About the Australian Nursing and Midwifery Accreditation Council

The Australian Nursing and Midwifery Accreditation Council (ANMAC) welcomes the opportunity to contribute to the review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions. ANMAC is a not-for-profit company limited by guarantee. We are the independent accrediting authority for nursing and midwifery under the National Registration and Accreditation Scheme in Australia. ANMAC plays a key role in protecting the public by setting standards for accreditation for nursing and midwifery programs, accrediting education providers and programs of study leading to registration or endorsement.

This submission responds to the questions raised in the discussion paper.

Improving Efficiency

Accreditation Standards

Q1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

There are a number of benefits that could be achieved with greater consistency and commonality in the development and application of accreditation standards. A set of core standards across the health professions will support sharing of best practice, facilitate interprofessional standard development, and ensure education providers maintain a similar level of quality across health programs.

In addition to the core elements, specific professional based standards would be required to reflect the specialised requirements that nurses and midwives must meet. This two-tiered system would need an overarching governance body to determine and monitor those standards that are consistent and common without losing the profession-specific requirements. The benefits to education providers would be less duplication of effort and evidence required to satisfy different accrediting bodies when they offer programs for multiple health professions.

Q2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

ANMAC incorporates the decisions of TEQSA/ASQA assessments and accreditation of education providers as part of program approvals. While the emphasis of TEQSA is on institutions as opposed to programs of study we support the inclusion of their decisions for all accreditation authorities to avoid duplication in any standards areas that may overlap.

Q3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

ANMAC endorses the benefits of adopting a risk-managed accreditation process within the existing 5-year accreditation cycles. We are currently implementing a new risk-based approach to accreditation introducing the concept of low, medium, and high risk program assessment. Development of the risk parameters was based on evidence from accredited programs (n= 229). The risk-based approach aims to clearly identify those programs that may be at risk, and continue to be at risk, to adequately apply the resources required to assess and monitor them. Annual risk assessments will be conducted to keep all risk profiles up-to-date and the risk rating of a
program/provider may change depending on factors such as monitoring, significant changes in program delivery, or substantiated complaints. The risk assessment and risk rating influences three key areas of accreditation: program accreditation, program changes and monitoring. Moving to a risk based accreditation cycle means that the emphasis for low risk programs moves to monitoring. Notwithstanding the move to a risk-based approach, ANMAC believes in maintaining a 5-year accreditation cycle to ensure a formal review of programs and providers in a health care environment that is constantly changing.

Training and readiness of assessment panels

Q4. 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?

ANMAC supports robust processes, policies and procedures in place around selection, education and the composition of assessment teams to ensure efficiency and consistency. ANMAC’s approach to recruiting, training and retention of assessment panel members is outlined in the National Accreditation Guidelines. Interprofessional collaboration between nursing and midwifery members of assessment teams occurs in the accreditation of dual degrees (Bachelor of Nursing /Bachelor of Midwifery). The inclusion of other professional groups within assessment teams could increase interprofessional collaboration e.g. a nursing professional on the assessment team for a medical degree and vice versa.

Q5. Should the assessment teams include a broader range of stakeholders, such as consumers?

ANMAC ensures that assessment teams reflect a range of stakeholders. Team members reflect education, practice and health-service management. We believe that there are issues to be considered prior to including consumers in assessment teams. What would their role entail? Would the role be additional to the existing team roles? Assessment teams evaluate the evidence presented by the education provider against the appropriate standards. How might consumers contribute to this evaluation?

Other options for community representation include appointment to governing boards and expert advisory groups. Terms of reference for expert advisory groups responsible for guiding the process of standard development for ANMAC provide for the inclusion of an appropriately qualified consumer. ANMAC considers that inclusion of consumers should be made on the basis of the expertise of the individual and not solely on nominations from patient or special interest groups.

Sources of accreditation authority income

Q6. 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?

