Introduction
Curtin University currently offers 14 degree programs (undergraduate and graduate-entry) in nine health professions regulated by AHPRA, and hence accreditation systems have a substantial impact on the University. Curtin is supportive of accreditation processes to the extent that they provide the necessary protection through quality assurance mechanisms for the public, students, education providers and employers in the health sector. Unfortunately, our experience of accreditation is that it is frequently unnecessarily bureaucratic, focused on inputs/processes rather than outputs/outcomes, and constrains agility and innovation when Universities seek to respond to changing workforce needs. For these reasons, Curtin strongly supports moves to create streamlined, simplified, outcomes-focused accreditation standards and processes.

As an outcome of the Independent Review, Curtin would like to see:

- One set of accreditation documents required for each profession’s programs (undergraduate and graduate-entry, for example as in Nursing), thereby reducing unnecessary duplication.
- Greater alignment of standards and terminology, including the interface with higher education regulators (TEQSA/ASQA); flowing onto documentation, templates, training of accreditation assessors and potential data sharing, aggregation, reporting and analysis across the NRAS scheme.
- Standards driven by evidence and practice. Currently there is no transparency on the fundamental drivers that create the standards. For example, is there any evidence that a staff ratio of 1:15 is necessary for effective small group work, or that a minimum of 600 hours vs 1000 hours of supervised clinical practice is necessary to graduate a competent practitioner?
- Similar expectations across professions for generic skills (eg ethics, professional behaviour), written as common generic competencies. These would need to be supplemented with specific discipline-specific competencies relevant to each profession.
- Outcomes-focused accreditation standards and processes. As a model, the Australian Medical Council’s approach is much more outcomes-focussed than many of the other professions.
- Standardised training requirements for accreditation panellists.
- Accreditation occurring before a course commences, such that students know before enrolment that the course they are entering has accreditation. Currently the point at which accreditation is bestowed varies across courses.

Improving efficiency

Accreditation standards

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

Curtin believes that there are substantial benefits to be achieved from greater standardisation in accreditation information requirements across each of the regulated professions. For example, each accreditation currently requires the provision of similar information regarding the University (eg financial position, facilities, resources) but in different formats, and in varying degrees of detail. Additionally, greater consistency in information requirements would increase efficiency by reducing unnecessary variations across the different accreditations with respect to the level of detailed evidence that relates to the standards, the processes for submitting evidence, and processes and requirements for regular reporting and notification of changes to accredited courses. It would also assist in fostering best practice in professional accreditation (including the scope and training of panel members), in defining and consolidating data needs and formats, and provide the potential for better coordination with TEQSA.

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?
Curtin supports the proposition that TEQSA’s decisions should be incorporated by accreditation authorities in their reviews.

There are significant opportunities for greater information sharing between accreditation authorities and the education regulators TEQSA/ASQA. MoUs between TEQSA and accreditation authorities could build on mutual areas of review, such as through the identification of common standards and informational requirements, while defining key review parameters, for example TEQSA’s focus on student outcomes and the accreditation bodies’ focus on competency/practice standards and public safety. The regulators often have a broader range of information available about education providers, though not necessarily more detailed information about all of the courses that they offer. Accreditation of higher education providers includes a review of high level policies that need not be repeated by accrediting authorities.

Closer coordination with TEQSA could also provide for a more agile approach to implementing changes for best practice that is often hampered by the accreditation authorities’ capacity to ensure timely action. In general, it is believed that closer collaboration between TEQSA and professional accreditation authorities would contribute to a more efficient process of continuous improvement and quality assurance, and would be welcomed by this University.

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

TEQSA’s risk-based regulatory approach allows HEPs who have a ‘strong record of delivery of higher education, sound financial standing, no history of non-compliance with the standards and a low risk of future non-compliance to have an engagement with TEQSA that is tailored to their context and therefore a lower regulatory burden on providing evidence’ (TEQSA Risk Standards Panel Paper, February 2015), while providing for a greater level of assurance from HEPs who do not. The greatest challenge in developing a risk based approach is determining the appropriate risk indicators for routine monitoring and thresholds for concern and the expectations of responses from higher education providers. The use of notifications data (relating to harm and professional conduct) from the National Boards could inform risk-based approaches to accreditation and/or curriculum design. There is no logical reason why a two-cycle approach could not be used to review different standards based upon their associated (high/low) risk profile. It may be that the “low risk cycle” could cover accreditation standards that are broadly shared across institutions (e.g. academic governance, policies) which would facilitate the development of “common accreditation data packs” by institutions to meet the related evidence requirements for accreditation. This would increase efficiency and lower costs for that component of accreditation.

