New Zealand Nurses Organisation

Submission to the Director-General of Health

On the

Review of the Health Practitioners Competence Assurance Act 2003

February 20, 2009 – extended March 6, 2009

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EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) is pleased that the Ministry of Health has reconsidered and allowed feedback on this important report, though again we express concern about the inadequate timeframe which is not commensurate with the State Services Commission Guidelines for Public Consultation. Though the review has taken over a year, NZNO, in concert with other health professional organisations, have noted that we do not feel sanguine that the consultation has been genuine or robust. Many issues raised in our original submission on the Review[1] remain unaddressed and some of the recommendations in this report have not been signalled during that period. We note that five of the recommendations refer directly to consultation and another five to 'working with', 'sharing' and 'collaboration' and wonder what confidence we can have in them when the Ministry's standards of consultation are demonstrably wanting.

2. We are concerned that this report to the Minister does not reflect significant issues in the health sector which relate to the Health Practitioners Competence Assurance Act 2003 (HPCA Act) and which NZNO has consistently identified as risks to public safety. Chief among them are the rise of unregulated roles within regulated health professions; the inadequacy of the language requirements for overseas-trained practitioners which are not fit for purpose, are inappropriately used as a proxy for cultural competence and are a barrier to the efficient and equitable use of much needed health practitioners; and the lack of accountability for poor processes, decision making and results. NZNO believes the Minister must have access to a report which fairly reflects the views of the whole health sector and we do not believe this report does that.

3. NZNO also notes that despite the disproportionately small numbers of Māori in the health workforce, poorer health indicators for Māori and obligations

[1] http://www.nzno.org.nz/Site/Submissions/GovernmentDept/HPCA_Review_Dec07.aspx

under Treaty of Waitangi principles, there is still no mandatory requirement for Māori membership or even consultation by RAs. We also note that in other sections of the report, especially those referencing or recommending alignment of regulatory environments with those from the United Kingdom (UK) and Australia in particular, there is little mention of the different culture that prevails in Aotearoa. Whilst alignment is useful, one size does not fit all. Despite superficial similarities, those cultures are geographically, demographically, and historically distinct from our own and have developed very different workforce and health sector regimes. The relationship between indigenous Māori and non-Māori in Aotearoa, as established in both principle and law, bears no resemblance to ethnic relationships on other countries. We draw your attention to Te Puni Kokiri's excellent "Principles of the Treaty of Waitangi as expressed by the Courts and the Tribunal"[2] and in particular comments by President Cooke in *Te Runanga o Muriwhenua v Attorney General (1990)*[3] that the duty to act reasonably, honourably and in good faith is "infinitely more than a formality"; and Justice Richardson that "In the domestic constitutional field….there is every reason for attributing to both partners that obligation to deal with each other and with their treaty obligations in good faith. That must follow from the nature of the compact and its continuing application in the life of New Zealand and from its provisions." NZNO does not believe that either the report or the recommendations meets those provisions[4].

4. Though NZNO supports most of the recommendations, we observe that several are so broad and self-evident - for example, that responsible authorities RAs work to keep costs down, or that agencies consult and collaborate; or are what we would consider to be core Ministry work - for example the provisions around workforce data, that they cannot be contested,

[2] http://www.tpk.govt.nz/en/in-print/our-publications/publications/he-tirohanga-o-kawa-ki-te-tiriti-o-waitangi/download/tpk-treatyprinciples-2001-en.pdf
[3] Ibid *Lands* Case, Court of Appeal, 1987. p77
[4] Ibid. p80

yet lack the substantive detail necessary for confidence. Some recommendations combine very disparate actions which should be considered separately and, as the report notes, others are technicalities which hardly seem to require consultation. We note with concern that the HPCA Act 2003, which marked a new direction for the regulation of health professionals, was implemented without meaningful leadership, guidance, input or monitoring by the Ministry. These recommendations address some gaps in the principles of operation but without firm guidelines and measureable criteria for qualitative performance assessment, the lack of accountability will remain.

5. The recommendations are discussed in detail below. NZNO was unable to use the electronic version on the Ministry's website, but, for your convenience, has used the same format and included website references where possible.

