Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions

3 May 2017

Response to Discussion Paper (February 2017) by the Community Reference Group

In 2013, the Australian Health Practitioner Regulation Agency (AHPRA) established a Community Reference Group (CRG). Its first meeting was in June of the same year. The intent behind the creation of the CRG was to establish a body that could work with AHPRA and the National Boards that made up the National Registration and Accreditation Scheme (NRAS) through a variety of initiatives and secure the ability to get community views and feedback in connection with those. This was the first time a national group of this kind, with a focus on health practitioner regulation, had been established in Australia.

The CRG has a number of roles, including providing feedback, information and advice on strategies for building better knowledge in the community about health practitioner regulation, but also advising AHPRA on how to better understand, and most importantly, meet, community needs. Its roles and responsibilities are set out in more detail in its terms of reference, a copy of which is at Attachment A to this submission.

While the group is a conduit between communities and AHPRA/National Boards, it is not representative of particular communities. Rather, members of the group bring a variety of experience and expertise as individual and independent community members. They represent only themselves and share their opinions as individuals.

Members are listed on the Community Reference Group Members page on the AHPRA website. Communiqués from CRG meetings are published on the Communiqués page.

The CRG has contributed to and provided feedback on a substantial range of AHPRA and National Board initiatives since its establishment, and is considered to play the important role of ‘critical friend’ in the development of AHPRA and Board projects. It is regularly consulted on the development and revision of codes of conduct and ethics, and on standards and guidelines under the National Law. It is an ongoing contributor and point of consultation in the development and refinement of publicly-focused processes and initiatives, including particularly the notifications process. Since its establishment, the CRG has attracted strong support from National Boards for its consultative inputs and has begun to attract interest from outside NRAS.

In preparing this submission the Community Reference Group (CRG) sought individual input from each of its members. Their feedback is presented as general comment and in direct response to the Discussion Paper’s Consolidated list of issues on pages 4–7:

General Comment

The CRG has read the joint National Boards/AHPRA submission to Accreditation Systems Review and is in support of the feedback provided.
Risk based approaches

- The CRG supports AHPRA/National Board suggestion regarding the possibility of combining cyclical and risk-based approaches so that the cycle to assess particular standards is different depending on risk, and an assessment of particular standards may be 'triggered' by the extent/type of change identified through monitoring.

Training and readiness of assessment panels

- The CRG supports cross-profession and collaborative approaches to assessor training and a common framework for selection and remuneration of assessors and panels.

- The CRG supports the idea of the assessment team including consumers. Without input from consumers, highlighting their reaction to and expectations of health practitioners, there is a risk that concepts like patient compliance with recommended treatment, patient disclosure of symptoms and ensuring follow up will just be assumed by the practitioners, rather than having them directed to the importance of proper enquiry and of developing a proper therapeutic relationship with a patient.

Consumers

- In relation to opportunities for consumer input in accreditation governance and decision-making, more involvement is prudent and always welcomed. It is important to consider what greater consumer involvement might mean, in order to measure the inputs and outcomes for consumer involvement.

- It would be beneficial if a framework for consumer engagement were developed to formalise the process so as to help ensure its effectiveness.

- If consumers were involved in assessment teams, for example, it is important that consumers are trained to undertake the required assessment work. The CRG is aware that this would require some funding, and is also aware that some bodies, such as the Australian Medical Council, already use some measures to help with this.

Input and outcome-based accreditation standards

- The CRG supports the implementation of outcome-focused accreditation standards, but is aware at the same time of the importance of observing appropriate process requirements in the course of delivering some services, particularly palliative care and mental health care management.

Health program development and timeliness of assessment

- The CRG supports a common approach to the development of professional competency frameworks, to the extent that it is reasonably possible and appropriate to do that.

- Competency frameworks should be flexible enough to respond to consumer needs and priorities as they change.

- If a common approach to the process for developing professional competency frameworks is adopted, consumer participation and involvement in the development process should be part of a greater consumer engagement framework mentioned in the Consumers section of this response.

Interprofessional education, learning and practice

- The promotion and support for interdisciplinary practice is crucial because of the need for patient care coordination/integrated care for complex chronic health needs of patients/consumers. This includes National Board support for appropriate interprofessional CPD experiences.

Clinical experience and student placements

- Consideration should be given to different types of possible location placements such as:
  - aged-care facilities
  - disability centres
  - Aboriginal and Torres Strait islander health services and communities
  - with people who have a disability, or
  - rural and remote communities.
However, at the same time, there must be an awareness of the limitations on experience (and consequently on suitability for registration) that may arise from such placements.

The delivery of work-ready graduates

- Patient and consumer participation in ensuring the ‘first time’ practitioner is ready for the workplace is critical. This should be a routine focus of educators, and employers should be encouraged to provide or continue this as part of workplace induction and training.
- The CRG is concerned that graduates might have less exposure to ‘real life’ situations due to difficulties in arranging placements and welcomes any opportunity for new graduates to be supported as they transition to practice.

