SUBMISSION TO THE INDEPENDENT REVIEW OF ACCREDITATION SYSTEMS WITHIN THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR HEALTH PROFESSIONS

April 2017

INTRODUCTION

Universities Australia (UA) welcomes the opportunity to make submission to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme (NRAS) for Health Professionals ("the Review"). UA understands that the Review and its associated discussion paper focuses on three main areas: improving efficiency; relevance and responsiveness and; future health workforce development. UA has responded to the discussion questions posed under each of these areas where applicable to universities and also provided further information where relevant.

ABOUT UNIVERSITIES AUSTRALIA

UA is the peak body representing Australia's 39 comprehensive universities. Our primary activity is public and political advocacy on behalf of our members. Where appropriate, we also work with members to coordinate a whole-of-sector approach to key issues. Health professional course accreditation is one such area. All universities conduct at least one health professional course regulated under NRAS/the Australian Health Practitioner Regulation Agency (AHPRA) and a number conduct multiple such courses[i]. Universities therefore play a key role in the entry level education and training of most NRAS health professionals and also many outside of NRAS. Reflective of this role, UA facilitates two health advisory groups: the discipline specific Health Professions Education Standing Group (HPESG) and the jurisdictionally based Health Education Workforce Group (HEWG) both of which have provided input into this submission.

ABOUT THIS SUBMISSION

UA supports accreditation and has itself worked with Professions Australia (PA) to develop joint Principles for Professional Accreditation to streamline and improve consistency in the professional accreditation of university courses[ii,1]. UA believes that, at its best, accreditation provides a valuable mechanism for protecting the interests of the general public (the primary focus of NRAS), students, education providers and employers by ensuring that educational programs are delivered at a level that meets or exceeds standards developed by experts within the professions [iii]. It enables continuous quality improvement, brings professional knowledge to university teaching practices, assists in the consistent delivery of competent and appropriately skilled health professionals and provides a pathway for developing the future health workforce in line with emerging trends. Accrediting authorities under NRAS also require monitoring of graduate outcomes and benchmarking which is useful and can otherwise be difficult to achieve in a competitive environment. NRAS's connection between accreditation and national registration through AHPRA also assists in gathering health professional data to support a range of activities including workforce analysis/planning and best practice course delivery.

[1] The Statement is designed for university course accreditation broadly, including, but not limited to, the health professions.

At its worst, however, experiences of health professional course accreditation can be overly bureaucratic. It can duplicate assessments better or already conducted by other regulatory authorities, focus unnecessarily on process and input rather than output and outcome measures and constrain innovation regarding future workforce development. While this is not the case all the time or across all health courses, UA considers that there are still some areas for improvement. These are addressed below under the three main discussion paper headings. Of note, while UA understands that the review is focused on the current fourteen[2] NRAS professions, reference is also made within the submission to the self-regulating professions.

IMPROVING EFFICIENCY

Accreditation standards

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?
2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?
3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

A common theme reported by members in relation to efficiency is unnecessary duplication of processes. There are two main issues here: duplication of health professional course accreditation standards with the Higher Education Standards against which the Tertiary Education Quality Standards Agency (TEQSA) monitors universities and; duplication of standards which are common amongst the NRAS professions. Of note, the "Harmonising higher education and professional quality assurance processes for the assessment of learning outcomes in health" commenced work which could be built on regarding both of these areas[iv].

In relation to the first issue, UA sees significant potential efficiencies to be gained in reducing the current duplication between health professional course and TEQSA accreditation. UA is informed by members that a number of the accreditation standards monitored by TEQSA are re-assessed under individual health course accreditation in some professions. (For example, the Australian Physiotherapy Council, has in the past commented to some universities with respect to compliance with Australian Qualifications Framework [AQF] requirements, which is clearly the role of TEQSA as have the Australian Dental Council [ADC], although it is also recognised that the ADC standards are generally well regarded and are used as a model by a number of other accreditation councils.)

As one university commented*: "TEQSA looks in detail at university governance structures and quality assurance processes. If the health profession accreditation cycle were aligned to that of TEQSA, the audit of the financial status and governance structure would not have to be repeated. Further, if the institution has a robust internal accreditation system for its courses and programs, the alignment of course-level learning outcomes, teaching and learning activities, and assessment will have been evaluated. In addition, alignment of course (program) and unit (subject) learning outcomes with professional entry-level competencies and the requirements of the AQF would form part of this internal process. The accreditation bodies could then focus on whether the graduating students are ready for entry-level practice in a given discipline. Outcomes-focused accreditation standards are potentially more appropriately aligned with these assurance mechanisms than are input-driven standards*."

Some disciplines, such as medical radiation, nursing and midwifery, already acknowledge that where the Higher Education Standards have been met, there is no need to reaccredit against these. UA is also aware that many of the NRAS accreditation councils have signed memoranda of understanding

[2] Soon to be fifteen when paramedicine is added to the scheme in July 2017

(MOUs) with TEQSA to bring greater efficiency to accreditation processes by sharing relevant information. While this has worked well in some cases (such as nursing and medicine) in others, the MOUs have not yet translated to notable changes in processes.

