Submission to the Productivity Commission

A model to develop a common training package for the professional health sector

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Acknowledgement

If the Commission were to use our model for inclusion in the final report the most appropriate way to sight our organisation would be:
The Centre for Innovation in Professional Health Education (CIPHE)
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Summary

The Centre for Innovation in Professional Health Education (CIPHE) proposes the exploration of the development of a common professional sector training package. The Training Package would cover generic skills and workplace-based assessment items that are common for practitioners in medicine, nursing, dentistry, allied health and health administration.

In addition to the evidentiary basis for such an initiative, a window of opportunity currently exists to collaboratively develop such a Training Package. The competencies contained within the recently developed National Patient Safety Education Framework provide a ready starting point to begin the process.

The package could be developed by a National Training Authority or similar organisation with representation from the professional colleges, professional associations, training providers, health providers, employers and governments.

The benefits associated with adopting a common professional sector training package would be widespread and would be implemented at the level of the individual health care worker, their professional body and the health care facilities within which they practice.

Any common professional training package would articulate or be compatible with the Vocational Education and Training (VET) sector HLT2 training package currently under review and with higher education awards. This will provide new opportunities in workplace based assessment and training across the health care sector.

Background

The content of this submission is based on:

- The wide experience of the authors in developing curricula for the professional colleges and associations
- Consultation with the Vocational Education and Training (VET) sector
- Extensive and national consultation with a wide variety of health care workers, managers, administrators and health consumers in many different health settings during the development of the National Patient Safety Education Framework. The framework was developed by CIPHE and Associate Professor Merrilyn Walton for the Australian Council for Safety and Quality in Health Care.

A funding application is currently before the Australian Council for Safety and Quality to fund a pilot to test the proposed model.

The opportunity

An opportunity currently exists in postgraduate professional health education in medicine, nursing, dentistry, allied health and health administration to use the development of 'generic' professional health competencies to precipitate real and lasting collaboration between professional colleges, professional associations, employers, health service providers, training providers and government.

Generic competencies in this context cover items such as team work, obtaining informed consent, managing adverse events, demonstrating leadership, fitness to practice, ethical practice and so on. Generic competencies do not include the specialty skills of a given profession – although development of generic competencies has led to a re-evaluation of just what skills differentiate health professionals and which are shared.

Current debate around changes in the regulatory/authorising environment surrounding health care education and training provides the necessary momentum to develop a collaborative common training package containing the generic competencies and assessment items for the professional sector. Ideally these competencies and assessment items would be developed under the direction of a consultative National Professional Training Authority or the like (akin to the Vocational Education and Training (VET) sector HLT2 Package and skills councils).

If this opportunity is missed, it may evaporate once professional colleges and associations take ownership of their 'own' competencies, thereby reducing the perceived benefits of collaboration.

What would be the benefit from adopting a common professional sector training package in generic skills?

- Improve patient safety and quality of service
- Facilitate the concept of 'a team approach' in delivery of health care
- Provide common standards in required performance in generic skills. This would:
    - Reduce duplication in training (while maintaining diversity)
    - Identify gaps in training
    - Allow for comparison between training programs
    - Assist employers to recruit/assess competent staff

- Formulise and facilitate collaboration and communication between professional colleges, professional associations, universities, health providers, employers and governments
- Facilitate the recognition of 'prior learning' for health trainees changing professional streams or during the development of new types of health care workers
- Facilitate the development of interprofessional training and multidisciplinary care
- Allow for real articulation between the VET and professional sector
- Improve the ability of health service providers and government to determine the generic competency of the professional workforce

What are the current drivers for the development of competency in generic skills?