ANMAC generally supports the continuation of the existing funding model that shares the cost of accreditation between a grant from the National Board and fees from individual education providers. Notwithstanding this general support, it would be useful to have a principled consistent approach to the allocation of funds from the National Boards making it a more transparent process. In 2017/18 financial year, ANMAC will be reviewing its fee structure following the successful implementation of the ANMAC’s Accreditation.
Review and move to a risk-based approach to accreditation. Once this has been successfully undertaken, ANMAC will be developing a hybrid activity-based costing model to adequately allocate costs across its various services in a move to determine an optimal pricing schedule.

Ideally ANMAC would be keen to adopt a new fee schedule that continues to rely on a mix of grant funding and fees for accreditation, while streamlining the fee schedule it charges to education providers. This would include the development of an appropriate fee structure to cover the cost of assessing major modifications and the introduction of an annual fee charge for all accreditation programs that would improve captivity to cover operational and infrastructure costs associated with monitoring and assessment.

Q7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for onshore programs?

Overseeing the assessment of the knowledge, clinical skills and professional attributes of overseas qualified health professionals who are seeking registration in a health profession under this law, and whose qualifications are not approved qualifications for the health profession, is a function of accreditation, part (d) of the Health Practitioner National Law Act, 2009 (National Law). As an arm of accreditation, it could be argued that the fees received for this function could contribute to the onshore component of accreditation.

ANMAC does not currently undertake this accreditation function as this is undertaken through the Australian Health Practitioner Agency. ANMAC has advised the Nursing and Midwifery Board of Australia that it is willing and able to undertake this function.

Under Regulation 2.26B (Relevant assessing authorities) of the Migration Regulations 1994, ANMAC is an approved assessing authority for the skilled occupations of Nursing and Midwifery and is appointed each year through a legislative Instrument. The Skilled Migration Services section of ANMAC undertakes this role and charges a fee for the delivery of this service. Over the last six financial years, Skilled Migration Services have subsidized the cost of Accreditation Services.

ANMAC undertook a review of Accreditation Services in 2016 and clearly identified the need to equalise the income stream from accreditation over the five-year period to ensure a better distribution of funds. ANMAC has been working with education providers to manage the distribution of accreditations over the five-year period aiming to manage the workload and the associated income.

Work is also being undertaken to more accurately cost the services provided at ANMAC through an activity-based costing project over the next financial year (2017/18) to address the cross subsidisation. The revenue from skilled migration services is firstly utilised for improving those services. The remaining funds are applied to support improvements in accreditation functions.

Relevance and responsiveness

Input and outcome based accreditation standards

Q8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?
ANMAC supports a move towards outcome-based standards. In doing so, we acknowledge the importance of developing an approach that combines input and outcome-based standards, an approach considered necessary for quality improvement.\(^3\)

The discussion paper refers to the Registered Nurse Accreditation Standards (2012), highlighting that the standards are predominantly outcome-based, but makes specific reference to Standard 3 and the stipulated minimum of 800 hours of workplace experience.\(^1\) The stipulation of 800 hours’ workplace experience was the result of previous consultations with the profession at a time when there was an excess of 1000 hours in clinical experience.

The profession was trying to balance the criticism that nursing graduates were not workplace ready with the increasing demand for clinical placements and the increasing number of placements at university for nursing students and the lack of evidence to support an appropriate workplace experience.

The transition to outcome standards would require consideration of supports and constraints. ANMAC considers that a crucial first step in the transition would be to develop a clear definition of the term ‘outcome-based’ to ensure consistency across disciplines and across standards within disciplines. Engaging stakeholders in the process is also crucial. A recent survey of ANMAC stakeholders (n=133) demonstrated that a majority of stakeholders (53%) have indicated a preference for a move to outcome-based standards\(^6\).

ANMAC considers that some prescriptive elements will be necessary. For example, we place emphasis on Aboriginal and Torres Strait Islander history, health and culture in accreditation standards. Ensuring that graduates of health programs are equipped to challenge and address inherent racism and disadvantage in health services, warrants a more prescriptive approach.

Q9. Are changes required to current assessment processes to meet outcome-based standards?

Outcome-based standards specify what graduates should be capable of demonstrating on completion of their education program. Where current standards rely on prescriptive inputs, the focus would move from assessing inputs to assessing the competence reflected in the particular standard. Outcome-based standards would need to be articulated clearly without ambiguity for this to be achieved.

