Improving efficiency

1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

This would be possible for some common standards. For example ethical standards. However, many are discipline specific.

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?

This would be a rational approach as the systems the assessments overlap. This may result in less duplication in the process.

3. What are the relative benefits and costs associated with adopting more open-ended and risk managed accreditation cycles?

Adoption of a risk managed cycle may result in more efficient less costly system.

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 interprofessional collaboration?

A centrally staffed and trained accreditation team who undertake all accreditations may increase consistency in the approach.

5. Should the assessment teams include a broader range of stakeholders, such as consumers?

In the experience of those who have participated in accreditation, the views of members of the teams are often coloured by their own experiences and professional affiliations. This can make it difficult to ensure that they adhere to the accreditation standards. For example someone with a mental health background may primarily focus on mental health issues. A broader range of stakeholders may only increase this variability. Stakeholders may have very strong views regarding their own particular experience rather than have the objectivity required.
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?**

The current practice is that members of accreditation panels are not paid if they are employed by another agency such as a University. However the education providers are charged for the process. This appears to be very inequitable. The process should be designed so it is cost effective. For example site visits should not be repeated for multiple programs. The cost for registrants should be based on the service provided not accreditation processes.

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?**

   No fees should be based on the service provided.

8. **Should accreditation standards be only expressed in outcome based terms or are there circumstances where input or process standards are warranted?**

   Accreditation standards should be predominantly expressed in terms of outcome based terms. However, this will not always be appropriate for example English language standards.

9. **Are changes required to current assessment processes to meet outcome based standards?**

   We are familiar with the Nursing standards and these are predominantly outcome standards.

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?**

   A common approach to development of standards would be a good initiative - some individual common competencies could be developed – others will not be possible. Consumers are not a homogenous group and inclusion may increase variability in the process.

11. **What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession specific requirements?**

   The development of some common elements and domains would reduce duplication, increase consistency – but as stated there would be a need to overlay the profession specific requirements to the standards.

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?**

   Low risk processes would be helpful to address this issue – different programs not having to require a separate accreditation process e.g. facilities and infrastructure.
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?

Use of the same standards is fundamental to the IPL framework. However, the exercise to capture the activity or provide the opportunity for students to achieve the standards will be different and localised.

14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?

A yearly forum could be held with stakeholders and policy makers to ensure that healthcare priorities are highlighted. A yearly list of healthcare priorities could then be available on the website and the accreditation managers could then ensure those conducting accreditation are informed regarding these priorities.

15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

Best contemporary education practice is already part of the accreditation criteria for Nursing and simulation-based education is well established.

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?

It would be rational for all professions to have some period of time of supervised practice or the opportunity to demonstrate safe practice.

17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

Work readiness should be defined through closer liaison between Education providers and employers – however there will always be unique workplace requirements to be addressed such as site specific orientation. The Education providers cannot hope to produce graduates who are able to work in any setting without some workplace education and orientation. However, it is the responsibility of the educator to produce graduates who meet professional competencies.

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?

We are not convinced that a national assessment would streamline the accreditation process. Assessment drives learning and a national assessment process may result in Education Providers simply aiming for graduates to pass such assessments. Assessments should be designed to challenge students with different learning styles. Assessment processes are inherently linked with the quality of programs and student outcomes.
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?

It is not clear whether this is the case.

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?

This appears to assume that the current accreditation authorities are not independent. The current process used by ANMAC appears robust.

21. Is there adequate community representation in key accreditation decisions?

Yes. We are not convinced that further community representation would necessarily improve the integrity of the accreditation process.

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?

We are not convinced changes are necessary.

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?

We are not convinced changes are necessary.

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?

No comment.

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;

This may provide greater consistency.
Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards. We do not believe a single authority could provide policy direction for all the professions concerned.

26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?
   As above.

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.
   The measures would need to be developed with care, but may include, timeliness, cost effectiveness and consistency.

28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?
   No comment.

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?
   No comment.

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?
   Continue to seek out wider views of education and professional groups

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?
   The control of levels of different professions need greater transparency. It appears the functioning of the colleges is steeped in tradition and does not seem to be scrutinised.
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?
   We are not aware of any valid reasons.

33. Is there 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?
   No

34. Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?
   We think this would be a sensible approach.

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?
   We consider that supervised practice is integral to the process.

36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?
   No comment, unsure.

37. If an external grievance appeal process is to be considered:
   • Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives? Yes
   • Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?
   Yes all functions should be considered.