Health Professions Council of South Africa

Maintenance of License

Information Pack

04 June 2020

GLOSSARY OF TERMS

Competence – mastery of relevant knowledge and the acquisition of a range of relevant skills at a satisfactory level, including interpersonal, clinical, and technical components at a certain point of education, usually graduation from a clinical training program. Competence is knowledge based, is only of value as a prerequisite for performance in a real clinical setting and does not always correlate highly with performance in practice.

Essential knowledge – knowledge that is vitally important for professional practice

Formative assessment - a range of methods use to evaluate in-process knowledge and skills to determine learning needs. The general goal of formative assessment is to collect detailed information that can be used to guide learning. What makes an assessment "formative" is not the design of the tool such as a test, technique, or self-evaluation but the way it is used—i.e., to inform in-process learning. Formative assessments are *for* learning.

Maintenance of license - is a process directed by the HPCSA. It is defined as the process by which practitioners must regularly demonstrate that they are up to date and fit to practice their profession. This will mean that they are able to keep their license to practice. Recertification and revalidation are terms synonymous with maintenance of license. Maintenance of license includes a focus on patient outcomes, peer review, and patient perceptions of care. Maintenance of license as a demonstration of performance in practice, ideally takes a work-based and a knowledge-based assessment approach. Maintenance of license can be considered a process rather than an event, and thus has both formative and summative functions.

Performance - the degree to which learners do what the learning activity intended them to be able to do in their practice. Performance describes what an individual actually does in a real-life encounter with a patient when applying learned knowledge and skills.

Performance Appraisal - a regular review of a practitioner or team's performance which provides feedback on the skills, achievements and growth which is used to guide a practitioner/ team's CPD learning program and application of learning to practice. Performance is assessed during and following encounters with patients and ideally includes assessment of patient

outcomes. Acceptable performance means practising to a standard acceptable to reasonable peers and to the community.

Planned Learning at or separate from the point of care, leading to the creation of a learning plan developed independently or in collaboration with peers and/or mentors.

Professional practice i.e. Professional role: clinician, teacher, researcher, administrator, manager, leader

Random Audit - a process undertaken by the HPCSA secretariat in which a random sample of health practitioners, from every register, will be selected for an audit to ensure compliance with MoL requirements.

Summative assessment - refers to assessments *of* learning. Summative assessments are used to evaluate learning progress and achievement at the conclusion of a specific period of learning. What makes an assessment "summative" is not the design of the tool such as a test, technique, or evaluation but the way it is used—i.e., to assess learning that has occurred.

REGULATORY FRAMEWORK

The Health Professions Council of South Africa is mandated by section 26 of the Health Professions Act, 1974 (Act 56 of 1974) to ensure that all registered practitioners participate in Continuing Professional Development. The Council is empowered to determine rules relating to the 1) nature and extent of the programme to be undertaken by practitioners 2) conditions relating to continued professional development 3) criteria for recognition of activities and 4) rules relating to penalties for non-compliance.

The Maintenance of Licensure programme emanated from a Council decision in 2013, where it was resolved that practitioners would require a License to practice. The primary purpose of such a decision is to assure the public that their health practitioner, as a member of the self-regulating health professions, is up-to-date and competent to practice. The goal is improved patient/client outcomes and health systems strengthening. Practitioners need to maintain, improve and demonstrate their professional knowledge, skills and performance in order to be issued a License to continue practicing.

WHY DO WE NEED MAINTENANCE OF LICENSE TO PRACTICE

The purpose of maintenance of License (MoL) is to encourage, support and enable a culture of ongoing learning among practitioners, based on assessments of knowledge and performance relevant to professional practice roles (i.e. clinical, teaching, research, leadership) and competencies. A goal of MoL is to assure practitioners, their patients, the public and employers that licensed health care practitioners are accessing evolving knowledge, use evidence-based practice, adhere to national guidelines, and are complying with expected professional practice standards. Licensed practitioners will be recognised and respected as competent, skilled and safe.

MoL is a quality improvement and a quality assurance process demonstrating the commitment of practitioners to life-long learning improvement and competence in their professional roles. In engaging with MoL, practitioners will determine their knowledge and performance for their particular professional practice relative to that expected by the profession, engage with the requisite learning, apply learning to practice and periodically demonstrate their engagement in an ongoing culture of professional assessment.

WHAT LED TO MOL? RATIONALE FOR MAINTENANCE OF LICENSE (MOL) TO PRACTICE

Upon successful completion of professional education and training and registration with the HPCSA practitioners remain registered for the rest of their careers. In recognition of international and national consensus that the initial qualification and subsequent registration alone were not sufficient to support quality care across a practitioner's career, the HPCSA, in 2007, required all registered practitioners to participate in Continuing Professional Development (CPD). The goal was to encourage practitioners to update their knowledge and skills to enable ethical and competent practice. Practitioners have been required to attend CPD programmes and document their participation (e.g. attendance at CPD events). Practitioners' compliance with CPD has not been satisfactory and the programme has not had sufficient impact on improving health service outcomes. For this reason, maintenance of License to practice has been included in a refined model of CPD.

