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

The Council of Deans of Nursing and Midwifery (ANZ) (CDNM) welcomes the opportunity to contribute to the review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions. CDNM is the peak body for education providers offering nursing and midwifery programs of study. CDNM plays a key role in preparing nurses and midwives for Australian health services.

This submission responds to questions raised in the discussion paper.

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. Commonality across professions will improve the sharing of best practice across health professions and increase interprofessional coordination, liaison and development. In addition, commonality in a set of core standards across the health professions will ensure education providers maintain a similar level of quality across health programs. Such a proposal would require central governance to ensure consistency as well as including the profession-specific attributes that graduates must meet. 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?

CDNM supports the incorporation of decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews.

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

CDNM endorses the benefits of adopting a risk-managed accreditation process within the existing 5-year accreditation cycles utilizing a risk-based approach to accreditation based on the concept of low, medium, and high risk program assessment. Annual risk assessments need to be conducted to ensure risk profiles are up-to-date where the risk rating of a program/provider may change depending on factors including significant changes in program delivery or substantiated complaints. Moving to a risk based accreditation cycle places the emphasis for low risk programs on monitoring. Regardless of a move to a risk based approach, CDNM believes in maintaining a 5-year accreditation cycle.

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?

CDNM supports robust processes, policies and procedures related to selection, education and the composition of assessment teams to ensure efficiency, equity and reliability. Interprofessional
collaboration between members of assessment teams would provide external independent assessment.

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

CDNM supports assessment teams that reflect a range of stakeholders to reflect education, practice, health service use and health service management. Matters to be considered prior to including consumers in assessment teams related to their role on the team.

Other options for community representation include appointment to governing boards and expert advisory groups. CDNM 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.

CDNM believes that students also represent a consumer group and their inclusion also needs to be considered. As above, their role on the team needs to be clear.

**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?

CDNM generally supports the continuation of the existing funding model that shares the cost of accreditation between a grant from the Nursing and Midwifery Board of Australia and education providers and fees from individual education providers. CDNM supports a hybrid activity-based costing model to adequately allocate costs across its various services in a move to determine an optimal pricing schedule.

This would rationalize the fee schedule being charged to education providers and would include a fee structure that covers the cost of assessing major variations and the introduction of an annual fee for all accreditation programs would improve budget planning processes.

**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?

CDNM supports the development of revenue streams that subsidise accreditation functions. If this includes assessment of overseas trained nurses and midwives then CDNM is also sympathetic to that revenue stream.

**Q8.** Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

Whilst the CDNM supports a move towards outcome-based standards, we recognize the importance of developing a methodology that includes input, process and outcome-based standards. For example, the Registered Nurse Accreditation Standards (2012) stipulate a minimum of 800 hours of workplace experience in an attempt to ensure that nursing graduates are workplace-ready despite the lack of evidence supporting an appropriate workplace experience. Moreover, previous review of nursing courses demonstrated the wider variation in workplace learning hours across education providers. Other input standards relate to public safety such as adequate English language standards.
A clear definition of the term ‘outcome-based’ is required to safeguard consistency across disciplines and across standards within disciplines.

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 experiences to assessing the competence reflected in the particular standard. This creates ambiguity between competence and accreditation specifications.

To achieve this, the standards must be expressed clearly without vagueness. Furthermore, there is pressure from stakeholders to include more and more information/content to equip graduates with such a broad base of knowledge that this could pose real difficulties for accreditation councils developing standards and education providers delivering programs.

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?

CDNM considers that some competencies are common across professions and others are profession-specific. Developing a common competency framework would require an approach that includes representatives from multiple disciplines and strong consultation. Such consultation would embrace a variety of stakeholders and this includes consumers.

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

CDNM supports the development of accreditation standards that take account of the commonalities between the professions, using an approach that synchronizes standards and ensures that specific professional requirements are retained and not diminished.

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?

