Review of Accreditation Systems
Monash Health response

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?

Monash Health response:
Within the health sector, the importance of robust and consistent frameworks is critical to the culture of a workforce that aims to deliver holistic, patient centred care. At present the preparedness of the health workforce to provide the type of care community members expect is variable.

Potential benefits of consistency and commonality includes:
- reduced duplication due to common learning outcomes and assessment principles
- shared learnings from other professions and health areas
- Consistency and transparency of accreditation nationally
- Potentially consistency of cost of training
- Clearly defined standards and expectations and therefore consistency of expectations across the workforce
- Shared language and expectations on certain domains of competency: e.g. communication/teamwork, clinical outcomes etc.
- Potential enabler to enhancing inter-professional training and learning with inter-professional competencies

Potential costs may be;
- Perceived ‘dilution’ of specialty areas
- Change process that would need to be undertaken to align current standards with any revisions

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?

Monash Health response:
Accreditation of professionals helps to provide for the safety of the community through the education and training of a suitably qualified workforce by ensuring that graduates of health professions’ degrees are equipped with the right competencies to perform to a level expected of them. There is certainly benefit for accreditation bodies to take into account relevant assessments undertaken by TEQSA/ASQA and other education providers, however this needs to be consistent to avoid the current variations described in the review.

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?

Monash Health response:
Current accreditation processes could be enhanced by encouraging more multi-disciplinary participation in assessment panels and teams. This would also need to be supported through the provision of training to assessors (e.g. in relation to enhancing understanding of inter-professional education).
5. Should the assessment teams include a broader range of stakeholders, such as consumers?

**Monash Health response:**
Involvement of a broad range of stakeholders, such as consumers, their families and other community members, provides a variety of perspectives that can provide valuable insight. However the purpose and benefit of such involvement needs to be clearly determined and documented. For example, the type of information that could be collected from stakeholders, the knowledge and experience of the individual stakeholders, how the provided information would be verified, and how it would be used as part of an assessment.

**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?

**Monash Health response:**
There is an opportunity to balance the standards by including both outcome and input or process standards. Monash Health acknowledges the necessity of outcome based terms but there may be some input / process examples that add value to the standards without hampering innovation. These may include:

- Complaints management, incident management, performance management,
- Process standards related to inter-professional practice (where outcome measurements are still being developed)

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

**Monash Health response:**
There may be a need to review the timing of assessment processes. For example in Pharmacy currently there is a 12 month Internship between graduation from the program of study to registration. It can be difficult to attribute the overall outcome of the program in terms of successfully registering to a particular program of study.

**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?

**Monash Health response:**
Yes, we support a more consistent and collaborative approach to the development of professional competency frameworks. Such an approach would need to identify and build on the similarities of the different professional competency frameworks whilst providing sufficient flexibility for the individual professions unique needs. An alternative way of leveraging commonality could be to have competency frameworks developed inter-professionally for professional behaviours and standards (e.g. communication, ethical behaviours, leadership, and person centred care) and tasks or activities (e.g. prescribing) where multiple craft groups need to be able to demonstrate that same competency.

Further, involvement of a range of stakeholders, including consumers, will provide external perspective and insight to help contextualise the framework(s), its purpose and its performance. The consumer voice would ensure that we are developing and preparing the future workforce to meet consumer expectations.

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

**Monash Health response:**
As a health care workforce there are many common professional attributes and behaviours that the public expect as part of their care. These expectations are continuing to change and increase as consumers
become more informed and more of an active partner in their health care experience. Common elements and domains are a strong step forward in meeting this need and there are many benefits. These include;

− Consistent expectations and provision of care to consumers from professional groups
− Reduced duplicity and thus reduced costs
− Increased efficiency
− Greater understanding and collaboration across professions
− Greater emphasis on the “soft skills” which are largely common across health professions
− Consistent capabilities with respect to elements such as leadership, professionalism, and interpersonal relationships

A perceived risk may be that accreditation standards become too generic and they may lack meaning for different professions, however with appropriate identification and articulation of profession specific competencies this risk can be negated.

The overlay with profession specific requirements is still important, as is any differentiation required within a profession. For example clear differentiation between enrolled and registered nurses standards.

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?

Monash Health response:
Having an excellent understanding of consumer expectations and aligning this with the education programs is critical. Teaching graduates how to partner with patients, clients and consumers in their health care delivery will ensure we are meeting the future needs of our community.

In addition to this is including training on how professionals need to work together as part of a team in the workplace. Much of this happens now as part of ‘on the job learning’ which could be considered as too late, but there is a greater opportunity for graduates to work together and understand each other’s roles well before they enter the workforce.

