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

Submission to the Discussion Paper

Cover Sheet

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Independent review of accreditation systems within NRAS

Response
1 May 2017

Thank you for the opportunity to provide a submission in relation to the independent review of accreditation system.

The Occupational Therapy Council (Australia & New Zealand) Ltd (OTC) is the peak independent organisation established to provide:

- Accreditation of occupational therapy education programs.
- Assessment of overseas-trained practitioners for practice in Australia.

To ensure the successful delivery of these services, and in all our activities, the OTC is committed to being:

- ethical;
- transparent, accountable, efficient, effective and fair
- professional;
- customer focussed.

The goals of the OTC have been identified as follows:

- Implementation of an effective and efficient entry-level occupational therapy program accreditation function.
- Implementation of an effective and efficient process for the assessment of overseas-trained practitioners.
- Establishment of a strong reputation with stakeholders.
- Establishment of a sustainable organisation with a strong governance structure.
- Identification, exploration and capitalisation of emerging opportunities for world-class standards for safe and efficient practice.

The OTC hopes to have provided responses to demonstrate its firm belief that accreditation of occupational therapy programs offered by education providers in Australia and the assessment of overseas-trained practitioners should remain the responsibility of the OTC.

Notwithstanding the above, the OTC acknowledges there may be areas that would benefit from review and change to remove duplications and strengthen collaboration, and the OTC welcomes the opportunity to contribute to and implement such initiatives.

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Review of Accreditation Systems (NRAS)

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?**

The ultimate consideration in this regard, as indeed is dictated by the Health Practitioner National Law (the National Law) is the protection of the public receiving health services from the relevant professional. Benefits and costs should be evaluated therefore not only purely from the prism of cost cutting, but rather quality should be the primary consideration in addressing standards. This said, the accreditation system should be cost effective and efficient, and this can be facilitated through well-designed and appropriate consistency in standards across disciplines.

To date, four accreditation councils have adopted the general framework of the standards developed by the Australian Dental Council, albeit with some profession-specific modifications made during consultation phases of reviews, and by National Boards. With reference to this work, the OTC is considering a similar approach to harmonisation as part of the current review of accreditation standards for occupational therapy.

There may be further efficiencies to be gained in terms of the wide consultation processes required by the National Law, where common, similar or identical standards do exist. This may be achieved perhaps by a joint consultation process on these standards across Councils, or other similar methodology which eliminates duplication in consultation processes in such a case. This may require modification to the requirements of the National Law around consultation.

As is elaborated in this submission, professional input and ownership of standards is important, and for this reason, we consider there is value in developing a combination of common and profession-specific standards.

Consideration would need to be given regarding consultations on evidence guides. At present, there appears to be considerable variation in the status of evidence guides and their use. More detailed discussion, through an appropriate mechanism, as will be discussed in this submission, would promote continuing use of evidence-based approaches to application of accreditation standards.

2. **Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditation of education providers as part of their own reviews?**

TEQSA processes are taken into account in current OTC processes, and have been for some years. Documents comprising a 'self-assessment/review' of performance against accreditation standards which are submitted by educational institutions provide an opportunity to explain the ways in which a program meets various requirements, such as those of TEQSA. Where education providers incorporate information from other review processes in their self-assessment, including information from internal reviews, this information is considered as relevant evidence for accreditation review purposes. The OTC is supportive of education providers which seek to align these various assessment and accreditation processes to present their programs in a comprehensive and efficient manner.

Evidence: The OTC has a Memorandum of Understanding in place with TEQSA.

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

The OTC considers it important to acknowledge that regular updating of knowledge within educational and professional contexts is part of ensuring the required competencies of graduates within changing work contexts. Processes within accreditation cycles should therefore be future-looking and promote innovation, not inhibit the capacity of education providers to take on inspirational, creative and flexible approaches.

As part of building our evidence base for accreditation, the OTC is currently undertaking a project to explore current risk-based approaches to accreditation. This project is part of a collaborative venture with the Optometry Council of Australia and New Zealand and the Council on Chiropractic Education Australasia.

To some extent, the OTC has always taken a risk-management approach to accreditation functions. Early identification of risk, both through self-assessment and annual reporting by education providers enables identification of issues for closer consideration during site visits, or for seeking additional information during a cycle. Desk-top review of proposed new programs is geared towards risk management, in particular ensuring that a provider has adequate resources and curriculum development expertise to introduce an occupational therapy program. The approach however is not overly-prescriptive.