The privilege of self-regulating professions requires demonstrated accountability of health care practitioners' continuing competence to act in the best interest of service users. As current annual registration does not require any competency-based assessment, there is no verification of HPCSA registered practitioners' ongoing competence, with the professions being unable prove to the public that the highest standards are ensured. Trend analysis of complaints received from the public by the HPCSA in 2019 reflect that the most frequent complaints related to quality of care (negligence constituting 31.2% and patient abandonment, 9.1% of the complaints). Cases of poor care by practitioners are reported in the media and erode public confidence in health care practitioners. It is important to restore the public's trust in the safety and quality of health care they can expect to receive, as well as to provide reassurance that health care practitioners are competent and maintain their competency throughout their professional careers.

Advancement in the practice of most health professions rapidly generates new knowledge and technology, posing challenges for practitioners to stay up to date in their practice. It becomes important to ensure practitioner competence in light of these advancements. Systematic reviews suggest that acquired knowledge is meaningful only when it offers an opportunity for a change in practice[1]. There are concerns regarding the variability of translating knowledge into evidence-informed decision-making. In addition, translation of knowledge into practice is

typically not optimal with a lag between acquiring knowledge and applying it in practice[2]. This lag in translating knowledge into practice in healthcare may be profound, with estimates of up to 30% to 40% of patients not receiving care that is informed by the best evidence, and 20% to 50% receiving inappropriate care[3]. Notions that years of experience equate to greater competence are challenged by findings that practitioner knowledge, competence and performance deteriorate over time: there is a 4.5% increase in relative risk for patient mortality for each decade of physicians' graduation from medical school[4]; and the probability of appropriate treatment intensification decreased by 21.3% for every decade since last board certification[5].

Several countries (USA, UK, Australia, New Zealand, Canada) have introduced national policies and programmes directed at validating the continuing competence of practitioners in order to reduce practitioner errors, ensure quality care and reduce patient harm. Such programmes are variously referred to as Maintenance of Certification (MoC), Revalidation and Maintenance of Licensure (MoL). These nations require practitioners to demonstrate evidence of their continued competence through assessments and performance data. There is a combination of requiring engagement with CPD and a demonstration of how learning has led to professional practice improvement or patient care outcomes.

The HPCSA, in 2013, took a decision to implement maintenance of License in keeping with its regulatory role to uphold the social contract between the health professions and the public, and require practitioners to demonstrate continued competence.

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THE EVIDENCE FOR THE VALUE OF MOL

What is the evidence to support the merit of the maintenance of License programmes? Research, despite some limitations, overwhelmingly demonstrates the value of the maintenance of certification, revalidation, and MoL strategies[1]. For ease of reference, this document will refer to these variously termed yet synonymous programmes as maintenance of License (MoL). Patient outcomes in a range of conditions and disciplines were significantly better where physicians had engaged with MoL. In a summary[1] and a narrative analysis[2], in 31 of 33 studies and in 37 of 39 studies respectively, MoL was associated with improved adult and paediatric care. Examples of improved care and patient outcomes are described.

MoL was associated with improved care of patients with diabetes. Diabetic patients of physicians who maintained certification more frequently met the annual standard for low-density lipoprotein (LDL) cholesterol measurement and all 3 diabetic standards[3]. Women's health benefitted from MoL. Biennial mammography screening recommendations were met more frequently among physicians who maintained certification[4]. Women who had not received prior mammography screening were 8.5% more likely to get screened when seen by a general internist who was required to maintain a License[4]. Physicians engaging with MoL demonstrated superior skills relating to cardiac conditions. Measures for LDL cholesterol testing in patients with coronary heart disease were met more frequently among physicians who maintained a License[3]. Use of MoL quality improvement strategies significantly reduced a composite measure of cardiovascular risk by 13.4% in children compared with the control group[5]. Fifty two paediatric cardiac centres achieved a 44% relative reduction in interstage mortality after hypoplastic left heart syndrome repair with the importance of MoL as an incentive for participation being acknowledged[6]. Emergency medicine physicians who participated in MoL were less likely to miss a diagnosis of acute myocardial infarction in the emergency department than noncertified physicians. Licensure status had a higher correlation with reduced patient mortality[7]. A lower rate (19%) of mortality in patients was reported for cardiologists who underwent licensure compared to those who lacked a License[8].

Paediatric care provided by MoL participants was significantly improved. There was increased vaccination capture rate for human papillomavirus (HPV) by up to 5.7%[9]; significantly increased use of asthma action plans and asthma control tests among their patients[10]; significantly increased preventive services at the 9 month and 24 month visits[11]; a 56% reduction in central line– associated blood stream infections among paediatric intensive care

patients[12]; a 23% reduction of medical errors among paediatric residents[13]; significantly increased remission rates for inflammatory bowel disease[14]; increased developmental screening, documented obesity self-management and asthma action plans[15], improved chart review scores (number of charts with documented completion of key clinical activities required for transitioning from adolescent to adult care)[16]; increased explanation of minor consents and parental notifications and increased confidential risk behavior screen completion with adolescents[17]; increased BMI documentation, nutrition[18] and physical activity counselling, and documentation of weight category[19]; increased use of injury prevention screening tool[20]; and increased pregnancy testing before cyclophosphamide infusion[21].

