NSW Rural Doctors Network

Independent Review of Accreditation Systems Within the National Registration and Accreditation Scheme for Health Professionals

Response to Discussion Paper February 2017

From

NSW Rural Doctors Network (RDN)

Improving Efficiency

Accreditation standards

1. The benefits are that minimum evidence based standards will need to be met. There may be benefits through embedding some consistent principles into all of the standards eg competency frameworks, interdisciplinary education and practice, and interprofessional team based learning. This should not be at the cost of loss of flexibility and innovation at the training provider level. There will be financial costs in terms of the effort to meet standards and provide an accreditation service but perhaps no greater than at present. However, there may be financial savings achieved through consistency and possibly reduced numbers of accrediting bodies.
2. This would make sense in terms of consistency and commonality.
3. There are risks in terms of an assurance that minimum standards will be met and there are benefits in terms of innovation and creativity at the provider level.

Training and readiness of assessment panels

4. RDN does not know enough about this to make a significant comment. However, the Review should look to the systems in place for health care accreditation eg National Standards as it is believed this is very successful. Interprofessional representation on accreditation panels might add value, reduce cost, improve understanding and benefit from interprofessional collaboration in both training and subsequent service delivery models.
5. Yes. Consumer involvement is considered important in addressing standards relating to, for example, ethical practice and currency in terms consumer/ family engagement in care. Consumer focus in care delivery might also be improved beyond what seems currently to be a largely provider oriented system.

Sources of accreditation authority income
6. Cost effectiveness and transparency must be guaranteed. It should be noted that already education providers such as specialist colleges levy their members for quite significant sums and there would be concerns for members should fees be further increased without obvious tangible benefits. This might include more consistency in registration fees, and transparency in accreditation of education provider costs and fee sources.

7. No. This is a separate function and already the accumulation of fees paid by for example IMGs is very high eg for college assessment of credentials. It would be unfair to expect these already high fees to be increased to subsidize on-shore programs. However, IMGs should share the cost of accreditation of subsequent training/courses undertaken by them to achieve professional qualifications beyond initial registration.

Relevance and Responsiveness

Input and outcomes based accreditation standards

8. Outcomes can be hard to measure effectively and input and process standards assessment are considered essential. Measurable outcomes need to be developed and embedded if not already.

9. Not enough detail is known to respond to this question.

Health program development and timeliness of assessment

10. Yes. There are core competencies that span health professional groups such as cultural competency, ethical standards, respect, dignity and team-based care that should include consumers, some of which should actually be determined by what consumers want (and pay for).

11. RDN can only see benefits in developing standards that have common elements. Health care models are changing and this approach will help to address these changes in a constructive way by supporting the breaking down of inappropriate professional barriers. Benefits might also include understanding, aspiration and agreement to eg attaining the Triple aim of healthcare.

12. RDN does not have enough information to comment significantly here. However, a greater understanding of consumer/community care expectations and greater commitment to breaking down the barriers to integrated team based care and Triple aim are essential. Accreditation requirements might include understanding of value of timely clinical information sharing, inter-professional respect and consumer centric care.

Interprofessional education, learning and practice
13. Until embedded in practice it is believed that an entire accreditation standard should be devoted to this. It should describe in particular the minimum requirements for inter-professional learning and perhaps team based simulated training.

**Clinical experience and student placements**

14. This can be supported through a basic understanding of epidemiology, evidence based practice, health economics and health politics and emphasizing these elements throughout the curricula and clinical experience.

15. Simulation is very important in terms of learning procedures when there may be limited opportunities to practice on people eg cannula insertion, resuscitation etc. This can be extended to the use of actors for the development of communication skills. Simulation provides a great opportunity for team based learning and development of inter-disciplinary trust and respect. It should go well beyond procedures and could be fundamental to the way in which care is delivered. It should be cognizant of the training and capacity of others and enable the exploration of appropriate service provider substitution (including skills acquisition) and redefine current funding based drivers for models of care.

**The delivery of work-ready graduates**

16. Yes most definitely and in particular in medicine but of course for all disciplines. In the case of some allied health professions such as social work and occupational therapy this may not be justified as these professions usually work closely as members of a multidisciplinary team where scrutiny of performance is commonplace after graduation.

17. Work readiness could be defined in terms of degree of autonomy required for the profession, possessing the requisite procedural and clinical knowledge, possessing the required communication skills, being capable of reflective practice, understanding the complexities of health care ethics etc. A common issue for most doctors and perhaps more so for IMGs in general practice is the concept of team based care, skills recognition of other professionals and subsequent delegation.

**National examinations**

18. A national assessment process is still important and would allow for a more streamlined and cost effective accreditation process.

**Producing the future health workforce**

*Independence of accreditation and registration*
19. RDN has insufficient knowledge to address this question in any depth. However, from an outcome perspective in relation to rural general practice, the evidence is that workforce need is not being met. The rapid evolution of digital health technologies may change this but equally National Boards will need to understand the challenges and benefits arising from this.
20. Potentially and particularly if there was some consistency about consumer needs and workforce realities (in rural practice).

Governance of accreditation authorities

21. The evidence suggests not.
22. There will always be perceptions of real or perceived conflicts of interest. However, by openly constituting expert panels that are reconstituted at regular intervals there may be an opportunity to minimize such perceptions. Also, the panels could contain educational experts not necessarily from the health sector.
23. Accreditation functions should be undertaken by independent non-government organisations so that these conflicts are minimized. The needs of consumers as well as providers may be better recognized as a consequence.

Role of accreditation authorities

24. RDN is unable to comment on this question

What other governance models might be considered?

25. It would be unwise for AHPRA to accommodate accreditation. It is already seems burdened by bureaucracy and is slow to respond. There should be a separate accreditation authority similar to what is occurring regarding health care standards.
26. By ensuring this standard is explicit, carefully developed and measured.

Accountability and performance monitoring

27. RDN is unable to comment on this question

Setting health workforce reform priorities

28. Presumably this should be an approval function informed by professional standards that meet community expectations without political imperatives.
29. Probably
30. Again, the model established for national health care standards may well be appropriate.
Specific Governance Matters

The role of specialist colleges and post-graduate medical councils

31. RDN is not able to comment in depth on this question. But one may question the drivers and the degree to which health outcomes informed by evidence, consumer and provider satisfaction with achievement of Triple Aim vs protections of professions, status and financial matters; are pre-eminent.

Assessment of overseas health practitioners

32. RDN cannot see why these cannot be aligned.
33. No
34. Yes- in the interests of fairness and transparency.
35. It is considered that supervised practice remains important because there is more to effective health care provision than clinical competence and expert knowledge. There are significant cultural issues that can impact health care that can only be assessed through supervised practice. There are also significant systems issues that are also difficult for locally trained, generally registered practitioners. RDN has considerable experience in this area particularly in entry to rural general medical practice and the inconsistencies that currently exist in the support, education and training for different categories of practitioners. There is a need for consistency in requirements for supervised practice and recognition of the resources needed to support this.

Grievances and appeals

36. No. There is still a need for a review/appeals mechanism.
37. Probably yes and the scope should be all encompassing.

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