In the absence of information, as being gathered during the current project, caution is expressed about adopting a 'one or the other' approach. Risk management incorporated into clear cyclic processes may well be a cost effective and realistic approach. Accreditation systems in the health and community services fields all maintain a three to four-year cycle approach, with a range of approaches to ongoing monitoring and risk assessment.

Evidence:
The OTC has raised the potential for alternatives to the present five-year cycle with heads of occupational therapy programs. We have received strong feedback that the cyclic external review, including site visit, is valued at program level, as it is used by program staff:

- as an opportunity to review their program;
- to receive external input about areas of strength as well as areas that need development, and
- to ensure the program strengths and development needs are highlighted to School, Faculty and University leaders.

A key benefit of the current five-yearly cycle is this accords with the review cycle expected by the international body, the World Federation of Occupational Therapists (WFOT). The OTC accreditation standards incorporate the WFOT Education Standards.

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?**

The OTC supports collaborative approaches, and is working with other authorities, as facilitated by the HPAC Forum. AHPRA workshops have also promoted sharing of learning about various accreditation processes.

Opportunities for shared training are worth continued exploration and it is hoped these activities will continue to be resourced. Accreditation authorities currently have access to shared resources and initiatives to develop these further are worth exploring. Participation in Forum inter-professional activities is considered an important benefit of such a body.

Inter-professional collaboration is also facilitated through observational participation in site visits conducted by other accreditation councils.

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

A broad range of stakeholders on an assessment team can potentially enrich the review process, and can also highlight priority areas for education providers. For example, the Aboriginal and Torres Strait Islander Health Curriculum Framework recommends the inclusion of an assessor who is an Aboriginal and Torres Strait Islander health practitioner, academic or a non-Indigenous person with well-developed cultural capabilities to address expectations outlined in the Framework, as well as to make statement about the need for education providers to do so.

As part of quality processes, the OTC regularly reviews its system of assessor teams, with regard to expertise required, as well as costs and logistics of managing site visits and streamlined review activities. Site visits are an opportunity for a range of stakeholders to be involved in reviewing programs.

Current OTC standards require explanation and evidence of consumer input into a range of curriculum and learning activities. Site visits regularly include discussion with consumers, including students, health services and users of occupational therapy services. To date, discussion with consumers as well as a range of stakeholders has led to feedback that consumers don't want to be seen as 'token' contributors to the process. A stated preference is to be involved in meaningful ways, and while this may include panel membership, the range of other options is currently reported as constructive by these participants.

Evidence

Current occupational therapy standards include the requirement for consumer involvement in roles other than as recipients of care e.g. curriculum design and learning activities. In recent years, there has been increased reporting by education providers of consumer involvement in curriculum design, as members of advisory panels, as well as teaching and assessment roles.

Three of the four accreditation site visits completed to date in the 2016-17 period involved consumers of occupational therapy services in meetings with the assessor teams.

The OTC board of directors includes three independent community representatives, who actively take part in all activities of the OTC, including review of accreditation standards. During 2017, independent directors will also become members of the accreditation and overseas qualifications committees.

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?

The OTC has taken the view that the best and most appropriate principle is user pays. The challenge has been to identify who are the users and the ability of OTC to obtain funding from each and all of those parties. In a broad sense, it is not only the education providers or applicants for assessment as overseas-trained practitioners. Clearly, National Boards, students and the public at large are all users of the outcome of accreditation. However, students already pay the education providers and would argue that part of their fees already contribute to the cost of the programs being accredited. It is difficult to conceive a process where the public at large would contribute to the cost of accreditation. Other than the education providers, the only remaining source is the National Boards.

The OTC made the decision the education providers should pay the full cost of program accreditation, including general administration and operating costs of the OTC. The same principle was adopted in relation to the assessment of overseas-trained practitioners. The OTC does not receive any funding from the National Board for either type of accreditation and has found the removal of an annual request for funding in these areas has contributed to a simpler and more effective relationship with the National Board that is more focused on the real issues concerning accreditation.

In arriving at the foregoing decision, the OTC was well aware of issues arising annually with other accreditation authorities and their respective National Boards concerning funding, with different National Boards having different interpretations, definitions and requirements. This lead to different accreditation authorities receiving different levels of funding for the same or similar work load. It was clear there was no uniformity of approach by the National Boards in determining the level of funding that would be provided each year.