- Repeatedly, the well publicised 'breaches' in patient safety involve inadequate training and assessment in generic competencies (Camden/Campbelltown, Bundaberg etc)
- Education frameworks such as CANMEDs that give equal weight to generic skills and specialist skills are increasingly being applied in professional health education and training
- Regulating authorities (such as the Australian Medical Council (AMC)) expect that new and revised curricula will emphasise generic skills
- There is increasing pressure on chief executives of health services to be responsible for the competency of their workforce
- There is increasing recognition that health care education urgently needs modernising
- There is a recognition that training and education have become secondary to service provision *(Doherty Inquiry 1988, Inquiry into Obstetric and Gynaecological Services at King Edward Memorial Hospital (WA) 1990-2000*
- There is a definite move towards performance-based outcomes in professional education and training as opposed to more traditional knowledge-based education and assessment. While this shift in emphasis does not imply that specialist skills (or indeed that all generic skills) can be dealt with entirely using performance-based education and training, it will provide a long overdue opportunity to fully explore the nexus between the two methodologies
- There is increasing interest in how the VET sector implements collaboratively developed training packages. Their experience in the development of common competencies for VET sector workers represents a major resource for the professional sector. A move towards generic competencies in the professional sector would allow for easier articulation between the two sectors – especially in evolving

crossover areas such as radiographers/radiologists, enrolled nursing/registered nursing etc.

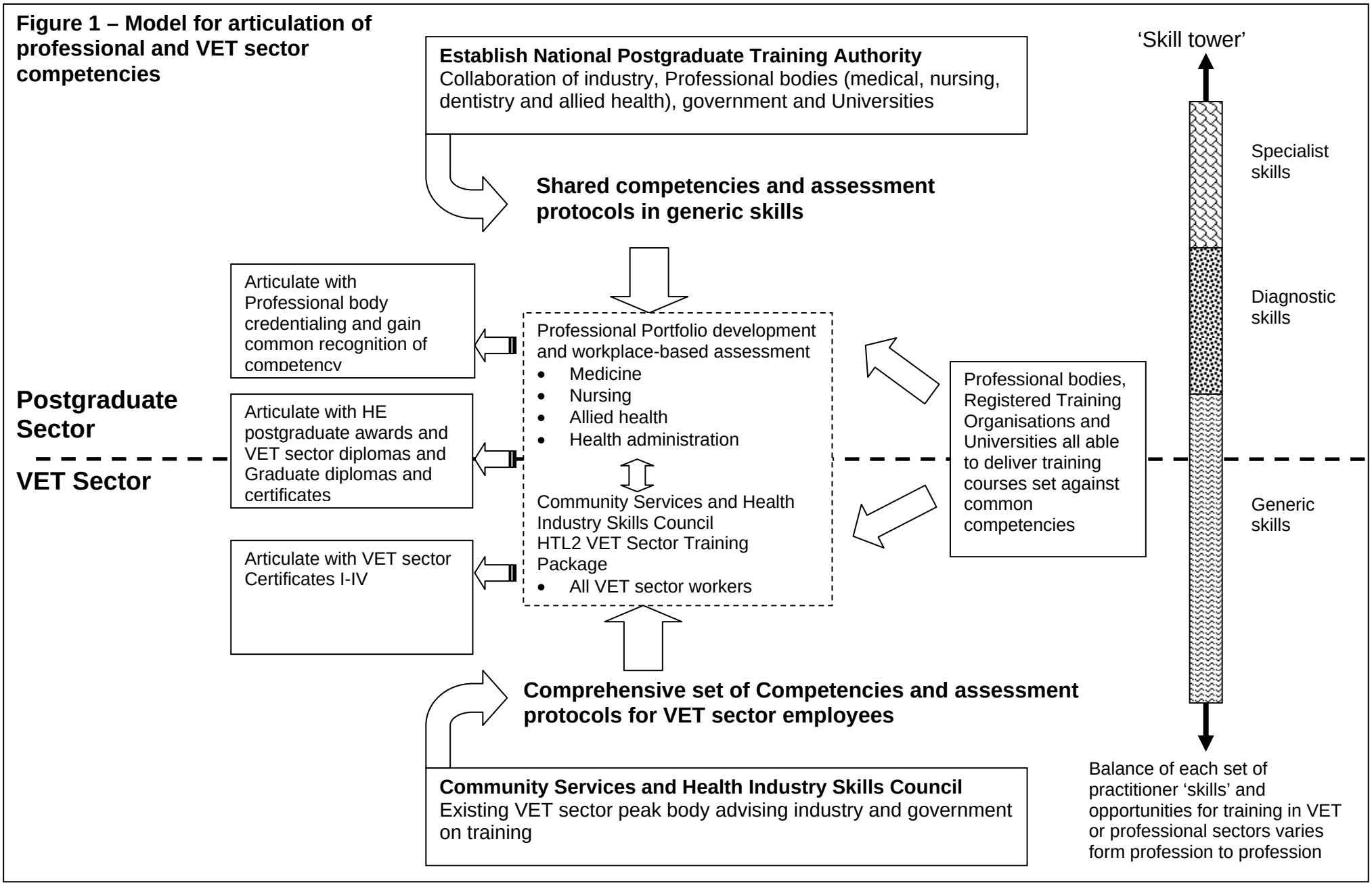
- The National Patient Safety Eduction Framework presented to the Health Ministers in July provides a ready made interprofessional framework of competencies in the generic skills required by health care workers.

