**Key submissions**

The current system of single profession specific accreditation authorities is hampering:

- equality of professionalism in accreditation;
- cross-disciplinary education.

The current system perpetuates:

- duplication of work both by accrediting authorities and education providers;
- lack of an overall health policy focus in relation to education provision;
- interests of each profession over wider community interests and the objectives of the NRAS;
- fragmented consideration of workforce requirements.

NSW supports the development of a single expert accreditation body which ensures input from each individual profession and recognises profession specific issues and also:

- is able to promote the achievement of the objectives of the NRAS and national workforce policy interests, as well as the interests of the individual professions in maintaining quality and safety;
- has a transparent mechanism of governance;
- has the ability to appoint expertise in the professions for profession specific advice.

This expert accreditation body would provide advice on the above issues to each of the National Boards when Boards are exercising their accreditation functions under section 35 of the Health Practitioner Regulation National Law.

The specific questions posed in the Discussion Paper are addressed as follows.

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

There are several elements common to education providers that are subject to duplicate assessment by each individual accreditation authority. Duplication of effort for education providers could be reduced by a single body accrediting appropriate aspects of education providers on a “once only” basis. “Single” accreditation of common or similar aspects would reduce compliance costs for the provider and promote efficient use of resources. The current “harmonisation” initiatives between individual authorities do not go far enough in terms of reducing duplication.

A single expert body would allow smaller boards that have less resources and capacity in relation to accreditation functions to utilise the experience and expertise of the body.

Greater consistency and commonality of accreditation standards through a single accrediting body would also support better training of assessors and more consistent application of accreditation standards. A consistently more skilled assessor group across all professions supported by content experts would be a more efficient approach to accreditation.
It is important to preserve the profession specific basis of the NRAS and recognise the requirement of the separate professions where they exist. A single accreditation body needs to achieve an appropriate balance between recognising commonality where it exists, and professional differences where they are necessary to ensure safety and quality are maintained.

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?

Incorporation of the decisions of TEQSA/ASQA assessments is likely to be most effective in the context of a single accreditation body. Otherwise, there is the danger of 14 different approaches to “incorporating” these decisions.

While incorporation of these existing assessments leads to several advantages as outlined in the discussion paper, consideration should be given to whether a single accreditation body should incorporate them without critical review. Automatic adoption has the advantage of efficiency, but the disadvantage of limited oversight. The Review’s guidance on this is sought.

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

NSW Health supports moving towards a more risk-based assessment approach, but this does not have to be at the absolute exclusion of a cyclical approach. The two could work in tandem, especially if there was a transition period, in order to develop an evidence base to determine whether the elimination of cyclical assessments is appropriate.

A risk-based approach is only as effective as the body monitoring the risks. NSW does not support 14 separate accreditation authorities developing separate approaches to risk monitoring. Resources should be pooled in order to provide for a highly professional and well-resourced body to provide this role. Again, this would be enabled by a single accreditation body with professional assessors.

Jurisdictions do not have a high degree of visibility of the current processes. A single body approach with responsibility for key elements of the accreditation process including a risk-based approach and transparent governance would allow jurisdictions more transparency.

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?

NSW Health has experience in other fields of accreditation of inconsistent approaches across individual assessors, even when assessing against the same set of standards. Inconsistencies will be compounded by multiple approaches and therefore a single expert body is more likely to achieve consistency in assessments in comparison to separate authorities.
Having a professional group of highly trained assessors supported by subject matter experts from the professions would support a more consistent approach across the professions to accreditation. Training of assessors is crucial. Although inconsistencies can never be completely eliminated, a single training approach would be of assistance. A single body could also deal with questions regarding inconsistencies in a more standardised manner.

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

It is important that the assessment process takes into account the views of all stakeholders in reaching a decision regarding compliance with accreditation standards. However, it is unclear if having assessment team representatives from different stakeholder groups is the most efficient and effective way of achieving this result. As already noted, it is important that all members of an accreditation team are properly trained and have an understanding of the accreditation process. This can be difficult to achieve and sustain with wide stakeholder participation in assessment teams. If the accreditation standards are robust, then properly trained assessors should be able, through consulting with a broad range of stakeholders, to assess how these standards are being met in regard to the different stakeholder groups.

Current NSW Health experience is that there is no consistent approach regarding both the role and purpose of stakeholders, such as jurisdictional representatives, in accreditation teams. In relation to jurisdictional representation on College accreditation teams, NSW Health experience has been that in some cases the jurisdictional representative has been a full participating member of the team while in other cases they have been excluded from certain aspects of the accreditation (e.g. interviews with trainees) and have been seen as simply there to provide clarification on jurisdictional policies.