Ideally, the National Boards should have an agreed funding template for all National Boards and accreditation authorities to use. Whether this template specifies the type of costs to be included, or set a benchmark percentage of the annual fees paid by registrants, would need to be fully discussed and agreed.

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?

There are significant overlaps of benefits associated with the assessment of overseas-trained practitioners and program accreditation and the cross-subsidisation that does occur should continue. Management of these processes is monitored through annual reporting.

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?**

The OTC considers the issue of outcome-based versus input or process standards to be more complex than the adoption of one or the other. While the OTC is generally in favour of outcome based approaches, it recognises the importance of process standards within a logical mix that must address both the competency of graduates, and the factors that create high quality education. The OTC believes accreditation standards should promote good practice and prevent poor quality outcomes. Hence evaluation of inputs and processes can potentially prevent poor outcomes

There are instances where a focus on inputs and process is needed. For example:

- the effectiveness of new programs can generally only be evaluated by considering inputs and processes being used to achieve the accreditation standards;
- input based standards are valuable to influence the activities of the education providers.

Recent examples include expectation for inter-professional education and the Aboriginal and Torres Strait Islander perspectives to be included in curriculum development as well as learning opportunities.

Consideration of inputs and processes are also appropriate where education providers have limited outcome data as to competency of graduates, for reasons including relativeness newness of a program, or lack of specific detail about practice in specific areas of practice.

The current OTC accreditation standards include a specific requirement for 1000 hours of practice education, a standard required by the World Federation of Occupational Therapists. The standard therefore relates to international benchmarking and ensures that occupational therapy education programs in Australia are not required to undergo a separate accreditation assessment via the professional association to meet international requirements for employment of graduates.

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

Current OTC processes are reported as reasonable by education providers working with the system and will continue to be reviewed as part of ongoing quality improvement processes. In general, education providers report having difficulty accessing meaningful outcome data for their programs, so have limited information to present as course outcome data. This remains an area of development for education providers.

The OTC observation is that education providers generally have strong systems in place to evaluate unit (subject) level outcomes, however have little in place to effectively evaluate program-level outcomes.

Occupational therapy program providers report they receive poor response to surveys/follow up of employers and graduates, so have limited information about graduate effectiveness. Data collected in graduate surveys conducted by education providers is of limited value in specifically informing program-level activity.

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?

The OTC recognises the value of common and 'good practice' approaches to developing professional competency frameworks and is supportive of the suggestion for a common approach to the development of competency standards. Within the current scheme the National Board, OTBA, is responsible for managing professional competencies and maintains strong collaborative links with the professional organisation as well as the accreditation authority. The revision, currently underway, of competency standards for the occupational therapy profession draws on the evidence base, inter-professional learning, as well as strong international professional links. This approach is important for the credibility of practice standards for the purpose of registration, specifically safety of the public. Accreditation standards make reference to national competency standards as well as those set by the international professional body.

Progressing work on common approaches to development of competency frameworks is best supported through existing processes and structures. For example, the Forum of NRAS Chairs has the capacity to coordinate across the health professions participating in NRAS, and through the relevant National Boards to bring together a range of stakeholders, including professions and consumers together to address professional competencies, building on their already wide consultative processes and creating streamlined avenues for consumers and representative groups.

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

Clear benefits exist through development of standards that have common elements/domains across health professions. As has been mentioned earlier in this submission, the importance of common aspects of standards is recognised and warrants ongoing development which is appropriately resourced and reviewed. A combination of common and discipline-specific requirements is considered optimal.

Advantages of common elements/domains include:

- consistent language is being used across professions, potentially creating clearer expectations for education providers;
- common priorities may become more evident and highlight areas needing shared action. For example, inter-professional learning activities are challenging to implement at program level. A clear and consistent standard will highlight the need for attention to this at a broader institutional level
- clear and streamlined pathway for involvement of broader stakeholder groups, including consumers in development of accreditation standards.

There are however, potential risks if standards are too broad. Potential disadvantages for broad and ill-defined elements/domains include:

- loss of detail that is required to ensure safety and competency to practise in a specific profession,
- potential for development of 'generic' professionals in practice areas where knowledge and skills will not be well-developed,
- evidence guides outlining profession specific requirements will become quasi-standards;

- common standards have the potential to mask the profession specific requirements and potentially the profession specific knowledge required to assess if the program is developing the special expertise that is expected of different professions.