6. NZNO has consulted its members and staff as far as was practically possible in the preparation of this submission.

RECOMMENDATIONS

7. In summary, with the qualifications noted below, NZNO **supports**

   - Recommendation 1;
   - Recommendation 3;
   - Recommendation 5- 9
   - Recommendation 11- 15;
   - Recommendation 17-37, noting Recommendation 33 is unnecessary;

8. NZNO **does not** support

- Recommendation 2
- Recommendation 10

9. NZNO believes there further consultation and information is needed before an informed decision can be made about:

   - Recommendation 4
   - Recommendation 16

10. NZNO also recommends that you:

    - **Amend** section 3 of the Report as detailed below;
    - **Amend** Recommendation 3 by adding “Māori” before *any other stakeholder* and “including means of showing consultation with and consideration of Māori, and adequate timeframes,” after *criteria and competencies;*
    - **Amend** Recommendation 6 by adding a reference to retaining cultural competencies relevant to Aotearoa New Zealand;
    - **Amend** section 4 of the Report to reflect current disquiet about the safety, relevance and effectiveness of the patented English language test used to the RAs to assess OST practitioners comprehension and communications skills, including those trained in English speaking countries;
    - **Amend** Recommendation 7 by adding “consistent” before *risk-based standards* and “in particular language and cultural competencies which are culturally and occupationally relevant to the health profession” after *overseas-trained practitioners*;

- **Amend** section 5 to reflect Treaty of Waitangi principles, particularly of partnership and active protection are met, by mandatory provision for consultation to consult with and consideration of Māori;

- **Amend** recommendation 9 adding "Māori" before *any other stakeholder* and "including having persons to each responsible authority who have knowledge skills and experience in Māori health and Māori health inequalities and have an understanding of the principles of the Treaty of Waitangi, and adequate timeframes," after *criteria and competencies;* and

- **Amend** section 10 to accurately reflect the consultation on elected membership of RAs both before and during the review.

11. NZNO further draws your attention to the following recommendations in our original submission on the Review of the HPCA Act recommends that this Report be amended to address them. NZNO recommended that you:

    - **Note** that HP competence is only one factor contributing to a safe health environment ;

    - **Agree** that the key elements of safe staffing as identified in the Safe Staffing Healthy Workplaces Committee of Inquiry Report (2006) are fundamental to the delivery of safe healthcare and should be taken into consideration when a health practitioner's competence is questioned;

    - **Agree** that minimum levels in aged care need to be regulated for the protection of both public and health practitioner safety;

    - **Add** provisions for the appointment of members to responsible authorities to include elected representation on RAs from professional associations;

    - **Note** the low level of understanding of the HPCA Act, particularly of employer responsibility, which has contributed to confusion about scopes

of practice, particularly for second level nurses, and unregulated health workers;

- **Agree** that a national reporting system to support *all* health care staff to report *any* incident relating to health and safety is a priority;
- **Resolve** the confusion surrounding title and scope of practice for second level nursing through proper consultation processes;
- **Note** NZNO's recommendation for one title and scope of practice for each level of HP in each discipline;
- **Note** the lack of clarity and contradictions relating to restricted activities;
- **Agree** to regular four-yearly review of scopes of practice in the HPCA Act;
- **Add** provision for appeal against RA decisions;
- **Consider** a two year term of APC and recertification activities;
- **Note** the increasing numbers of unregulated Health Care Assistants and clarify who should be responsible for them in a clinical setting;
- **Agree** to address the broad range of issues arising from the high levels of migration in the health workforce especially in ensuring immigrant practitioners are supported with programmes to gain the cultural and clinical competencies needed to practise safely in New Zealand;
- **Agree** to develop bilateral agreements particularly with the Pacific islands;
- **Agree** to implement strategies such as a standard on-line learning package and test on the NZ health system and the Treaty for all migrant HPs to complete;