Why would the stakeholders collaborate in the development of a common training package in generic skills when they haven't in the past?

- The evidence regarding the extent of adverse events in the health system has only been available in the last decade. Analysis of the causes of errors in the system points to the design of health care education and the need to deliver care in multidisciplinary teams as central feature that needs fixing.
- Generic skills training and assessment is a relatively new area and professional colleges and associations are grappling with the development of curricula and assessment items in this area. In particular they are struggling with engaging their fellowship in providing generic skills training as many of the items are as new to the trainers as the trainees.
- There are obvious advantages for these groups in pooling resources in the development of these competencies and assessment items and recent forums have indicated a strong willingness to collaborate (AMC/Professional College assessment workshop Melbourne 2005).
- Being proactive in the collaborative development of a national training authority to develop common competencies and assessments items would provide an alternative to the imposed training authority model as adopted in the UK (AMC/Council of the Deans of Australian Medical Schools (CDAMS) conference 2005).
- Generic skills lend themselves to a collaborative development approach and if interprofessional training and multidisciplinary care are to be taken seriously then the development of common competencies and standards is a prerequisite.
- It is likely that assessment of performance in generic competencies will require workplace based assessment and collaboration with third party training organisations and health care providers. It will be difficult to coordinate this without formal collaboration between stakeholders that include the health care providers, professional colleges, professional associations and health care training providers.

Figure 1 outlines a schema for a possible model for articulating professional and VET sector education, training and assessment.

Figure 1 – Model for articulation of professional and VET sector competencies



Educating for patient safety: safe health care is everybody's business

Merrilyn Walton
Faculty of Medicine
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Australia

The way we were
The way we are now
Where do we want to be?

The way we were

Rene Laennec
(1781-1826)
Inventor of the first
stethoscope

18th Century

19th Century

St.Vincent's Hospital Sydney (1857)
Source: The Mitchell Library, State Library of New South Wales

HOSPITALS

Pre 19th Century

Multipurpose centres (charity work and sheltering the sick and poor)

Since the 19th Century

Institutions for the treatment of patients, medical research and education of medical students

Role of hospitals (19th century- 2005)

- Treating patients
- Medical research

&

- Medical education

Hospitals

- Development of specialist hospitals (end 19th Century)
- By the 20th Century doctors were the primary providers of medical care
- End of the 19th Century hospitalised patients came from all socioeconomic classes not just the poor

The way we are : impact of technology and specialisation

Changes in hospitals

- Rapid growth of technology from the1960s

  - Contributed to the development of high technology hospitals and increasing costs.