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?

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 on-shore programs?

The fees that are set for assessment of overseas qualified practitioners should be determined by the cost of undertaking these assessments by the education providers and not used to cross subsidise accreditation functions for on-shore programs. It is recognised that even if an overseas health professional has their qualifications successfully recognised by an Australian education authority, it does not guarantee them employment in Australia. Charging a fee that is more than the cost of assessment may be perceived as unethical, particularly as there is no guarantee of employment after assessment of the qualifications. Fees should not be set to discourage applicants from applying for assessment of their qualifications but to cover the costs of the assessment process.

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

NSW Health supports the principle of outcomes based standards. Increasingly, health professional training is being undertaken in a range of different settings. Outcomes based
standards support training in a range of different settings while prescriptive, input standards tend to restrict where training can occur.

In medical training it is recognised that training in rural and regional settings provides valuable experience for medical trainees. However many rural training sites struggle to meet the medical college accreditation standards because they are not able to comply with the input standards that often prescribe staffing levels which are based on metropolitan not rural/regional hospital models. An outcomes based approach would address this issue.

There are circumstances, however, where it may be appropriate to give guidance about minimum requirements that need to be demonstrated to ensure that outcomes are met. As an example, the Australian Medical Council (AMC) Graduate Outcome Statements outline the requirements that medical students must demonstrate at graduation. While each medical school has met these as part of the accreditation process the Review of Medical Intern Training has identified that many medical graduates are not considered work-ready when they commence internship. As an example, the AMC graduate outcome statement 2.6 says “Select and perform safely a range of common procedural skills.” However it does not specify what these common procedural skills are, which may contribute to the variability in intern work readiness skills. To address this issue, employers should develop an agreed description of the core common procedural skills that all medical graduates must be able to perform at the commencement of their internship. These could be included in the graduate outcome statements as a guide to medical schools on what is expected and what should be assessed.

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

It is acknowledged that outcomes based assessment is more complex than input or process standards and therefore assessors need to be trained in outcome based assessment. A single accreditation body with a pool of trained assessors could more effectively support this approach.

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?

NSW Health supports the establishment of a single expert accreditation body, and this could lead to a common approach in this regard.

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

Development of common elements with overlaying profession specific requirements would work well when administered by a single accreditation body with specialist assistance for profession specific elements. One of the risks in this approach is that there may be no agreement on the common elements and everything becomes specific. A single body would need sound governance to counter this risk in its approach to development of agreed common elements. An appropriate balance between the common elements and the professional specific elements needs to be achieved.
One benefit of having common accreditation standards is that it would support better training of assessors. It also would simplify the accreditation process for education providers who must meet requirements of different accreditation authorities.

The Australian Health Ministers’ Advisory Council (AHMAC) Accreditation of Specialist Medical Training Sites Project developed generic accreditation standards for medical colleges. The AMC Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Accreditation Standards reference the generic standards developed by this Project: “The AMC endorses work to develop tools to support consistent approaches to accreditation, such as those of the Accreditation of Specialist Medical Training Sites Project. The accreditation standards under 8.2.2 draw on the domains for accreditation in that report and education providers are encouraged to use these 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?

Feedback processes and communication channels across education providers, service providers and employers are not effective. Therefore education providers are lacking in terms of timeliness and responsiveness needed to ensure that they meet current and future workforce requirements. Feedback processes and information sharing need to be improved to ensure that education programs are delivering graduates who are fit for purpose.

The issue of medical graduate work-readiness is a case in point. Current mechanisms to share information between employers and medical schools concerning the work readiness of medical graduates are not well developed. The National Intern Work Readiness Forum held in September 2016 stated:

There was a consensus that exchange of student information between universities and health services could and should be improved. There should be better communication from universities about the skills of their graduates and from health services about their expectations and requirements. Health services should provide feedback to universities on the performance of the graduates as interns and any areas of weakness……Forum discussions identified that the information exchange between universities and health services is complex, that the current situation is not meeting the needs of either party and will require more detailed consideration (National Intern Work Readiness Forum – Summary of Proceedings p 8).

As noted the challenge is for the accreditation process to take in the views of all stakeholders, including employers, and to ensure that health workforce requirements are always considered. There is often little or no consideration of workforce requirements in the accreditation process which often only considers education program requirements.

