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

Submission to the Discussion Paper

Cover Sheet

First Name: **David**

Surname: **WATERS**

Individual or Organisational submission: Organisation

Organisation (if relevant): **Council of Ambulance Authorities**

Position in organisation: **Chief Executive Officer**

Email: **dwaters@caa.net.au**

Preferred contact number: **0011 64 4 499 2621**

Please select one of the following:

☐ This is a public submission. It does **not** contain 'in confidence' material in the main submission or its attachments and can be placed on the COAG Health Council website.

☐ This submission contains **some** 'in confidence' material which has been attached as a separate file to the main submission, and is not to be placed on the COAG Health Council website.

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

The Council of Ambulance Authorities (CAA) is pleased to make a submission to the Independent Reviewer Independent Review of Accreditation Systems within the national Registration Scheme for health professions.

Introduction

Independent review of the National Scheme

In 2014, the Ministerial Council appointed Mr Kim Snowball, the former Director-General of the Department of Health in Western Australia to conduct an independent review of the National Scheme. The independent review involved an extensive consultation process which included consultation forums in each capital city and over 230 written submissions were received.

The independent review acknowledged the significant achievements made by the National Scheme and National Law.

Ministerial Council's response to the independent review

The final report of the independent review made 33 recommendations. The Ministerial Council announced its response to the report on 7 August 2015 and accepted nine recommendations, accepted 11 recommendations in principle, did not accept six recommendations and deferred decisions on seven recommendations pending further advice.

Health Ministers during the 7 August 2015 meeting noted the significant issues relating to the high cost, lack of scrutiny, duplication and the prescriptive approach to accreditation functions highlighted in the Final Report. Ministers stated that while the NRAS Review recommendations go some way to improve Australia's accreditation arrangements, they believed that more substantive reform of accreditation functions was required to address the issues raised. Health Ministers requested the Australian Health Minister's Advisory Council (AHMAC) to commission further advice and undertake a comprehensive review of accreditation functions. The terms of reference for this review have included comparative analysis of the Australian and United Kingdom systems as well as further consideration of the 2005 Productivity Commission's *Australia's Health Workforce* report findings to specifically address the concerns related to cost, governance and duplication highlighted during the NRAS review. This review is to be undertaken within 12 months and advice provided to Health Ministers by December 2017.

The Independent reviewer (reviewer) has provided a comprehensive Discussion Paper which outlines systemic issues within the current Australian accreditation model which has largely grown in an ad hoc way following the establishment of the National Scheme.

In parallel with the Snowball review recommendations the reviewer has noted a high level of duplication across accreditation councils and education regulators. The reviewer has further noted that some other models including the United Kingdom's Health and Care Professions Council (HCPC) have markedly less duplication whilst at the same time appearing more efficient models.

Queensland Ambulance Service has noted issues highlighted in the Discussion Paper and will provide comment on each of the issues as laid out in the paper.

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?

Through greater connectivity across accreditation councils utilising common competencies, outcomes based standards and inter-professional learning, duplication would decrease leading to enhanced efficiency and reduced costs.

It should however be recognised that there are limits to 'commonalities' in practise within the various professions which require specific content and learning and development approaches to develop the professional capabilities for practise.

On balance this appears to be satisfactory across the current higher education under graduate programs being delivered by Universities in Australia and NZ and should remain in the province of 'discipline specific' accreditation bodies.

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?

Yes, and there needs to be clear alignment between TEQSA/ASQA which is not the case at present with some councils working within TEQSA framework and other councils and committees working within the ASQA framework.

Acknowledgment of the elements assessed within the TEQSA framework can provide assurance within programs accredited under NRAS and allow accreditation assessments by nominated Councils/committees to focus on profession specific outcome elements.

This alignment would also reduce the burden of multiple accreditation processes on providers.

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

Being tied into fixed timeframe cycles as many councils are at present leads to lack of innovation as little innovation can be achieved during a fixed cycle (where providers are tied into the agreed parameters within the cycle). A Risk-based open ended cycle can lead to further innovation within the parameters allowed by the risk thresholds.

Risk based approaches however need to give specific consideration to program accreditation evaluation processes that recognise 'significant or major' change from the initial evaluation of the program/s. This would allow evaluation timing to be more 'fluid' in response to program changes when they occur.

Similarly re-accreditation of programs could be risk based with the same provisos.

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?