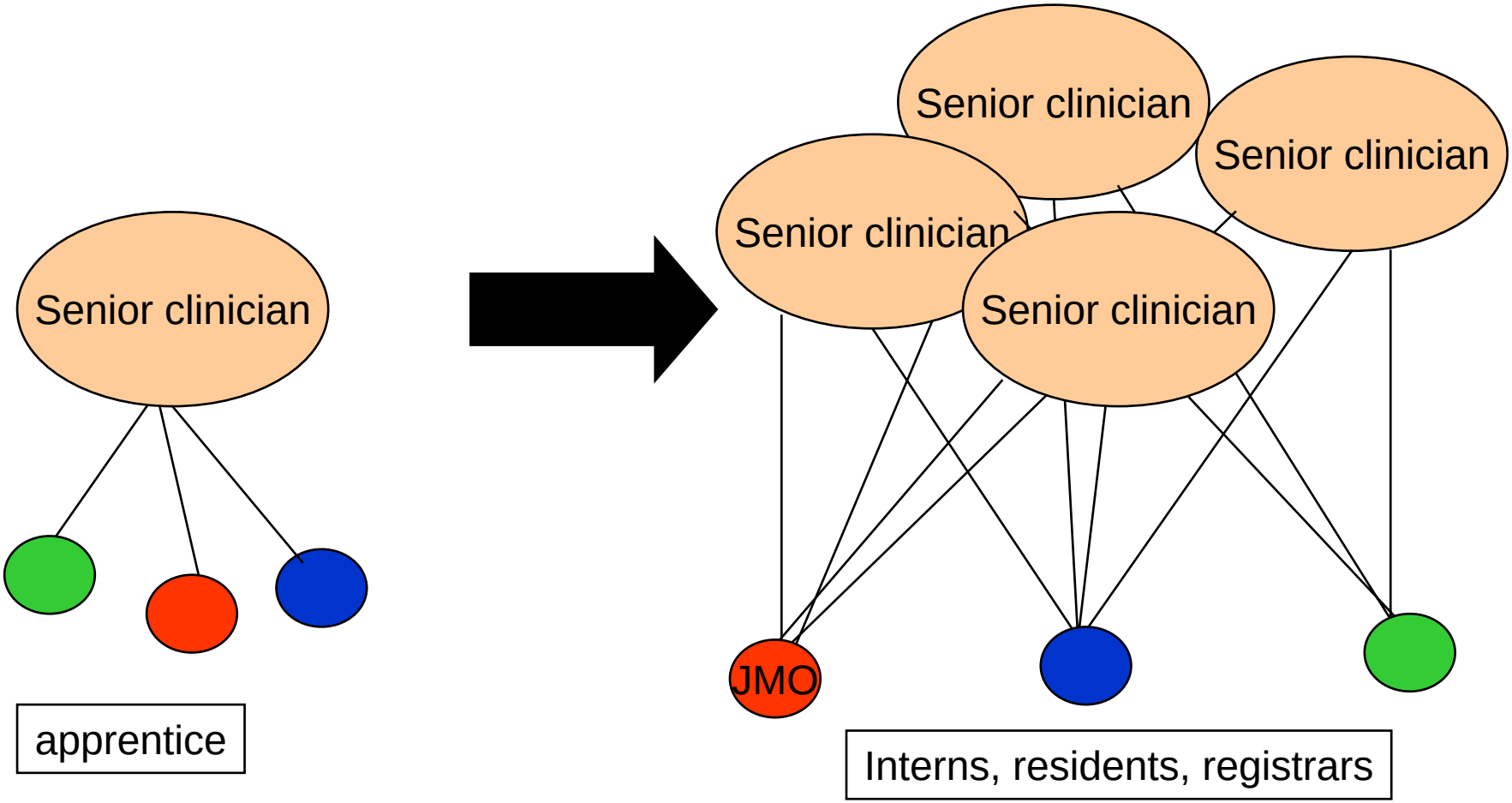
- Technology includes drugs, equipment, operating theatres, surgical procedures, intensive care units, medical devices and instruments.

  - Imaging

    - ultrasound was introduced in the 1960s and successive decades have seen the development of Computerised Tomography (CT) scanners, Magnetic Resonance Imaging (MRI) Positron Emission Tomography (PET).

