

The Australasian Osteopathic Accreditation Council Submission to the Independent Review of Accreditation Systems 1 May 2017

About the Australasian Osteopathic Accreditation Council

The Australasian Osteopathic Accreditation Council (AOAC) welcomes this opportunity to contribute to the review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions. AOAC is a not-for-profit company limited by guarantee. AOAC is the independent accrediting authority for Osteopathy in Australia under the National Registration and Accreditation Scheme. AOAC plays a key role in protecting the public by setting standards of programs leading to registration as an osteopath in Australia and programs of study leading to endorsement. AOAC also assesses the suitability of overseas qualified osteopaths to practice in Australia.

This submission responds to the questions raised in the discussion paper. AOAC is a member of the Health Professionals Accreditation Collaboration Forum (HPACF/the Forum) and supports the Forum submission to this review. The information below is intended to add discipline-specific perspectives from the experience of AOAC. AOAC engages the Australian Nursing and Midwifery Accreditation Council (ANMAC) to provide comprehensive executive support. Consequently the two organisations frequently collaborate and there are some similarities in both the ANMAC and AOAC submissions.

Executive Summary

The aims of the National Regulation and Accreditation Scheme (NRAS) include protecting the public by ensuring that only suitably trained and qualified practitioners are registered and enabling the continuous development of a flexible, responsive and sustainable Australian workforce. Accreditation functions contribute to these goals by ensuring accreditation standards and processes are responsive to changes in education and practice, outcome focussed, rigorous while allowing for innovation and flexibility in delivery of education and encouraging stakeholder buy-in. Accreditation processes are underpinned by contemporary and professionally relevant capability/competency standards which form the benchmark for outcome based accreditation of educational programs and assessment of overseas graduates. Effective governance structures are crucial in ensuring appropriate checks and balances and that decisions at all levels of the Scheme are informed by appropriate expertise, and are accountable, transparent and efficient. Given the rapid pace of change in education and health care delivery, agility is essential.

AOAC is the accrediting authority for osteopathy, the smallest profession by number in the NRAS and discharges accreditation functions of developing accreditation standards, evaluating courses of study against these standards and evaluating overseas trained osteopaths to inform both registration and skilled migration processes.

AOAC considers that one of the key strengths of the NRAS is the independence of decision making which maintains appropriate separation between registration and accreditation. The separation enables educational providers and input from wide-ranging and effective stakeholder engagement to contribute to establishing and maintaining high standards for

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health professionals and the capacity to respond to innovation in education, practice and policy.

Potentials for improvements exist within governance of the NRAS to achieve more appropriate expertise in decision making and in co-ordinating and facilitating implementation of policy objectives and efficiencies. AOAC supports the Forum proposal for a policy co-ordination group with representation from national boards, accreditation authorities, AHPRA, community representatives, education providers and possibly policy advisors.

A move towards appointment of National Boards with a focus on achieving the required expertise from within and outside professions including representation from other health professions and consumer representatives is proposed to better equip Boards in accreditation decision making. The challenges of achieving appropriate expertise within the Boards of smaller professions with limited pools of educational and accreditation expertise within the current constraints of representation by jurisdiction limited to a specific profession is discussed. The AOAC's constitution recognises the principle that selection of personnel should be based upon achieving the required expertise at all levels of governance: within the board, committees and assessment teams by recruiting from outside and within the profession. The AOAC routinely appoints community representation within the board and committees and assessment teams include expertise from within and outside the profession. We support this principle throughout NRAS governance and accreditation functions. We propose the most appropriate use of consumer representation is as stakeholders in the development and review of accreditation and competency standards. Improvements in contractual arrangements between AHPRA and accreditation authorities are proposed to make the arrangements clearer, more closely aligned to the purposes of the Scheme and increase accountability while gaining efficiencies.

We describe a case study which compares the parallel review of accreditation standards (managed by the AOAC) and the Capabilities standards (managed by the Osteopathy Board of Australia with guidance from AHPRA) and observe that the governance of AOAC contributes to agility, efficiency and quality thereby better supporting the objective of the NRAS.