ANMAC considers that, in combination with outcome-based standards, some prescriptive elements would be required; for example, determining competence within the current registered nurse standards where minimum practice hours are mandated. In outcome standards, it could be argued that a student who demonstrated competence at a point in the program prior to completing the 800 hours need not complete the remaining hours. However, practice hours are not only about competence, but are also about the overall clinical experience which goes beyond the knowledge and skills assessed and provides the opportunity of experiential learning, application of theoretical knowledge and growing familiarity and comfort with the workplace environment and requirements such as shift work. Many of these elements are not easily measured or assessed through competency assessments. It should be noted that it is these elements that positively contribute to workplace readiness.

See response to Question 17.

---

\(^1\) Practice requirements for UK\(^4\) and New Zealand\(^5\) are 2300 hours & 1100 hours respectively.
Health program development and timeliness of assessment

Q10. 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?

Consultation undertaken by the regulator when developing competency frameworks includes consumers. Requiring a common approach to competency frameworks depends on what is the purpose and outcome of this approach. The Nursing and Midwifery Board of Australia develop professional practice standards following the development of registration standards. ANMAC considers that the format of practice standards, as opposed to competency standards, may be more closely aligned with outcome-based accreditation standards.

ANMAC is now aligned to the NMBA process in developing the education accreditation standards. This works well within the professions of nursing and midwifery. For additional information please see the response from The Health Professions Accreditation Collaborative Forum.

Q11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?

ANMAC supports an approach to developing accreditation standards that takes account of the commonalities between the professions and is currently reviewing its framework for standards. ANMAC supports an approach that harmonises accreditation standards and ensures that specific professional requirements are not either lost or reduced to a minimum. Where there is a need for health professions to learn and deliver similar care, then ANMAC supports a consistent approach based on evidenced standards. An example of this in Nursing and Midwifery is the acceptance and adoption of the prescribing standards as developed by Health Professionals Prescribing Pathway under the auspices of The National Strategy for the Quality use of Medicines.

ANMAC has also undertaken a mapping exercise against the other health professions accreditation standards frameworks prior to developing the Registered Nurse Accreditation standards in 2017/18 financial year. The framework and standards will be subject to the consultation process as required under the National Law.

Interprofessional education, learning and practice

Q12. 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?

ANMAC considers that contemporary accreditation standards are the key to ensuring education programs reflect the requirements for a contemporary workforce. A formal review of ANMAC’s approved accreditation standards for nursing and midwifery education programs in Australia takes place generally every five years. This requires considering the purpose of professional education accreditation. The review is concerned with the quality of the profession and its work, from a public interest and community safety perspective. It is part of a broader process of assuring the community that, having completed an
accredited program of study, beginning professional practitioners have achieved agreed professional outcomes and can practice in a safe and competent manner because they are equipped with the necessary foundation knowledge, professional attitudes and essential skills. ANMAC’s review of the accreditation standards relies on a set of agreed and contemporary competency standards existing for the profession, against which the capability of intending graduates of entry to practice programs can be assessed. While a formal review of each set of standards is undertaken every 5 years, the standards are not worded in such a way to prevent evolutionary change within education programs during the period of accreditation.

More information on the review of nursing and midwifery standards can be found by referring to ANMAC’s Protocol for the Review of Nursing and Midwifery Accreditation Standards.

Clinical experience and student placements

Q13. **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?**

ANMAC supports the inclusion of interprofessional education (IPE) in nursing and midwifery programs in Australia. Standards 2.4, 3.5 and 8.4 in the Registered Nurse (2012) and the Registered Midwife (2014) Accreditation Standards require education providers to include opportunities for nurses and midwives to engage in activities that facilitate interprofessional learning for collaborative practice.

Further development of IPE across the professions would require a shared standard with a clear definition for the term IPE together with criteria to ensure consistency. The standard needs to be sufficiently broad to enable innovative approaches by education providers to meet the standard while taking account of the structural constraints education providers face in delivering interprofessional learning.