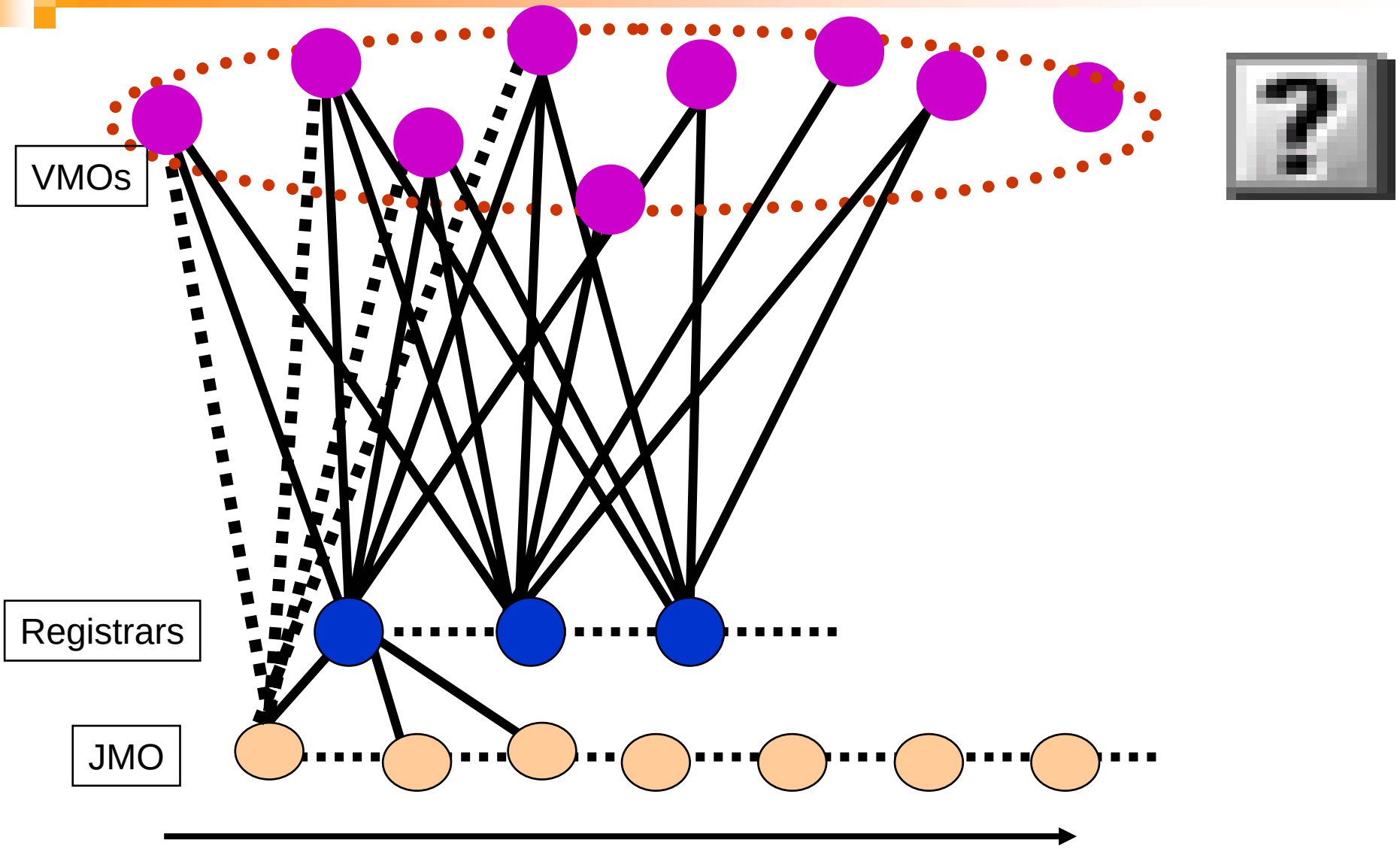
Registrar
Resident
Intern

Apprenticeship in
The 21st Century



Apprenticeship up to 20th Century

Apprenticeship up to 21th Century



A system past its use by date?

Why has this structure endured despite these problems?

1. Immediate needs of hospitals often dictate the make up of the medical workforce.
2. Training needs of the interns and residents are often secondary to the need of the teaching hospitals to provide services.
3. Most junior medical staff do not work in a primary health care setting.
4. People move through the system at a relatively fast rate.
5. Senior staff are costly.

Unanticipated outcomes of specialisation – by 1900

- Separate departments and research centres emerged with their own medical hierarchies and career paths

- These specialties were **added onto** existing structures without reference to the needs of patients or overall organisation

Unintended consequences of specialisation – by second half of 20th Century

- duplication and inefficiencies

- a system designed for the work routines of busy clinicians

Medicine, once an individualistic, intuitive and personal enterprise

a complex interdependent and impersonal social service

Knowles JH. *Hospitals doctors and the public interest*. Cambridge MA: Harvard University Press, 1965.