Another component is clinicians being equipped with change management skills, improvement and innovation skills and resilience so that they can easily adapt to the changing demands of healthcare.

A stronger feedback loop between the education provider and the employers of graduates would also enable timely and responsive changes if required. All of this leads to a more agile workforce and should help inform the content and delivery of programs of study to meet the evolving needs of the health sector. The timing of accreditation reviews needs to be responsive and flexible to this.

Inter-professional education, learning and practice

13. 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?

Monash Health response:
As an employer of health care workers, the expectation is that our staff are able to work together to best meet the needs of our patients. There is a greater recognition on inter-disciplinary practice and the benefits this has on the health care outcomes of the community.

Embedding inter-disciplinary education / practice into the curriculum and standards is one way of achieving this.

Standards could also consider outcomes such as;

• ‘knowledge of roles of others’ ‘communication across professions’ ‘collaboration within and across teams’
• Evidence that graduates are equipped to practice in an interdisciplinary environment
• Inter-professional subjects taught together assists professional groups to work together but is not sufficient on its own
• Monash Health has also had great success (in relation to disciplines working together) through inter-professional placements and student led care
• For providers who only offer single discipline programs there may opportunities for external partnerships with other providers to meet inter-professional learning needs

We recognise that some roles / disciplines may not always practice in an interdisciplinary setting however a principle based approach that is not prescriptive and enables local/regional adaptation would ensure a balanced approach.

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?

Monash Health response:
In addition to relevant information from responses to other issues, the following suggestions could assist;
• Teaching students a greater understanding of the healthcare context, political influences, government objectives etc. will aid in a great understanding and preparedness for the workplace
• Teaching students how to respond to and adapt to an ever changing healthcare environment – this includes a greater understanding of how clinicians and teams can proactively manage the increasing burden of chronic disease
• An expectation that clinical placements include an opportunity for students to practice within teams
• An avenue for health care services to feed practice trends, issues and changes back to the educators. Both the ‘what’ and ‘how’ of service delivery. This would ensure students and graduates are prepared for the potentially confronting issues faced by health practitioners.

The balance between outcome based standards and healthcare priorities incorporated into curricula would ensure the curricula can be agile and enable them to be responsive to emerging health priorities. This needs to be done in a way that ensures changes can be made in a timely and efficient way. The introduction of the Electronic Medical Record is an example for the need for curricula and clinical experiences to be flexible and responsive to the changes in environment and healthcare priorities so that graduates are work ready. Another example is the need to be aware of health care accreditation systems, particularly the requirements of National Standards.

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

Monash Health response;
Differentiating between clinical experience and clinical placements in standards would be useful to ensure students receive a balance in their learning.
Simulation based education can take many forms and one area that is of huge benefit for preparing students is the relationship and engagement between the practitioner and the consumer. This could be incorporated into education practice as a standard.
Furthermore simulation could be incorporated into both the delivery of the course by universities and in the clinical experience components, but simulation does not replace ‘hand on’ clinical exposure. Simulation provides some aspects of care delivery and can be used for students to become familiar with both technical skills but also important aspects of practice such as working in teams, responding to emergencies, engaging with and partnering with consumers etc.
Other contemporary practices to compliment simulation and clinical placements may include electronic resources like teleconferencing, virtual reality (medical emergency training and simulations), web based remote video consultations and supervised procedures which all hold a strong place in the future of healthcare.
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?

Monash Health response:
The opinion of the professional groups at Monash Health is that all health professions with clinical contact should have some level of supervised practice prior to general registration. This can be done during the course of study or between graduation and full registration.

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

Monash Health response:
This is an important issue and the concept of work readiness will have different meanings for different settings. Having said that work readiness should be aligned to the health care worker and not the health care setting. A comprehensive consultation process with strong consumer representation will elicit common capabilities required of the workforce.

At a minimum work readiness should include basic quality and safety requirements, as well as professional behaviours and attributes required of the workforce (differentiated from clinical knowledge, tasks and expertise).

There are a number of existing frameworks such as those previously published by Health Workforce Australia or the Victorian Allied Health Credentialing, Competency and Capability Framework which provide example structures of how this might take form.

This is certainly an accountability on workplaces, such as Monash Health, in their role in orientation, induction, and specific workplace training that is required. The workplace is also responsible for ensuring continued competence within scope of practice and development of additional competence for expanded scope or new clinical practice.

