NRAS Review Feedback 1 May 2017

The key principles which Faculty of Pharmacy at The University of Sydney has used in providing this feedback are:

- The primary aim of the NRAS scheme is the protection and/or safety of the public.
- The secondary (though clearly critically important) aim is to create a flexible, responsive, agile and sustainable workforce as envisaged under the national law s3(2).
- The former aim should be approached as a relative risk assessment and management activity given that absolute protection of the public cannot be assured.
- Consideration of risk should include assessment of the:
  - likelihood of education programs continuing to be sustainable
  - likelihood of education programs maintaining appropriate standards of education
  - likelihood that graduates are qualified to enter the profession and practice safely.
- The secondary aim is also addressed to some extent by the above risk-based approach.
- It is noted that “the aim of the accreditation process is not just about quality assurance, but also to support continuous quality improvement of professional education and training in order to respond to evolving community need and professional practice.” (Quality Framework, cited p. 21 of the discussion paper.)
- This could be expressed as ‘the accreditation process should address quality assurance while facilitating rather than constraining the continuous quality improvement process or innovation’.
- Given the current diversity, a universal or one-size-fits-all model is unlikely to provide net positive over net negative outcomes; even though it may be a desired eventual aim/outcome but this would require significant structural reform and a longer timeframe; however steps should certainly be taken in this direction as part of this review process. The Faculty of Pharmacy’s comments with respect to the specific questions posed in the discussion paper are summarized below:

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

   There would be a reduced financial burden on education providers and fewer resources would be required if there were greater consistency and commonality. There would perhaps be fewer Accreditation Councils conducting a larger number of accreditation reviews. We strongly support the principles of reduced duplication, and reduced regulatory and financial burden on universities (and students), while allowing for appropriate nuance for the different professions. Achieving this balance is the challenge.

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?**

   For some disciplines it might be appropriate that accrediting bodies rely more on TEQSA for evidence, thus reducing duplication. For others, particularly those with clinical, experiential or practical aspects, information gathered by TEQSA may not be fully sufficient (or appropriate) to ensure maintenance of professional standards for the discipline. Again, within the boundaries of what is required for clinical and health professions, we support the principle of reduced duplication and any relevant determinations as part of TEQSA/ASQA should be taken into consideration. We note that a number of Accreditation Councils have recently signed MOUs with TEQSA but we are not aware of any tangible
benefits or reduction in duplication that this has delivered for education providers. In addition, there should not be any dilution of the self-accrediting principle as part of NRAS with respect to governance of Universities.

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

We are in favour of a risk-based, open-ended approach to accreditation cycles, which does not require regularly scheduled re-accreditation cycles after a fixed period, rather there should be some material/major change in the program which triggers a re-accreditation process. This will reduce the burden of reporting to accrediting bodies and will allow for greater innovations in degree programs at self-accrediting institutions. There should be wider and robust transparent discussions with education providers on what constitutes material/major changes that trigger re-accreditation.

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 inter-professional collaboration?

Identify a suitable pool of members of assessment teams for any given year. There should be an open call for membership after a matrix of the skills, backgrounds and experience that are required of members of assessment teams is developed through consultation with education providers. This is especially true of specialized expertise that is required of assessment teams like inter-professional education and cultural competence, to mention just a few examples. Choice of Chairs and members needs to be carefully planned on an annual basis (based on the assessments that forms the slate of accreditation work for that year) and should not be on an ad hoc basis as it appears to be the case currently.

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

The question to be asked here is what purpose and value-add will a wider range of stakeholder (including consumer) involvement deliver? If it is purely for inclusiveness, then the work (and decisions) of the assessment teams will not be enhanced. Our experience as assessment team Chairs and members is that community and hospital pharmacy members struggle to contribute effectively on assessment teams and most of the (hard) work then falls to team members from academia.

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?

First of all we need to determine the body of work and the resources required for a risk-based accreditation process then open this up for wider public consultation. Then a subsequent discussion should occur on who should pay for this. The boundaries are: payments fully by education providers (many programs at Universities will become financially unsustainable with this model; governments (there may not be political appetite for this) or a mixed model that operates currently (Boards and education providers pay with subsidies from other functions like assessment of O/S qualified professionals). One could argue that if the primary goal of NRAS is public safety then there should be sharing of the financial burden by all parties. One issue that does need reform is transparency re how much the Boards contribute (from the registration
fees) to the accrediting function so that Accreditation Councils have certainty of this guaranteed income as part of taking on the accrediting role on behalf of the Boards.