MoL was associated with fewer disciplinary actions in Emergency medicine[22] and in Internal medicine[23]. MoL was also associated with a reduction in health care costs without quality being sacrificed. Those required to maintain licensure were reported to save the US healthcare Medicare costs approximately $5 billion per year[24].

There is also a link between MoL assessment scores and performance. Physician MoL examination scores were significantly related to their performance and the diabetes outcomes of their patients[25]. Receiving care from a physician who scored in the top quartile of their MoL assessment was associated with a 17% increased odds of guideline compliant diabetes care compared to those who scored in the bottom quartile[26]. Scoring in the top quartile on the MoL examination was associated with a greater likelihood of mammography screening than physicians in the lowest quartile[26]. The risk of disciplinary action declined as scores on the MoC assessment increased, suggesting that better medical knowledge was related to fewer disciplinary actions[23].

The preponderance of evidence suggests that programmes aligned with MoL can be viewed as means to enhance healthcare quality and protect the public. These studies have been conducted by the medical profession. Research from other professions would contribute to a more holistic picture.

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RATIONALE FOR HPCSA MODEL OF MAINTENANCE OF LICENSE TO PRACTICE

The focus of the HPCSA's system of CPD has primarily been on continuing education to update knowledge. A more comprehensive model that links CPD to the maintenance of License (MOL) is proposed. The rationale is to guide genuine learning, enable improved practice and facilitate demonstration of continued professional knowledge and performance. This model will replace a system of CPD which has required practitioners to record the number of credits (Continuing education units i.e. CEUs) acquired for attending or engaging with CPD activities. Equating the number of CEUs accumulated with competence[1] has been suggested to be erroneous[2], as it does not necessarily indicate genuine learning nor does it equal a change in the quality of performance.

Currently, practitioners meet the requirements for mandatory CPD CEUs opportunistically, erratically or casually[2]. The impact of many CPD activities is limited when undertaken in an ad hoc manner outside of a defined structure of directed learning and contributes little to improved clinician performance or patient/client health outcomes[3]. Learning activities that are planned and which are interactive, encourage reflection on practice, provide opportunities to acquire and practice skills, involve multiple exposures, help practitioners to identify between current performance and a standard to be achieved, and are focused on outcomes, are the most effective at improving practice and patient health outcomes[3]. There is a greater responsibility on practitioners to set out their learning requirements, engage in focused learning and demonstrate improvement in their professional performance. Such models more explicitly recognize that different professionals will have different development needs and require individual practitioners to take greater ownership of their professional development.

The new HPCSA model will shift control of learning to individual health practitioners, enabling them to reflect on their learning needs and to design their own learning programmes[1]. It is essential that such a programme effectively addresses the gap between optimal evidence-based practice and actual clinical practice. The critical requirement is for practitioners to demonstrate that they have the essential knowledge and skills to in order to be issued a License practice their profession.

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ADVANTAGES OF MOL FOR THE PRACTITIONER

The autonomy of health care practitioners is fostered, as personal responsibility is given to individual practitioners to participate in the process, to identify their own learning needs, to engage with learning directed at improving their own professional practice-related knowledge and performance. The relevance of learning (CPD) and assessment (MoL) is increased as these are aligned with a practitioner's professional practice. Practitioners spend time confirming that they are indeed up to date, meeting relevant practice guidelines and offering evidence based/ best possible service. MoL will guide reflection to include an outcomes-based orientation. Alignment with international professional standards will be fostered while context-specific developments will be a particular focus.

THE HPCSA MODEL FOR MOL

The HPCSA model for MoL is integrated with CPD. It is a quality improvement and a quality assurance process designed to guide and demonstrate continuous improvement and performance in professional roles throughout a career. In engaging with MoL, practitioners will reflect on and determine (using a range of tools) their knowledge and performance for their particular professional practice relative to that expected by the profession. There will be multiple opportunities to engage with a range of tools and obtain feedback to assist with determining learning needs. Practitioners will engage with learning opportunities to enhance and refine knowledge and performance in accordance with identified learning needs. The learning will be applied to practice and periodically practitioners will demonstrate that they have the requisite knowledge and performance by engaging in ongoing professional assessment. Each time a practitioner succeeds in demonstrating the requisite knowledge and performance, credits will be allocated and reflected in the practitioner's personal MoL portal on the HPCSA website. Professional Boards will specify the nature and number of knowledge and performance assessments to be undertaken by their practitioners in a five-year period.

The core components of the model for MoL include:

- Reflect on and assess knowledge and performance across domains of practice,
- Determine learning needs,
- Develop and implement an individualized learning plan,
- Apply learning to practice, and
- Demonstrate knowledge and performance.