Better communication between the health accreditation councils (and committees) with the education sector where previous work in this area by Health Workforce Australia (HWA) showed promising results and synergies which were available (but HWA was unable to complete this work due to the fact it was dissolved and absorbed within the (C'wealth) Department of Health).

The loss of HWA as a body has meant that much of the support inter-professional collaboration, facilities, development and program innovation including expanded simulation activities is no longer available.

Revisiting this work would allow the identification of opportunities to incorporate common frameworks for key elements of the accreditation process.

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

Yes, and cross professional members who can raise issues that may be missed by members of the drawn only from a particular profession.

This would give some 'credence' to current dialogue around IPL, which on 'face-value' of the comments received from education providers, has been extremely difficult to implement at the student interface, however could still prove useful in breaking down professional boundaries at a higher level.

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?

- *Efficiencies resulting from this review should allow the percentage split between registrant fees and educational providers to be reduced on both sides. National Boards could liaise with education providers to finalise the percentage from each. It is noted the cost of accreditation from fees provided by the National Boards share increased by over $2M over three years. Further alignment of courses would see additional savings.*
- *There is a need for further transparency in the system. Costs of accrediting individual programs must be reviewed as it has been noted that the cost can sometimes blow out to $100,000 for one course.*
- *Pricing should reflect cost-recovery elements only and should be based on accreditation processes that represent best value to education providers and to the community in terms of their confidence in the quality of programs to deliver capable graduates[1].*

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?

Yes. Fees charged for the assessment of overseas qualified practitioners already cross-subsidise accreditation functions for on-shore programs. AHPRA and the National Boards review the cost structure on an annual basis and must adhere to the guiding principles of the National Law which require the Scheme to operate in a transparent, accountable, efficient and fair way. The costs of accreditation necessarily vary between professions in response to complexity, volume and risk profile and this diversity cannot be overlooked in any cost analysis.

The extent to which these funds should be relied upon does however need examination in terms of the efficiency and effectiveness of current accreditation processes that are being used across the existing fourteen registered health professions.

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?

Overseas models have shown improved efficiency with outcomes based models and in the main it could be argued that this is a sensible approach.

[1] Cost of Accreditation in the National Registration and Accreditation Scheme, November 2016, AHPRA

Process and output standards should be limited to only those areas where it is essential to have commonality/specificity across all programs as essential underpinning/s to achieve the required practise capability outcomes.

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

Clear and relevant assessment processes are required which should be reflect the achievement of the respective 'professional competency standards' for entry to practise level. Outcomes to be clear and transparent but leave it to the providers to work through the detail on how they meet these outcomes.

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?

A set of common competencies could be developed similar to those used by the UK HCPC and used to complement profession specific competencies, as well as providing a higher level of consistency across registered professions. The intra-disciplinary opportunity arising from the common competencies arrangement would be valuable especially in rural and remote settings where training opportunities can be infrequent.

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

The risks are that the common elements/domains provide enough relevance for the specific program for a profession whilst considering the risk that broadening the approach to 'main-stream' the majority of competencies, would actually result in the diminution of the quality and outcomes of programs in meeting the needs on the profession. Conversely if the overlay is too profession-specific, there will be minimal opportunity for commonality and less opportunity for improving the efficiency of processes and enhancing opportunities for inter-professional learning. Ensuing end point after negotiation across the councils must not lower the threshold/standard just in order to achieve consensus.

Discipline specific elements become obvious when for example, emergency pre-hospital practice is examined. In these circumstances the practice environment is far less controlled and some aspects of good practice are arguably not under the full control of the practitioner.

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?

The introduction and adoption of common frameworks, guidelines and formats for use in the accreditation process and the engagement of education providers would significantly reduce the current variations in approaches used by Councils and Committees currently undertaking NRAS accreditation roles,

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?

Common frameworks and competency elements would provide opportunities for training providers to implement inter-professional learning strategies. This is would have particular value in rural and remote areas where the opportunities for training can be limited.

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?

Feedback from employers indicates that new graduates are generally not work ready and this in an imposition employers are forced to address by implementing intern programs. The question is, who should fund this intern arrangement. Universities need to implement more inclusive and targeted clinical training to address and work a lot more closely with employers to arrive at an equitable solution. Examples in the nursing profession indicate the current arrangements between training providers and employers is not working well.

There is however an ongoing real challenge to secure clinical placements including those within Emergency Ambulance Services. This is exacerbated where needs are driven by university student intake numbers rather than closer examination of industry workforce needs.