Overall UA believes that despite these encouraging moves from the NRAS accreditation councils, there could be greater harmonisation of health professional course and the Higher Education Standards and that a significant amount of efficiency could be brought to bear by mapping the Higher Education Standards against those in health courses. Where standards are common, TEQSA accreditation could then be accepted as accreditation against those same standards in relevant health courses. While UA recognises this is a significant body of work, we believe the overall efficiencies are worth it. TEQSA could undertake the mapping work with appropriate resourcing. Additional efficiencies may also be possible if the internal accreditation, external accreditation and TEQSA cycles are appropriately sequenced.

Recommendations:

Resource TEQSA to map health course standards against the Higher Education Standards. Where accreditation against relevant shared standards is met, there is no need to reaccredit under separate health professional course accreditation processes.

Regarding the second point UA is not supportive of a single accreditation agency that accredits all health professional courses as this would not sufficiently capture the important differences between disciplines. There are, however, a number of areas where health course standards overlap and/or a common set of descriptors are required across courses or are required in different ways in different courses. For example: staff to student ratios; student retention rates; number of international/domestic students; research areas; the nature, extent and focus of clinical simulation used in the program and the human and physical infrastructure available to support its use; models of clinical education used and the like. As one UA member said:

"A lot of professions consider each course as a stand-alone entity and treat each case as separate even where there are information requirements common to all. There is definitely common information that could be standardised which would reduce duplication across courses while retaining the discipline-specific approach that universities consider important."

Some efficiency could be brought to bear by ensuring that terminology for common questions is standardised across disciplines and/or grouping common questions into a core set across the health professions that only need to be assessed once within an institution or used for different courses as relevant. Many universities also commented on the need for standardisation of financial reporting for accreditation purposes. Development of a shared standard financial reporting template across the different accrediting bodies would be very beneficial to creating efficiency in this area.

Recommendations:

Undertake work to standardise terminology for shared questions and group common questions across the different health professions to reduce reporting burden and enable greater efficiency. Develop a standardised financial reporting template for accreditation purposes that can be used across different courses and professions.

Training and readiness of assessment panels

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and inter-professional collaboration?
5. Should the assessment teams include a broader range of stakeholders, such as consumers?

There is significant variation in the quality and consistency of the accreditation panels: some are excellent while others show room for improvement. A common comment from universities relates to panel members acting outside of the scope of their role and intervening in institutional autonomy as well as experiences of inappropriate intrusiveness into university business. For example, one university was written to in relation to their intentions regarding replacing an academic health course staff member before the university itself had been informed that the staff member had resigned. At another university, a panel member insisted on touring food outlets at each campus to ensure healthy food options were available for students.

There is sometimes also a lack of communication and understanding about the role of the accrediting council and that of the professional body as this example from one university's experience of undergoing psychology course assessment shows:

"Our last accreditation was 2013 and this was the second accreditation our department team had co-ordinated. Present both times were representatives from the APS Colleges. They had expected a submission to their colleges respectively as to how we achieved their needs. This was a requirement we had not been advised of, and there were no templates on the APAC website advising of these dual requirements. Ideally, organisations should share information, and improve communications about full requirements for the accreditation process."

UA believes that a useful way to address such issues is through a standardised national approach to training accreditation panel members, customised for each discipline. Such an approach would go a long way towards producing greater accreditation panel consistency, panel member inter-rater reliability and standardising the approach of panel members across different disciplines, particularly with respect to the depth and variability of their questioning during site visits. This approach could also include training and information on what to do and where to refer matters to if an accreditation panel has concerns with processes that lie outside of their scope.

In relation to broader representation on accreditation panels, UA understands that consumers, both students and health service end users, do already sometimes have a voice in the accreditation process but that it is not yet universal. UA is supportive of bringing these and broader community voices, such as employers, public and private health service providers, community representatives and professional associations to the accreditation process as good practice. UA believes the best way for this to occur is through relevant community consultative or advisory groups. The use of such groups could be included in accreditation standards. Such groups could also feed into a national approach to panel preparation and training. Some UA members also believe there would be benefit in including as a panellist, a member of another profession who is an experienced educator who can look closely at the educational processes leading to the assurance of graduate outcomes.

Recommendations:

Implement standardised national training, relevant to different disciplines, for accreditation panels to improve consistency in the understanding and execution of health course accreditation.

Include consumer and broader community voices in health course accreditation processes, predominantly through community consultative groups.

Sources of accreditation authority income

6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?
7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?

How accreditation is funded needs review however, UA is not supportive of cross-subsidisation from assessments of overseas practitioners, nor of raising registration fees. The former offers a perverse incentive and is also likely to be a decreasing source of revenue given the growing domestic workforce numbers across multiple disciplines in Australia. The latter creates further imposts on the professions: accreditation funding from registration fees has already risen from 65% to 73%[v].

Accreditation funding is also related to costs. There are administrative cost pressures on both universities and accrediting bodies and administration is seen to be a large part of the cost[vi] . A number of universities commented that the fee paid to the external accreditor is only one cost factor. Other costs to the university can also be significant:

"The costs of external accreditation exceed the fees paid to the external accreditation body. Staff are employed within universities to support the preparation of the documentation and to support academic staff in developing the curricula. For example, [university name withheld] employs 3 full-time staff to provide administrative and curriculum support for both internal and external accreditation processes (two covering curriculum support and one covering external accreditation support)."