The HPCSA model for MoL can be seen in Figure 1.

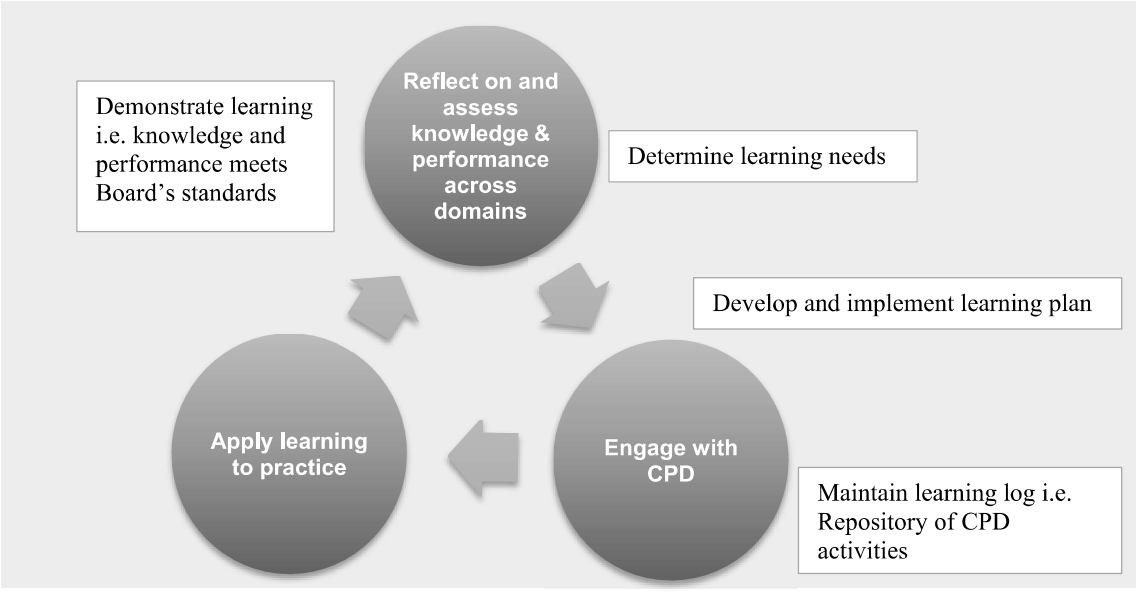

FIGURE 1. HPCSA MODEL FOR MAINTENANCE OF LICENSE TO PRACTICE

COMPONENTS OF THE MODEL

Reflect on Own Practice and Determine Learning Needs

Practitioners are required to reflect on their own professional practice, across all domains to identify areas of practice where improvements could be made, or to engage with further learning to remain up to date and fit to practice. In addition to reflection, practitioners will be able to gather supporting information via formative engagement with assessment tools, developed by the Professional Boards, to identify areas of practice where improvements could be made or further development undertaken.