Accreditation standards need to ensure that Universities have high level involvement of the industry / profession and health sector in program monitoring and review activities to ensure that emerging trends, workforce requirements and changes in technology/clinical practice are reflected in current programs being delivered.

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

Simulation needs to be accepted as a legitimate method of capability development within professions alongside clinical placement in health delivery settings and periods of supervised practice.

There is a need for further funding to enable better access (especially rural and remote) to simulation-based education and training.

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?

There are a range of arguments that could be considered relating to this question.

Employers are required to provide appropriate period/s of induction for new staff. The induction process varies according to professions however usually involves orientation to the particular workplace, the legislative responsibilities, codes of practice, policies, procedures and work instructions applicable to the employee as well as orientation to the equipment, PPE, 'scope of practice' and a period of supervised practice prior to the employee being allowed to work unsupervised.

This is a different circumstance to meeting the requirements for registration and indeed the outcome expectations of any periods of clinical placement undertaken during programs of study to achieve the qualifications required for practice in the profession.

As such, supervised practice across professions varies widely, some professions by nature require more supervised practice than other. The goal is to get the mix correct, this is an area of failure where some cohorts have seriously affected workforce numbers coming through by insisting on onerous clinical training models.

From a paramedicine perspective, work is currently being undertaken to review clinical placement requirements for programs being offered by Australian and NZ Universities with the view of putting in place arrangements that are consistent and reflect informed agreement on minimum requirements whilst also taking into account clinical placements in non-frontline operational ambulance environments, multi-i disciplinary environments and acceptance of simulation as an essential component to clinical capability development.

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

There is need for further research to highlight where successful models can be evidenced.

A distinction and acknowledgement is however required between what should reasonably be expected from a registration process, focussed on safe delivery of health care to the community from a reputable health practitioner, and the responsibility of employers in recruitment of graduates as 'novice' practitioners who meet 'entry to practice' requirements for roles within health service provision environments.

Within the paramedicine environment there is a widespread recognition that graduates presenting for employment, although qualified , are at the novice practitioner level, and as such will require a period of supervised practice prior to being 'credentialed' by the organisation for independent practise.

National examinations

18. Does a robust accreditation process negate the need for further national assessment to gain general registration? *Yes*

Alternatively, does a national assessment process allow for a more streamlined accreditation process? *No. If the accreditation is 'sound' recognising the outcome requirements for professional practise that has been assessed against robust standards, employers and the community should be confident that the health practitioner at graduation, albeit novice, has met the practise capability requirements for the profession.*

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?

No, some Boards have been guilty of making biased judgements which have impacted on the growth of their particular workforce and limiting broader inter-professional practise and learning.

There is a need during the recruitment stage for at least one or more Board member of each Registration Board to have comprehensive knowledge of education and accreditation expectations for the profession as well as the ability to offer challenges to the limitations institutional practise thinking and the 'absolutes' of protecting professional boundaries at the expense of delivery of high quality health care to meet community needs, particularly in rural and remote areas.

Contemporary health practise should be driven by the recognition of the changing health care needs of Australian community in the foreseeable future horizon.

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?

No.

Accreditation should be aligned to a common framework that recognises the particular requirements and nuances of specific professions.

At their 'core' should be common elements alongside subject matter specific and peculiar practise elements relevant to the needs of each profession. Standardisation offers the opportunity to improve consistency, avoid confusion and reduce duplication in process and application across the professions within an appropriate moderation model.

This would allow education providers 'streamline' their responses and commitment of resources to responding to the accreditation requirements of individual professions, in turn delivering a range of desired process efficiencies and focus on key practise outcome elements of the accreditation processes.

Governance of accreditation authorities

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

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?

Agencies could look to engage panels of experts, similar in process to complaints panels.

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?

Accreditation should not be a revenue generation 'businesses within councils. It is important to separate the accreditation activities and involvement of the profession from other activities of accreditation providers. Accreditation costs should, within reason, be recouped strictly on a cost recovery basis. Stand-alone committees within the councils with external stake-holder representation should be part of accreditation councils/committees composition.

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?

A review of the wording of this clause should be included in this review, given some less-than-satisfactory outcomes in regard to workforce issues have resulted from the current arrangement. Professions have expectations that this clause will allow sufficient room for accreditation bodies to include innovation and workforce reform.

