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

Consolidated list of issues

Western Australia (WA) – Department of Health, Office of the Chief Medical Officer (WA OCMO).

Note that this submission prepared by the WA OCMO reflects the views of the medical profession stakeholder group. Other groups in WA following the stakeholder forum conducted on 20 March 2017 have not provided written submissions.

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?

   Answer:

   The WA OCMO notes differences in discipline- and profession-specific outcomes that may result in little commonality. Real or perceived understanding of whether each professional body can adapt to common accreditation standards may be a barrier to implementing change. WA OCMO notes the UK HCPC frame-work and implementation of change will require a commitment of resources, as well as engagement of stakeholders.

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?

   Answer:

   For profession and discipline specific accreditation processes WA OCMO sees little functional utility in adopting the TEQSA.

   WA OCMO would support, to promote consistency in application savings in assessment and administration effort, to apply the ASQA standards. This would not add value to the educational process.
3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

Answer:

WA OCMO is not supportive of a system that does not monitor and anticipate risk awareness. It is acknowledged that some of the quality metrics in patient outcomes could be incorporated into the accreditation process, but further refinement is required. The annual reporting cycle can be maintained, but outcomes based reporting could be refined. The administrative burden of accreditation is not minimal and any increase in requirements needs to be offset to make this less onerous. There is a fine balance that needs to be achieved between sufficient risk information to monitor the health of the training environment.

WA OCMO supports a risk based approach, and for cyclical reaccreditation there are risks of lack of adherence to accreditation standards if external visibility is reduced.

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 inter-professional collaboration?

Answer:

To the extent that we are aware, the accreditation teams are broadly based. Purposeful cross professional training and education regarding the accreditation standards would be of more utility than further changes to the accreditation process.

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

Answer:

WA OCMO would not support this, as it is understood there is already good representation of stakeholders in assessment teams.

Sources of accreditation authority income

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?
Answer:

WA OCMO supports a beneficiary pays approach to accreditation. Where the system alignment is not a user pays arrangement we advocate for a system shift in line with beneficiary pays.

Further international benchmarking against other health systems, determination of a definition regarding costing of activities, and determination on cross-subsidisation will be required.

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?

Answer:

WA OCMO submits that consideration of a beneficiary pays principle in accordance with the philosophy of delivery of a user pays commercial relationship is appropriate.

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?

Answer:

WA OCMO preference is the former.

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

Answers:

WA OCMO submits that these require development.

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?

Answer:

WA OCMO considers a profession-specific competency framework approach rather than a common approach more appropriate. Those professions which do not have a competency framework could look toward developing specific ones. We do not consider consumers necessary in the development.

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

Answer:

In a team based working environment, to optimise patient outcomes and team function, WA OCMO supports a team based educational approach. There is little evidence however for a cross professional model prior to meeting educational requirements.

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?

Answer:

WA OCMO submits the following:

- Outcomes and competency based emphasis
- Failure to fail trained assessors
- Culture of training is an important aspect, which needs further work.

*Interprofessional education, learning and practice*

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?

Answer:
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?

Answer:

WA OCMO supports that clinical safety and quality issues should be incorporated, however beyond that a broad brush approach is more desirable.

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

Answer:

There is sufficient evidence for simulation to be incorporated routinely into education. Simulation can be component of progression to independent/unsupervised practise, but is not a standalone assessable entity.

WA OCMO do not suggest it is a requirement but be viewed as an adjunctive tool.

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?

Answer:

Ensuring the supervision is adequate is another significant issue. We see difficulties with poorly applied supervision especially in the context of sub optimal supervision, so yes for all professions. Supervision requirements need to have the ability to be fine-tuned for doctors in difficulty.

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

Answer:

This is a significant issue that we consider warrants further exploration. There are international contemporary models of work readiness (New Zealand, for example) which should be examined. Currently there is insufficient weight applied to
preparedness to practise at a university level, and suggests the standard process applied by the medical schools has intruded rigidity, making it hard to fail struggling students.

**National examinations**

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?

**Answer:**

WA OCMO agrees there should be a national standard but there is not consensus on the mechanism to invest this in the system.

**Producing the future health workforce**

**Independence of accreditation and registration**

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?

**Answer:**

Boards need to be carefully balanced and most medical boards have made substantial inroads into balancing board members.

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?

**Answer:**

Commonality may compromise specificity. This needs be carefully balanced. Independence is encouraged in a robust external assessment process. Innovation with a defined outcome.

**Governance of accreditation authorities**

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

In principle, yes.

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?

Answer:

Accreditation processes are well documented, transparent, accountable and well tested.

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?

Answer:

As far as WA OCMO is aware it is sufficient for functional separation to occur.

**Role of accreditation authorities**

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?

Answer: Yes

**What other governance models might be considered?**

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.

Answer:

For medicine WA OCMO don’t believe a new mechanism is required apart from the AMC/ Medical board current process.
26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

Answer:

See response to Q11.

**Accountability and performance monitoring**

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?

Answer:

There are greater than 50 disciplines in medicine that require qualitative and quantitative performance measures. Transparency will be difficult to achieve.

**Setting health workforce reform priorities**

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

Answer:

WA OCMO believe there is an appropriate separation of accreditation and registration from the political environment. We would advocate this continuing.

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?

Answer:

WA OCMO do not consider this to be an appropriate requirement in the current framework. We would advocate for the separation of political decision making from maintenance of professional standards. Standards for registration should reflect professional competence and not workforce requirements. Accreditation creep in artificial division of competence is not supported by the WA OCMO.

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?

Answer:

Improved jurisdictional liaison is required. State and Commonwealth intersection needs to be optimised.

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

Answer:

Effective coordination and the utilisation of current structures needs to be improved. The federal / state relationship fine.

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?

Answer:

Yes - All have consumer representatives, Junior Medical Officer representatives, Medical board representatives, etc.

Public interest may be situationally specific and require a delegated authority to interpret this in a complex situation.

*Assessment of overseas health practitioners*

32. Are they any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

Answer:

Ability to register is a separate function from workforce and immigration requirements.
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?

   Answer: Yes

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

   Answer:
   
   Yes, consistency in assessment pathways is laudable, and as far WA OCMO is aware this is the case.

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?

   Answer:
   
   Yes, an important issue. There is anecdotal feedback that in some disciplines as little as 25% of the supervision required is undertaken, and then, not always by accredited or suitable supervisors. There needs to be greater assessment prior to any sign off undertaken by the colleges.

   **Grievances and appeals**

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

   Answer: Nil response..

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

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

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

Answer:

No an external appeals process should occur and be sufficiently invested in the system.