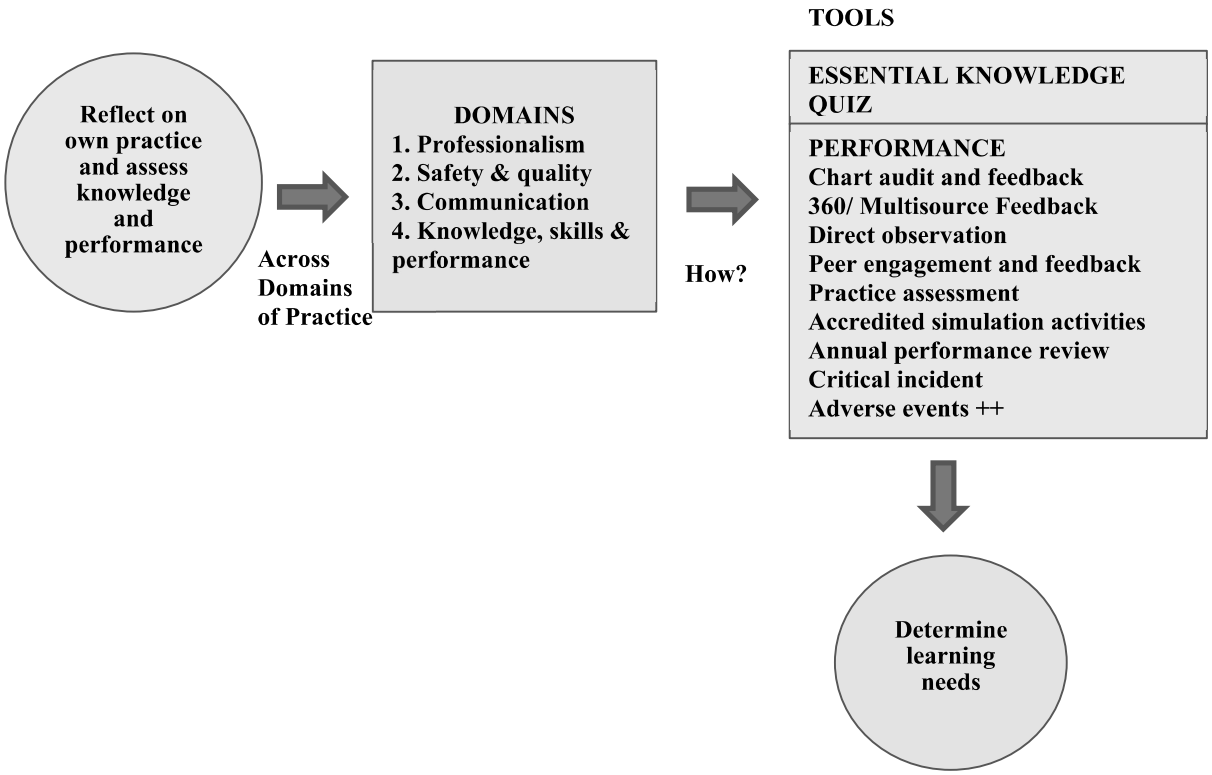

FIGURE 2: REFLECT ON OWN PRACTICE AND DETERMINE LEARNING NEEDS

Develop and Implement Learning Plan

Once learning needs have been determined, practitioners will develop an individualized plan to improve performance across the four domains of practice. Practitioners will select CPD activities and engage with learning in accordance with an individualized plan.

Apply Learning to Practice

Practitioners apply knowledge and skills acquired to practice/ patient/ client care/ health system.

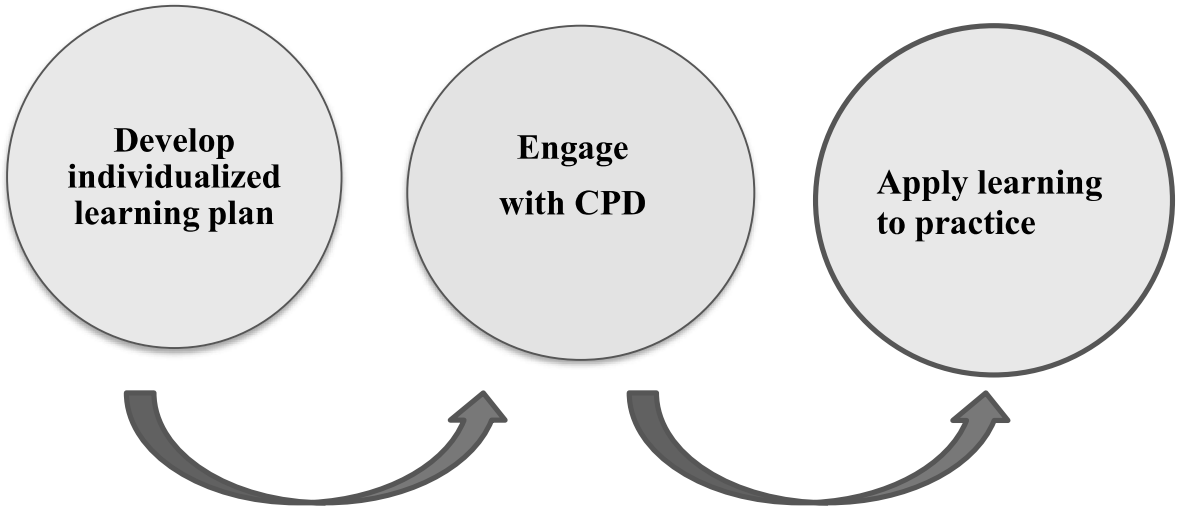

FIGURE 3: APPLICATION OF LEARNING TO PRACTICE

Demonstrate Knowledge and Performance

Practitioners will demonstrate the requisite knowledge and performance across all domains of practice, in a continuous manner by using a range of tools. There must be a demonstration that the requirements for knowledge and performance have been met within a 5-year period in order to be Licensed to practice. The License to practice is effective for 5 years.