In general terms, an open-ended, risk-managed accreditation cycle could significantly reduce the regulatory burden on HEPs who have a track record of compliance, while providing more efficient use of resources to concentrate on higher risk providers.

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?

The quality and expertise of accreditation panels differs across accreditation authorities. In some cases panel experts are too closely invested in a particular discipline or profession, without the range of experience required relevant to the review. Frequently, this manifests in a lack of understanding by panel members regarding both the scope of their role and the nature and functioning of Universities. For example, where a panel makes recommendations regarding the need for a University to provide a new purpose-built building for a profession, where such capital investment is neither viable, affordable or achievable. Better training and consistency of assessors would be welcomed, including the use of interprofessional reviewers.

There are broad differences in the composition of panels across different accreditation authorities. In many cases the panel of assessors have deep professional expertise but do not have deep educational expertise; if the membership of panels included members with such qualifications it would give greater public confidence
in their assessments. While the panel should be discipline-specific and accreditation-specific there is room for broadening the membership while maintaining the standards.

There is also a perception that panel members are frequently overly supportive of their profession, at the expense of fulfilling their mandate for protecting the public by ensuring that the education is appropriate. Improved training of assessors could potentially mitigate such perceptions, however a broader membership of panels (cross-professional representation, academics, consumers etc) would also be of assistance (see also the response to question 5). The Australian Pharmacy Council has developed online training materials that could be made more widely available. Consistency of terminology and standards would also facilitate training, leading to the creation of a shared pool of assessors for accreditation authorities.

We therefore support the notion of standardised training to be an Accréditeur, and Accréditeurs should be required to meet certain benchmark standards in order to be selected onto a panel.

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

Yes, Curtin believes that this is important. At present some accreditation authorities have assessment teams that include stakeholders, usually experienced academics, who are not registered practitioners. Utilising more academics with expertise in higher education regulation and curriculum is seen as beneficial, as it would facilitate more objective accreditation reviews that are less aligned to the profession, thereby potentially countering public perceptions of some accrediting authorities who are seen as a “closed shop”. There are nuances in the Higher Education Standards Framework (2015) and Australian Qualifications Framework that require accreditation panel assessors to have expertise (rather than long experience) in higher education to accurately assess programs (e.g. the relationship between qualifications and teaching/ supervision requirements). Greater health consumer involvement in assessment teams would also be welcome (as has been implemented in the United Kingdom). The new Occupational Therapy standards now require schools to demonstrate consumer involvement. However careful consideration needs to be given to the selection, training and empowering of consumers in order for them to be able to contribute effectively as members of assessment teams. Essentially an assessment team should be constructed on the basis of skills they bring to the assessment, ensuring the team’s membership contains all the requisite skills.

Sources of accreditation authority income

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?

Key principles related to funding that should apply across the NRAS scheme are transparency and consistency in how accreditation costs are derived. Curtin supports the articulation of a consistent, clear, publicly stated philosophy or set of principles that relate to funding of activities of accreditation authorities. Remuneration of Accrediteurs should be standardised across all professions.

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 onshore programs?

These two accreditation functions should be operating independently, and funded on the same basis. Although both functions aim to provide for a safe and competent health workforce, accreditation of higher education courses should not cross-subsidise/be cross-subsidised by other accreditation functions. Moves to streamline accreditation processes and make them more efficient, as recommended elsewhere in this response, should be seen as the primary mechanism for reducing the growing costs of accreditation of programs.

Relevance and responsiveness

Input and outcome based accreditation standards

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

Outcomes-based standards for accreditation represent best practice in higher education and are therefore preferred, wherever possible. Outcomes-focused standards assure quality by breaking the assumption that
inputs guarantee outputs, and they also facilitate flexibility in both curriculum content and learning mechanisms. Input or process standards should only be required in situations where it is very difficult or impossible to specify and measure outputs/outcomes. The Health Professions Accreditation Council itself actively supports the use of evidence-based accreditation standards, though this is yet to be fully implemented by all members. Assessors (and guidance) should also focus on how the program contributes to the achievement of the NRAS (e.g. rural and regional practice, interprofessional practice). Speech Pathology accreditation standards provide a good example of outcomes-based standards.

9. Are changes required to current assessment processes to meet outcome-based standards?
Yes. A suite of funded projects have defined threshold learning outcomes necessary for entry into practice. These competency frameworks (e.g. in medicine) were developed in collaboration with clinical academics and medical education experts and provide a broad consensus framework for entry into both supervised practice and advanced practice. That framework can and has been used to guide assessment of undergraduates. That model could be extended for use in other health professions.