The recent transition to the Master degree (MD) qualification by a number of medical schools illustrates the disconnect between consideration of education program requirements and health workforce requirements in the accreditation process. The transition to an MD qualification has been driven by universities without consideration or consultation on workforce requirements. The Review of Medical Intern Training Final Report noted that “While respondents broadly endorsed the knowledge and thinking development component
of medical programs, concerns were raised about: the work readiness of graduates; the variability in the quantity and quality of clinical experience; the addition of the MD research requirement adversely impacting on clinical exposure” (p16).

AMC accreditation of these changes in qualifications has been robust - but has had a narrow focus i.e. on the educational merits of an MD program but not consideration of whether it was meeting a workforce requirement. The AMC accreditation process does not consider the workforce impacts or requirements of medical programs.

The accreditation standards are developed in an educational framework which is appropriate. However it is also important that these standards additionally ask: how does the course support workforce requirements and workforce needs?

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?

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

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

These are matters upon which a single professional accreditation body could advise after consultation with stakeholders.

16. Is there a defensible rational for a period of supervised practice as a pre-condition of general registration in some professions and not others?

Please refer to our response to questions 18 and 35.

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

Please refer to our response to question 18.

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?

It is unlikely that expansion of national assessment processes, such as exams, would be acceptable to the community, if they represent another barrier to entry and impose more red tape, without corresponding streamlining within the accreditation process.

Medicine requires medical graduates to complete a 12 month internship before being eligible for general registration. It is noted that other health professions, such as nursing and dentistry do not require an internship and graduates are eligible for general (full) registration at the completion of their studies. It is unclear if it is differences in accreditation processes between these programs and medicine that support these students to obtain general registration at the completion of their studies or other factors.
The Review of Medical Intern Training has made a recommendation 4(g) that there is **Examination of the capacity to assess and certify the capabilities and performance required for general registration within university programs – to be undertaken across different medical programs and health service settings within 2-5 years.**

It is acknowledged that if recommendation 4(g) were to be implemented, it would require review of accreditation standards to ensure they support the process. However it is a complex issue that requires consideration of a number of factors such as the capacity to assess the capabilities and performance within a medical school program and that simply strengthening accreditation may not fully address the issue. A fundamental consideration is the clinical exposure that a medical student has in a clinical setting and the scope of activities that they undertake to be able to assess their capabilities for general registration.

Formation of a potential national assessment process should include consideration of how the process will address key issues. As noted above, the Review of Medical intern Training identified variability in medical graduates and a lack of work readiness. A national assessment may address the issue of variability however it may not address the issue of work readiness if the assessments were not valid. The easiest way to administer national assessment is via multiple choice examination, however that process may not be the appropriate in assessing non-technical skills such as teamwork and communication skills. Further clarification of medical graduate outcomes with a more robust accreditation process would better address issues concerning work readiness.

**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?**

**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?**

National Registration Boards have a minimum membership of 9 and the largest board currently has 12 members. A board’s knowledge and skills can be highly dependent on its individual members, rather than the categories of membership set out in the National Law, which relate largely to jurisdictional practitioner representation. For this reason, there is always a danger that an individual board does not have appropriate knowledge and skills in any given domain. Further, board members are not full time professionals, and their role is an “oversight” one, which has to consider realistic time constraints of its members. Boards therefore need professional and comprehensive advice which adequately supports their oversight and decision making role.

The formation of a single accreditation body should be able to provide the necessary expertise and advice to boards and/or the approving authority for accreditation standards (see comments on “governance structure” at the end of this submission).

This is not to suggest that a single accreditation body should usurp the role of Boards and exercise complete independence over accreditation functions. This may have its own dangers, in that accreditation becomes too separated from registration and that the two mechanisms diverge in inconsistent ways. NSW supports the continued oversight of Boards in relation to accreditation standards and approval of programs of study, but with improved expertise, advice and support for all Boards from a single accrediting body.
The issue at hand may not be the *skills* of National Boards to assess workforce requirements but rather *how* workforce requirements are considered in the accreditation process.

NSW experience concerning medical accreditation is that workforce requirements appear to be outside the scope of the accreditation process. For example, the transition to MD programs and accreditation of offshore medical campuses appear not to have taken workforce requirements into account.

Greater or lesser independence may not be the key issue for considering improved alignment of education and training with evolving needs of health consumers (as well as workforce requirements). A more effective approach may be to make the evolving consumer needs and workforce requirements more explicit in accreditation standards and processes.

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

Jurisdictions’ visibility over key accreditation decisions is limited, making this question difficult to answer.

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.**

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?**

A single accreditation body with transparent governance should be able to manage such conflicts of interest.

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?**

There is limited visibility to jurisdictions as to how accreditation authorities are meeting their commitments under the agreement, and therefore this question is difficult to answer.