Managing change from existing development and implementation of accreditation standards must also be considered. Another level of detail is required to inform processes and mechanisms to manage transition from discipline-specific to a combination of common and discipline-specific.

The OTC is exploring common approaches to development of standards through its current 5-yearly revision of accreditation standards for occupational therapy. Exploration of application of common outcome-based standards currently approved for dentistry, optometry and physiotherapy professions is underway. These standards have similar criteria that will indicate if the standard has been met. The criteria provide for some profession specific variation, with the profession specific variation primarily embedded in evidence guides, which provide explanation of what could/should be provided to demonstrate a standard has been met.

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?

Acknowledging the importance that accreditation systems and process be timely and effective, the OTC regularly reviews processes, through consultation with education providers and the professional body, regular review processes and the 5-yearly review of accreditation standards which requires extensive consultation.. The OTC is not aware of any recent instances where its standards or processes have delayed relevant program development or change, and aims to be proactive in this area of operation.

As noted in the consultation document, OTC guidelines suggest new program documents should be submitted 12-18 months prior to commencement of a new program. The OTC developed this indicator following feedback from occupational therapy education programs who requested guidance as to what is a reasonable time needed for an education program to be developed. With the increase in the number of new occupational therapy programs being developed, new providers sought advice about accreditation processes to inform timely course development, in particular curriculum development and staff appointments. This situation arose subsequent to two education providers being refused accreditation because of poorly developed documentation being submitted to the (then) accreditation authority, which determined that these programs were far from meeting accreditation standards. In particular, with introduction of National Registration and the requirement for students to be registered prior to commencing fieldwork education, the need is evident that accreditation standards are assessed prior to course commencement.

Reporting mechanisms are also important in the monitoring of graduate competencies. The OTC uses annual reporting to identify program changes that have potential to impact the capacity of education programs to deliver graduates appropriate for the current and future workforce. Identification of risk events, such as loss of key staff, or significant loss of clinical placement opportunities trigger requests for submission of further information from education providers. Implementing an annual process has increased the timeliness of the OTC to respond to emerging issues.
Similarly, the annual reporting process enables education providers to report more regularly on improvements to programs, achievements against recommendations from previous reporting rounds, and successes in research activity, student performance and

graduate outcomes. Education providers have responded positively to these recent monitoring initiatives.

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?

Inter-professional education has been a focus of the Forum and from an OTC perspective is a successful example of the collaboration afforded by the activities of the Forum. Occupational therapy accreditation standards include inter-professional practice knowledge and skills, and are widely accepted by education providers, fitting well within the international education and practice context. Barriers to implementation are not considered to be the standards, and are more likely to be organisational and resource issues. It is difficult at program level to enact effective inter-professional learning unless support is evident at the education provider level.

Having specific accreditation standards is only one strategy to promote inter-professional education and practice. There will be value in developing agreement on the processes that are effective in developing effective inter-professional competencies for practice. A number of education providers are successfully incorporating shared learning in foundational subjects, and some focussed inter-professional learning activities. These are frequently situated in early years of a program. The OTC believes greater attention must be paid to providing capstone (later in a program) learning activities and learning activities that address the power imbalance/hierarchies that exist in workplaces. Collaborative clinical experiences in practice environments are not easy to manage, even when several professions exist in the same university unit. Support through well- resourced innovative projects, and links with existing interprofessional entities (for example All Together Better Health, Australian Collaborative Education Network (ACEN), could result in research and evidence-based initiatives.

Significant gains in effective interprofessional practice are likely to be made if education providers, employers and professions collaborate to address 'real' workplace issues. Education, to which accreditation standards apply, is the first step along a continuum of professional education and development. Employers and professions, through establishing practice culture and continuing professional development need to provide a workplace reality that reflects the priority of effective interprofessional practice.

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?

The OTC standards and processes incorporate strong requirements that programs need to address National and State health priorities, within local contexts. For example, current standards include: *The program incorporates content in response to major national, state/territory and local health priorities and practice standards.* Evidence from monitoring and reporting processes support this standard as already adopted by all occupational therapy educational providers.