Health program development and timeliness of assessment
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?
See the response to question 9 above. As also noted in the response to question 1, greater alignment of standards and terminology (e.g. some professions use the term ‘patient’ whilst others refer to ‘consumer’) is desirable. Standardised questions across the 14 professions would also be useful. A set of generic competencies, alongside discipline-specific competencies would be beneficial and would also encourage true interprofessional practice. Many standards relate to good pedagogical practice across professions. Generalist postgraduate degrees for example, where graduates are registered in their principal profession but can undertake extended scope of practice, are a Queensland government initiative.

11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?
See the response to question 1. Physiotherapy has combined standards for Australia and New Zealand.

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?
The framework referred to in the response to question 9 was developed with an eye on contemporary practice, vertical integration and future workforce needs. The process once established could be used to update the framework to reflect future workforce needs, as well as reinforce skills/competencies that appear to be high risk (e.g. through notification data).

At present there is a perception that the accreditation standards are stifling innovation and the ability of higher education providers to change curriculum in response to industry and profession needs. This is an issue on both sides – there can be a disproportionately high administrative burden placed on higher education providers by accrediting agencies that in turn makes them ‘hold off’ on changes until the next accreditation cycle.

Interprofessional education, learning and practice
13. How best could interprofessional education and the promotion of interdisciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?
Many projects funded through Health Workforce Australia have focused on interprofessional education as a means to developing capability in interprofessional practice. There are shared definitions of interprofessional education and competencies for interprofessional learning, however these are inputs for the outcome of capability of interprofessional practice. Interprofessional practice must be promoted and modelled in clinical practice settings so as to reinforce interprofessional learning and practice outcomes. This could be facilitated through collaboration amongst NRAS Boards to promote interprofessional practice e.g. through
interprofessional CPD. Until accreditation standards truly focus on interprofessional practice and it is mutually re-enforced across professions, the desired workforce outcomes are unlikely be achieved.

One of the AMC’s overarching standards is that the ‘program ensures that students work with/from/about other health professionals, including experience working in interprofessional teams’. It then includes a series of more detailed standards as sub-standards.

Interprofessional practice is the way of the future, and should be a major significant component of all programs, but it also has to be achievable within current accreditation frameworks. Curtin regards itself as a leader in interprofessional education. For example, Curtin offers an interprofessional first year to all health science students; this required lengthy and somewhat difficult negotiations with each of the nine accrediting bodies.

Clinical experience and student placements

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

National health care priorities rarely emerge suddenly, so there is generally scope within the review cycle for accreditation standards to ensure that such priorities are codified in standards and frameworks. Some curricula also include these in their mission statements – for example, meeting rural and regional health care needs, addressing underserved populations, etc. Accreditation standards also include statements that reflect national priorities e.g. Aboriginal health care. With a focus on outcomes-based accreditation standards and appropriate competence frameworks, it will be necessary for graduates to demonstrate the skills relevant to those priorities, without prescribing curriculum approaches or hindering innovation in the achievement of those outcomes.

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

While simulation-based training is already incorporated into many curricula, particularly when preparing students for clinical placement, most accreditation authorities will not allow it to substitute for clinical placement hours. Yet it has been shown that certain types of simulation represent a good substitute for placement requirements with respect to specific activities. In certain placement settings it is difficult for students to demonstrate particular skills because there are too few patients to work with, or the opportunity does not arise in a specific placement location at a specific time (eg highly agitated clients, highly vulnerable clients). There could be great advantage to demonstrating the skills in a simulation setting where all students have time to learn the skill and then demonstrate it in a more controlled environment. It is possible that many of the early year placements in degrees could be substituted by simulation-based education and training, thereby relieving placement sites of early year students and making more time for longer and more complex placements in the later years of degrees. The placement sites would also gain more experienced students to assist with their work, which would improve the relationship between placements sites and education providers.

The delivery of work-ready graduates

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?

The National Law provides for multiple pathways to registration, which may include an education program with or without supervision. Evidence within the academic and clinical literature for each profession should inform requirements for supervision. In medicine, for example, several years of supervised practice is clearly supported as a mechanism for promoting patient safety. In other professions, evidence supporting compulsory periods of supervised practice, such as an intern year, is less clear.

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

There should be consistent definitions across professions for the related terms of employability and work readiness, noting however the range of (contested) definitions already in practice within the higher education sector. The workforce needs of industry tend to evolve while universities grapple with a balancing act between
what is required by accreditation, what the employer wants in a university graduate employee, and what the university produces within its various constrains (eg financial, resources).