- **Agree** to show leadership in ensuring RAs are consultative, cooperative and consistent;
- **Add** a clause describing proper consultation processes to Section 14 (2);
- **Delete** section 11 (2);
- **Delete** the words "*and ethical conduct"* from Section 118(i)
- **Delete** the words *"including"* and *"the principles set out in section 13"* from section 124;
- **Delete** the words *after consideration of an auditor's report completed under section 124 about an authority* in Section 125 (1);
- **Add** the words "*regulated by that authority"* after the words "*a majority of members who are health practitioners*" in section *120 2 (a);*
- **add** the words **"***consistent with the outcome of research and international data"* after the words **"***To promote education and training in the profession"* to Section 118 (j); and
- **Add** the following clause to Section 120 (2) *"As far as practicable two persons to each responsible authority who have knowledge skills and experience in Māori health and Māori health inequalities and have an understanding of the principles of the Treaty of Waitangi".*

ABOUT NZNO

12. The New Zealand Nurses Organisation (NZNO) is the leading professional body of nurses and nursing union in Aotearoa New Zealand, representing over 42 000 nurses and health workers. Te Runanga o Aotearoa is the arm through which our Te Tiriti o Waitangi partnership is articulated. Our

members include nurses, midwives, students, kaimahi hauora, health care workers and allied health professionals.

13. The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations.

QUESTIONS

Chapter 2: Overall conclusions

Recommendation 1: *That it is noted that the Health Practitioners Competence Assurance Act 2003 is currently operating largely as intended, and that the Director-General of Health is instructed to carry out a further review of the Act starting in 2012 (page 11*).

NZNO believes that while the HPCA Act is generally working well, there is a gap in provision for reviewing/challenging/discussing decisions in the wider health context. Central issues affecting nurses in relation to the HPCA Act, are firstly that regulated nurses are unduly bearing the burden of responsibility for the increasing use of unregulated Health Care Assistants (HCAs); and secondly that confusion around some scopes of practice has resulted in inconsistent decisions by employers which has *increased* the risk to public safety and compromised the nursing workforce. (See comments re Recommendation 2).

Chapter 3: Communication and engagement for stakeholders

Recommendation 2: *That responsible authorities and the Ministry of Health do more to inform the public about the Health Practitioners Competence Assurance Act 2003 through their websites, publications and other means – including making information about registered practitioners freely available (page 13).*

There are two issues here which should be considered as separate recommendations.

NZNO supports the first part of this recommendation, that the public be made more aware of the HPCA Act and recommends adding “and relevant parties” as it

is clear that ignorance of the Act extends to practitioners, employers and government.

We do not support the second part of this recommendation. Nurses are generally not self employed and there is no reason why personal information, other than that they are registered nurses, should be available through this avenue, which could potentially tempt patients into contacting them out of hours. We also note that there are significant costs in maintaining a separate (for security reasons), accurate public database especially of the size necessary for nursing. We could possibly support a recommendation that allowed practitioners to "opt-in" to allow what private information they felt comfortable about being made publicly available.

Recommendation 3: *That responsible authorities improve the processes around scopes of practice including developing a set of principles and guidelines, regular review, a central web-based point for notifying new consultations, and processes to allow any interested party to propose new or amended scopes (page 14).*

NZNO strongly supports this recommendation, particularly the stipulation for review which we suggest should be extended to read "regular review of all scopes" to ensure that it does not only apply to new or amended scopes.

We agree with 3.9 that narrow scopes of practice are unnecessarily and at times unsafely, restrictive, and are particularly injurious to public health and safety where scopes, or their interpretation, have led to the exclusion of regulated practitioners from unregulated roles, and/or where competent and experienced practitioners have been stopped from continuing tasks suddenly deemed out of scope. However, as our original submission on the Review of the HPCA Act noted, other issues, not just the scope, have given rise to such anomalies and it is clear that there is considerable confusion and lack of co-ordination between RAs and employers and the health workforce. Currently there is no mechanism for reviewing RA decisions *as they are put into practice* to prevent or resolve the workforce disruption that has occurred. Our previous submission listed numerous

instances, for example, where the combination of NCNZ regulations, confused Ministry 'guidance', and employers' interpretation of regulations and rulings had resulted in unsafe and unworkable situations. By promoting better communication this recommendation, which we suggest should specifically mention employers and relevant health workforce, is useful, but it does not provide a secure process for challenging/reviewing poor decisions or actions. Thus the training of health professionals can continue to be disrupted, they can continue to be excluded from employment in favour of unregulated workers, and nurses will continue to carry an unfair burden of responsibility for supervision of untrained workers who are not accountable under the Act. .

