Response to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professionals

The University of Newcastle welcomes the opportunity to provide feedback on the Accreditation Systems Review.

The University of Newcastle (UON) offers 13 regulated health professional programs and four self-regulated health degrees. The degrees are in the following discipline areas.

**NRAS regulated health disciplines at UON**

**Undergraduate Degrees**

- Medicine
- Nursing
- Midwifery
- Medical Radiation Science – Diagnostic Radiography
- Medical Radiation Science – Radiation Therapy

**Postgraduate Degrees**

- Nurse Practitioner
- Mental Health Nursing – Nurse Practitioner
- Clinical Psychology

**Self-regulating health disciplines at UON**

- Podiatry
- Nutrition and Dietetics
- Speech Pathology
- Social Work
Specific review questions are addressed below.

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

There is generally two aspects to accreditation processes and documentation; profession specific competency/threshold standards, and program accreditation standards which assess the accreditation standards of the higher education provider.

There would be enormous benefit in greater consistency and commonality in the development and application of these standards.

All accreditation authorities could use a common approach to assess the accreditation standards of the higher education provider. For example, areas of questioning about academic governance, University-wide student support services, staff development (performance review and training), support for staff research activity, policies and procedures affecting staff and students, e.g. Code of Conduct, review of progress, adverse circumstances etc., could all be expressed in a common format across accreditation bodies. Where standards can already be assessed from information available through the TEQSA accreditation process (see question 2 below), the information should not be requested again.

Further commonality could also be found in reviewing the profession specific competency/threshold standards of each profession with a view to determining which standards are shared by all professions and which are genuinely profession specific. With respect to standards common to all health professions, the standards could be expressed in a common language and a standardised template used to collect relevant information with respect to individual professions. This would save considerable time and resource and allow greater focus on addressing the profession specific competencies. It would also encourage an interdisciplinary approach to the accreditation of health professional education which would flow on to other innovations in modes of educating and training the healthcare workforce of the future.

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

Accreditation authorities should incorporate the decisions of TEQSA/ASQA assessments as they pertain to the standards assessed regarding the quality of the institution to provide health professional degrees. There should not be a requirement to provide this generic information again (in a different format) to each accreditation authority.
3. **What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?**

At the moment a number of accreditation authorities require both regular reporting and full accreditation visits. There would be enormous benefit in either awarding longer-term or open-ended accreditation with annual reporting regarding outstanding issues and changes to outcomes required, together with a requirement to report on an ad-hoc basis to the accreditation authority of any changes in curriculum delivery or outcomes in degrees. Current accreditation cycles are too short. Often there is insufficient time to introduce change or innovation, as discussed at a previous accreditation visit, and evaluate it, before the next accreditation cycle is underway.

If adopting more open-ended and risk-managed accreditation cycles it is important for accreditation authorities to clearly identify the key risks that need to assessed and reported on.

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?**

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

A trained pool of appropriate people should be the source of appointees to accreditation teams. Accreditation team members could be drawn from discipline-specific and non-specific staff from universities, practising clinicians from acute and community-based sectors, teaching and learning experts and healthcare consumer groups. The team should be multi-disciplinary with respect to health disciplines represented. Each accreditation team should be chaired by an experienced health academic who understands the university environment. A larger team of well qualified and trained individuals could be managed if the accreditation cycles were more spaced out e.g. full accreditation only occurring on a 10 year basis for those universities and degrees that received a positive outcome in the previous accreditation cycle.

6. **What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?**

The key principles should include an established mechanism to set and review accreditation fees that takes into account actual costs and a requirement to keep costs to a minimum. The mechanism should be transparent, consistently applied and monitored on a regular basis.

In addition to the fees charged by the accreditation authorities, there are additional costs to education providers associated with the preparation of documentation for major accreditation visits and the provision of regular updates and reports to accreditation authorities between visits.
7. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

In general, expressing standards as outcomes should be sufficient to also explore how the outcomes are achieved. It is possible to introduce granularity in the outcomes required such that it enables process to be explored. However, there may be occasions where an input measure may be used as a proxy measure where there is not a clear outcome measure or where delivery methods and processes assure safety.