CDNM considers that accreditation standards ensure education programs reflect the requirements for a contemporary workforce. Accreditation standards for nursing and midwifery education programs are reviewed every five years. Annual monitoring of education providers enables the accredditor to review program delivery and be satisfied that the accredited program is being delivered faithfully reflecting contemporary competency standards for the workforce, professional attributes and ensuring public safety.

While a formal review of standards is undertaken every 5 years, the standards are worded to enable evolutionary change within education programs during the period of accreditation, reflecting changes in evidence and pedagogy.

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?
CDNM supports the inclusion of interprofessional education (IPE) in nursing and midwifery programs and current standards require education providers to include opportunities for nurses and midwives to engage in activities that facilitate IPE for collaborative practice.

A common standard with a clear definition of IPE and associated criteria to ensure consistency must be developed. Such a standard needs to be appropriately comprehensive to enable innovative approaches by education providers to meet the standard though acknowledging the operational limitations faced by education providers when attempting to deliver IPE.

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

CDNM believes that standards need to be comprehensive but not prescriptive regarding curriculum content. Education providers would need to demonstrate that their curricula are evidence-based, contemporary and reflect changing Healthcare priorities.

Q15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

CDNM acknowledges that simulation enhances practice and therefore may reduce the time taken to achieve competency. Nevertheless, there is limited evidence that simulation should replace workplace learning experiences. CDNM supports the development of standards for simulation that are contemporary and achievable. Constraints to providing experiences include the cost and maintenance of equipment, teaching and practice time and the expertise required to develop and implement learning experiences.

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.

CDNM 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 new graduates begin a twelve-month structured program provided in the workplace in which they are paid employees. The program is designed to support their transition to safe, confident and accountable health professional practice.

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 new graduates 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.

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?**

CDNM believes that robust accreditation processes negate the need for further national assessment to gain registration. 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.

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?**

The Nursing and Midwifery Board of Australia is constituted from representation from the States and Territories. Board appointments are made by Ministers, who should be cognizant of the requirements. AHPRA has a separate accreditation policy area that provides advice on matters related to 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?**

CDNM supports greater independence of accreditation authorities in the development and approval of standards and programs of study. CDNM 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.

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 Australian Nursing and Midwifery Accreditation Council (ANMAC) has two community members on its board and ANMAC’s 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 a joint accreditation committee meeting to be held later this year.

Whether students should be considered consumers needs further investigation and discussion.

**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?**

CDNM considers that robust processes, policies and procedures must be in place related to the selection and education for health professionals’ role in accreditation to safeguard integrity and diminish the possibility of conflicts of interest. Board directors, members of accreditation committees and assessment teams must understand the ethical and legal obligations of their role and be cognizant of the policies for identifying and managing conflicts of interest.

**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?**

CDNM expects ANMAC to function for the good of the professions and this means retaining a focus on quality accreditation standards and processes and that the governance arrangements in place reflect this.

**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. Accreditation standards are devised on evidence and consultation as prescribed by the National Law and therefore any governance structure needs to be within the responsibility of the scheme.

Developing accreditation standards for new workforce roles would not be difficult, particularly if accreditation agencies have agreements with both TEQSA and ASQA and work collaboratively with both agencies. The Health Professionals Accreditation Collaborative 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-profession 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, not a board;
• 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;
• That it should have a formal and clear channel of communication with ministers;

That is, it should be both accountable, and be able to enforce accountability, regarding accreditation decisions.

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

CDNM supports the development of mechanisms for recognising and accrediting cross-professional competencies and roles in health. 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.

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

Q33. 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?

CDNM supports 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.

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

CDNM supports the development of an external grievance/appeal mechanism. Whilst ANMAC claims its processes for managing complaints regarding accreditation matters is designed to be rigorous, fair and responsive, education providers are not necessarily included.
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?

CDNM supports the need for robust review of the decisions made by accreditation authorities and expects an approach to appeals from education providers regarding decisions that emphasizes the independence of the appeal process. A national health practitioner ombudsman would be one such mechanism.

CDNM further supports the scope of complaints to encompass all accreditation functions including fees and charges.

References


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