Independent Review of Accreditation Systems: submission in response to the discussion paper

June 2017

Overview and introductory comments

While the current accreditation arrangements established under the National Registration and Accreditation Scheme (the NRAS) have appropriately supported the professions regulated under the NRAS to date, the consultation paper establishes a good case for review of the current processes to deliver long term efficiencies and cost benefits to the NRAS. However, this should be balanced with the need to ensure that accreditation processes are evidence-based; can respond to industry need both now and into the future; and provide for innovation and change over time.

This response comments on the three themes of the consultation paper in the context of the current accreditation functions across the 14 professions.

As a minimum, the accreditation bodies for each of the professions are well positioned to evaluate their own processes, learn from and collaborate with each other, and to engage more actively with stakeholders (including the jurisdictions). The Forum of National Board Chairs and similar mechanisms should be considered by accreditation authorities as good examples of interprofessional engagement.

Any move to wider changes will be informed by the outcomes of the Review and will require robust consultation and planning. However, an increased future focus and development of a suite of agreed Key Performance Indicators (KPIs) across the domains of ‘improving efficiency’, ‘relevance and responsiveness’ and ‘producing the future health workforce’ for accreditation functions would be supported.

Improving efficiency

Efforts should be directed to improve efficiency in accreditation systems, and while this has been discussed in terms of overlaps and duplication of existing functions across the professions, other opportunities for improvements should be explored similar to the approach taken by the National Boards determined to be of smaller regulatory burden. These Boards have focussed on operational efficiencies as an alternative to consolidation of their functions. This could be further informed by mapping of similarities and differences (in standards and processes) across professions to establish where greater consistency and commonality is possible.

The reference to the NRAS Review and more specifically the Professional Standards Authority (PSA) input on accreditation functions within the NRAS professions (page 19) is noted. The PSA noted variations amongst accreditation authorities in the fee structures, fee-setting methods and duplication of processes and that the costs associated with this function in Australia exceed those of other systems. However, while DHHS agrees with the PSA that firm conclusions cannot be made without detailed analysis to understand the differences in performance, process and approach, it is widely accepted that improvements in efficiencies and costs within the NRAS are necessary.

In terms of harmonising standards, existing differences across the professions (or between specialties within a profession) may be justified. Conversely, areas of commonality may exist
with benefit to be gained from working towards greater consistency and this should be explored as part of a broader mapping exercise.

It is noted that working towards consistency in registration standards has evolved since the commencement of NRAS, and similar thinking in the accreditation activities of the professions may be a natural progression. A broader framework for accreditation functions may also create opportunities for a strengthened evidence base into the future.

It is acknowledged that the purpose of accreditation is to ensure that accredited programs deliver competent, safe practitioners who are adequately prepared with knowledge, skills and the attributes necessary for the profession’s scope of practice. Inherently, variations in scopes of practice will necessitate a degree of variation in accreditation standards. The core principle of safe practice should remain a focus of the Review.

Efforts to reduce duplication and increase the alignment between professional accreditation processes and the education accreditation processes for which the Tertiary Education Quality Standards Agency (TEQSA), and the Australian Skills Quality Authority (ASQA) are responsible, is supported. This has occurred for nursing and midwifery, where accreditation standards developed by the Australian Nursing and Midwifery Accreditation Council (ANMAC) have largely achieved this through robust review and consultation processes.

It is worth noting Skills Tasmania is Tasmania’s State Training Authority and has an additional layer of accreditation over and above the ASQA framework for its funded training providers. The Endorsed Register Training Organisation (ERTO) system is designed to increase and assure the quality of government subsidised training for learners and employers in Tasmania.

It is noted the discussion relates to more open ended and risk management focused accreditation cycles (rather than the current cyclical/fixed period accreditation processes). Should this be supported, an appropriate form of monitoring would be required to ensure that approved programs of study continue to meet the competency/practice standards required of health professionals and any advancements in techniques and scope of practice.

Relevance and responsiveness

It is suggested that accreditation standards are best applied in a mixed model of outcome and input based standards. This is especially important for health services providing clinical placements to support students in achieving competence against registration standards, and for the student’s expectations of performance assessment. To be effective, outcome-based standards need to be empirically evaluated and validated. It is important that assessors receive appropriate training to ensure that assessments of outcome-based standards are reliable and consistent across multiple accreditation processes.