It is also important to consider the guidelines that accompany accreditation standards as this is where input is specified (and assessed), not in the standard.

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

If learning outcomes in degrees are also expressed in outcome-based terms, the assessment of learning outcomes should also assess outcome-based standards. There should be a requirement that education providers demonstrate how their assessment is outcomes-based. In some cases this may require changes in assessment processes, and in other cases it won’t. Many current assessment processes already assess outcomes-based learning goals and standards. Assessors in this area would also require training and where proxy measures are required, they should be developed.

9. 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?

The value of a consistent approach to the development of professional competency frameworks would be seen in the subsequent joint ownership of the standards (between all stakeholders including accreditation authorities, national boards and professional associations), a better understanding of how standards interact, and are assessed and interpreted, and how they should respond to changing health care needs. There would be greater opportunity for cross-disciplinary discussion (and innovation) and a similar stakeholder group including consumers could be employed throughout these discussions.

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

Much of this has been addressed in question 1. The primary benefit to education providers would be the consistency in required information and the subsequent streamlining of the accreditation process such that the focus is on profession-specific requirements. A further benefit is the potential to identify common standards between accredited programs that will encourage greater sharing of resource and teaching innovations between programs offered in the same institution. The main risk could be the adoption of the lowest rather than the highest standards and a standardised
approach to teaching activities that does not allow for innovation or a differentiated approach.

11. What changes in the accreditation system could improve the timelines 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?

A risk-based approach to program delivery should be implemented together with a focus on reviewing major changes required in programs if a major accreditation visit is required.

Accreditation authorities should focus on ensuring that graduates have the fundamental skills and knowledge required of their profession. Producing graduates who can function in a future health workforce involves broadening the practice/clinical experience of students beyond the current prescriptive requirements and encouraging students to undertake international practice opportunities (currently not accepted for credit in many degrees).

12. How best could inter-professional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

The requirement for inter-professional education is already expressed in the standards with different accreditation authorities placing different emphasis on it. However, good inter-professional practice is not commonly seen in the workplace so translating education to practice is difficult and the priority of IPE in curricula and for students is diminished.

Greater inter-professional collaboration in the development of accreditation standards should result in a shared view of inter-professional learning and how it might be achieved both by education providers and different health professions.

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

Developing a structured learning portfolio that students complete would provide a framework. Tasks addressing healthcare priorities could be completed and students assessed as competent (or not competent). Students would need to be signed off as competent in these areas to complete the degree.

The outcome-based statements of graduate knowledge, skills and attributes in relation to current and emerging health priorities could be developed by an advisory group within NRAS who would identify such priorities.

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

Simulation-based training is already incorporated into curricula, particularly when preparing students for clinical placement. However, most accreditation authorities will
not allow it to substitute for clinical placement hours when certain types of simulation may represent a good substitute for placement requirements with respect to specific activities. In certain placement settings it is difficult for students to demonstrate certain skills because there are insufficient patients to work with or the opportunity does not arise in a specific placement location at a specific time. 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 with 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 are also gaining more experienced students to assist with their work which would improve the relationship between placements sites and education providers.

15. Is there a defensible rationale for a period of supervised practice as a precondition of general registration in some professions and not others?

A requirement for a period of supervised practice for recent graduates of all health professions would be good in an ideal world but difficult to enforce in the current labour market where there are often not enough new graduate positions to go around. Therefore, it is difficult to mandate supervised practice prior to general registration. An intern system similar to that implemented for medical graduates would have to be put in place for all health professions. This would mean controlling the number of graduates in each profession and creating an expensive postgraduate training framework. Pharmacy currently requires that recent graduates complete a graduate training year and undertake a national exam before full registration is awarded. If a Pharmacy graduate cannot find a graduate position, which may be difficult in the current job market, their degree may be wasted.