Programs such as structured graduate programs also support the development of work readiness but their application varies across disciplines. Graduate programs are often in place where the undergraduate training is only 3 years, but the 4th year of learning is essential prior to clinicians being ready to practice, in contrast to 4 year programs with embedded clinical placements.

It may be worth further exploring the evidence and costs behind these models and considering if there would be benefit to a consistent approach.

The other matter which is worth considering is how the future workforce is prepared for and understands important legislative or reporting requirements. This might include mandatory reporting, reportable conduct, how to report and respond to family violence etc

Producing the future health workforce

What other governance models might be considered?

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

Monash Health response;
Establishment of a Competency / Capability framework (such as those previously mentioned) would ensure consistent application across all professional groups.
Setting health workforce reform priorities

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?

- Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

Monash Health response;

A strong governance model with appropriate representation from all professional groups and service settings would assist in meeting this objective. Monash Health acknowledges the number and complexity of external stakeholders, however if we require the workforce to work in an inter-professional/interdisciplinary manner than the approach at a national level also needs to reflect this. Again the consumer voice in this is critical.

If there was consensus at a national level or a considered approach to workforce planning then this would be able to feed directly into the accreditation process. If agility is built into the process then accreditation can be responsive to changing community needs.

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

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?

Monash Health response;

The multiple layers of these bodies leads to differentiation and variation in approaches. This has the potential to become very complex and repetitious for the health workforce and health care employers.

Below are summaries of how this impacts the medical and nursing workforces.

As a summary for medical arrangements;

- The specialist colleges and post-graduate medical councils work independently and have different methodologies for their assessments.
- The Postgraduate Medical Council of Victoria which accredits interns and second year doctors has a transparent methodology. The accreditation is intensive and detailed with a high compliance cost.
- The specialty medical colleges function autonomously and set their own standards. There is not a common core of requirements across all colleges. There are 17 specialty medical colleges, but each have subspecialties that run their own accreditation systems. For example the Royal Australasian College of Surgeons has 9 societies, The Royal Australasian College of Physicians has 22 adult and 14 paediatric chapters. Most Colleges accredit hospitals, not health services, so for a health service with multiple facilities multiple independent accreditation visits can result.

It is difficult for a health service to have oversight over College accreditation because there is no annual schedule, inconsistent channels of communications from colleges and therefore there is no central register of findings and recommendations.

Whilst each professional college has aspects of accreditation relevant to the specific craft group there is a common core of vocational training accreditation that could potentially be undertaken by an independent agency.

From a nursing workforce perspective;

Currently the Australian Nursing and Midwifery Accreditation Council accredits nursing and midwifery programs leading to a specific registration type, namely; enrolled nurse, registered nurse, registered
midwife and nurse practitioner. With growing complexity of health care; knowledge, skill, competence and capability requirements of nurses and midwives are increasingly becoming both more specialised and more comprehensive. These skills are often obtained through formal post-graduate qualifications offered within the higher education sector at graduate certificate, graduate diploma and master’s level.

At present, there is no external accreditation program for these courses and as such they vary considerably in content, quality, fee structures and requirements.

Consideration could be given to the establishment of accreditation for post graduate nursing and midwifery programs leading to an advanced level of clinical practice within a specialty area.

In addition, the inclusion of this function could be extended to assess overseas post-graduate qualifications for equivalence to AQF programs.
Submission to the Discussion Paper - Monash Health Consumer Advisors

Introduction

This submission is by, and on behalf of, volunteer consumer advisors at Monash Health, Victoria. It should be read in conjunction with the submission made by the Monash Health organisation. This submission focuses particularly on the issues raised by the Independent Reviewer at the Consumers’ Health Forum in March 2017.

Consumer expectations of the national accreditation system

A primary purpose of the National Registration and Accreditation scheme is promoting patient safety and avoiding harm. Its key aim is to protect the public, and it does this by ensuring accreditation standards support practitioners to achieve the clinical skills relevant to safe and effective practice in the regulated profession. In addition to clinical skills, effective practice requires health practitioners to possess certain attributes (commitment to ethical practice as an example) and to develop certain non-clinical-technical skills (effective communication skills as an example). Consumer advisors from Monash Health expect that the accreditation system has consumer participation embedded within it and that accreditation standards are developed in partnership with consumers. Accreditation standards must require the program or course under review to evidence how it is delivering graduates who understand and commit to delivering patient centred care.