Q14. **How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?**

Healthcare priorities are evolutionary and contextual and embedding them within curricula and clinical experiences is complex. ANMAC considers that this is best accomplished through setting standards that require students to be exposed to the healthcare priorities without naming the actual content that is to be included (e.g. palliative care; COPD; mental health) all important, but caution is required in meeting the needs of the student to meet the required competencies and the requirement of stakeholder groups.

Standard 4.2 in the Registered Nurse Accreditation Standards (2012:16) states “The central focus of the program is nursing practice, comprising core health professional knowledge …..and incorporate national and regional health priorities……”.

Q15. **How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?**
ANMAC supports the development of guidelines or standards for simulation that are contemporary and achievable for providers. Standard 3.7 in the Registered Nurse (2012) and standard 3.9 in the Registered Midwife (2014) Accreditation Standards state: “Content and sequencing of the program of study prepares students for workplace experience and, wherever possible, incorporates opportunities for simulated learning”.

A range of research evidence has highlighted that simulated learning is beneficial with impacts on students’ knowledge and practice. IPE has advantages over didactic approaches to learning and low and high fidelity approaches are equally useful. High fidelity does not necessarily involve high technology as simulated patient scenarios are highly relevant for situated learning without the need for high technology. IPE is particularly useful where the type of situation is infrequent i.e. emergencies. Simulation does enhance practice and therefore may reduce the time taken to achieve competency; however, there is no evidence from the literature that simulation should replace clinical practice.9

Constraints to providing experiences include the cost of equipment, time and expertise required to develop and implement learning experiences.

The delivery of work-ready graduates

Q16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?

Newly graduated nurses and midwives face many challenges in their first year of paid employment. Opinions differ as to preparedness of graduates to successfully meet the challenges of a rapidly changing healthcare system. Other professional groups (medicine, pharmacy, psychology) require a period of supervised practice to consolidate knowledge, skills and competence in the workplace; however, supervised practice is not a requirement for graduates of nursing and midwifery programs.

ANMAC does not support a period of supervised practice to address the perceived gaps without evidence of the benefits for nurses and midwives. Issues such as objectives of the placement, optimum time frame to achieve program objectives, costs and availability of supervised placements and the impact on workforce planning need to be addressed.

On entering the workforce, many newly registered nurses and/or midwives undertake a twelve-month structured program provided in the workplace in which they are a paid employee. The program is designed to support their transition to safe, confident and accountable health professionals.

Questions surround the effectiveness of transition programs and research suggests there is tension between the education providers and health services in relation to the practice readiness of newly registered nurses. Exploring the meaning of the concept of practice readiness from the perspective of industry and education providers may lead to the development of more effective transition programs.10

Additionally, some thought should/could be given to exploring remedies for the current constraints (cost, availability) of providing quality clinical experience for undergraduate programs to better prepare nurses and midwives. The benefits and challenges of introducing a four-year bachelor degree should also be considered. A four-year bachelor degree would enable the growing...
requirements for undergraduate programs to be more adequately incorporated and should include a period of consolidation in the clinical setting towards the end of the program.

Q17. **How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?**

Haddad, Moxham and Broadbent (2013) contend that the concept of readiness for practice in nursing (and we would argue midwifery) is complex and highly contested. Since the movement of nursing education into the tertiary sector in the mid 1980s, the work readiness of newly registered nurses has been a source of debate between industry and education providers. Rather than delineation between requirements and responsibilities, Greenwood (2000) argues that nurse education is a joint enterprise and authorities, health, and education providers share the responsibility for ensuring quality graduates between them. This perspective reinforces the need for all involved to work together to provide quality clinical experiences for undergraduate nursing (and midwifery) programs and to offer quality professional education, induction and support programs to better prepare graduates.

**National examinations**

Q18. **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?**

ANMAC believes that robust accreditation processes negate the need for further national assessment to gain registration. Internationally, many countries who have national examinations also have accreditation processes e.g. New Zealand has national exams for nursing and midwifery and accreditation. Accreditation and examinations perform different functions. Accreditation examines the quality of programs and education providers while examinations provide a snapshot of the individual student’s capabilities under set conditions and limited time. National examinations are costly and have poor predictive value for work readiness. They are not conducive to assessing an individual’s performance as a member of a team in a clinical setting.