With regard to 3.11 NZNO takes strong exception to describing the protracted proceedings to address the unjust infringement of ENs employment and professional rights as "a controversial incident". We consider the continued characterisation of years of disruption to thousands of nurses in such a manner to be indicative of the Ministry's obstinate refusal to either understand or recognise the significance of this nursing workforce issue to public health and safety; we refer you to our recent feedback to the Nursing Advisory Committee on the Clinical Workforce to Support Registered Nurses[5]where we detailed what amounted to disinformation in the way in which this issue has been presented. The fact is that the consequences of that 'controversial incident", as NZNO foresaw, opened the way to unregulated, untrained caregivers taking on nursing roles in an entirely ad hoc manner, and the public, and nurses, are bearing the less-than-satisfactory results. In this context we note that while the report frequently refers to UK and Australian policy and practice, it does not point out the very different pathways each followed, which would have been instructive. The UK abandoned second level nursing with the result that it has now a very large unregulated workforce which, to no-one's surprise, they are now

5 http://www.nzno.org.nz/Site/Submissions/Recent/Feedback_to_the_Nursing_Advisory_Committee_on_the_.aspx

considering regulating; Australia supported and extended the opportunities for second level nursing and has a highly motivated and successful enrolled nurse workforce whose role is not confused with that of HCAs. We also note that the confusion around second level nursing disrupted an important pathway for Māori entry into the professional health workforce where they are already disproportionately underrepresented.

NZNO agrees with Point 3.12 that it *is* important "to look closely at the findings of the Regulations Review Committee (RRC)" and notes that the reason that the RRC's recommended change was "only because of the retrospective nature of the Notice" was that was what pertained to the Committee's jurisdiction. It was simply not within its scope to comment on whether or not the decision was sound in terms of practice, public safety or employment equity as was clearly stated:

"We note that our decisions are based on the grounds set out in Standing Order 315(2). We do not make decisions based on the substantive merits of a complaint and so are not in a position to give the type of relief requested by the complainant."

We strongly recommend that the above is added to 3.12 and that "controversial incident" is replaced with "confusion around the scope of practice for second level nurses".

Recommendation 4: *That responsible authorities consult on and take account of the health services impact of their decisions and carefully weigh these up against considerations of public safety and, where appropriate and safe, they consider using the power they have under section 21 of the Act to authorise scopes of practice for individual practitioners (page 15).*

This is another "double" recommendation. Of course NZNO supports RAs consulting and considering the impact of their decisions. However we would be very cautious about RAs authorising individual scopes of practice, having no indication of how such a clause would be implemented. There is a risk of the

regulator becoming overly concerned in what are really work-related situations, as professions expand and treatment modalities change.

Our view is that scopes of practice should be of a broad and general nature so as to encompass a wide range of experience, skills and expertise and allow the professions to be responsive to changing needs. While authorising specific scopes of practise may give greater flexibility initially, in time it is likely to lead to a proliferation of narrow scopes, stifle innovation and increase bureaucracy without contributing anything to public safety.

This recommendation to encourage the RAs to exercise tighter control may only see more of the same confusion and disruption which ensued when NCNZ decided that the Surgical First Assist role was outside the RNs scope of practice in spite of the fact that nurses have undertaken this role competently for many years. The consequent potential to limit surgery in the private sector and/ or introduce a "new" scope of practice which replicates what the nurse already does sets a dangerous precedent for a clause of this nature.

Recommendation 5: *That responsible authorities, mindful of the impact of practitioner fees on the health care system, try to restrain cost growth, look for ways to make efficiencies, minimise fee increases, and openly explain the basis for their fees and any increases (page 15).*

NZNO believes efficiency and transparency are important principles, but would be surprised to find any RA that didn't believe it was adhering to such.