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.

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

NSW favours a single accreditation body and considers it to be the appropriate body to provide advice on recognition and accreditation of cross-professional competencies and roles. For general comments on governance structure, see comments under the heading “Additional comments on governance structures” at the end of this submission.
27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS?

NSW Health considers that other respondents may have greater expertise in this area.

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

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?

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?

Please refer to our comments under the heading “Additional comments on governance structures” below

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

NSW Health experience is that there is variation between specialist medical colleges regarding the assessment of overseas trained medical practitioners, the delivery of medical specialist programs and the accreditation of training sites by medical colleges. As a simple example there is variation between medical colleges on the composition of accreditation teams and the role of jurisdictional representatives.

However it is unclear if it is the multi-layered assignment arrangements concerning medical program accreditation that are responsible for this variation.

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 the NRAS?

NSW Health does not have expertise in the manner in which qualifications for skilled migration visas are set or assessed.

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?

NSW Health experience is that there is variability in the resources and expertise with medical colleges, both in the oversight of specialist education and training and the
assessment of overseas trained doctors. College processes vary as do outcomes. This variation is of significant concern. For example a number of medical colleges require substantial comparability for medical practitioners applying for Area of Need positions. This appears to be inconsistent with the Medical Board of Australia guidelines for the assessment of overseas trained doctors and also with the approaches of other medical colleges.

The variations are probably attributable to the variations in resources and expertise available to medical colleges and also different/varying risk management approaches to assessing overseas trained medical practitioners.

Other jurisdictions, such as New Zealand, while seeking advice from medical colleges have a different and separate body to assess overseas trained medical practitioners. This approach has merit and NSW would support having one body assigned to assess overseas trained medical practitioners rather than devolving it to separate medical colleges. This approach would result in a more consistent approach to the assessment of overseas trained medical practitioners.

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

Whether such a proposal is desirable or achievable, turns on the variables between professions. A single accreditation body could provide advice on the feasibility of such a proposal.

35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements as such as supervised practice and how might this be achieved?

Currently, medical practitioners seeking general registration via the competent authority and standard pathways must complete a period of supervised practice before being eligible for general registration. It is acknowledged that with the increase in locally trained medical practitioners entering the health system it is becoming increasingly difficult for these overseas trained doctors to obtain suitable positions to complete their supervised practice requirements. The lack of available positions should not be a reason for dispensing with the requirement if there are valid reasons for having this period of supervised practice.

The assessment process applied in the supervised practice year may be more effective if it identifies specific capabilities for assessment. The supervised practice year is of most value in assessing non-technical skills such as communication and teamwork and the practitioners understanding of working in an Australian healthcare setting. Simulation may have some role in the assessment of these non-technical skills. However many of these non-technical skills benefit from more continuous assessment rather than sampling/snap shot assessment.

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

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?

NSW Health makes no submission in this regard.

**Additional comments on governance structures**

As the Reviewer is aware, there is a review of the governance structures of the NRAS currently underway, auspiced by the Health Workforce Principal Committee and being led by NSW Health. Several of the questions in this issues paper overlap with the matters being considered in that review.

One common area is the role of the Ministerial Council in providing oversight of various regulatory instruments generated under the National Scheme. For the governance review, this includes registration standards, codes and guidelines. The NRAS governance review is considering in what circumstances it is appropriate for these instruments to be approved by the Ministerial Council (as is currently the case for registration standards) or by another delegated body. Views have been put forward that the Ministerial Council’s time is being unduly expended on approving instruments (including amendments to instruments) that have no strategic impact in terms of the Scheme’s objectives. Consideration therefore needs to be given to (a) possible delegates in relation to some of these approval powers; (b) bodies responsible for giving advice or guidance to the delegate; and (c) protocols for guiding such delegated approvals.

In relation to accreditation standards, this may be relevant if it is anticipated that entities in addition to Boards have some oversight or approval role in regard to accreditation standards, for example if Ministerial approval of accreditation standards were to be mandated. In that case, it may be that the findings from the governance review could also be applicable to accreditation standards. Further liaison between the two reviewing groups is advisable.

Another common issue is how the various entities within the NRAS are provided with advice to enable them to consider implications related to the objectives of the National Law, and around issues regarding workforce priorities. Currently, the Health Workforce Principal Committee is the primary structure through which jurisdictions provide policy advice to the NRAS. However, the NRAS Governance Review Issues Paper points out several problematic aspects of this process. Consideration is given in the review to how workforce priorities and related issues can be better communicated to the NRAS entities. Any recommendations in this regard may also be applicable to accreditation functions.