Another university commented that duplication and lack of standardisation adds to cost: *"There is an unnecessary difference in the terminology used and the structuring of information across the [internal university] requirements…and the various external accreditation bodies. Core information could be standardised and this would save time and some cost."*

Increasing efficiency of processes as mentioned above could help to minimise costs – although UA acknowledges that, as the NRAS professions have become more established, costs appear to have been kept relatively stable in relation to the number of courses accredited and professionals registered.[vii]

In relation to accreditation costs charged by external accreditation agencies, with the exception of one or two examples of high costs, the most common feedback from UA members regarding costs is the lack of transparency, clarity and consistency about how accreditation costs are derived.

Many universities recognise that accreditation staff work solidly when undertaking the accreditation process however more transparency in what costs cover would be welcomed. While UA members also recognise that accreditation councils need to run as businesses, they are not-for-profit and prices should reflect this. Other comments in relation to accreditation costs include that course accreditation

costs the same irrespective of the number of students who take up the course, there are double accreditation costs for double degrees even where this seems inappropriate, sometimes two separate course accreditation fees are charged for two courses in the same discipline (for example an undergraduate and postgraduate entry level course) even when accreditation of both courses has occurred during the same site visit. UA members also report that inconsistency in financial reporting formats across courses and the quantity of other/hard copy reporting requested by some accrediting bodies also add to cost and time burden.

Changes in the length of accreditation cycles have also been cited as leading to increased charging. For example, one university reported that when their Occupational Therapy course accreditation changed to an annual monitoring process, an annual report was introduced (increasing reporting burden) to which an annual payment was also linked with a concurrent increase in overall fees charged[3].

Overseas clinical placements are also an issue in relation to both cost to accredit these and constraints that may be placed on them. Costs for overseas placements can appear unnecessarily high. There are two types of placements in this regard:

1. Where components of an on-shore program are conducted off-shore, for example short three to six week placements of health students in overseas services and;
2. Where a whole program/course is conducted offshore.

UA believes that student mobility is to be encouraged in a productive free trade agreement environment, and where health workforce is becoming increasingly globalised. However, some efficiency could be brought to bear by mapping what differentiates the off-shore and on-shore campuses to determine what elements are the same (and can be covered in the on-shore accreditation) and which are different and need to be assessed. There are also concerns about the size of the accreditation team needed to undertake off-shore assessments, especially for short placements rather than a whole course, as team size significantly impacts on costs.

Recommendations:

UA recommends greater transparency in how accreditation fees charged to universities are determined and used.

RELEVANCE AND RESPONSIVENESS

Input and outcome based accreditation standards

8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?
9. Are changes required to current assessment processes to meet outcome-based standards?

UA believes there is a balance to be gained between input and outcome measures, or in some cases *output* measures. The use of outcome standards is generally preferred where they support and encourage greater flexibility and innovation. A number of NRAS disciplines such as physiotherapy, occupational therapy, nursing and medicine have already moved more towards output/outcome measures and this is welcome. UA recognises however, that outcomes can be difficult to measure and also that sometimes, input measures are sufficient or even the best way to determine if a standard has been met. In such situations, UA acknowledges the use of input measures. This might include

[3] UA notes that the discussion paper and Review consultation forums have discussed the pros and cons of long accreditation cycles with regular monitoring compared to intensive accreditation processes every three to five years. While UA generally supports a monitoring approach and understand that this can introduce more upfront reporting work, we do not support a resulting increase in fees unless this is transparently accounted for and justifiable.

elements such as curriculum design, scaffolding of learning, and assessment of progress in relation to safe practice.

Some current input measures are, however, unnecessarily prescriptive and constrain innovation and learning. For example where numbers of hours are mandated for particular aspects of study in the absence of evidence that they are required to achieve learning outcomes (for example the continuity of care standards in midwifery); where standards are silent on or restrictive of simulated learning experiences (SLE - for example occupational therapy standards restrict the percentage of SLE training to 20 per cent); and/or where comments on staffing numbers and or academic levels are made. (For further examples, see also "Accreditation requirements in allied health education: Strengths, weaknesses and missed opportunities"[viii]). Such prescribed requirements can be difficult to attain and place significant pressure on university course providers without necessarily leading to more competent practitioners or higher quality courses. In such cases it would be would be useful to reduce the requirements to a reasonable output/outcome measure and provide the higher education provider with flexibility about how they deliver to the standards. Assessments of standards attainment could be made based on descriptions and evidence provided by the university in the accreditation report.

At times the right balance of input and outcome measures may not be as black and white as input measures for one standard and outputs for another but may require consideration of input measures in the context of other elements. For example:

- student to staff ratios say little about graduate quality in themselves, but can be important when considered in relation to the overall delivery and teaching intensity of the curriculum.
- the 800 mandated clinical placement hours for nursing are a useful guide to practicum hours needed to develop nursing competency but some flexibility around assessments of exceptions/individual cases where, for example, some placements may have been missed due to illness, would assist universities and students.