Chapter 4: Collaboration among responsible authorities

Recommendation 6: *That responsible authorities work together and with Australian counterparts to identify and share best practice principles and arrangements for accreditation of educational institutions and programmes and that the Ministry of Health gives further policy consideration to developing a Trans-Tasman joint accreditation system for regulated professions (page 19).*

NZNO is broadly supportive of the TTMR scheme and would certainly support moves towards Trans-Tasman joint accreditation for regulated professions. In

this context we note that some professions have expressed strong concern about TTMR because people from outside Australasia, for whom it was not originally intended, have used the easiest regulatory access point, to gain entry elsewhere. Training organisations have also taken advantage of TTMR, offering courses which offer the fastest route to qualification regardless of the country or state the student lives in. Both are strong motivating factors for ensuring that there is consistency and commonality between Australia and Aotearoa New Zealand where possible in health professional regulation.

However, we note that there is fragmentation within the Australia between state and federal systems and caution that New Zealand, as one of eight parties, could be marginalised in a move towards homogenous standards and regulation. There are some areas of competency where common standards work very well, but in other areas it is important to retain the competencies unique to Aotearoa.

Recommendation 7: *That responsible authorities should collaborate with the Ministry of Health and Australian authorities to develop risk-based standards, processes and assessment models to be used for assessing overseas-trained practitioners (page 20).*

NZNO supports this recommendation and recommends adding "consistent" before risk-based standards. In this regard NZNO would particularly like to see some examination of language requirements and provision for standards for cultural safety.

NZNO notes that there is no mention of one of the principle barriers to registration of overseas trained (OST) health practitioners and a possible cause for the number of complaints against them indicating a risk to public safety, namely the International English Language Test System (IELTS). This omission is surprising and unsatisfactory in view of the media attention it has attracted, discussion in the consultation workshops and submission and the attention it has been given by the professional associations, particularly NZNO, the Council of

Trade Unions, RAs and the Ministry itself, not to mention the OST practitioners and the public.

Although unacknowledged in the report, even in the relevant appendix, it is highly relevant that the RAs have specified the "English language tests" necessary – IELTS or OET. It is relevant to public safety, the chronic shortage of health professionals, the high number and turnover of OST health professionals in New Zealand that a major barrier to OST registration, the IELTs, is a patented, foreign-based test which has nothing whatever to do with health occupations, was never developed for the purpose for which it is being used and is entirely unsupported by any evidence that it is a safe or effective tool to discriminate comprehension or communication skills in the New Zealand health sector. The many deficiencies of the language testing component are outlined in NZNO's submission to the NCNZ[6] on the proposed changes to the English language policy January 2009, deficiencies which have been acknowledged and which have prompted efforts by the Ministry, DHBs and training institutions to address them. We note the Pharmacy Council's is proposing to drop such testing in favour of more constructive assessment.

NZNO believes it is essential that the report conveys to the Minister sector disquiet about the safety, relevance and effectiveness of the patented English language test used to the RAs to assess OST practitioners comprehension and communications skills, including those trained in English speaking countries.

Recommendation 8: *That responsible authorities actively explore ways in which they can share with and learn from other authorities in order to improve quality and, where possible, reduce costs (page 25).*

NZNO supports this recommendation.

6 http://www.nzno.org.nz/Site/Submissions/Recent/Proposed_changes_to_English_language_Policy_from_J.aspx

Chapter 5: The Ministry of Health's role

Recommendation 9: *That the Ministry of Health consults with responsible authorities and any other interested stakeholders about the processes for appointing members to responsible authorities and to the Health Practitioners Disciplinary Tribunal panel, and develops a set of criteria and competencies to help ensure the best appointments are made (page 31).*

NZNO supports this recommendation as appointment processes should be transparent.

We strongly also suggest that Māori are specifically mentioned before "any other stakeholder" and that it be mandatory for every RA to consider and show how Māori are adequately consulted with and considered.