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?**

Depends on #6 above; however overseas trained health professionals should not be exploited solely to solve this financial dilemma. It would appear that Accreditation Councils and Boards have exploited this funding stream, however there would appear to be little justification to subject overseas practitioners to such punitive measures in order to subsidise NRAS’ accreditation role.

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

We are of the view that input and process standards should be included, where warranted. Educationally speaking, this issue, and #9 below, speak to a broader and important point about assessment, outcomes and standards. All three should be closely aligned, particularly as some risks to the sustainability and quality of the programs are input-related, for example, governance, finances, staffing profile in terms of qualifications and expertise, quality and numbers of the student cohort.

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

The above question implies that a disconnect between assessment and outcome based standards is appropriate or acceptable. As mentioned above, these should be carefully constructed and aligned to ensure educationally sound outcomes. An appropriate question that could be posed is “What forms of assessment/evidence are appropriate for evaluating the achievement of outcome-based standards?”

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?**

It depends on what is meant by ‘common approach’? If it is meant to imply adoption of common guiding principles in the development of professional competency framework, then of course this should be adopted across the various professions. See our earlier comments (under #5) re inclusion of consumers and others.

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

We agree there are some core accreditation standards that can be across all professions (e.g., cultural competence, standards related to privacy/confidentiality, professional ethics, collaborative practice to mention a few) and then the profession-specific standards can be overlayed on these.
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?**

Accreditation process can be too slow or cumbersome especially if major innovations like a new professional degree program is introduced. We have first-hand experience of this with our new Bachelor of Pharmacy and Management degree, a five year integrated program where the B Pharm component is the same as our flagship B Pharm degree. The rate limiting step appears to be the national board rather than the Accreditation Council. National boards would not appear to be proactive or agile enough to respond to innovations from education providers. Boards should foster a culture of continuous innovation and collaboration with the higher education sector and not be a barrier to improvement and innovation.

13. **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?**

This needs to happen but the down-stream consequences of mandating this or being prescriptive about this should be carefully thought through. Data on the determinants of inter-disciplinary practice (including IPE) should drive this discussion (see for example the following related references: Reeves et al: Interprofessional education: effects on professional practice and healthcare outcomes (update). Cochrane Database of Systematic Reviews 2013, Issue 3, Art. No.: CD 002213. DOI: 10.1002/14651858.CD 002213.pub3; Reeves et al: Interprofessional education: effects on professional practice and health care outcomes, Cochrane Database of Systemic Reviews 2008 (Issue 1) Art. No.: CD002213. DOI 10.1002/14651858. CD002213.pub2 (References # 1 and # 2).

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

If flexibility and responsiveness are the desired qualities of an education program, then the focus should be on creating practitioners who are able to change with the evolving context – which includes evolving health care priorities. This suggests a skills development priority as part of the education experience.

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

Simulation should be another/additional modality in the L&T/education armoury. It cannot (and should not) replace all other modalities but be an adjunct to current modes. Simulation is more expensive than other modes of ‘traditional teaching’ and it should not be thought of as a less expensive mode of teaching. It requires large initial infrastructure investment as well as ongoing operating costs.

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?**

From a risk perspective, the paramount criterion is public safety. Currently some professions (e.g., physiotherapy) have education programs which are considered to produce registrable graduates at graduation; others (like pharmacy) do not. It would be ideal to have a system where graduation and registration were simultaneous, but this would require a number of professions (including pharmacy) to
undertake major structural reforms for which the appetite in the profession as a whole may not be readily apparent (or indeed the profession may be actively resistant to a dialogue about such a change). For the pharmacy profession there should at least be a rational discussion on the most appropriate model and the accrediting body (the APC, the Australian Pharmacy Council on behalf of the PBA) should gather data which informs such a profession-wide discussion. PBA should play a leadership role in taking stewardship of this discussion.

With respect to pharmacy programs published data from NZ that attempted unsuccessfully to make such a structural change, [Brailsford and Duffull, Integrated Pharmacy Programme Feasability Study (including Consultation Document, University of Otago, May 2014] (References # 3 and # 4) provided in this submission and from Ireland [Wilson and Langley: Pharmacy Education and Accreditation Reviews (PEARs) Project Final Report, June 2010 (Reference # 5)] would facilitate a rationale discourse on this issue.