Where accreditation councils have moved to more outcomes-based standards this has been accompanied by re-training of the council's assessment team members. Accreditation assessments using outcomes-based standards also need to consider other quality assurance measures. This requires assessment teams to be more aware of other assessments or quality assurance processes with potential overlap. Common elements in assessment team training across professions, for example through standardised national accreditation panel training, would assist in this aspect as would mapping relevant health course standards with TEQSA and across professions.

Recommendations:

A balance is needed between input and output/outcome measures. The latter should be used to support innovation and flexibility in course delivery against standards, the former where there is evidence to support their use or where output measures are not feasible.

Health program development and timeliness of assessment

10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?
11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?
12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

Frameworks such as the Teaching and Learning Outcomes (TLOs) are broad and need further discipline specific information for use in an accreditation process. Some disciplines have developed general competency frameworks or professional entry-level competencies. The ownership of this information is variable, some sits with professional bodies, some with boards or councils. Creating a central repository for this information could assist in the further development of entry-level professional competency frameworks within disciplines. However attaining national consistency in the assessment of clinical competencies is challenging.

At the level of individual/professional competencies, there are however some core basic elements common to most/all health professionals e.g. professional behaviour, cultural awareness, ethics, basic communication, health care system funding and regulation, evidence based practice, lifelong learning. Basic level competencies in these areas should be consistent across professions, and could be jointly developed and collaboratively owned by all professions and accreditation authorities. This would simplify accreditation assessments in these areas. Higher levels of competence would be required for different disciplines for discipline specific skills, which would need to be individualised to disciplines.

In relation to future workforce development (see also next section) longer term work will be required to cover questions such as: “What does the future health professional look like?’ ‘What will we need in 10 years’ time?’ ‘How will the roles change?’ ‘Will some disappear?’

A long lead time is required to set up training for new roles. Future workforce development requires long term resourcing and commitment and there is currently no national health workforce planning body. A dedicated workforce development group including representatives from the professions, higher education, government, and accrediting bodies would be of use. This could sit over and above the national boards and AHPRA and ensure ongoing communication with the boards to monitor the uptake of new evidence-based standards aligned with future workforce roles into the professional accreditation standards.

Interprofessional education, learning and practice

13. How best could interprofessional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

UA is supportive of encouraging inter professional learning (IPL) however notes its place in clinical education and training needs to be put into perspective. For example, while comprehensive multi-disciplinary care has an important role, particularly in some areas of the health system[ix], highly specialised care is also an increasing part of current and future health care delivery[x]. Integrating specialist and generalist approaches and achieving the right balance between these will become increasingly important[xi]. There are however, specific health service settings where IPL is a growing and necessary area, for example primary health care (PHC: multidisciplinary team work is especially relevant to the new health care homes), rehabilitation, ambulatory care and community health settings.

The most significant obstacles to IPL are not accreditation issues. A major barrier is that clinical training opportunities are very limited in the settings where IPL is most relevant (such as PHC, ambulatory care, rehabilitation and community settings) are few: 70 – 80% of clinical training for health professionals currently occurs in public hospitals[xii] - despite the majority of healthcare being provided in other settings[xiii].

There are also health service obstacles and significant coordination issues which get in the way of IPL: Organising inter-professional placements is logistically challenging. There are also unresolved questions about who funds cross-discipline training and training in primary care and other sectors which are largely private small businesses. (In general practice, Practice Incentive Payment (PIP) program funding covers medical student and registrar supervision and training, payments to practices

for nurses can assist with nursing supervision, but there is currently no payment or financial incentive to support allied health supervision in general practice. As general practices have to run as small businesses, without funding to support allied health training, taking such students on can be problematic). Workforce issues in non-traditional (non-hospital) settings may also mean that a relevant registered professional may not be available or eligible to supervise a cross-disciplinary student.

Inter Professional Learning (IPL) in a General Practice Super Clinic:
In keeping with Super Clinic objectives, one Super Clinic in Victoria [name withheld] provides multidisciplinary team based care and supports the future primary care workforce. Through an agreement with its local university, the Super Clinic takes students from a range of health professional disciplines, particularly medicine, nursing and some allied health. The Super Clinic provides students with an experience of interprofessional culture and a working model of interdisciplinary team based service delivery. A fundamental enabler of IPL and multidisciplinary care in the clinic is the staff co-location and commitment of all practitioners to team based care and learning. All students attend educational programs run by the clinic and can participate in team-based case conferencing. Another important enabler is access to and use of the same patient management system by all practitioners and students. Managing the training rosters, arranging tutorials and providing supervision takes resources. PIP and nursing payments support the clinic to supervise medical and nursing trainees, however lack of funding for other allied health disciplines often limits their involvement to more observational activities (supervising non-subsidised training activities impacts too much on the business side of the clinic). While medical and nursing students at the Super Clinic generally speak highly of their learning experiences and the exposure to multidisciplinary care is important, other students could also benefit from this experience if funding for allied health supervision in primary care was available.

