health professional' restrictions but I wonder if it is flexible enough for future changes in professional scopes. There should be a process for review of this section episodically perhaps to allow further inclusions/exclusions as professions develop.

Any aspect of care that limits safe access to care should be reviewed on request from an authority e.g. prescribing.

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?

The Act itself is less of a problem than the share volume of work that restricts authorities ability to respond in a timely manner.

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

I can really only comment for nursing but I believe they are. Some authorities seem to have a large number of presumably separate scopes of practice that require specific entry and competence criteria. I am not sure why a 'trainee' scope is required in radiology if the provisions of oversight and supervision are clearly outlined in the Act.

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?

Conditions are usually based on original qualifications in nursing and are not always easily interpreted in the changing landscape.

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 are levels of practice within a scope from new graduate to advanced practice and I think nursing does this well while some other authorities appear to have separate scopes for phases of development of practice. I think the right to determine scopes should stay with the authorities however without undue political influence.

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.

There is always considerable debate around this issue as development is interdependent and I believe one flexes to match the other over time. The descriptors for scopes of practice fit the current scopes well and training programmes are being regularly reviewed to fit the descriptors. Experiential knowledge remains a difficult aspect of transition between scopes and I would like to see a staged education pathway that allows nurse to build on existing knowledge to reach the next scope rather than start again. I believe this is more an authority issue than a problem with the Act however which is really quite straight forward.

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)?

The underlying framework works well but the process is cumbersome in some authorities and slows the time required to be recertified.

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

The assurance of competence is always a 'spot check' much like other accreditation methods but with the addition of on ongoing education requirements in most professions. This requirement to develop competencies through education and practice is a reasonably robust one on international evidence.

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)?

No comment.

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

No comment.

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

Consistency.

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?

I think there has been a history of sound processes in this area with the Nursing Council of New Zealand and a well tested process of peer review around this issue. The process of initial review is quite protracted however a recent review taking six months for the professional conduct committee to meet with the parties (although information was collected in the interim).

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

I am concerned that once other agencies have been notified that there is a risk of harm there does not appear to be a robust mechanism for notifying the same agencies if the

complaint or issue is not progressed. This has the potential to leave a question mark over some practitioners.

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?

None.

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?

I think that it works for some people but there is reluctance, in my personal opinion, to do so before other avenues have been exhausted which I think is also good. In my experience I would prefer to work with a colleague who has insight and is working to do better than have mandatory reporting at that point. I think mandatory reporting has a place where there is a lack of insight or reluctance to work on the problem under proper supervision.

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

Yes.

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.

It is always difficult to know what the correct balance is. To restrict practice is a major issue for a health professional and there is a significant responsibility not to do that without due cause. I think that a format for reporting would be helpful in which an employer could indicate when immediate action is warranted.

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

I would say competence programmes are aimed at specific issues while recertification programmes are more global across all competencies as where someone has been out of practice there is a need to prove competence in every sphere of the scope.

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?

Members of the public who experience care of this nature and make a complaint should have that complaint reported to an authority as a mandatory act.

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

Yes as far as I can tell from my limited experience.

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.

These are very valuable but I think the reporting lines are excessive for professional groups who are well versed in ethical management of audit and quality improvement. The confidential process is some what revealed when reporting requires statement of quality improvements made.

27. Are PCCs being used by the registration authorities you are familiar with, how often and for what reasons?

Have had dealings with two to date and both were very representative of the issues involved.

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?

As protective as the next employers checking system.

29. What, if any, additional steps should be taken into account when determining to suspend an annual practising certificate?

The process time frame is quite tight for professionals who may not be familiar with the process. Authorities need to make sure that clear information in this regard is given to professional involved so that they can appeal within the required period.

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?

Have not been involved in this process.

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)?

No comment.

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?

I think it is important that individual professionals are judged within their own professions standards and therefore I would not support a multi-disciplinary process of HPDT at this point. I am supportive of MD audits and quality processes however.

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)?

No comment.

34. Are the appeal provisions operating well and what, if any, changes would you recommend?

No comment.

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?

No comment

36. Are the provisions for adding new professions or health services working and what, if any, changes would you make?

No comment until Q 44.

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?

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?

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.

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?

Suggest a review of the words "oversight" and "supervision". I believe there is a need to consider "professional supervision" within this document as a definition that is separate but related to each of the existing definitions. The current definition of "supervision" has reporting lines that are not appropriate in 'professional or clinical supervision' which is a confidential process that perhaps better relates to the acts definition of 'oversight'. Should just be more clarity around the differences in these definitions as the Act as a specific purpose in using 'supervision' as an official process ordered by an authority to supervise the practice is a health practitioner who is not about to work independently for some reason determined by the authority.

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