It is suggested that education providers need to work more closely with health services to have the confidence that capacity to provide clinical placements is matched with accreditation requirements. Some concerns have been raised regarding the sometimes lengthy timeframes of accreditation processes having a negative impact on workforce supply (particularly with regard to overseas trained medical practitioners). In regards to some allied health professions, such as occupational therapy, there has been a significant increase in the number of student places offered by universities (as indicated by the number of student registrations increasing over the period 2012/13 to 2015/16). This subsequently results in increased demand for clinical placements, particularly in the public health system and there is little evidence to support a correlation between the increase student intake and workforce requirements.
Ensuring relevance and responsiveness in the development of accreditation standards requires a sound evidence base and many of the professions articulate that this has been problematic. It is therefore important that accreditation bodies seek to partner with researchers to build a stronger evidence base that is relevant to the workforce operating environment and adds value to the function’s objectives.

A greater emphasis on outcome and risk-managed accreditation processes is considered an enabler to greater flexibility and innovation for educational providers. A growing emphasis on outcome-based standards is supported, but it is recognised that there are circumstances where input-based standards are warranted in order to protect quality of outcomes, for example minimum clinical placement hours. There is significant variation in the minimum hours of clinical placement for some registered professions. This includes for example 800 hours for nursing, 1000 hours for podiatry and up to 1500 hours for psychology. It is widely accepted that an evidence base does not exist to support the current requirement of 800 workplace hours (minimum) as cited in the Registered Nurse Accreditation Standards. Notwithstanding, setting hours as a guide for the undergraduate’s experience in clinical environments and practice is supported. As a point of contrast, some accreditation standards do not specify a minimum number of clinical training hours. A potential consequence of this could be the production of graduates with insufficient clinical experience on entry to practice.

Across a number of professions there are particular challenges for rural health services in providing clinical placement opportunities that meet accreditation requirements, and greater flexibility in this area is strongly supported; creation of workforce pipelines ideally begins with undergraduate clinical placements.

The interface between accreditation bodies is unclear and there is merit in engaging in an interdisciplinary systems review to consider whether the differing approaches to such things as supervision standards, use of simulation, promotion of cultural safety for Aboriginal and Torres Strait Islander peoples, and clinical placement hours are meeting core objectives. Creation of a closer interface could result in efficiencies in terms of how functions are undertaken and the evidence base against which profession specific standards are measured. Simulation is a good example of a wide training variation across the professions. Successful use of simulation education could be translated to great effect in terms of driving innovation in education methodologies to support the delivery of health services into the future.

Furthermore, where common elements/domains exist, establishing the core of the standards for the professions overlayed with profession-specific requirements would be consistent with a move to common registration standards for the NRAS professions. It is acknowledged that there is a fine balance between a ’one size fits all’ approach versus the distinct knowledge and practice base of individual professions but this should be considered in terms of the interprofessional environment that could evolve naturally across education programs as a result. This may be of value to accreditation councils and committees in their assessment of overseas trained health professionals wishing to register in Australia. It is important that an established framework that recognises education equivalence and competence of practitioners is applied while effectively supporting the assessment of experienced clinicians.

The varying interpretations of the notion of ‘work readiness’ is of concern, but it is recognised that the expectations of the novice practitioner must be supported by appropriate workplace support (i.e. to induct, train and develop newly qualified practitioners). The value of a national assessment process is unclear in the absence of more information.
Producing the future health workforce

It is noted that in the current system of governance there is a need for National Boards and accreditation bodies to work together and with key stakeholders more effectively and more regularly. While the National Boards have improved their engagement since the commencement of the NRAS, this has not been as apparent with accreditation councils/committees. A stronger engagement model would be supported.

Alignment of processes for determining eligibility for registration in Australia and those for skilled migration visas is supported. This would help to prevent situations whereby a health professional entering Australia under skilled migration is then unable to obtain registration in Australia and therefore is unable to practice in this country. Future consideration of the potential establishment of mutual recognition arrangements for comparable training programs internationally would also be supported.

Workforce flexibility is a key issue in Tasmania and most jurisdictions are engaged in supporting new workforce models such as non-medical prescribing. There appears to be limited alignment to workforce redesign, accreditation and regulation. Strengthening these approaches is necessary and would assist workforce innovation and service models including private practice.

The increasing pressures towards sub-specialisation require further review and consideration of the value that this brings to professional practice. While there is some support for specialisation, the critical role for generalists is becoming less obvious. Generalists in the rural and remote environment are the ‘backbone’ of healthcare for these communities and any discussion about specialisation must be balanced with the need for generalist roles.

Greater consumer involvement may be beneficial in the development of practice standards, service models and workforce models, but consumers must be adequately supported for their valuable input to be realised and maximised.

There is a gap in current national strategic workforce development and planning and a greater focus on this work is needed. Strengthened partnerships with key Accreditation Bodies would be helpful and increasingly necessary for this work to meet its objectives.