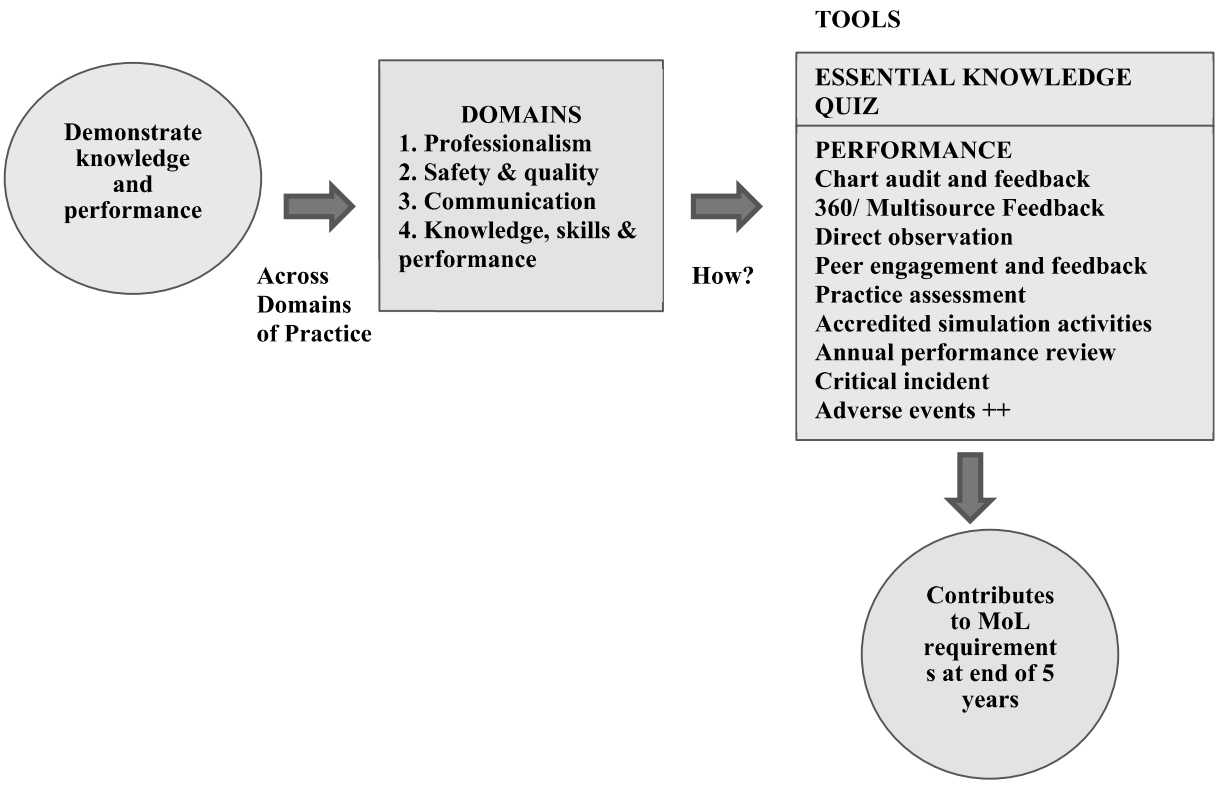

FIGURE 4: DEMONSTRATION OF KNOWLEDGE AND PERFORMANCE

THE REQUIREMENTS TO OBTAIN A LICENSE TO PRACTICE

Practitioners will be expected to engage annually with CPD which includes both assessments of knowledge and performance (Category 3 of CPD), as well as learning activities (Categories 1 and 2 of CPD). If the minimum annual requirements are met, then the practitioner will be adherent. If the requirements are not met, then the practitioner will be non-adherent, and both the practitioner and the professional board will be notified. Practitioner will be encouraged to be adherent.

At the end of a five-year period, practitioners will need to have met all requirements for CPD, inclusive of MoL assessments, as specified by the professional board annually and cumulatively (as illustrated in Figure 5). If all requirements are met, then the practitioner will be Licensed for a further 5 years. If the requirements are not met, then non-compliance results in no License to practice. Professional boards will specify guidelines for practitioners to become compliant and regain a License to practice.

Year 1	Year 2	Year 3	Year 4	Year 5
Category 1	Category 1	Category 1	Category 1	Category 1
Category 2	Category 2	Category 2	Category 2	Category 2
Category 3	Category 3	Category 3	Category 3	Category 3
Category 1 = Group learning CPD activities				
Category 2 = Individual CPD learning activities				
Category 3 = Assessments				
Weightings in each category to be determined by the professional boards				
Year 1 to 5				
Every year practitioners should be adherent with the required minimum credits and within 5 years achieve the total number of HPCSA determined credits across categories to be Licensed				

FIGURE 5: INTEGRATED CPD AND LICENSE REQUIREMENTS

PURPOSE OF ASSESSMENT IN MOL

Assessment is a key driver of learning, and formative assessment in MoL functions to assist practitioners to direct their learning to address any identified gaps between current and expected professional knowledge and performance.

Assessment (summative) is a key element of the MoL process and affords practitioners the opportunity to demonstrate to their patients, peers, employers and the public, that they have the required essential knowledge and skills for safe and evidence-based practice.

GUIDELINES FOR DEVELOPMENT OF ASSESSMENTS IN MOL

These guidelines are intended to support the development of assessments for MoL.

1. Assessments are designed to have both a formative and a summative function, with the purpose being clearly stated.

2. Assessments are planned against the competencies essential for evidenced based practice/ current best practice/ as per guidelines/standards of professional practice.

3. The end point of the assessment is defined with the appropriate standard (minimum competence) set in advance. Where possible, standards are set for each assessment, item by item.

4. Validity of the assessments is important so that the assessments measure what they claim to assess. The assessment measures relevant aspects of clinical and other skills required for patient care. Consideration is given to selecting the most appropriate assessment formats for the competencies to be assessed. For example, MCQs are not be the best measure of clinical competence skills and other performance indices.

5. Issues of assessment reliability are addressed. There are a range of assessments that adequately sample the desired attributes as competencies vary across different tasks/skills.

