28 April 2017

Professor Michael Woods
Chair, Independent Review of Accreditation Systems
c/o COAG Health Council

Dear Professor Woods,

Re: Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions

Thank you for the opportunity to contribute to the Independent Review both in writing and at the Forum in Brisbane on Wednesday 8th March. I am responding on behalf of the Faculty of Medicine at the University of Queensland (UQ). The UQ Faculty of Medicine is responsible for graduating around 500 medical students each year. We are committed to ensuring that our graduates are safe and effective members of healthcare teams from the first day of their internship and that they continue to adapt to changing healthcare needs throughout their careers.

Our response is confined to considerations about medical student education and clinical practice as members of teams. Therefore we have focussed on those questions related to accreditation standards; training and readiness of assessment panels; input and outcome based accreditation standards; interprofessional education; clinical experience and student placements; the delivery of work-ready graduates and national examinations.

Accreditation standards

While recognising the need for discipline-specific standards, we see value in greater consistency and commonality in the development and application of accreditation standards. Shared standards around areas such as governance, organisational structure, feedback mechanisms to students, would enable better benchmarking among disciplines. It would also enable more consistent data reporting. Similarly the use of consistent standards (ideally expressed as outcomes) across professions for common areas such as team-based practice would help provide a benchmarked view of how each of the professions treats this important attribute. Standardising components of the process could potentially decrease the complexity and therefore the length of time taken by an accreditation council to consider and process submissions.

By highlighting the benefits of common standards in some areas, we must reaffirm the necessity for profession-specific standards which reflect their specific role and contribution to
patient care. Specific educational standards that are developed, maintained and consistently applied via rigorous process, by individual health professions, offer greater confidence to consumers, students, trainees and the profession.

As is currently the case with the Australian Medical Council, we support a risk-managed approach to accreditation as opposed to a strictly cyclical approach. We recognise that this is dependent on the development of appropriate risk indicators and welcome the work that is already under way between the accreditation councils in this area.

**Training and readiness of assessment panels**
Panels should be configured to include the necessary breadth and expertise to cover the standards. This should involve all the relevant constituents i.e. multiple members of the profession plus representatives from each of the following areas: students, consumers, employers and other members of the health care team. We support the principle that panel membership positions should be advertised with a rigorous selection process. Appointees must be appropriately trained and remunerated.

**Input and outcome based accreditation standards**
As is already the case for medicine, accreditation standards should primarily be outcome-based. However, we recognise that to promote best practice and drive cultural change, there is a need for process metrics e.g. widening participation, addressing geographic inequalities.

**Interprofessional education, learning and practice**
We recognise the vital role high functioning teams play in improving patient outcomes. However, the nature of the healthcare team is changing as more patient care shifts to community settings and the healthcare system adapts to address the needs of an ageing population, chronic conditions and co-morbidity. While healthcare professionals are key partners in these teams, the other members include patients, carers and the voluntary sector. Therefore we need to prepare our graduates for team-based practice and not just interprofessional practice. This is an area where accreditation councils can promote good practice through shared outcome standards and the dissemination of good practice.

**Clinical experience and student placements**
As noted above, there is a role for accreditation councils to promote best practice through case studies and conferences. We would caution against prescribing the input or process measures. This applies to contemporary educational practices such as simulation-based education. For example, rather than prescribing set amounts of simulation-based education, the standards should focus on reducing the risk to patients and the public.

**Delivery of Work-ready Graduates and National examinations**
A robust accreditation process should negate the need for further national assessment to gain general registration. It is likely that a national assessment process would be in addition and not instead of existing accreditation processes. We note that the United Kingdom General Medical Council is currently consulting on the role of a medical licensing assessment. This has been
purposefully described as an assessment and not just an examination recognising that evidence about performance in a range of different settings and not just examinations is needed to make judgement about work-readiness. We would recommend that further research is needed in Australia to determine whether a national assessment would add value to our current accreditation system and that this study should draw upon the experience and evidence from other countries.

Thank you once again for affording us the opportunity to submit feedback to this important review.

Yours sincerely,

Professor Stuart Carney
Deputy Executive Dean and Medical Dean
Faculty of Medicine