Consultation name:	**Allied Health Rural Generalist** **Education Program Accreditation System**
Consultation paper available at:	https://ahha.asn.au/allied-health-rural-generalist
Submit to:	Kylie Woolcock at kwoolcock@ahha.asn.au
Due date:	30 April 2018 (Extension granted until 11 May)

If responding on behalf of a stakeholder group, please identify:

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Jurisdiction represented (if applicable): *[Please reflect national /state /territory; metro/rural/remote]*	National – all geographies.
Stakeholders represented:	Universities

If responding as an individual, please identify:

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Profession (if applicable):	
Jurisdiction: *[Please reflect national/state /territory; metro /rural/remote]*	

Introduction and context

Thank you for the opportunity for Universities Australia (UA) to provide input into the Australian Health and Hospital Association's (AHHA) consultation on the Allied Health Rural Generalist (AHRG) Education Program Accreditation System.

UA is the peak body for Australia's 39 comprehensive universities and undertakes advocacy for the sector accordingly. All universities offer health professional entry-level courses. Such education and training underpins Australia's continued delivery of high quality health care. UA is supported in its health professional advocacy and policy development activities through the Health Professional Education Standing Group (HPESG). HPESG comprises representation from all councils of deans of health professions as well as all jurisdictions (information sheet attached). This includes the Australian Council of Deans of Health Sciences (ACDHS) who represent university deans of allied health education. We refer AHHA to ACHDS's submission on AHRG accreditation, particularly in relation to discipline-specific matters. UA's short submission is from a university viewpoint as it relates to general professional accreditation. Answers to the questions below are provided from this perspective from the viewpoint of a university delivering this course.

Summary of consultation questions

Consultation questions for Resource 1: Competency Framework

1.1. Please identify any changes required. Please provide rationale for your recommendations wherever possible.

1.2. Please consider the profession-specific areas listed. With reference to the information in the Education Framework, what work needs to be done to ensure these clinical focus areas are well understood by all stakeholders?

UA refers AHHA to the ACDHS submission in response to these questions.

Consultation questions for Resource 2: Accreditation Standards

2.1 Please identify any other changes required. Please provide rationale for your recommendations wherever possible.

2.2 Please provide any comments about evidence expectations for meeting each of the standards.

Specifically:

2.3 Please consider the responsibilities of TEQSA accreditation vs professional accreditation.

- What overlap do you see? How do you recommend this be addressed?
- What alignment in evidence requirements do you see? How do you recommend this be managed?

UA supports the approach of mixed outcome, output and input measures as a general approach to accreditation evidence, with increased progress towards output and outcome measures where these are feasible. However as mentioned elsewhere in this submission, the evidence required for professional accreditation is largely determined by the profession, in conjunction with the accrediting entity, once the standards have been set.

UA supports clear delineation between accreditation processes and evidence that universities supply regarding quality course delivery, as self-accrediting institutions under the Higher Education Standards (HES) Framework governed by TESQA and those course standards set and

assessed by the profession/accrediting entity in relation to professional accreditation. UA refers AHHA to the UA/Professions Australia (PA) Joint Statement of Principles for Professional Accreditation which clearly outlines these separate processes (available [here](#)) and also to UA's submission to the Accreditation Systems Review (ASR) which provides UA's views on this matter. Of note, improved delineation between these processes is also currently being explored by the Higher Education Standards Panel (HESP) and the Department of Education and Training (DET). It would be useful for AHHA to consider outcomes from both this work and the ASR in relation to proposed AHRG accreditation processes.

2.4   Please consider that students for these programs will have a primary health professional qualification and be practising under the regulatory instruments relevant to their specific allied health profession (unlike those for professions currently using the ADC standard template for entry-level programs).

- How does this impact on the standards?
- What evidence requirements need to be considered in relation to this?

See responses below.

Consultation questions for Resource 3: Accreditation Procedures

3.1.   How early should the relationship between the accreditation entity and institution be established?

As early as possible. By way of explanation: The profession sets the accreditation standards and competencies based on its professional expertise and knowledge and then the university applies its knowledge and expertise in education course design and delivery to meet those standards as well as meeting its own requirements under the TEQSA governed accreditation processes. The accreditation entity then assesses the course against the course standards set by the profession. Universities often need <u>at least</u> 18 months to design, develop and undertake the internal approvals required to set up and run a new course so ideally the relationship between the profession, the university and the accreditation entity should be established as early as possible. The challenge UA sees in the AHRG accreditation is that there is currently no single profession or accreditation body to set these standards and to accredit the course. Determining the professional standards and appointing the accrediting entity are priority activities in relation to the AHRG accreditation. UA believes that answers to many of the questions below will be clearer once both of these are established.

3.2.   Should there be a requirement that an accreditation decision be made prior to accepting students?

This is the ideal as it prevents the situation in which students undertake the course only to later discover that it is not accredited. Unlike entry-level health professional courses however, this course is a post-registration sub-specialty. It seems unlikely that rural or other employers will make this qualification mandatory for employment. The health professionals involved will still be able to practice and apply for rural positions if they undertake a course only to later find it was not accredited. Therefore, making it a requirement for an accreditation decision to be made prior to accepting students may be too stringent. It is, however, good practice to do so where conditions allow. At a minimum it would be useful for the accreditation entity to give a reasonable indication to the university regarding the proposed course's accreditation status prior to accepting students.