Accreditation standards do include supervision requirements however, and where these are restrictive about cross-disciplinary supervision, this adds to the challenges of IPL. For example, nurses can supervise medical students but student nurses can only be supervised by a registered nurse (RN). Other disciplines, such as physiotherapists, can supervise more broadly. Accreditation processes need to be sufficiently flexible to enable cross-discipline supervision and a review of standards across all professions would assist with this.

In relation to the inclusion of IPL in accreditation standards, it is important to ensure that it is not just a box-ticking exercise. IPL standards would particularly benefit from being outcomes rather than input based. For example, a number of studies have shown that where students from different disciplines are taught together, there is greater subsequent interdisciplinary awareness and respect, with increased confidence in some professions in speaking with other professional groups[xiv],[4]. However while classroom based IPL (that is where classes are simply undertaken together) has a place, it is not sufficient and rarely translates to greater inter-professional working, which is the main goal. Embedded and web-based approaches to IPL are much more effective[xv],[xvi]. Student-led clinics also provide useful IPL opportunities. There are also suggestions that virtual “games” which involve multi-disciplinary team based problem solving, may lead to better, longer-term interprofessional team work[xvii]. This may be another area where simulated environments could assist with IPL both through linking students from different disciplines and in being able to offer training opportunities outside of health service timetables or supervisory restrictions. Accreditation standards that constrain the use of simulation (for example Occupational Therapy and Exercise Physiology) may need to be revised to support such approaches. Options for measuring IPL course outputs and outcomes in accreditation standards could include universities explaining how they are providing IPL learning opportunities, how different disciplines are learning to work together as a result and how knowledge of the attributes of the different disciplines has or can be applied in addressing particular clinical problems.

[4] Although it was not a corrective for medical hegemony[4].

Recommendations:

UA recommends that government support and resource the expansion of multidisciplinary training places in non-traditional (non-hospital) community, PHC and other settings where inter-professional approaches are required.

UA recommends that accreditation standards across disciplines are reviewed to ensure they allow cross-discipline supervision and simulated learning activities that support IPL and joint problem solving approaches.

Clinical experience and student placements

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?
15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

Defining and implementing healthcare priorities are complex, long term processes, which vary considerably according to the healthcare setting. There are numerous stakeholders and views. Accreditation processes have a limited role in implementing these priorities and are not in a position to address many of the barriers (such as funding, Commonwealth-State responsibilities, priorities of different professional interest groups) to better align clinical training with healthcare priorities.

UA supports the embedding of best practice clinical training within accreditation standards. Sometimes however, the barriers to best practice placement experiences are not accreditation processes but rather health service constraints. For example, distributed, (two plus three) placements in nursing can assist in integrating practical learning with theoretical education[xviii]. Not all health services recognise or accommodate this however, and universities are required to revert to block placements for hospital service convenience. Finding health services that will accommodate varied approaches can be challenging in an environment where there is already competition for placements. It is also increased in smaller regions/jurisdictions where choice of health services is more limited.

Simulation/simulated learning environments (SLE) are an important adjunct to clinical training to support the development of safe practitioners[xix],[xx]. They can assist students in mastering techniques in a clinically safe environment and as mentioned may have a role in providing virtual IPL training experiences and better preparing entry level professionals for working in teams (see below). SLE is already incorporated into most health professional courses, although some disciplines (for example, psychology) are less amenable to SLE training than others. While SLE can alleviate pressure on face-to-face clinical training and placements, it is expensive, particularly where high fidelity equipment is used, requires training and is, at times restricted by the accreditation standards as previously mentioned. There are also other important ways of alleviating pressures on training in the acute setting such as expanding placements into the community/PHC/ambulatory care services and increasing support for clinical supervisors.

The delivery of work-ready graduates

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?
17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

UA does not support the introduction of a compulsory year of supervised practice for all health professions as a pre-condition of general registration. We do, however, accept that in certain

disciplines such as medicine, several years of supervised practice after general registration is essential to ensure patient safety. UA is also aware that the evidence base for such years in some other health professions which currently require them (such as pharmacy) is lacking or unclear. An examination of the necessity of such years in those non-medical professions which currently require them would be useful.

As outlined in the discussion paper, a lack of work readiness is more commonly due to a lack of systems thinking and knowledge of how to operate in a health service structure rather than deficiency in clinical skill. UA notes that work readiness is not uniformly defined (for example, there are varying views on whether it includes awareness of different health service HR requirements). Assessing work readiness is complex and there are few, if any accepted assessment tools and no agreement on what is appropriate for graduates of different health courses. Experiences that support IPL and team-working could assist with this. Team working is a complex, higher order skill more usefully introduced at the later stages of training. When done effectively however it is possible[5] that it may assist in addressing some of the work-readiness issues experienced by entry level professionals. UA reiterates that many barriers to IPL lie outside of the accreditation system. However, ensuring that IPL is supported within accreditation standards by, for example, enabling cross-disciplinary supervision and the use of SLE environments for virtual team building games, could assist with this.