For future development of standards, and in particular those addressing inter-professional competencies, it is considered important that high level principles are addressed, establishing commitment to innovation, and driving improvement while not being prescriptive.

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

Within the occupational therapy profession, agreement has been established that contemporary education practices are valued and should be explored. Current entry-level accreditation standards require programs to use and report on contemporary education practice, using relevant research and evidence. Current initiatives include collaborative trials of techniques, for example simulation. It is agreed that high level principles will enable innovation and not be prescriptive. This approach is important for allowing education providers to continue innovation, and also to recognise costs of new initiatives, for example, the costs of developing quality simulation resources.

Feedback from education providers to the OTC indicates:

- many of the established simulation facilities provided by education providers (wards, patient simulators) are of limited value for learning in occupational therapy;
- the complexity and cost of establishing relevant high fidelity simulation activities is a barrier to simulation within occupational therapy, hence access to established and relevant simulation resources is needed.

Evidence

Current occupational therapy standards are informed by HWA-funded research within occupational therapy. *Rodger, S., Bennett, S., Fitzgerald, C. & Neads, P. (2010). Use of simulated learning activities in occupational therapy curriculum. University of Queensland on behalf of Health Workforce Australia.*

The OTC is currently represented on the oversight committee of a Randomised Control Trial for occupational therapy, being undertaken by the Australian Catholic University. This project, *Embedding Simulation in Clinical Training in Occupational Therapy, Phase 2,* is led by Professor Christine Imms, with funding from the Commonwealth Department of Health.

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?

The defensible rationale for supervised practice as a pre-condition to registration is related to risk and the requirements necessary to assure public safety.

Within occupational therapy, as with other professions, supervised practice is incorporated within accreditation standards, requiring both quantitative (minimum 1000 hours) as well as qualitative components (different practice contexts, for example). The requirement of hours is established through international practice standards and has been reviewed regularly through research at an international level. Few jurisdictions internationally require a period of supervised practice post qualification in the occupational therapy profession. Where this is known to be the case, supervised practice is in place to make up for a lack of supervised practice within the educational program.

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

As with supervised practice, deliberations of work-readiness and the complexities of transition to practice are influenced by multiple factors and warrant ongoing deliberations between Boards, authorities, health services, education providers and professional bodies, as well as broader stakeholder groups.

Feedback received by the OTC during accreditation assessment is that some employers expect graduates to be 'site-specific' ready at graduation (i.e. have the specific skills relevant to that work-site) rather than work-ready (i.e. have achieved the broad competencies to enable them to practise). A number of employers report they will only consider job applications from graduates who have previously had a practice placement in that, or a similar organisation as this reduces the need for induction.

Supporting competent transition to work environments is a current area of development within occupational therapy education programs, often as part of wider education provider initiatives addressing graduate employment. Many programs have reported research-based initiatives addressing development of broader skills such as communication, time and project management skills, alongside the 'clinical/technical' skills of practice. The OTC standards enable these initiatives which include clinical placements that provide learning opportunities as transition points between education and practice. For example, completion of projects designed within a practice setting. Research indicates employers have a responsibility to provide continuing professional education, orientation and support/supervision for employees including those newly graduated.

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?

There are various processes internationally for gaining general registration for occupational therapists, including national examinations, state or regional-based licensure examinations or the like, as well as various approaches to accreditation of educational programs. Irrespective of the existence of other elements, all approaches internationally incorporate accreditation of educational programs in the occupational therapy field.

The occupational therapy profession in Australia has supported current registration and accreditation processes and has not supported a national examination for the purposes of registration.

Examinations were used for assessment of competency for overseas-trained practitioners prior to the commencement of NRAS. This process was discontinued some years ago, as it was determined to be ineffective in managing assessments of competency within the context of occupational therapy practice.

PRODUCING THE FUTURE HEALTH WORKFORCE

Independence of accreditation and registration

19. Do national boards, 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?

The National Boards are, and remain best placed, to retain their current role and authority regarding approval of accreditation standards and programs of study. There is a rigorous selection process through the COAG Health Ministerial Council with strong profession input. The National Boards, as currently constituted, require a practitioner member from each state (depending on the size of the profession) and two or three community members (depending on the size of the profession).

Boards proactively assess the skills mix required on Boards to ensure it can address all areas of its statutory responsibility and this is inputted into the COAG appointment process. The intersection between the education and training element, and the registration/professional conduct and ongoing development elements of the health profession is significant and best coordinated by a single independent source. This provides, in combination, a strong basis to address workforce needs and ensures flexibility and responsiveness which would be eroded if these elements of professional regulation were separated.