There is an important difference between ‘work readiness’ and ‘employability’. Work readiness may be defined as demonstrating the threshold competencies for practice and ability to commence work as a registered practitioner. Employability, by contrast, is conceptualised as a set of achievements which constitute a necessary but not sufficient condition for the gaining of employment. Employability is a much more dynamic state, whose characteristics include ‘soft skills’ (eg leadership, teamwork, communication, critical thinking, problem solving). Smith et al (2014) have identified six dimensions of employability related to work readiness: 1. Professional practice and standards (Threshold standards) 2. Integration of theory and practice 3. Lifelong learning 4. Collaboration 5. Informed decision-making and 6. Commencement-readiness (confidence to start a job in the discipline).

**National examinations**

**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?**

There is a requirement for national and international external benchmarking of academic standards by higher education providers under TEQSA’s Higher Education Standards Framework for all programs offered by the institution. The availability of competence frameworks and/or specific graduate learning outcomes facilitates this process, though not all professions yet have such frameworks. The use of a national examination would be one method of external referencing, however there are other approaches that are also being used across the country such as the sharing of core examination questions and development of common clinical assessments across institutions.

The development, validation, implementation and maintenance of a national examination is an expensive process that will involve many people over a considerable period of time. Such an examination would effectively impose a specific method of external referencing upon higher education providers that may limit their ability to choose the most appropriate method of external referencing with national and international partners. It is understood that Pharmacy requires an examination for full registration, but in general Curtin does not support national assessment and does not believe it would result in a more streamlined accreditation process.

**Producing the future health workforce**

**Independence of accreditation and registration**

**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?**

Academic programs are reviewed internally by higher education providers and by external accrediting authorities, generally on a five-year cycle. It is to be expected that higher education institutions would consider national health workforce priorities arising out of stakeholder consultation in their cyclic comprehensive course review process. Curtin and other institutions often align comprehensive course reviews, accreditation activities and reviews of academic schools to gain maximum synergy and efficiency of processes.

In general, accreditation authorities develop accreditation standards that are approved by National Boards. Accreditation standards are reviewed on a 3-5 year cycle using a consultative process. In additional to open consultation, professional and academic expertise and perspectives of other stakeholders (consumer, disability, cultural, service providers) can be brought to bear on the development/review of accreditation standards through governance arrangements such as Advisory Boards or Steering Groups etc. Formalising a consistent governance process across professions may be one strategy for ensuring that standards reflect service delivery expectations and workforce needs.
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?

Common guidance or formalising a consistent stakeholder consultation process across professions for development and review of accreditation standards may be strategies for ensuring that standards reflect service delivery expectations and workforce needs, but Curtin perceives a real risk that greater independence of accreditation authorities would result in greater insularity and rigidity in accreditation processes.

Governance of accreditation authorities

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?

Consumers are often involved in accreditation processes, though there appears to be no consistent approach for doing this across authorities. Professional and academic expertise and perspectives of other key stakeholders (consumer, disability, cultural, LGBTI, other professions, service providers) can be brought to bear on the development/review of accreditation standards through governance arrangements such as Advisory Boards or Steering Groups etc.

Greater consistency and transparency in funding philosophy and development of a common set of qualitative and quantitative KPIs for accrediting authorities across NRAS may provide greater public confidence in accreditation of professions and the scheme more broadly.

What other governance models might be considered?

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;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

The current process needs to be more transparent. AHPRA controls the boards as well. It would be better if there was one body that just looked at accreditation. See also the response to question 26.

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

TEQSA utilises a Higher Education Standards Panel to provide objective expert guidance for the development and review of policy and standards and other formal projects that relate to their standards. The panel is widely respected for processes and outcomes achieved. Establishing a similar body (e.g. an NRAS Accreditation Standards Panel) across the NRAS professions may be an option.

Accountability and performance monitoring

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?

A NRAS Accreditation Standards Panel (see response to question 26) could be responsible for developing qualitative and quantitative KPIs against which accreditation authorities report, and that National Boards would monitor.
**Setting health workforce reform priorities**

**Assessment of overseas health practitioners**

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?

Some of the National Boards already align registration and assessment of qualifications for individuals seeking skilled migration visas (e.g. Chinese medicine, Dentistry), which seems to be effective and efficient.

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?

Greater consistency in assessment pathways afford opportunities for system efficiency and cross-professional collaboration, while simplifying and demystifying this process for health care practitioners. It may also offer opportunities for higher education providers to develop educational programs to facilitate the transition of internationally qualified practitioners into the workforce.

**Grievances and appeals**

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

The AHPRA/HPACF guidance document for the management of complaints related to accreditation would be more helpful if it were more widely adopted by accreditation authorities, and so provide a framework for consistency across authorities. There should be a formal Appeal process where all matters are dealt with in a transparent manner by an independent arbiter in a timely manner.

37. 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?

See response to Question 36.