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System for admitting and treating patients remained essentially unchanged.

- Patients are still admitted under an individual clinician who usually makes decisions about admission and discharge.
- While clinicians may ‘own’ their patients, the day-to-day needs of patients are managed by a hierarchy of nursing and medical staff and allied health.

The roles of the Visiting Medical Officers/ Consultants have not changed substantially since the nineteenth century

Consequences of the options explosion

- **Exponential increase in interdependencies** :
  - 2 people : 1 relationship
  - 10 people : 45 possible relations / interactions [x=n(n-1)/2]

    → *Increased risk of communications problems at interfaces*

- **Cumulative error rates in a multi-stage process (assuming 95% error free) :**
  - 1 stage - 5 % chance of error
  - 10 stages - 40% chance of cumulative error

    → *increased in risk of adverse events*

Early recognition of problems

- Lack of continuity between universities and hospitals
- Fragmentation between undergraduate, graduate and vocational training.

Medical Education in Australia: Present Trends and Future prospects in Australian Medical Schools:
Education Research & Development Committee (ERDC), AGPS Canberra, 1978. Report

- Manpower implications of vocational training,
- Actual and required numbers of training posts in each state
- Funding of postgraduate training programs, and
- The service commitments of trainees and length of training programs.

The Commission of Inquiry into the efficiency and administration of hospitals : Jamison Inquiry 1981 (ToR)

- Explicit statement about the relationship between the training of doctors and the delivery and financing of medical care

- First ToR - the adequacy of the internship year for producing medical graduates with the appropriate skills and competencies to meet national health care needs.

The Doherty Inquiry 1988

- A stressful experience for interns and residents
- Random acquisition of practical skills
- Learning depends on personal initiative
- Registrars and nurses who once assisted in teaching practical skills- now too busy.
- not due to increasing numbers of patients, or to changes in health care scheme, but to technology creep which means that
  - the same number of inpatients in the 1980s generates considerably more work (eg serum theophylline assays, antibiotic assays, ultrasound examinations, etc.) than in the 1960s (when the number of test and treatment options available was comparatively limited).
  - Workloads have changed, so that interns are now tending to learn by experience and experimentation as well as by guidance.

Sir Charles Gairdner Hospital (Western Australia) submission to Doherty Inquiry

Acknowledged the major change in the latter part of the 20th century

- but the legacy of the historically based tradition of medical education within acute hospitals remained
- problems included emphasis on curative medicine at the expense of preventative medicine
- separation of physical from mental illness

Doherty Inquiry 1988

- continued focus on high technology medicine in the acute care setting.
- lack of community involvement
- continued misapplication of high technology medicine to patients with chronic, disabling or irreversible disease.

Doherty Inquiry 1988

Inquiry into Obstetric and Gynaecological Services at King Edward Memorial Hospital (WA) 1990-2000

- Inadequate supervision of junior medical staff by consultants was a serious problem facing the hospital.
  - Unsupervised junior doctors had major responsibility for assessment and providing care in many complex clinical situations
- Recognised that residents did not have the necessary knowledge and experience to manage complex cases.

- multiple stakeholders
- no accountability framework for medical training
- no objective measures for training posts
- no reporting of educational outcomes
- training roles undervalued by hospitals
- inadequate selection and recruitment procedures
- training mainly confined to the public system
- no clear links between training posts, service needs and workforce planning
- inflexible work practices
- inadequate training for unstreamed residents

5th International Medical Workforce Conference;
November 2000; Canberra.
Australian Medical Workforce Advisory Committee 2001 Canberra

Implications for training & education

- Supervision/apprenticeship model unsustainable
- Inadequate learning opportunities
- Limited/too much responsibility
- Insufficient time for reflective thinking
- Need vertical rather then horizontal integration (multidisciplinary teams)

Where do we want to be?

&

How do we get there?

A new way

- New models for training & education required
- Integrated teaching/learning/service environment
- Recognise interdependencies
- Multidisciplinary learning & training

Vision for patient safety

All health workers are educated and trained to deliver patient-centred care as members of multidisciplinary teams, using evidence-based and ethical practice, quality improvement approaches and information technology.