As an example of this, some National Boards, including the OTBA, develop the competency framework for their profession. Incidental to this, competency frameworks developed by National Boards are usually governed by steering groups which include a range of key stakeholders bringing in a range of skills and perspectives, as well as consumer representation. This framework is in turn a key document relating to the accreditation function.

However, there should be a consistent framework within which each National Board/accreditation authority sets its own standards. This could entail both profession-specific standards, as well as some inter-professional standards that are common to all health care professions. This would provide greater consistency across professions, making the processes more straightforward for education providers.

The main responsibility of the National Boards is setting qualifications, standards for competencies and ethical conduct to ensure the safety of the public. Once the competencies for each profession are set, the competencies then determine the accreditation standards. Competencies in many professions are now evolving to allow much needed integration across professions, to meet future needs of the growing population. The National Boards are best placed to ensure this integration does not cross boundaries that will risk the safety of the public or hinder progression of healthcare practice.

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?

Accreditation authorities already have a significant degree of independence in undertaking their functions. Collaboration with the National Boards is important in terms of translating this work into broader workforce considerations.

The separation of standards-setting and regulatory oversight is essential to ensure credibility and transparency in setting the standards and approval of those standards.

The OTC considers its current level of independence sufficient to achieve the objectives of the National Scheme, and the existing processes provide an appropriate avenue to achieve the balance required.

Governance of accreditation authorities

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

The OTC has strong arrangements in place for community input into decision-making, with three experienced independent directors with full voting rights on the Board, contributing to its governance and policy decision-making. This approach to community input is now being expanded by having community based directors participate in the work of the OTC's committees involved in the accreditation of programs and the assessment of overseas-trained practitioners. The constitution of the OTC has also been amended to permit a non-occupational therapist to be elected as Board Chair or

Deputy Chair. A community member already serves as Chair of the Governance and Strategic Affairs Committee.

The OTC consults widely on accreditation standards and seeks and welcomes community input into this process. The OTC is open to the concept of including trained lay representatives on the program accreditation teams if this would improve the contribution profile of stakeholders on assessment teams. As mentioned earlier in this submission, positive reports are received about lay representation in accreditation review processes. A future option may be for accreditation authorities to pool assessment team candidates to provide a source of trained and experienced lay representatives.

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?

The OTC employs external professional expertise, professional advisors, to assist in the management of the accreditation processes. The OTC also utilises the expertise of external professionals as program accreditation team members. In both instances, there is potential for conflicts of interest to arise. In relation to program assessment team members, they are required to sign an agreement that includes reference to conflicts of interest.

The OTC provides all education providers with formal, written guidelines detailing how program accreditations will be undertaken. These guidelines include a section referring to Conflicts of Interest. All members of the assessor panel, the OTC Program Accreditation Committee (PAC) and OTC staff must formally declare any issues that might influence or be perceived to influence their ability to serve effectively as an assessor, administrator or committee member for a specific accreditation. All meetings of the PAC and the OTC have 'Conflict of Interest' declarations as a standing agenda item. Directors, committee members and all employees are required to declare any actual, perceived or potential conflict of interest.

Assessors are not permitted to hold an appointment with the education provider or have any strong connection to the program being reviewed. Members of assessor teams are usually drawn from states/territories outside the state where the program is offered.

The academic leader of the occupational therapy program being assessed is provided the names and relevant professional background of proposed assessors and any other person involved in an accreditation assessment, prior to their appointments, to determine if there is an actual, perceived or potential conflict of interest, and if the academic leader objects to a specific person's involvement in the accreditation team. If the latter is identified, alternate assessors will be appointed and the academic leader's agreement sought and obtained.

The OTC considers it has sufficient checks and balances in place to avoid conflicts of interest with no real need to undertake a major overhaul of these governance arrangements.

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?

The OTC does not believe there is any conflict or inconsistency between its accreditation activities and its other obligations as a company. OTC is a public company limited by guarantee and is required to meet the requirements of the Corporations Act. This imposes a financial and governance rigor to the accreditation authority. In addition, the company is a not-for-profit charity registered under the Charities Act 2013.