As noted in the introduction NZNO is dismayed at the lack of even nominal commitment to Treaty of Waitangi principles appalled that this section of the report should see fit to reference a United Kingdom White Paper on criteria and competencies for Councils yet not mention Treaty obligations. What is culturally appropriate?

We also suggest that "processes" should specify an adequate timeframe (that is at least two months, not including public holidays) as NZNO continues to find this approach to consultation problematic and unhelpful.

Recommendation 10: *That section 120(4) of the Health Practitioners Competence Assurance Act 2003, which gives the power to have some members of responsible authorities elected, should remain unchanged and the question of whether to allow elections should continue to be considered on a case-by-case basis (page 34).*

NZNO does not support this recommendation because in the past this section has been used inconsistently, with only one group of health professionals being favoured with elected representatives; there is no guarantee of continuity between one Minister and the next; and it does not adequately assure the confidence of the profession.

NZNO supports all RAs having a proportion of elected members.

NZNO recommends that adding “Consultation on elected representation was only sought in respect of the Medical Council and no other health practitioner group until the current Review” at the beginning of 5.34. We are aware that statements about “consultation on elected representation” have been made throughout the review process implying that consultation has been comprehensive when in fact it has been limited to this one group. We question whether using a simple tally of responses in favour or against is, on its own, sufficient to give an accurate picture of the sector’s response to this issue.

From NZNO’s point of view it is not sufficient for our submission representing 42, 000 members, an appreciable proportion of the entire health workforce, to be counted as one submission equal to that of one individual. Similarly, it is not acceptable to mention the minority 15 responses in favour of the status quo, noting that some were from RAs and others from unnamed (but “non-medical”) professional organisations, yet remain silent on the source of the 38 responses (i.e. 88% of the nearly 40% who thought the issue important enough to comment on) who wanted a change! It is difficult to avoid drawing unfavourable conclusions relating to gender and other equity issues here when the voice of the vast majority of nursing workforce has been so consistently ignored and/or marginalised.

NZNO strongly recommends this section is rewritten to accurately reflect the fact that a significant portion of the health workforce, wants elected representation for the same reasons as their medical colleagues: to be confident that the RA is informed by those who have a sound understanding of current professional and practise issues.

NZNO appreciate that there is a wide variety of health professions and respect the right of each to make the decision appropriate for them. We do not have confidence in Ministry processes for appointments which have been poor and opaque, and we do not think more 'transparency' as has been suggested will make any difference.

Recommendation 11: *That the restricted activity concerning psychosocial interventions be revoked by Order in Council (page 36).*

NZNO supports this recommendation.

Recommendation 12: *That the Ministry of Health arranges for a set of indicators to be developed in consultation with responsible authorities and other interested stakeholders to measure the effectiveness of the Health Practitioners Competence Assurance Act 2003 and to measure the performance of responsible authorities (page 37).*

NZNO supports this recommendation; consistent reporting and streamlined processes are useful. NZNO would like to be assured that these measurements will be made public so the public and health sector can measure performance.

Recommendation 13: *That the Ministry of Health consults with responsible authorities and other interested stakeholders to establish a standard template for authorities' annual reports and standard information to accompany notices of scopes of practice and fee changes (page 37).*

NZNO supports this recommendation; it is sensible and efficient to have consistent reporting.

Recommendation 14: *That, as part of national workforce planning, the Ministry of Health works with responsible authorities and other stakeholders to improve the collection, collation, analysis and dissemination of comprehensive, accurate, comparable, timely and non-identifiable information about the registered health practitioner workforce and advises the Government as to whether any increase in resources or legislative change is required to make those improvements (page 38).*

NZNO supports this recommendation which we regard as core Ministry of Health business. We also strongly recommend that workforce data is made public –

many groups rely on RA data that is not available elsewhere yet it is often difficult to access quickly.

Chapter 6: Extension of the Act to further groups of practitioners

Recommendation 15: *That the Ministry of Health examines and consults on criteria for statutory regulation of unregulated health occupations with reference to criteria such as those proposed for Australia (page 42).*

NZNO supports this recommendation. However we like to be assured that decisions will be implemented. With note that there was strong support for regulation of the Anaesthetic Technician role but that the process of Reviewing of the HPCA Act has been used to delay implementation. There must also be a focus on unregulated worker categories appearing within regulated professions, for example HCAs and consideration of the introduction of the midwifery assistant.