Safety+Quality
COUNCIL

National **Patient Safety** Education
Framework

The Australian Council for Safety and Quality in Health Care - July 2005

Principles underpinning education about patient safety

- Patient-centred
- Incorporates community views
- Emphasises quality of care
- Simple, flexible and accessible
- Generic
- Uses standardised and clear English
- Evidenced - based or identifiable best practice
- Template for flexible working environment
- Safety is everybody's business

What is the Framework?

It sets out the knowledge, skills, behaviours and attitudes that all health workers need to provide the safest possible care to patients.

Communicating effectively
Involving patients and families as partners
Communicating risk
Communicating honestly with patients after an adverse event
Obtaining consent
Being culturally respectful and knowledgeable

Identifying preventing and managing adverse events & near misses
Recognising, reporting and managing adverse events and near misses
Managing risk
Understanding health care adverse events and near misses
Managing complaints

Using evidence and information
Employing best available evidenced–based practice
Using information technology to enhance safety

Working safely
Being a team player and showing leadership
Understanding human factors
Understanding complex organisations
Providing continuity of care
Managing fatigue and stress

Being ethical
Maintaining fitness to work or practice
Professional and ethical behaviour

Continuing learning
Being a workplace learner
Being a workplace teacher

Specific issues
Preventing wrong site, wrong procedure and wrong patient treatment
Medicating safely

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Duncan Neuhauser
George Rubin
Bill Runciman
Andrew Wilson

Education
Stewart Barnet
Greg Ryan
Simon Willcock
Natalie Collison

Consumer
Meryll Green

Validation Group

National & international Experts

Stakeholders and wider community

Wide consultation through targeted focus groups and web-based review and feedback

Trail sites

6 hospitals
1 nursing home
1 general practice
1 Community centre

Safety+Quality COUNCIL

Who is it for?

- Individual health care workers
- Educational institutions for curricula development (TAFE and tertiary)
- Training providers in the hospital and primary health care sectors
- Professional bodies
- Accrediting bodies
- Employers

Multiple uses

- Reviewing competencies in existing programs
- Identifying gaps
- Developing new education and training programs
- Reviewing and developing job descriptions & performance criteria
- Development of accreditation standards

The context is the individual health worker in the workplace

Be prepared, have the intention and be ready to work safely

Learn from mistakes

Manage Incidents appropriately

Communicate effectively

Reduce risks to patients, themselves & colleagues

Work safely even after all foreseeable risks have been reduced

Challenges

- Finding the best teaching & training approaches
  - Evaluation of learners' needs, learning environment, learning objects etc.
  - Role of opportunistic learning

Multiple assessment methods

- Performance measurement through observation
- OSCE (Object Structured Characteristic Examination)
- Patient surveys
- Peer review meetings
- Seminar presentations
- Simulation
- Formal examinations
- Portfolios.

Prerequisites for a revitalised education and training system

- Leadership
- Multidisciplinary team-based learning
- Engagement with patients
- Effective learning and assessment
- Multiple teaching methods at multiple sites.
- Collaboration: joint initiatives to review and develop outcome-based curricula.
- Incentives.

Change of direction

- Promoting performance-based education and training in patient safety
  - Decrease reliance on the structure and process-based system defined by exposure of learners to specific content for allocated time periods.
  - Lecture-style formats do not permit the learners to integrate or apply the information provided. (Wass et al Lancet 2001)
  - The evidence suggests that competency or performance-based education programs lead to improvement and better performance in examinations. (Wass et al Lancet 2001)

But

- There is debate about the nature of ‘competence’ itself
  - What it is, how it should be demonstrated and who should mandate it.(Grossman Am Journal of Occupational Therapy 1998)

- What is a ‘right way’ for learners to acquire the required knowledge and skills?
  - Further research and evaluation of teaching and assessment approaches
  - Use of multiple strategies that match local resources and assessment guidelines.

Some light in the tunnel!

- Experience of the Vocational Educational and Training (VET) sector
- Potential for integrating competencies into regulatory and governance frameworks
- Potential for integrating competencies into formal and informal education and training programs (high school, universities, TAFE, medical, nursing, allied health, informal training on the job)
- Workforce is under the spotlight

Evolution or Revolution?

Revolution