In the OTC's case, our company objectives are exclusively focused on our accreditation and assessment functions and as we are also a registered charity, our obligation as a company is entirely focused on fulfilling this public role and this is regulated through multiple avenues.

The OTC notes that the National Boards and AHPRA are also bodies corporate (the latter with financial responsibilities similar to those of the OTC), albeit incorporated under a separate statutory mechanism, and these obligations are managed in those cases. The principles of governance of those NRAS entities and those applicable to accreditation authorities differ little despite the different "method" of incorporation.

In terms of any conflict of interest, common best practice approaches could be established through the Governance Framework which would allow accreditation authorities to address any concerns through existing mechanisms. Alternatively, the National Law could be amended to legally constitute accreditation authorities directly under the National Law in the same way as National Boards and AHPRA, and thus be subject to the same discipline under the Act. Another suggestion would be to amend the current legislation to make some clear provisions around how accreditation authorities must conduct themselves to ensure they serve the public interest.

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 NRAS?

The OTC considers the regular reporting requirements to the National Board, including those prepared pursuant to the Governance Framework, are comprehensive and adequate. Notwithstanding the foregoing, the existing instruments such as the Governance Framework could be enhanced to ensure alignment with the NRAS objectives along with appropriate measures to ensure performance, without making major changes outside existing mechanisms.

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.**

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 is the current model. This model allows for collaboration between the National Boards and their respective accrediting authorities. The current model has overall been efficient and effective in carrying out the accreditation functions of the National Law. Work has been proceeding apace to enhance the collaboration between accreditation councils and indeed National Boards to address the above objectives. Existing mechanisms can be used to address these issues further without need to resort to major reform.

The AHPRA Agency Management Committee is the executive committee of the administrative arm of the scheme. Its function is not policy making and it would be inappropriate for it to give policy direction, and indeed, would undermine the impact the National Boards can bring to bear having the overall responsibility for policy making within their profession, as well as jointly through the strong collaborations that have developed between National Boards for the benefit of the scheme overall, coordinated through mechanisms such as the Forum of Chairs. The AHPRA Agency Management Committee could make only broad based "generic" policy direction in the form of "one size fits all" where that was applicable, but could not drill down to the policies, codes and guidelines required by different professions.

As noted above, current mechanisms could be used to achieve the above objectives without wholesale change such as creation of a single accreditation authority, which would impact on profession-specific input and leadership within each profession. Major change would carry significant risks such as loss of corporate knowledge and intellectual property that have been built up with significant effort and investment since the commencement of the scheme and are overall functioning well.

The Forum, in collaboration with AHPRA, funded and supported by National Boards could have a strong role in coordination in the same way AHPRA works with the Forum of National Chairs to help coordinating the work of National Boards in similar respects to good effect. An effective funding mechanism would be allocation of funds from National Boards to accreditation authorities for the purpose of resourcing the Forum.

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

There is opportunity within existing mechanisms to address this issue through agreeing common competencies across professions, undertaking mapping of competency standards across professions, and the like. This could be coordinated through the Forum.

Alternatively, a framework could be developed that was overseen by the National Boards, setting a small set of supplementary standards that go across all professions but are then built into the assessment process for all accreditation authorities. Obviously, there would need to be input from the Boards to get agreement, and perhaps the Forum is the appropriate place for this to occur.

This framework could include:

- clear goals and objectives of accreditation program and standards;
- code of conduct for accreditation councils;
- common principles that guide development of all standards;
- national interdisciplinary standards that all professions must include in their standards and assessment;
- process/timeframe for evaluation of standards and process

Accountability and performance monitoring

27. What should be the standard quantitative 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?

Accountability of the national scheme is important and has to relate to the accreditation-related roles of accreditation entities, National Boards and AHPRA under the National Law.

The OTC recognizes there could be some performance measurement of how all the elements work together. Timeframes around the completion of accreditation and assessment processes and improved reporting through existing mechanisms could both be areas to consider in the development of key performance indicators.

However, developing quantitative performance measures needs to be focused on value adding, not just "nice to know" data; otherwise, there is the risk of spending scarce resources on what is a relatively lean operation of data collection and reporting at the cost of other outputs. The scope of performance measures needs to ensure the costs of recording and reporting do not outweigh the benefits gained. It should be kept fairly high level and rely on the regular reports to the National Board as the main source: i.e. number of assessments (to show work load and trends over a three-year period), number of accreditations that have conditions imposed, and time to close out any conditions are several examples.