In addition the various pathways leading to general registration as a pharmacist in UK, Canada, US and Ireland should be useful to such a discussion.

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

This definition would vary from profession to profession, depending on the requisite knowledge, skills and behaviours for that profession. The study by Merga, M., (2016) [Gaps in work readiness of graduate health professionals and impact on early practice: Possibilities for future interprofessional learning. *Focus on Health Professional Education: A Multi-disciplinary Journal*, Vol. 17, No. 3: 14-29], (Reference # 6) identified gaps including caseload and time management, clinical administration, employability, conflict management, stress management and reality shock and reflect quite high level capabilities of pharmacy graduates. Many healthcare professionals take years to learn how to effectively manage these issues. Many education providers would argue that these capacities are work-based and not educational provider-based. The perceived or actual misalignment between education provider outcomes and employer expectations is at least partly due to a lack of understanding of the former by employers. This may be a function of the dual healthcare/small business aspects of community pharmacy, but it is likely to be a more complex phenomenon. A one-size-fits-all model is difficult to envisage in the current climate given the diversity both between and within professions and/or practice sites.

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?**

The accreditation process should not negate the need for further national assessment especially for professions that have a pre-registration year before registration. If the pre-registration year were removed, there would need to be a review of whether further national assessment is required, whether this is of a capstone nature or not.

If national registration remains in place, any and all results need to be transparently available in an identified form to all education providers; this is not currently the case for such assessments conducted by the PBA.
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?

The current Pharmacy Board of Australia membership does not have the appropriate knowledge or skills to make such decisions or to lead appropriate profession-wide (or public) discourse on these issues. This is particularly so with respect to development (and refinement) of accreditation standards which has been led by the Australian Pharmacy Council with expertise from University academic staff. Apart from collecting supply side workforce data (as part of surveys conducted annually from renewal or new registrations) the PBA does not have any expertise or has not led discussions on workforce needs in an evolving healthcare environment. The Board needs a skills-based membership.

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?

Yes it would if there was greater independence from the Boards and if the Boards did not have a final authority to accept or reject the recommendations of the accrediting councils. If this status quo is to be maintained then it makes it even more imperative and urgent for the Boards to have skills-based membership.

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

The question is what additional outcomes are being sought and can these be obtained only by having community representation. What is lacking in terms of process and decision outcomes needs to be reexamined to arrive at a logical answer to this question (see also earlier comments under question # 5).

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

Transparency of appointment process and criteria adopted to make appointments is paramount. Open and transparent calls for EOI based on publicly advertised and documented skills base should be in place for all accrediting 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?

At the moment this separation does not appear to be occurring universally with all Councils. Boards should be seeking formal direct feedback from education providers and umbrella organisations (like Council of Pharmacy Schools, CPS A & NZ for Pharmacy) and other stakeholders when evaluating performance of accrediting councils.
24. 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?

We do not have direct experience of the operation of this clause with respect to the objectives of the NRAS. It would be prudent, however, to examine whether there are explicit KPIs to ensure the objectives of the NRAS are able to be achieved as part of the funding arrangements.

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;**

As an education provider we have not had any dealings with the AHPRA Agency Management Committee. We are not aware of the specific TOR of this Committee. The Functions of the Agency Management Committee are available on the AHPRA website but these are very broad and high level. It would be useful to have specific TOR for this Committee.

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

Whether establishing a single accreditation authority to provide policy direction on or approving accreditation standards is the appropriate way to go needs to be informed by what is lacking in the current system versus what efficiencies can be gained from such a move while retaining profession-specific standards.

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

One avenue might be via the Health Professions Accreditation Councils’ Forum (HPACF); we are not sure if HPACF carries any regulatory or other formal purpose or mandate. If HPACF were to take on greater formal or informal roles then a freer flow of information on its activities needs to occur especially to education providers.

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?