This would entail consumers partnering in:

- establishing a common approach to the development of professional competency frameworks;
- establishing the knowledge, skills and attributes required in each profession, including identifying what elements or domains are common across regulated professions;
- establishing how accreditation will be undertaken and what evidences “patient centred care”;
- establishing a basis for undergraduate and graduate training, and education and ongoing awareness activities, which includes a fundamental component of patient stories, case studies and involvement of consumers in the delivery of training in identified core focus areas;

and

- being a core component of assessment teams.

Consumers expect that undergraduate courses will demonstrate commitment to the culture of graduates being skilled in working effectively in multi-disciplinary teams delivering safe, effective, life-enhancing care. It is crucial that accreditation standards for all health professions reinforce this principle. We recognise that significant cultural change is required to break down silos between health professions; however, we consider that to expect hospitals and other places of further training to begin to engage health graduates in concepts of multi-disciplinary practice is too late in practitioner development. It is also too late to expose graduates to patient stories for the first time when they commence in-hospital postgraduate training. Exposure to patient stories is critical to the development of an understanding of how patient centred care differs from traditional physician-led or other-profession-led care models where the patient is a passive recipient of services that may or may not meet their personal needs and goals.

Critical to patient centred care is that all health professionals should have excellent skills in engaging with their patients and clients. Too often, communication skills appear to mean that the health professional is skilled in explaining what they will do to the consumer because they are the expert. What is actually needed is for clinicians to attain skills in engaging with patients and clients and their families and carers to understand what the consumer’s goals are and being influenced by the consumer so as to develop a care plan that meets those goals, rather than necessarily providing every technologically feasible procedure. As populations age, demand will increase for life-enhancing care plans that focus on quality of life “What matters to me...” and professionals will need to be able to identify when a medical “cure” of a particular condition will not enhance consumers’ lives.
Changing the conversation from “what is the matter with me?” to “what matters to me?” requires a cultural shift to recognise that while the health professional has certain expertise, the consumer is an expert through their experiences and that the health profession exists to enhance this experience. The culture in the health system has shifted significantly, in that it is now moving to recognising that it is there to provide a quality, safe and customer centred service.

The Review provides a critical opportunity for all competency frameworks and professional standards to be built on these principles and experiences. All standards across regulated professions address the development of knowledge, skills and attributes. There are some commonalities of skills and attributes across all registered health professions – examples of this are communication skills and attributes espoused in Codes of Conduct. The development of some common standards across registered health professions would streamline review and enhance consumer involvement. An analysis of the differences in Codes of Conduct across the fourteen professions currently registered has shown substantial similarities and identified the opportunity to develop one common standard about ethical conduct. It is likely that there are other commonalities across the professions.

The development of commonalities across accreditation standards will not be without costs, including those costs of health professions working together across boundaries to develop common standards. Work will need to be inter-professional as well as intra-professional and may well take time initially; however, the longer-term benefits will out-weigh these costs. These benefits are likely to include improved quality and consistency, as well as streamlining future reviews and facilitating consumer input. Furthermore, consistency across professions contributes to public confidence in standards and systems in general and also promotes cross-health profession understanding of particular issues, such as what constitutes patient centred care and what key principles must be adopted in order to deliver patient centred care. A common approach would facilitate effective and efficient consumer input by streamlining requests for input.

The review provides a number of opportunities to streamline and enhance the current system where the fourteen different professions are developing accreditation standards independently of one another. One enhancement with the potential to reduce duplication and gaps, and to promote learning across professional boundaries, would be for each profession to work within a structured working group format with a centralised conduit to the Australian Health Practitioner Regulation Agency’s Community Reference Group. The input of the Community Reference Group could be sought on a core set of issues and gaps at a high level, rather than focusing on the specifics of each standard. It would also be practicable to work with the Community Reference Group to set a minimum standard of consumer/patient centred principles to enhance consumer involvement in the development of accreditation standards.

Consumer involvement in developing and implementing accreditation systems and standards and in assessing proposed courses against standards provides opportunities to ensure that the patient and the patient’s experience is at the centre of assessing the appropriateness of standards and courses. Critical to the delivery of patient centred care across all health services is the need for students to have access to patients with a variety of conditions and life-goals so as to start the process of understanding the complexity of patients’ lives. This would help break down barriers to continuity of care once health professionals are practicing and enhance the “work readiness” of graduates of all the regulated professions.

In summary

The Independent Review of Accreditation Systems provides a critical opportunity to improve the quality of accreditation standards and the assessment of courses and other training and development modalities through imbedding the consumer voice at all stages. This will support the development of patient centred principles and the delivery of patient centred care. Patient centred care brings with it the possibility of reduced costs and improved outcomes for bot