National examinations

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

UA is not supportive of the introduction of a national exam for all NRAS professions (or all health professions). National exams are not considered to be good measures of work readiness and do not provide accurate assessments of the depth of health professional skills. Moreover, there is concern that a national exam would only measure standard elements and would not capture the diversity of information taught across different Australian universities over and above the core elements of health professional education and training that all universities provide. If institutions 'taught to the exam" this diversity would be lost. This would be undesirable in a country as varied as Australia.

Recommendations:

Retain health course diversity which would lost by the introduction of a national exam.
Develop an evidence base for the pros and cons of a year of compulsory supervised practice in non-medical professions where this is currently a pre-registration requirement.
Build the evidence base and professional support for using SLE in IPL and team working and ensure that accreditation standards do not constrain its use.

PRODUCING THE FUTURE HEALTH WORKFORCE

Independence of accreditation and registration

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?
20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

[5] The evidence base for this still needs to be built

Governance of accreditation authorities

22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

Cross referencing between professional registration and accrediting functions is important and requires effective communication between professional boards and accreditation agencies where these are separate bodies. Some professional associations (none under NRAS) are however responsible in the one body for both accreditation standards and professional registration through membership. UA believes there should be a degree of auditing of these two processes to avoid conflicts of interest where both are managed by the one body.

What other governance models might be considered?

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:
    - Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
    - Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

Setting health workforce reform priorities

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:

- As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
- Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

Many of these areas have already been touched on in previous responses. As discussed above, defining and implementing healthcare priorities involves complex, long term processes which also vary with the healthcare setting. Numerous stakeholders and different levels of government are involved in their development and implementation. With the demise of Health Workforce Australia, there is no current national body with responsibility for aligning health workforce training with healthcare priorities. Accreditation processes themselves have a limited role in implementing, let alone developing, these priorities and are unable to influence many of the barriers (such as funding, Commonwealth-State responsibilities and professional group interests) which help to better align clinical training to health care priorities and health workforce reform. In this context, UA believes that the primary measures of effective governance of accreditation should be the capacity to promote cross-profession development, education, accreditation consistency/efficiency and innovation.

Of note, interprofessional education (IPE), interprofessional practice, team-based health care, changing scopes of practice, skills escalation, new/emerging models of care and the role of technology are all important in future workforce development. Yet only some elements of these areas are able to be influenced by accreditation. For example, many of the health profession accreditation standards cover IPE yet, as mentioned previously, barriers beyond just accreditation processes remain in its effective implementation. Changing scopes of practice and skills escalation are similarly maturing fields which can only be partially influenced through accreditation. To be useful, accreditation

governance can however, ensure that no unreasonable barriers exist in accreditation processes in relation to these issues. As these areas develop, it may also be helpful for accreditation panels to include more than one profession and, in particular, include experts in interprofessional, collaborative learning and practice, and changing scope of practice.

As mentioned in response to Qs 10-12, future workforce development requires policy direction, dedicated funding and support with input from professional bodies, higher education providers, accrediting bodies, health service providers and government. Best practice approaches need to be embraced by *all* stakeholders - within government, regulatory agencies, the professions and particularly health services as these are the places where health professional education and training experience is gained. Accreditation standards do, variably, incorporate new evidence (for example, the AMC has recently modified all its accreditation processes for medical schools, Prevocational Medical Councils and Colleges to incorporate new standards on patient safety and on bullying and harassment. However these must also be reinforced within health services to be fully effective.

Future health workforce planning and development requires a whole-of-system approach. UA recognises that individual professions already work to incorporate new evidence into their individual accreditation standards. However, the fragmented nature of Australia's health system where responsibility and funding is currently shared across multiple players and levels of government makes it difficult for accrediting agencies to incorporate new workforce models relevant to a systems approach where, for example, change of scope in one profession impacts on another. UA suggests that consideration is given to creating an overarching group to undertake a systems view, build evidence and fund innovation in future workforce needs/models of care. Mechanisms through which the professions, higher education providers, accreditation agencies, different levels of government and other relevant stakeholders could provide input would be a critical component.

Recommendations:

Develop an overarching group that takes a systems perspective to future workforce development, evidence building and innovation funding. Ensure the group includes mechanisms through which relevant stakeholder input, including from the professions, higher education providers, accrediting bodies, health service providers and government is attained.

Grievances and appeals

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?
37. If an external grievance appeal process is to be considered:
    - Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?

See section below regarding appeals processes relevant to the self-regulated professions.

OTHER

Self-regulating professions:

UA understands that the focus of this Review is the NRAS professions. However universities are also required to undergo accreditation by self-regulated, non-registered health professions. In most cases UA views the NRAS professions as having well established accreditation processes in place and has welcomed the opportunity to meet with the Health Professions Accreditations Council Forum (HPACF) to discuss how universities and the Forum can work collaboratively on areas of improvement as well as supporting appropriate future health workforce development. Similarly a number of the self-regulating professions also have good processes in place (for example, speech pathology, audiology).

However, poor practices by a few self-regulating professions are regularly raised with UA including accreditation processes that are often input-based and place an unnecessary burden on universities with no appeals process available if accreditation is not granted. Dietetics and exercise physiology are consistently mentioned. It is UA's view that the non-regulated professions be required to observe some sort of national accreditation code. This would produce greater consistency, introduce an appeals process and genuinely enable accreditation to be a continuous quality improvement approach - for the higher education provider, the profession and the accreditation agency – across all health professions.