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

Graduates should at a minimum be able to perform satisfactorily at the lowest level graduate position available in that profession. A work-ready graduate should also demonstrate the capacity to learn from employers and possess the skills to be a life-long learner. It is the employer’s responsibility to induct the graduate into specific service delivery systems and provide organisational knowledge.

17. Does a robust accreditation process negate the need for further national assessment to gain general registration? or vice versa?

National assessment as an end-point for registration would drive the way students learn throughout their degrees and the way teaching is conducted. The focus will be on being exam-ready and not on learning. There will be no room for innovation or differentiation in degrees to accommodate, for example, a regional context.

Pharmacy currently has a national exam post-graduation to gain full registration. This has not negated accreditation of Pharmacy degrees. They are still subject to a 5 yearly re-accreditation cycle with regular additional reporting throughout the 5 years.
18. 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?

The relationship between accrediting authorities and their boards may inhibit
innovation and slow down processes. Certainly, boards can take some time (many
months) to officially announce the accreditation status of the program which could
place the education provider in a difficult position with its students and external
stakeholders.

However, conferring independence on accrediting councils may not remedy that
situation and would not necessarily guarantee prompt responses to changes in
workforce reform priorities. The combined effect of isolation from boards and also
other accreditation councils, may result in greater insularity and more rigid
accreditation standards.

19. 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?

The standard clause is not prescriptive and does not mandate certain activities. Also,
NRAS objectives are not clearly stated. Therefore, the standard clause would not
suffice to ensure that the accreditation councils align their functions and responses to
NRAS objectives.

20. 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:
   a. Expanding the remit of the AHPRA Agency Management
      Committee to encompass policy direction on, and approval of,
      accreditation standards;
   b. Establishing a single accreditation authority to provide policy
direction on, and approval of, accreditation standards.

The establishment of a single accreditation council would be the ideal but would
involve the assent of all professions which may take some time. In the short term, the
expansion of the AHPRA Agency Management Committee may be more appropriate.
Whatever the final configuration of the governance model, it would also be useful to
include the accreditation of the self-regulating health professions under its
jurisdiction.

21. How best in any governance model could recognition and accreditation of
cross-professional competencies and roles be dealt with?
With respect to the education and training of entry-level health professionals, an initial review of current standards/competencies should identify those which are common to all accredited health professions. Greater scrutiny of how the competencies are achieved and assessed could lead to agreement between relevant parties that specific competencies have been achieved by another health profession, and appropriate credentialing provided. A sub-committee of the accreditation authority could be tasked with the development of a suitable credentialing system for cross-professional competencies.

22. 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?

Performance measures should primarily measure the composition and conduct of the accrediting authorities against a set of criteria that includes many the attributes of an ideal accrediting council discussed in previous questions. The number of appeals against final decisions of councils may also be an appropriate outcome measure and/or ad-hoc or regulated audits of decisions taken over time by specific accreditation authorities with respect to their appropriate consideration of changing health system and health workforce priorities, innovations in teaching and learning, inter-professional education etc., in their decision-making processes, may also be appropriate.

23. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:
   a. As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
   b. Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

An annual forum could be conducted. The forum would comprise all health professions meeting to discuss workforce models, innovation across all parts of the health sector and training requirements. Attendees should include educators, clinicians, consumers and relevant experts. Specific topics could be discussed in breakout sessions and then main themes brought back to the general forum. The forum could also be conducted as a virtual conference which enables people to contribute from across Australia without having to travel to one location. It would be possible to have virtual presentations and posters, and a chat stream running through these sessions. Key points from discussions could be collected and broadcast for those unable to attend.
24. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

No, the current guidance document does not manage accreditation-related complaints in an appropriate manner.

A formal appeals process should be introduced where all issues are dealt with in a transparent manner and by an independent arbiter.

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

The Ombudsman should be the second layer to a complaints process, with an alternative arbitration process implemented by the accreditation authority in question, being the first layer. The appointment of another small team from a trained pool of accreditation officials should undertake an independent assessment of the substance of the complaint and the evidence provided. They should also provide a transparent report of their findings with evidence.

The scope of the complaints review system should encompass all accreditation functions.