**Producing the Future Workforce**

**Independence of accreditation and registration**

Q19. **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?**

National Boards are constituted from representation from the States and Territories. Board appointments are made by Ministers who should be cognisant of the requirements. AHPRA has a separate accreditation policy area that provides advice on matters to do with accreditation. The accreditation area in AHPRA appears to be becoming utilised more by the Boards which appears to support the notion that the National Boards are not constituted for purpose.

Therefore, the Terms of Reference for each National Board should demonstrate that the board is constituted in a way that supports robust discussion and informed decision making.
when approving accreditation standards.

Q20. 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?

ANMAC supports greater independence of accreditation authorities in the development and approval of standards and programs of study. ANMAC supports the separation of standard setting and the approval of the education program for regulatory purposes. The separation of powers makes for a more robust system of checks and balances between education and regulation.

Governance of accreditation authorities

Q21. Is there adequate community representation in key accreditation decisions?

Professionals are members of the community. Standards are developed through broad consultation with stakeholders, and community representatives are part of this process. The ANMAC Board has two community members and the newly constituted Strategic Accreditation Advisory committee will have a member from the community. The addition of community members onto the four accreditation committees will be discussed at the joint accreditation committee meeting to be held later this year.

Q22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

ANMAC considers that robust processes, policies and procedures in place around selection and education for health professionals’ role in accreditation ensure integrity and mitigate the possibility of conflicts of interest. Board directors, members of accreditation committees and assessment teams understand the ethical and legal obligations of their role and policies for identifying and managing conflicts of interest as outlined in all relevant ANMAC publications.

Q23. 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?

ANMAC is structured as Not-for-Profit company Limited by Guarantee and governed by Australian company law, as well as the Charities Act 2013. ANMAC is registered with the Australian Charities and Not-for-Profit Commission (ACNC) and the Australian Securities and Investment Commission (ASIC). The company directors have a duty to ensure that the company continues to conform to the definition of a charity within the legislation and to act appropriately should that no longer be the case.

ANMAC provides the executive support for the Australasian Osteopathic Accreditation Council (AOAC) and has provided this service since 2015. ANMAC was the successful tenderer and the service is managed through a contract with performance indicators. AOAC is a separate entity managed by a Board of Directors and remains an independent Not-for-Profit Company limited by Guarantee registered through ACNC and ASIC. ANMAC
receives a fixed amount for services which is reviewed each year. This arrangement works well because of the exchange of Interprofessional information and processes while maintaining a separate identity.

ANMAC has engaged with the AOAC over the last two years and sees the benefit of managing the two organisations together. During the time that ANMAC has provided administrative services to AOAC there have been benefits to both entities including the ability to clearly see opportunities for inter-professional collaboration and sharing of information.

ANMAC’s administrative staff have worked to ensure that the business side of AOAC mirrors the reporting requirements for the Board and Board committees. Other commercial operations could be managed through the creation of separate entities and separation of governance and financial reporting mechanisms.

Role of accreditation authorities

Q24. 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?

ANMAC believes that there could be a better structure to the AHPRA agreements without the yearly schedule and twice-yearly quality reports. The agreement should be more business based with performance indicators and aligned to the objectives of NRAS and the accreditation functions. ANMAC believes that the quality report should be replaced with a performance report linked to the funding provided and adds value to the function of the scheme. The information within the Quality Report is often a replication of information provided through the year and other information that does not provide value.

What other governance models might be considered?

Q25. 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.

Accreditation has limited power to effect change without having a strategic informed policy regarding the health workforce. It is relatively easy to include national policy decisions and strategic health priorities into accreditation standards, particularly with a move to more outcome-based standards. ANMAC builds its accreditation standards on evidence and consultation as prescribed by the National Law and therefore any governance structure needs to be within the remit of the scheme.