UA notes the existence of COAG's National Code of Conduct for Health Care Workers http://www.coaghealthcouncil.gov.au/NationalCodeOfConductForHealthCareWorkers but is unclear about the degree to which it can be used in relation to accreditation processes for such professions.

The UAPA joint statement of principles for professional accreditation and their associated guidelines (currently under development) are another potential reference source.

Alignment with National Safety and Quality Health Standards (NSQHS):
It is important that in the development of accreditation standards for all health professions align with the National Safety and Quality Health Standards (NSQHS) developed by the Australian Commission for Safety and Quality in Health Care (ACSQHC) is attained. The NSQHS have public safety uppermost in mind, consistent with NRAS. Alignment with these standards will assist further with patient safety and consistency of standards for health professionals.

Recommendations:
Develop a national accreditation code or guidelines for all health professional accreditation. Ensure alignment of the National Safety and Quality Health Standards (NSQHS) with all health course accreditation standards.

SUMMARY OF KEY POINTS

UA supports accreditation and generally sees the NRAS professions as undertaking these processes well. However UA believes that benefits could be gained by revision in some areas. UA particularly sees a need for reducing the duplication that currently occurs both across the different health professional courses and between health course accreditation and university accreditation against the Higher Education Standards. UA does not view the solution to this as a single accreditation body that accredits all health courses. We instead recommend that a relevant mapping process be undertaken to identify and then address any duplication of standards. UA also recommends that where accreditation with TEQSA is gained, any associated health course standards already encompassed within this are not reassessed. Other areas where efficiency could be gained include the development of consistent terminology for questions asked about the same matters but in different ways across different health professional courses and development of a single standardised financial reporting template for all health course accreditation.

UA acknowledges that as the NRAS professions have become more established, costs relative to numbers of professionals registered and courses accredited have been kept relatively stable. However UA members seek greater transparency and equity of costs charged to universities for accreditation processes. Greater efficiency in accreditation administration as outlined would also assist in reducing further cost escalation.

UA is supportive of IPL approaches in relevant parts of the health system such as primary care and ambulatory care and calls for greater opportunity for clinical training to occur in such settings, many of which run as small private businesses. UA also sees the NRAS accreditation standards as largely supportive of IPL and views other factors such as health service protocols, funding and coordination logistics as greater barriers to effective IPL than current accreditation processes. However UA recommends that where current accreditation standards inhibit effective IPL, they are revised.

In relation to future workforce development, UA views the current lack of an overarching body that can take a systems perspective on workforce design, evidence building and innovation as a greater barrier than current approaches from accreditation agencies and professional bodies per se. UA supports the development of such a body into which the professions, accrediting agencies, higher education providers, health service providers, government and other stakeholders would also provide input.

UA sees a broader overall issue around health course accreditation as lying with some of the self-regulated professions and recommends a national code or guidelines for accreditation activity in all health professions. UA believes that many of the current NRAS accreditation standards and processes already align with such a code and could themselves provide useful input into the development of such guidance. The UAPA principles for accreditation processes and the National Safety and Quality Health Standards (NSQHS) also offer a useful platform for such development and at a minimum need to align with existing and future health course accreditation standards.

SUMMARY OF RECOMMENDATIONS

Resource TEQSA to map health course standards against the Higher Education Standards. Where accreditation against relevant shared standards is met, there is no need to reaccredit under separate health professional course accreditation processes.

Undertake work to standardise terminology for shared questions and group common questions across the different health professions to reduce reporting burden and enable greater efficiency.

Develop a standardised financial reporting template for accreditation purposes that can be used across different courses and professions.

Implement standardised national training, relevant to different disciplines, for accreditation panels to improve consistency in the understanding and execution of health course accreditation.

Include consumer and broader community voices in health course accreditation processes, predominantly through community consultative groups.

Enable greater transparency in how accreditation fees charged to universities are determined and used.

Balance input and output/outcome measures. The latter should be used to support innovation and flexibility in course delivery against standards. The former should be used where they are evidence-based or where output measures are not feasible.

That government support and resource the expansion of multidisciplinary training places in non-traditional (non-hospital) community, PHC and other settings where inter-professional approaches are required.

Review accreditation standards across disciplines to ensure they allow cross-discipline supervision and simulated learning activities that support IPL and joint problem solving approaches.

Retain health course diversity which would lost by the introduction of a national exam.
Develop an evidence base for the pros and cons of a year of compulsory supervised practice in non-medical professions where this is currently a pre-registration requirement.

Build the evidence base and professional support for using SLE in IPL and team working and ensure that accreditation standards do not constrain its use.

Develop an overarching group that takes a systems perspective to future workforce development, evidence building and innovation funding. Ensure the group includes mechanisms through which relevant stakeholder input, including from the professions, higher education providers, accrediting bodies, health service providers and government is attained.

Develop a national accreditation code or guidelines for all health professional accreditation. Ensure alignment of the National Safety and Quality Health Standards (NSQHS) with all health course accreditation standards.