6. When assessment is used for summative purposes, the score at which a practitioner will pass or not pass is defined. An absolute standard is defined, below which practitioners have not demonstrated their fitness to practice. Such standards are set by criterion referencing. (Norm referencing is not acceptable for MoL assessments which aim to ensure that practitioners are safe to practice). Decisions based on the score reflect the concept that is measured (e.g., those that do well on the assessment should also do well in actual practice).

7. Assessments facilitate learning that is relevant, meaningful, and explicitly and authentically linked to individual practitioners' professional practice roles. Practitioners are able to select and weight areas relevant to them from a dashboard of areas of professional practice. Each practitioners' assessment reflects their own particular weightings and areas of practice to increase relevance.

8. Assessments are relevant to practitioners' daily practice. MoL teams engage with practitioners, e.g. via focus groups and surveys, to invite input on the frequency and

importance of each topic area to determine relevance. For example, national datasets are used to match the relative frequency of patient conditions seen in practice. Each topic area is broken down by tasks performed by practitioners in the course of practice for example, tasks could include assessment; diagnosis; management/care decisions; risk assessment/prognosis; pathophysiology; basic science, etc. Invite practitioners of the professional community to co-create assessments that are valued and accepted. Assessments contain at least 75% of questions that address high importance content and no more than 25% of questions address medium-importance content.

9. Development of relevant assessment content, such as high-quality clinical-scenario questions / patient vignettes are created by involving MoL committee members and practitioners at large. This brings more diversity to the content development process, lead to larger item pools, and potentially generates assessments with increased validity. The Professional Board (or delegated authority) continues to maintain oversight of the questions that appear on the assessments. Essential knowledge assessments require critical thinking, clinical reasoning and application of knowledge as opposed to simple recall of information.

10. Assessment are continuous over the course of the practitioners' career.

11. There are no once-off high-stakes assessments.

12. Practitioners are allowed to take assessments more than once to demonstrate their learning over time. Each time the assessment is taken includes new/ randomly generated questions on the topic.

13. Assessments are generally designed to occur at-home or in-office and not in a centralized location/ venue, based on practitioners' probity. Assessments are not time limited unless required for the competency/skill being assessed.

14. Feedback is critical for learning. Provision is made for sharing detailed information of practitioners' performance and any knowledge gaps following the assessment. The feedback is provided in a user-friendly format and may include the correct answer, a brief explanation of why the selected response is correct, appropriate additional

background information about the topic, and links to references or resources pertinent to this topic.

15. Practitioners, as far as is possible, receive their results immediately after the assessment. Delays in communicating outcomes cause stress and anxiety related to not knowing whether one has passed or not.

16. During the assessment, practitioners are allowed access to resources (e.g. UpToDate, books, articles, etc.). Closed book assessments are not realistic in an age when practitioners have constant access to internet-based and other resources. Learning is the key goal and accessing resources also improves authenticity to current practice. Access to an online resource reduced practitioners' anxiety about taking the examination and was shown to enhance the assessment's ability to differentiate between high and low performances.

17. Peer reviewers are familiarized with the relevant assessment tools, processes and guidelines. Potential for bias is managed.

18. Performance assessments are integrated into existing assessments of practitioners so as not to be overly burdensome (to practitioners and employers). MoL teams collaborate with employers to embed the critical assessment components for MoL into existing performance tools. Employers understand the developmental (and summative) nature of assessment and make provision for the practitioners to acquire the requisite skills.

19. Assessment integrates the domains of practice.

ATURE OF ASSESSMENTS

Assessments should address, at the least, two broad areas: essential knowledge for professional practice, and performance in practice. Examples of assessments for each are listed. *[Hyperlinks to developed tools]*

Self-reflection tools

Critical incidents

Compliments

Complaints

Review of clinical outcomes

Clinical audits

Feedback on teaching effectiveness

Patient feedback

Referral practices

Essential knowledge assessment tools

Includes online quizzes accredited by the Professional Board to assess essential knowledge for practice which can be taken at the beginning of an MOL cycle to determine learning needs and help to devise learning plans to address any gaps.

Skills assessment tools

Standardized patients

Simulators

Objective structured clinical examinations (OSCE).

Performance assessment tools

- **Multi-source /360 feedback** *[Link to descriptor and tool/ templates]*

Descriptor Multi-source/ 360 feedback should be aimed at quality improvement and is a collection of views from a range of sources (peers, team members, colleagues, line managers, patients, students, receptionists, administrative personnel, etc.). Practitioners review the feedback and demonstrate how it has been used to improve performance. Individuals providing feedback use structured rating scales devised by the Professional Boards MoL team.

The feedback is collated, and the results are used to make a judgement about an individual's performance. In order for this to be effective it is essential that practitioners select individuals who have both observed the behaviour they are assessing and are able to make a judgement about it. This may not be possible for some of the questions, in which case there is an "unable to comment" option. In addition to answering specific questions, addition of free text is encouraged.