Setting health workforce reform priorities

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

The Ministerial Council should not duplicate the work of the National Boards and their respective accreditation authorities. It is difficult to conceive a situation where a profession regulated under the current National Law, with its checks and balances, could depart from its "intended path".

29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation system may have a substantive and negative impact on the recruitments 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 requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation system may have a substantive and negative impact on the recruitment or supply of health practitioners, is sufficient to encompass all the National Law objectives and guiding principles, and should not be modified. The Ministerial Council's power should remain at a high level and the independence of the decision-makers, both accreditation authorities and the National Boards, should be maintained. This independence would be impaired if the Ministerial Council could intervene more broadly.

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

There is a lack of clear direction from Government concerning future workforce requirements. Health Workforce Australia had a remit to fulfill this role and support the work of various agencies around health workforce. This was transferred to the Department of Health and appears to have largely been lost.

There appears to be a need for resources to be provided for research and modeling to be undertaken before informed discussion can occur. One option may be to strengthen the role of the Forum, alone or along with a complementary strategy of an annual workforce conference with NRAS partners and other stakeholders.

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?

The OTC does not currently have arrangements that encompass specialist or postgraduate qualifications, so does not have views to express on this issue.

Assessment of overseas health practitioners

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 OTC supports reasonable alignment between these processes, recognising there might be professional differences. The OTC is currently appointed by AHPRA and the Department of Immigration and Border Protection/Department of Education and Training to undertake a Stage 1 qualification assessment for both registration and skilled migration respectively. This process works efficiently and effectively as it reduces duplication of documentation for all parties involved.

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?

These functions are complementary to each other and should be undertaken by the same authority where there is continuity of professional knowledge. The OTC has been providing both these functions successfully for many years.

The two functions provide income streams that are relevant to support each function and which can be used to support organisational priorities for areas of operation where there are shared operational issues and priorities.

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

There may be opportunities for increased consistency across the National Boards in their assessment pathways for granting registration to overseas-trained practitioners, for example. A combination of common and disciple specific standards may be desirable.

An example of effective work in setting common standards is that applied to the English language requirements for overseas trained professionals making an initial application to register as a health professional in Australia.

Transferable skills or “work ready skills” could be a further area for consideration of consistency. These skills could include inter-professional and collaborative practice competencies, workload management, reflective practice and communication skills

However, discipline-specific standards are essential to assess the application of knowledge, skills and attitudes to the cultural, social and professional environment in which the health professional is to practise. The OTC has a robust two-stage process involving a desk top assessment of the application (Stage 1) and the development, by the practitioner, of a supervised practice plan with specific goals to be achieved during the period of supervised practice (Stage 2). This period of supervised practice ensures overseas-trained practitioners are confident and competent to practise independently in the Australian environment.

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?

The period of supervised practice is a key element in ensuring the safety of the public as it requires the overseas-trained practitioner to receive direct supervision focussing on attaining competence in the application of knowledge and skills. The OTC also requires that competence is demonstrated providing culturally relevant interventions specific to the Australian context, including first Australians and Australia's changing and increasing migrant population.

At the NRAS Research Conference, 2016, several papers supported the timely use of data, shared between accreditation authorities and National Boards. One area of interest is that of proactive measures to support overseas trained practitioners transitioning into practice, particularly in their first year of practice in the new workplace. Preventive action can be planned, specifically to address, for example, cultural issues, communication and interprofessional practice. Research, drawing on notification data supports the need for elements of supervised, or supported practice to successfully address management of risk and assurance of public safety (NRAS 2016 Research Summit, *Partnering in risk-based regulation for patient safety,* 25/8/16, Melbourne).

Grievances and appeals

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

The OTC has established appeal mechanisms and feedback. In addition, accreditation authorities are required to report any complaints to the National Board.

To date, the process established by AHPRA/HPACF has served the requirements of the OTC. There have been no issues that have not been managed within the management process and requiring referral to external processes.

37. In 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 complains encompass all accreditation functions as defined under the national Law, as well as fees and charges**?

The OTC believes the current system works well. However, if a change in that system were to occur, the OTC believes the external appeal facility should be with a body akin to the National Health Practitioner Ombudsman or be a separate system. However, the cost of such an external body should be carefully considered before implemented.