Developing Accreditation standards for new workforce roles would not be difficult, particularly as ANMAC has an MOU with both TEQSA and ASQA and works collaboratively with both agencies. ANMAC is also a member of the Health Professionals Accreditation Collaborative which now includes the four AHPRA Committees and ANMAC does not believe that this is the appropriate forum to develop into a governance role.
In the ACT, ANMAC/AOAC, The Australian Medical Council and the Pharmacy Council are co-located, forming an accreditation precinct. The CEO’s of the organisations meet on a regular basis to discuss avenues for collaboration. Planning is currently underway to develop cross-professional accreditation interest groups.

The Health Professions Accreditation Collaborative Forum (HPACF) has provided a response to this area as follows:

One potential solution would be a policy coordination group with representation from all three major types of organisation within NRAS: national boards; accreditation authorities; and AHPRA, as well as community representatives and education providers. This group would be able to reflect the requirements for intra and inter-professional coordination by nature of its representation. It would have accountability for progressing cross-professional issues in accreditation standards, and would be accountable to ministers through a transparent process. Some of the key points to ensuring the success of such a group would be:

- That such a group should be a committee and report directly to the Agency Management Committee (which may need revised terms of reference and membership)
- That it be a committee not a board;
- That the committee be responsible for monitoring the performance of accreditation authorities, AHPRA and national boards in delivering on their accreditation functions under the national law
- That the committee have capacity to identify priorities for cross profession work, and to provide resources for agreed work
- That such a committee be sufficiently resourced to undertake policy work, but otherwise be as lean and efficient as possible;
- That the committee should be fully funded within NRAS;
- That the committee membership be restricted to a number consistent with agile decision-making but enable appropriate representative from the professions in the Scheme and an independent chair;
- That is should have a formal and clear channel of communication with ministers;
- That is should be both accountable, and able to enforce accountability, in areas of responsibility.

The Forum considers this is the type of solution that stands the best chance of addressing policy, cross-professional coordination, and accountability gaps while preserving the best aspects of the current system. However, it is worth considering other possible models for the purposes of comparison and perspective.

Q26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

ANMAC supports the development of mechanisms for recognising and accrediting cross-professional competencies and roles in health. One such mechanism is The Health Professionals Prescribing Pathway (HPPP)\textsuperscript{12} which provides a nationally consistent approach to the
prescribing of medicines by health professionals (other than medical practitioners) registered under the NRAS. The principles outlined in the document underpin standards for prescribing for nurse practitioners and endorsed midwives. There is need for a governance framework that determines and monitors cross-professional competencies to ensure the regulated profession continues to meet the scope of practice and mandated competencies.

Accountability and performance monitoring

Q27. 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?

ANMAC supports the need to be accountable for the delivery of the accreditation functions across NRAS. As in question 24 we suggested that a proper business agreement with performance indicators be applied in the contact format. The current system with a quality report does not, to the Board’s knowledge, provide a mechanism for quality improvement. The Accreditation Authorities are independent companies and any reporting should be based on performance indicators related to the functions of accreditation, rather than information that is relevant to managing the company.

ANMAC would like to see that the indicators are relevant and measurable rather than being requested to provide policies and governance documents. ANMAC would be delighted to be part of a process that developed meaningful reporting that is transparent and can be shared with our stakeholders.

Setting health workforce reform priorities

Q28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?

The current role is sufficient as Ministers determine the macro policy level of health and education. ANMAC is cognisant of broader health policy and the health and workforce issues that face Australia. To support this further, ANMAC has established a Strategic Accreditation Advisory Committee to provide advice to the Chief Executive Officer which supports information going to the Board. The Committee has been established at a high level with key stakeholders from education and health and will provide input into the accreditation issues at ANMAC

Q29. 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?

Please see response to question 28
Q30. 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?

Please see response to question 25

ANMAC has developed a stakeholder engagement framework that supports its consultation process for the development of accreditation standards which includes a wide range of stakeholders from education, nurses, midwives and jurisdictions through the Health Workforce Principle Committee and the Chief Nurse and Midwifery Officers.

This can sometimes be a challenge due to the Federation and the difference in opinion and balancing the outcome. ANMAC has recently reviewed the process for standards development and will be improving its consultation process.