Recommendation 16: *That section 114 of the Health Practitioners Competence Assurance Act 2003 is amended to give the Minister the power by Order in Council to join and restructure two or more existing authorities in situations where, after consultation, the Minister is satisfied that it is in the public interest to do so and that the authorities and their professions are generally in agreement (page 47).*

NZNO cannot support this recommendation because the issues were not well raised or debated during the consultation and it requires significantly more thought before we would make a decision. It is difficult to see what the intention is: “where the professions are generally in agreement” is open to wide interpretation. Considering the recommendations for closer alignment with Australia where the RA comprises a single Nursing and Midwifery Council, is it the intention of the Ministry to encourage reuniting the Midwifery and Nursing Councils in Aotearoa? Since there has been no agreement as to process or consideration of the implications, we cannot support this recommendation.

Recommendation 17: *That the Ministry of Health reviews the process for groups seeking to have a new health service regulated as a profession in order to gather full information with which to advise the Minister of Health as to whether statutory*

occupational regulation is recommended and, if so, what arrangements are best for appointing a responsible authority in respect of that profession (page 47).

NZNO supports this recommendation and further advises that only those recognised as meeting the hallmarks of a profession – that is with its own body of knowledge, evidence and research base, and enjoying the confidence of society should be recognised under the HPCA Act.

Recommendation 18: *That, after this report has been tabled in the House of Representatives, the Ministry of Health moves rapidly to make recommendations to the Minister of Health in respect of those groups for which it has already been decided that statutory regulation under the Health Practitioners Competence Assurance Act 2003 is appropriate (page 48).*

NZNO supports this recommendation.

Chapter 7: Complaints and disciplinary matters

Recommendation 19: *That sections 64 and 118 of the Health Practitioners Competence Assurance Act 2003 are amended to specifically recognise that it is a function of responsible authorities to receive complaints about the appropriateness of a practitioner's conduct and to protect complainants against civil or disciplinary proceedings unless they have acted in bad faith (page 50).*

NZNO supports this recommendation.

Recommendation 20: *That section 68(2) of the Health Practitioners Competence Assurance Act 2003 is amended to give responsible authorities discretion whether to refer practitioners who have been convicted under a minor offence listed in section 67(b) to a professional conduct committee (page 51).*

NZNO welcomes this recommendation as it provides a proper balance between low level offences and more serious ones.

Recommendation 21: *That sections 69 and 93 of the Health Practitioners Competence Assurance Act 2003 is amended to restrict interim suspension to situations where there are reasonable grounds to believe that a practitioner's conduct poses a risk of serious harm to the public (page 51).*

NZNO supports this recommendation which is consistent with the serious consequences a conviction implies.

Recommendation 22: *That paragraph 17 of Schedule 3 to the Health Practitioners Competence Assurance Act 2003 is amended to allow the responsible authority to delegate any of its functions, duties or powers to a committee or to its Registrar (page 53).*

NZNO supports this recommendation to give the RA some administrative flexibility, and suggests that guidelines for monitoring and auditing delegated functions are developed.

Recommendation 23: *That section 95 of the Health Practitioners Competence Assurance Act 2003 is amended to allow the Chair of the Health Practitioners Disciplinary Tribunal to issue, on his or her own, an order for non-publication of material in circumstance where all parties to a hearing consent to the non-publication order (page 54).*

NZNO supports this recommendation.

Recommendation 24: *That section 102 of the Health Practitioners Competence Assurance Act 2003 is amended to enable the Health Practitioners Disciplinary Tribunal to set a minimum period before which a health practitioner whose registration has been cancelled cannot apply for re-registration (page 55).*

NZNO supports this recommendation.

Recommendation 25: *That section 103 of the Health Practitioners Competence Assurance Act 2003 is amended to give the Health Practitioners Disciplinary Tribunal the power to instruct the appropriate executive officer of the Tribunal to notify any employer of orders of the Tribunal if the Tribunal is satisfied that such disclosure is in the public interest (page 55).*

NZNO agrees that employers should only be notified of the Tribunal's orders where it is clearly in the public interest to do so.