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;

  No, the Agency Management Committee (AManC) are not education/accreditation content experts and their remit is closely aligned with governance of the Boards, needs to be an independent body.

- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

  Yes, as recommended by the Productivity Commission, a single accreditation authority (perhaps similar to the arrangements for the HCPC) to provide policy direction on, and approval of, accreditation standards would be the preferred model. This overarching body could then have

profession specific committees made up of the current accreditation authorities. The Productivity Commission made the following recommendation which should be reconsidered[2]:

"Initially, at least, the Board could delegate responsibility for functions to appropriate existing entities, on terms and conditions set by the board. Such entities would be selected on the basis of their capacity to contribute to the overall objectives of the new accreditation regime."

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

By having a full and equal representation on the authority Board of all registered professions.

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?

The Board could report against these measures, audited by the AManC.

Consider structural outcome and process indicators which can direct attention to (and health goals can be focussed on) the patient. Provide clear pathways for Action.

On approach would be to look at optimal risk-adjustment models which result from a multidisciplinary effort that involves the interaction of clinicians with statisticians, as well as with experts in education, information systems and data production.

Given the complexity of health systems, accreditation could consider composite indicators which combine separate performance indicators into a single index or measure and are often used to rank or compare the performance of different practitioners, organisations or systems, by providing a 'bigger picture' and offering a more rounded view of performance.

Composite indicators can offer policy-makers at all levels the freedom to concentrate on areas where improvements are most readily secured, in contrast to piecemeal performance indicators.

Setting health workforce reform priorities

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

Review of new programs including common competencies for programs and specialty programs where appropriate as advised by the accreditation agency. The Ministerial Council is the final arbiter prior to decision making and should only be considering finalised programs. Operational issues should not be submitted for their consideration/deliberation.

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?

The current provisions for directions by the Ministerial Council are adequate. The Ministerial Councils role should be concerned with overall direction and national policy in respect to NRAS and not be overloaded with operational matters.

[2] Australia's Health Workforce, 22 December 2005, Productivity Commission

Operational matters should be dealt with and managed by AHPRA against articulated performance criteria unless matters arise that require the express consideration/discussion/determination by the Ministerial Council.

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?

  Regular review by the Australian Health Minister's Advisory Council and advice to AHPRA. Furthermore AHPRA should report on how these matters have been socialised with the various Boards and stakeholder representatives and report back to the AHMAC on those discussion to inform policy review/development.

  Workforce reform, workforce redesign and training requirements in the health sector are regularly reviewed by the Health Workforce Principal Committee (HWPC) of AHMAC. Any issues involving workforce reform in accreditation should be reviewed by the HWPC.

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

  The HPACF and the HWPC to meet annually for a governance review monitoring the engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts.

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?

Governance review of these functions should be included in HPACF and HWPC annual meeting. AHPRA should report the outcome of this meeting to the AHMAC and advisement to the Ministerial Council for consideration.

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 NRAS?

The major legislation governing Immigration (Commonwealth legislation) and NRAS legislation (State and Territory legislation) differs markedly.

Alignment of these disparate types of legislation would be time consuming and expensive, however may be an area that the Ministerial Council through AHMAC determines to allocate discrete resources to achieve. A National approach to assessment may be advantageous to 'harmonising' processes.

33. Is there is 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?

Once an understanding by the NRAS body of Commonwealth Immigration Legislation was complete, this could be achieved, notwithstanding the previous comment. A 'centralised' national policy approach and support is desirable.

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

Yes, one body with input from expert (profession specific) panels could achieve this in conjunction with a nationally agreed policy framework.

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?

A greater focus on assessment processes could be promulgated, but caution is required to ensure standards for overseas trained practitioners are equivalent to Australian standards and includes amongst other criteria, cultural training where required (e.g. rural and remote practice).

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?

Yes

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

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

  Given issues with the Commonwealth Ombudsman during the formative years of NRAS (different – Commonwealth legislation), the National Health Practitioner Ombudsman and Privacy Commissioner would be preferred.

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

  Yes

Closing Comment/s

The Council of Ambulance Authorities (CAA) supports the independent reviewer in the investigation of a more efficient accreditation model for Australia. It is CAA position that such a model should include a single overarching accreditation body supported by profession specific committees. Accreditation bodies should pursue inter-professional programs that are possible using common competencies. This model would be subject to annual governance review by a combined HPACF/HWPC audit.