3.3. What information about the program is important for the accreditation entity to review at the point an institution notifies them of their intent to develop a program?
From a university perspective the information required is that relevant to <u>professional accreditation purposes only</u> and does not include information about: [university] provider registration standards; provider category standards; provider course accreditation standards; and the qualification standards which are all covered under universities' self-accreditation processes under the HES framework's Threshold Standards (available [here](#)). The information required for the professional accreditation process is largely determined by the profession and accreditation entity.

Information that universities use to advertise the course could also be important in relation to question 3.3. However, universities will be challenged to provide such information until the professional standards, knowledge, skills and competencies for the course have been set by the professional body.

3.4. What expertise and experience are required by those evaluating a program? How should an evaluation team be composed to balance rigour and efficiency?
UA believes that these questions are best answered once the professional standards for the AHRG have been established.

3.5. To what extent is profession-specific input to a program evaluation required? How should this be implemented?
UA refers AHHA to the ACDHS submission in relation to this question.

3.6. What opportunities are there to align with existing team selection processes or training mechanisms? How might this work?
The professional governance and accreditation structure for the AHRG course will be key to determining this. That is, the team selection process will vary according to whether the accrediting entity is: independent to any one of the seven allied health professions involved, is a subset of them, or is a built into each individual discipline's own accreditation process. UA suggests however that "piggy backing" the AHRG accreditation onto an existing accreditation system and process that already includes experienced accreditors will increase consistency and continuity of accreditation. Again, determining how this professional area of allied health rural generalism will be governed (i.e. will it have its own professional body and a single, joint or existing/new independent accreditation entity) and the standards, competencies and scopes of practice associated with it, are a priority. Once these are determined, answers to many of the questions above and below will be much clearer.

3.7. Are site evaluation visits necessary or can an evaluation of the program be done remotely (e.g. desktop review of documentation and internet-enabled interviews)? Please explain your response.
See previous response. Professional course standards, skills, knowledge and competencies need to be set/established before these questions can be adequately answered.

3.8. Will a typical accreditation decision-making structure (i.e. team→committee→board) be most appropriate for education to effectively support the AHRG Pathway? If not, what are the other considerations/recommendations?
See above.

3.9. If an accreditation committee is established, how should it be composed?
See above.

3.10. What opportunities are there to align with existing decision-making structures and processes? How might this work?
See response to question 3.6.

3.11. What recommendations do you have for indicators of program quality or risk that should be monitored for education to effectively support the AHRG Pathway?
General education quality is monitored through the HES framework processes. Professional quality and risk are determined through professional accreditation standards. Indicators for these are largely a matter for the professional body/accreditation entity.

UA also refers AHHA to the ACDHS submission in relation to this question.

3.12. What recommendations do you have for the emphasis being placed on ongoing monitoring rather than a set period of accreditation?
As outlined in UA's response to the ASR, UA supports an ongoing monitoring approach to professional accreditation where this is implemented using reasonable and realistic reporting requirements.

3.13. Is it feasible to provide a mechanism for accreditation of a selection of standards within the Competency Framework? If so, is there a minimum level of program alignment to the standards that should be used as a threshold for an application for accreditation (e.g. minimum number of professions with a clinical training pathway in the program, any requirements to include both the inter-professional and clinical/profession-specific components in a single program)? What are the implications of this approach for different stakeholders? Are there alternative approaches that should be explored?
Again, it is difficult to answer this question until specific course standards are known.
Re minimum number of professions within a training pathway; clearly this qualification involves a large degree of interprofessional activity and learning. Universities vary in the number of allied health professional courses they offer. Where all seven disciplines involved in the AHRG pathway are not available within a given institution, there may be opportunities for interprofessional education through shared/partnership programs with other universities/services. This needs to be considered in developing the standards.
See also the ACDHS submission.

3.14. What mechanisms should be put in place for grievances in relation to accreditation of education supporting the AHRG Pathway?

Every university has avenues though which students can provide feedback and register grievances about courses. Academic boards within universities also regularly review course standards under the HES Framework. Any grievance process regarding AHRG professional course accreditation should therefore focus solely on the professional standards and aspects of the course and not on other matters which are covered by TEQSA.

A number of existing health accreditation councils, especially those governed under the National Registration and Accreditation Scheme (NRAS) already have effective professional course accreditation grievance processes. These provide useful examples on which the AHRG grievance process could be built. UA refers AHHA to them.

UA also refers AHHA to the ACDHS submission in relation to this question.

3.15. Please provide any other feedback you have on the procedures for accreditation that are being developed.

UA has provided this response from the perspective of a university/universities delivery the course. While UA would support this mode of delivery we also acknowledge that delivery of the AHRG could be a health-service led process.

Most of the above comments are also based on the situation where the AHRG is delivered as a stand-alone course. Another option, however, is for it to become an elective unit/units within existing accredited allied health degrees. Registered allied health professionals who have not already undertaken the relevant AHRG unit(s) as part of their entry-level training could then opt to undertake them once qualified using a micro-credentialing approach. Accreditation processes for a new unit(s) would apply. Whether this is feasible depends on what level the profession(s) overseeing the AHRG pathway determine the AHRG qualification needs to be set at. If postgraduate, not all allied health entry-level degrees could accommodate this.

UA is interested in understanding the number of allied health professionals that might undertake this course annually. This could affect the mode of delivery (e.g. largely online, number of universities able to and/or interested in delivering the course and the like) which has implications for accreditation.

In general UA believes that many of the above questions about process and mechanisms will be best answered once the professional standards regarding skills, knowledge and competencies for the AHRG have been developed.

UA welcomes the opportunity to continue to engage with AHHA about the AHRG accreditation and to provide any further feedback as required.