Recommendation 26: *That section 6(5) of Schedule 1 of the Health Practitioners Competence Assurance Act 2003 is amended to bring it into line with the repeal of the Evidence Act 1908 and the enactment of the Evidence Act 2006 (page 56).*

NZNO supports this recommendation.

Recommendation 27: *That section 104 of the Health Practitioners Competence Assurance Act 2003 is amended to clarify that responsible authorities are responsible for paying running costs of the Health Practitioners Disciplinary Tribunal, including costs not directly related to individual hearings and the costs of training tribunal panel members (page 57).*

NZNO supports this recommendation with qualifications as the cost implications for individual RAS are not clear. We do support the training of Tribunal members.

Chapter 8: Protected quality assurance

Recommendation 28: *That section 55(3)(a) of the Health Practitioners Competence Assurance Act 2003 is amended so that a person responsible for quality assurance activities is not required to be independent of the activity (page 62).*

NZNO supports this recommendation.

Recommendation 29: *That section 58 of the Health Practitioners Competence Assurance Act 2003 is amended to simplify and reduce the administrative burden of the reporting requirements for quality assurance activities (page 63).*

NZNO supports this recommendation. We further suggest, and take this opportunity to advise that in general reporting requirements be aligned with what data is needed and how it is to be used. We note that lengthy Protected Quality Assurance Activities (PQAAs) reports delivered to Ministry were not even acknowledged, while other reports containing data arguably essential to workforce planning, not only remained undelivered but the omission was never noticed.

Recommendation 30: *That District Health Boards review their provisions for protected quality assurance activities and apply for any necessary amendment to the relevant regulation so that, where appropriate, the regulation covers information from all practitioners involved in the activity, whether or not these practitioners are employees or independent practitioners (page 64).*

NZNO supports this recommendation. We suggest that consideration be given to including Professional Development and Recognition programmes (PDRP) and

Quality and Leadership Programmes (QLP) for nursing and midwifery respectively in PQAAs. This would be more equitable.

Recommendation 31: *That the Ministry of Health and the Quality Improvement Committee consider research into the value and use of protected quality assurance activities (page 64).*

NZNO supports this recommendation and suggests that the potential conflict between PQAAs under the HPCA Act and the proposed National Incident Reporting system needs immediate consideration and resolution.

Chapter 9: Other issues for consideration

Recommendation 32: *That a definition is added to section 5 of the Health Practitioners Competence Assurance Act 2003 so that it is clear that the term 'emergency' includes prolonged emergencies such as a pandemic (page 65).*

NZNO supports this recommendation.

Recommendation 33: *That section 12 of the Health Practitioners Competence Assurance Act 2003 is amended to clarify that responsible authorities have the power to revoke an educational institution's accreditation (page 66).*

NZNO suggests that Section 14 (1) *An authority may at any time, by notice in the Gazette, amend revoke or replace a notice under section 11 or section 12* is sufficiently clear.

Recommendation 34: *That section 15 of the Health Practitioners Competence Assurance Act 2003 is amended to give responsible authorities the power when necessary to recognise New Zealand qualifications as equivalent to qualifications that have been prescribed under section 12 (page 66).*

NZNO supports this recommendation.

Recommendation 35: *That the Ministry of Health works with responsible authorities to clarify the intention of section 16 of the Health Practitioners Assurance Act 2003 when judging fitness for registration (page 67).*

NZNO supports this recommendation.

Recommendation 36: *That section 17(4) of the Health Practitioners Competence Assurance Act 2003 is amended to include fines and costs imposed on practitioners by disciplinary findings under the relevant former legislation on professional registration (page 67).*

NZNO supports this recommendation.

Recommendation 37: *That section 49 of the Health Practitioners Competence Assurance Act 2003 is amended to allow a responsible authority to require an examination by a medical practitioner or another appropriate health practitioner (page 69).*

NZNO supports this recommendation to extend section 49.

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