Specific governance matters

The roles of specialist colleges and postgraduate medical councils

Q31. Not relevant to AOAC

Assessment of overseas health practitioners

Q32. 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?

ANMAC is gazetted to undertake the skilled occupation assessment and has undertaken this role for over five years. The process for assessment is more efficient if the applicant has registration within Australia. There is no reason why the two processes cannot be done at the same time, however as detailed previously the revenue from Skilled Migration Services has supported accreditation services at ANMAC. ANMAC has now honed its skills in this area as the process requires a different assessment process with reliance on different documentation.

We have consistently reviewed the service provided and have improved the waiting time for assessments from 16 weeks to 8 weeks. ANMAC has developed a process to manage documents that cannot be verified from work placements in different countries.

ANMAC would suggest that the assessment of IQNMs sits well within the functions of the organisation and would be an adjunct to the assessment process for IQNMs as there are two streams for assessment.

A full skills assessment is available to those nurses that have completed a minimum Bachelor qualification from the United Kingdom, Canada, Ireland, the United States or Hong Kong. These
nurses hold current registration in those countries and have not yet obtained registration in Australia with the Nursing and Midwifery Board of Australia.

A modified skills assessment is available to nurses who hold current nursing registration with the Nursing and Midwifery Board of Australia. Most of these nurses have completed an accredited ‘International Registration for Overseas Nurses’ training course, or have obtained an Australian nursing qualification.

Q33.  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?

ANMAC strongly recommends that assessment processes for IQNMs are managed through the Accreditation Councils. We support the alignment of processes for assessment of qualifications for skilled migration visas with assessment of qualifications for registration. The National Law identifies assessment of overseas qualified health professionals as an accreditation function and ANMAC is gazetted as the skilled migration assessment body but is currently not responsible for the assessment of nurses and midwives for the purpose of registration. ANMAC has demonstrated capability of managing this process, which could easily be extended to include assessment for the purposes of registration. ANMAC is the education standards experts for nursing and midwifery and therefore best placed to make judgements regarding whether or not programs of study conducted and/or accredited by authorities in other countries provide the nurse or midwife with the knowledge, clinical skills and professional attributes necessary to practice in Australia.

The Nursing and Midwifery Board has undertaken a project to determine the best mechanism to assess internationally qualified nurses and midwives. ANMAC and AOAC are working with the National Training Centre to explore the establishment of an examination centre for the assessment of internationally qualified osteopaths.

The CEO of ANMAC has recently been invited to become a member of the Australian Medical Council Innovations in the NTC Group which is looking at best practice improvements in the assessment of internationally qualified health practitioners.

Q34.  Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?

ANMAC supports the perspective that assessment of the internationally educated nurse and/or midwife must be relevant, fair and transparent. Applicants whose educational preparation meets the Australian standards and competencies for nurse/midwife should be eligible for registration. There are opportunities to explore this if the assessment of IQNMs is linked to the NTC; however, the practice requirements of each profession should not be lost. The key areas for exploration for all professions is how to assess their ability to work in a multidisciplinary team and how well they communicate patient information.

Q35.  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?

ANMAC questions the need for periods of supervised practice for overseas educated nurses and midwives. Robust standards and assessment processes should be the basis on which registration is
gained. Supervised practice is generally a post-registration treatment rather than a pre-registration requirement.

Q36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

ANMAC processes for managing complaints regarding accreditation matters is designed to be rigorous, fair and responsive. See Question 37 for more information.

Q37. 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?

ANMAC supports the need for robust review of the decisions made by accreditation authorities and utilises an approach to appeals from education providers regarding decisions which emphasizes the independence of the appeal process and is outlined in ANMAC National Accreditation Guidelines. To date, this process has not been tested; however, one explanation for the lack of appeals may lie with the robustness of the processes outlined and a committed collaborative approach to solving issues raised by education providers obviating the need to enter the appeals pathway.

If an external entity is considered necessary, ANMAC supports the National Health Practitioner Ombudsman as an appropriate channel for grievances and appeals. ANMAC further supports the scope of complaints to encompass all accreditation functions including fees and charges.
References