Specific quantitative and qualitative performance measures might include time frames for accreditation of existing and new programs (like those that exist for drug registration process by the Therapeutic Goods Administration, for example); reporting against innovations that have been facilitated (or embraced) by the NRAS or Accrediting Councils as well as Boards. Other performance measures might address how health workforce mobility has been impacted and how the NRAS has encouraged and kept pace with innovative degree programs in our neighbouring countries (for example, some of our Asian neighbours have a Doctor of Pharmacy, Pharm D, as entry level Pharmacy qualification whereas we in Australia...
cannot get such a discussion on the profession’s or Board’s agenda). For monitoring performance, certainly not AHPRA, however perhaps its Agency Management Committee might be suitable. The membership of this Committee needs to be reviewed in order to incorporate the expertise and input of education providers.

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

The Ministerial Council is at too high a level to do this. The TOR of the Council state that “the COAG Health Council (CHC) and its advisory body, the Australian Health Ministers’ Advisory Council (AHMAC), provide a mechanism for the Australian Government, the New Zealand Government and state and territory governments to discuss matters of mutual interest concerning health policy, services and programs”. Having the Ministerial Council playing this role has the potential to introduce another layer of delays that is not going to add directly to safety of the public.

29. **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?**

S11 (3) (d) of the Law provides policy direction:

(1) The Ministerial Council may give directions to the National Agency about the policies to be applied by the National Agency in exercising its functions under this Law.
(2) The Ministerial Council may give directions to a National Board about the policies to be applied by the National Board in exercising its functions under this Law.
(3) Without limiting subsections (1) and (2), a direction under this section may relate to—
   (d) a particular proposed accreditation standard, or a particular proposed amendment of an accreditation standard, for a health profession.

Such a policy direction appears to be of a general nature and inconsistent with the above question.

30. **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?**

A broader workforce reform agenda would require the Government to commit resources to such an activity that requires longitudinal data gathering and discourse on the changing nature of the health workforce. For example, the Government has funded workforce data gathering and studies over many years for the medical workforce but not for other health practitioners like pharmacists. A general agency looking at all workforce issues should be tasked with gathering data on the supply side of the equation (somewhat easier) but more importantly also on the demand side which is more complex but which has the potential to explore additional opportunities for the different health professions as well as addressing the mal-distribution of the workforce in rural/remote versus metropolitan areas.
• **Have regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?**

While this has improved mainly due to the proactive efforts of APC in the case of pharmacy, this needs to be more structured and regular rather than ad hoc as it has tended to be.

31. **Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?**

To our knowledge the National Law does not explain these arrangements. We have no experience of this but from a distance it would appear to be a non-transparent arrangement and should be opened up for greater public scrutiny to ensure that is not anti-competitive and is in the best interests of public safety.

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?**

These should be aligned and unless someone (or some organizations such as the Boards or Accreditation Councils) can provide data/evidence to suggest otherwise, this principle should be adopted.

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?**

We cannot think of a defensible justification unless this is backed by well documented national or international evidence/data that has been published or there is a consensus on this.

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

Yes and similar guiding principles should be the basis of making rational decisions. The overall guiding principle is safety of the public so it makes sense to have all other secondary underlying principles underpinning the overall guiding principle and uniform for all National Boards. The previous National Office of Overseas Skills Recognition, which previously was part of the Commonwealth Department of Education, provided a consistent, base level of information about overseas University degrees and their comparability to the Australian qualifications framework, however we are not aware if the continuing work of the Australian Department of Education provides the same level of support to education providers and assessment authorities.

35. **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 and how might this be achieved?**

Yes unless there is published evidence to suggest that supervised practice is the only way to ensure O/S trained practitioners are able to meet Australian practice requirements. There should be genuine reason(s) for having this requirement rather than imposing this as an additional burden for O/S trained practitioners. We have had situations where O/S trained and registered pharmacists who are being
appointed to professorial level positions at this University are required to do ‘some’ supervised training before registration is granted.

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

Subsequent to the 2014 Review, AHPRA & HPACF released a guidance document on management of complaints related to accreditation functions under NRAS. This guidance document deals principally with individual or other complaints against education providers and their programs rather than on all aspects of NRAs by all stakeholders including education providers. The scope of the guidance document is too narrow. As an education provider we have no experience of this process, however the scope of the grievance process should be wider and at arms-length to AHPRA.

37. If an external grievance appeal process is to be considered:

- Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?

We have not been involved in any such grievance appeal process.

- Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

Most definitely, as the financial burden on education providers needs to be assessed independently of AHPRA/Boards or Accrediting Councils on the basis of the cost of ensuring the safety of the public versus the financial sustainability risks of education provider programs.