APPENDIX 1: FULL DISCUSSION PAPER QUESTIONS

Improving efficiency

Accreditation standards

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?
2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?
3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

Training and readiness of assessment panels

4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and inter-professional collaboration?
5. Should the assessment teams include a broader range of stakeholders, such as consumers?

Sources of accreditation authority income

6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?
7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?

Relevance and responsiveness

Input and outcome based accreditation standards

8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?
9. Are changes required to current assessment processes to meet outcome-based standards?

Health program development and timeliness of assessment

10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?
11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?
12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

Interprofessional education, learning and practice

13. How best could interprofessional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

Clinical experience and student placements

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?
15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

The delivery of work-ready graduates

16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?
17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

National examinations

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

Producing the future health workforce

Independence of accreditation and registration

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?
20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

Governance of accreditation authorities

21. Is there adequate community representation in key accreditation decisions?
22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest? 23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

Role of accreditation authorities

24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS?

What other governance models might be considered?

25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:
    - Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
    - Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.
26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

Accountability and performance monitoring

27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?

Setting health workforce reform priorities

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?
29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?
30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:
    - As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
    - Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?
33. Is there is a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?
34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?
35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

Grievances and appeals

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?
37. If an external grievance appeal process is to be considered:
    - Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?
    - Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

REFERENCES

[i] Higher Education Information Management System (HEIMS) data 2015. Data provided to UA by the Department of Education and Training.
[ii] Universities Australia and Professions Australia Joint Statement of Principles for Professional Accreditation March 2016: http://bit.ly/2p9MxJN
[iii] Council on Education for Public Health (CEPH) 2017: https://ceph.org/constituents/students/benefits-of-accreditation/
[iv] O'Keefe M, Henderson A, Jolly B et al 2014. Harmonising higher education and professional quality assurance processes for the assessment of learning outcomes in health. Final Report. https://digital.library.adelaide.edu.au/dspace/bitstream/2440/94314/3/hdl_94314.pdf
[v] COAG Health Council. February 2017. Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions. Discussion Paper: http://bit.ly/2oOAfDc
[vi] ibid.
[vii] Costing Working Group on behalf of the Accreditation Liaison Group November 2016: Cost of Accreditation in the National Registration and Accreditation Scheme. http://www.healthprofessionscouncils.org.au/files/bee87cefcf48c29c1fc227c280f9dadf9b3d7841_original.pdf
[viii] McAllister L and Nagarajan SV. 2015: Accreditation requirements in allied health education: Strengths, weaknesses and missed opportunities. Journal of Teaching and Learning for Graduate Employability: http://bit.ly/2pN4RK7
[ix] Harris M, Zwar N, Walker C et al. 2011. Strategic approaches to the development of Australia's future primary care workforce. Medical Journal of Australia. 194 (11): 88 https://www.mja.com.au/journal/2011/194/11/strategic-approaches-development-australia-s-future-primary-care-workforce
[x] OECD Heath Policy Studies 2008. The Looming Crisis in the Health Workforce – how can OECD countries respond? http://www.who.int/hrh/migration/looming_crisis_health_workforce.pdf
[xi] Dixon, A. 2011. Do we need more generalists in our hospitals? The Kings Fund. https://www.kingsfund.org.uk/blog/2011/10/do-we-need-more-generalists-our-hospitals
[xii] Buchanan et al 2014. *Student clinical education in Australia:* A University of Sydney scoping study. The University of Sydney.
[xiii] Australian Bureau of Statistics. 4839.0 – Patient Experiences in Australia: Summary of Findings 2012-2013: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4839.0main+features32012-13
[xiv] Doel M and Shardlow SM 2005. Part II "Direct Practice – Context: issues around interprofessional learning" in Modern Social Work Practice: Teaching and learning in practice settings, 3rd Ed. Ashgate Publishing England.
[xv] Pulman A, Scammell J and Martin M 2009. Enabling interprofessional education: The role of technology to enhance learning Nurse Education Today. Vol 29, Issue 2, 232-239: http://bit.ly/2pyxUQY
[xvi] Lapkin S, Levett-Jones T, Gilligan C. 2014. The effectiveness of web-based interprofessional learning modules on health professional students' behavioural intentions in relation to medication safety: A quasi- experimental stud: https://fohpe.org/FoHPE/article/view/45
[xvii] Verbal communication with Associate Professor Christine Phillips, Social Foundations of Medicine, Medical School, Australian National University
[xviii] Birks M, Bagley T, Park T et al 2017. The impact of clinical placement model on learning in nursing: A descriptive exploratory study. Vol 3, Issue 3. Australian Journal of Advanced Nursing. http://www.ajan.com.au/Vol34/Issue3/34-3.pdf
[xix] Boet S, Bould D, Layat Burn C et al. 2014. Medical Teacher Informa Healthcare. Twelve tips for a successful interprofessional team-based high-fidelity simulation education session: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4245993/
[xx] Weller J, Nestel D, Marshall S et al. 2012. Simulation in clinical teaching and learning Med J Aust; 196 (9): 594: https://www.mja.com.au/journal/2012/196/9/simulation-clinical-teaching-and-learning