Governance of accreditation authorities

- If common guidance on community representation/engagement is provided and linked to the Quality Framework, consideration should be made for diversity of community representation and ways by which it might be possible to ensure that voices beyond the mainstream can be accommodated and incorporated to the appropriate extent.

Setting health workforce reform priorities

- It is in the community/consumer interest for a nationally-articulated workforce reform agenda to be provided.
- Development of a national workforce reform agenda should address the needs and expectations of consumer and community stakeholder groups, and incorporate community consultation to the extent required to achieve that.

Assessment of overseas-qualified health practitioners

- Assessment of overseas-qualified health practitioners is an area that has consistently been identified by consumers as requiring attention. The CRG understands that assessment of overseas-qualified health practitioners continues to be a focus of discussion at national board and specialist medical college level, and that a balance between access to medical services and the maintenance of local standards of practice is critical.
- For overseas-qualified health practitioners to be able to practise in the Australian context, issues around culture may need to be addressed as part of supervised practice requirements.

The CRG thanks the Independent Reviewer, Professor Michael Woods, and his team for the opportunity to respond to the Discussion Paper and is available for further comment if required.
Community Reference Group

10 July 2015

Terms of reference

1. **Purpose**

The Community Reference Group will complement the role of community members of National Boards, by:

1.1 providing information and advice on strategies for building community knowledge and understanding of the role of AHPRA and National Boards in protecting the community and managing professional standards

1.2 providing information and advice to AHPRA and National Boards on strategies for consulting the community about issues relevant to their work

1.3 providing feedback and advice from a consumer and community perspective on National Board standards, codes, guidelines, policies, publications and other specific issues, as requested by National Boards, and

1.4 providing consumer and community perspectives and advice to the National Boards and AHPRA about issues relevant to the National Scheme.

2. **Accountability**

2.1 The Community Reference Group will have an advisory role to the AHPRA CEO. The advice of the Community Reference Group will be provided for information to the Agency Management Committee, National Boards and AHPRA’s National Executive.

2.2 National Boards and AHPRA may choose to seek advice from the Community Reference Group through its Secretariat.

3. **Membership**

3.1 The Community Reference Group will have up to 10 members in addition to the Chair, selected through an expression of interest process and appointed by the CRG Steering Committee.

3.2 The following persons are ineligible for appointment:

3.2.1 anyone who has served as a member on an AHPRA National Board, Panel or Committee

3.2.2 anyone who has been involved in any official capacity in the National Registration and Accreditation Scheme, or

3.2.3 a currently registered health practitioner.

3.3 Members will be appointed for up to three years.

3.4 AHPRA staff may attend as observers at the discretion of the group.
4. **Chair**

   4.1 The Community Reference Group will be chaired by a current community member of a National Board. This provides:

   4.1.1 a clear connection to the National Boards

   4.1.2 assurance that the operations and processes of the Community Reference Group are aligned with the National Boards, and

   4.1.3 assurance that National Boards’ strategic direction, projects and activities that impact or are of interest to the community are discussed at Community Reference Group meetings.

   4.2 The Chair is selected through an expression of interest process and appointed by the CRG Steering Committee for up to three years.

   4.3 When a Chair vacancy is unfilled the CRG Steering Committee can appoint a member of the Community Reference Group to act as interim Chair until a full expression of interest process to appoint a full-term Chair, as identified in Section 4.1 of the Terms of Reference, is completed.

5. **Meetings**

   5.1 The Community Reference Group will meet face to face at least twice each year and by teleconference as required. The Group may also make decisions out-of-session electronically. Members will abide by their signed confidentiality agreement.

6. **Quorum**

   6.1 The quorum is to be at least 50% of the group.

7. **Procedures**

   7.1 The Community Reference Group will adopt procedures consistent with the National Boards, which will include declarations of any conflicts of interest.

8. **Communications**

   8.1 The Community Reference Group will publish agreed Communiqués on the AHPRA website after each meeting.

   8.2 The Secretariat, with authorisation from the CEO, will manage any external requests for comment made to the Chair or members.

9. **Terms of Reference review period**

   9.1 The Community Reference Group Terms of Reference to be reviewed every two years.

10. **Remuneration**

    10.1 The Community Reference Group will receive a sitting fee for attending meetings at the same rate as National Board members.
11. Secretariat

11.1 The Secretariat will be provided by AHPRA.

12. The Community Reference Steering Committee

12.1 The Community Reference Group Steering Committee advises on the ongoing functions of the Community Reference Group. The Steering Committee is responsible for:

12.1.1 establishing the terms of reference for the Community Reference Group
12.1.2 selecting the Community Reference Group Chair
12.1.3 advising on the Community Reference Group membership configuration and meeting schedule, and
12.1.4 advising on the selection recruitment and appointment process for members to the Community Reference Group.