The specific procedure for obtaining the feedback will vary depending on the tool used. Practitioners nominate a number of individuals in the different categories to complete the questionnaire about them. Practitioners also complete the same questionnaire. The feedback from colleagues and self-analysis are submitted to the HPCSA, anonymized, amalgamated and a report is generated which benchmarks the practitioner's scores against those of peers so that the differences can be compared. Practitioners can use the feedback to identify learning needs, discuss with peers, develop goals and implement learning plans to improve performance.

The feedback should: be anonymized, focus on the scope of the practitioner's work, be conducted confidentially, contain data externally inputted, collated and analysed to ensure an objective review of the information provided, allow for a comparison of practitioner feedback with that of an appropriate peer group.

- **Peer review**

Evaluation of performance of individual /group by members of same profession/team and/or multidisciplinry team. The process could be formal or informal. A formal process would include systematic review of aspects of work in accordance with set standards and includes feedback, guidance and critique of performance. Practitioners can use the constructive feedback to plan learning to improve performance.
Examples of peer review include: Joint review of cases; Review of charts; Practice visits to review health care practitioner's performance; Peer input into 360 appraisals and feedback; Critique of video review of consultation; Discussion groups; Interdepartmental meetings which review cases and interpretations of findings; Mortality and morbidity meetings.

- **Practice review: in practitioner's usual practice setting**

Descriptor
Practitioners will demonstrate learning/ actions taken to improve practice over the 5-year period. Assessments will address performance attributes specified in the different domains of practice.
Standard: Board sets the standard: A practitioner should be practicing at a standard acceptable to reasonable peers and to the community: Includes making safe judgments, demonstrating a

level of skill and knowledge required for safe practice, behaving appropriately and acting in a way that does not adversely affect patient/ client safety – across all domains of professional practice.

Assessors: Board to determine criteria and training for assessors; and to devise mechanisms to support objective assessment to promote fairness, reduce bias /subjectivity.

Process: Tools will be developed by the Professional Boards. The process could include: Interview with practitioner, Observation of practice/ consultation, Records review, Case based oral assessment, Peer ratings, Interviews with colleagues, Review of logbooks, audit outcomes and 360/ multisource feedback, and– where applicable analysis of data concerning prescribing and laboratory use. In addition, the process must include the provision of constructive feedback to assist the practitioner in identifying and addressing learning needs.

Outcome: Professional Boards will make a determination on the fitness to practice of those who continue to perform poorly e.g. supervised practice, non-renewal of License to practice.

- **Clinical audits/ Audit of practice/ Focused practice improvement/ Chart reviews:**

Descriptor

Process should be embedded in workflows. Clinical audits include a systematic critical analysis of own/team practice used to continuously improve clinical care/ health outcomes based on explicit and measurable indicators of quality OR To confirm current management/practice is consistent with current available evidence/ accepted consensus guidelines

*Note***:**

Topic for the audit relates to area of own practice that may be improved

- Audit may be multidisciplinary
- An identified or generated standard is used to measure current performance
- An appropriate written plan is documented
- Outcomes of audit to be documented and discussed
- Where appropriate, an action plan is developed, specifying actions to be taken and the process for monitoring, to maximize patient/client/health systems outcomes
- Subsequent audit cycles planned contribute to the process of continuous quality improvement.
- Professional Boards will develop tools to support practitioners with audits (practice review)

Healthcare Outcome Assessments

Descriptor

Potential tools include:

- Health care indicators
- Intervention outcomes
- Analysis of:
    - Patients' outcomes (complication rates and symptom relief); clinical audits are useful to assess patient outcomes. Note: Patient outcomes are the results of interaction between a patient and the health care delivery system (of which the medical practitioner is one component). Indicators include mortality, morbidity and patient-centered indicators of a patient's assessment of their own health and their evaluation of the care and services they receive.
    - Practice patterns
    - Patient referrals
    - Prescription practices
    - Optimal use of resources

FAQs

1. **What happens if the requirements for the MoL to practice are not met?**

   Options include:

   1.1. Non renewal of License to practice

   1.2. Professional board will specify guidelines for practitioners to become compliant and regain a License to practice

2. **What is the relationship between Registration and MoL**

Registration

Registration with the HPCSA requires practitioners to have successfully completed accredited education and training professional programmes and the payment of a once-off registration fee. Applicable to practitioners who do not practice their profession, but who wish to remain registered with the HPCSA. There will be no requirement to meet CPD or maintenance of licensure requirements.

License

Awarded to practitioners who practice their practice their profession and who meet the requirements for maintenance of License.

3. **Does MoL differ from the Health Market Inquiry's definition of License**

The Health Market Inquiry describe the License as the process of "…granting legal permission to do something, such as to produce a product or provide a service. The License confers a right which the person or firm did not previously possess. Some Licenses are granted free of charge, but most require payment."

4. **How does MoL for health professionals link to the National Health Insurance objective of accreditation of health establishments**

The National Health Insurance objective on phase 1 is to manage the "*process for the accreditation of health care service providers, which must require that health establishments are inspected and certified by the Office of Health Standards Compliance, health professionals are Licensed (MoL) by their respective statutory bodies (HPCSA) and health care service providers comply with criteria for accreditation"*