AOAC supports moves towards commonality of processes of development and structure in accreditation and competency standards where this produces efficiencies for stakeholders and does not dilute quality and responsiveness. The rationale for utilising a mix of outcome based and input/procedures and how AOAC has framed input measures to assure quality without constraining educational delivery and innovation along with how efficiencies are gained by utilising Tertiary Education Quality and Standards Agency (TEQSA) assessment decisions are discussed.

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Improving Efficiency

Accreditation Standards

Q1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

There are a number of benefits that could be achieved with greater consistency and commonality in the development and application of accreditation standards. Commonality across professions will improve the sharing of best practice across health professions and increase inter-professional coordination, liaison and development. In addition, commonality in a set of core standards across the health professions will ensure education providers maintain a similar level of quality across health programs. The benefits to education providers would be less duplication of effort and evidence required to satisfy different accrediting bodies when they offer programs for multiple health professions. This could be further enhanced by health professions developing core competencies and core education units to support inter-professional education.

The challenges would be in achieving processes which are relevant to all of the professions and across the diverse range of settings in which they practice. In the Australian Capital Territory ANMAC, AOAC, the Australian Medical Council and the Australian Pharmacy Council are co-located, forming an accreditation precinct. The CEO's of the organisations meet on a regular basis to discuss avenues for collaboration. Planning is currently underway to develop cross professional accreditation interest groups.

Q2. Should accreditation authorities be required to incorporate the decisions of TEQSA/ASQA assessments and accreditations of education providers as part of their own reviews?

AOAC considers that incorporating the decisions of TEQSA/ASQA assessments achieves efficiencies and AOAC has a MoU with TEQSA and incorporates the decisions of TEQSA assessments and accreditation of education providers as part of program accreditation. The following is an extract from AOAC accreditation standards (AOAC 2016):

Standard 1.1 Education provider registration and standing

1.1.1 The education provider delivering or planning to deliver a program of study in osteopathy is a registered Higher Education Provider recorded on the National Register of higher education providers (TEQSA).

1.1.2 Throughout the accreditation process, the education provider will make available documentation produced for TEQSA and other internal and external quality assurance processes as deemed necessary by AOAC, to fulfil its duty to confirm its current status to the Board [or any other regulator]. Information received in this context will be treated as commercially sensitive and details will remain confidential.

This information enables AOAC to confirm that the education provider:

1.1.2.1 Has comprehensive systems of corporate and academic governance in place

1.1.2.2 Satisfies statutory requirements relating to financial viability and sustainability

- 1.1.2.3 Has effective systems of corporate and academic management in place
- 1.1.2.4 Uses comprehensive quality assurance systems to monitor academic provision and performance
- 1.1.2.5 Applies appropriate risk management systems.

Q3. What are the relative benefits and costs associated with adopting more open-ended and risk-managed accreditation cycles?

As with other accreditation authorities, AOAC recognises a role for both cyclical and risk-based approaches to accreditation and recognises that focusing on the accreditation cycle without an emphasis on monitoring affects the quality improvement cycle for education programs. Cyclical accreditation provides an opportunity for comprehensive assessment of the quality of programs. Applications for cyclical accreditation have often triggered a whole of program review by the educational provider leading to adoption of innovations in education and practice. An open ended accreditation system may detract from keeping programs up to date and contemporary. AOAC therefore favours continuation of cyclical accreditation with ongoing engagement between accrediting bodies and educational providers.

AOAC has a five year accreditation cycle and endorses the benefits of adopting a risk-managed accreditation process within the existing 5-year accreditation cycles. AOAC is currently reviewing accreditation procedures in light of the ANMAC risk based model for accreditation.

AOAC frequently utilises conditions/requirements deliverable over the period of accreditation as part of cyclical accreditation decisions to support innovation and quality improvement by educational providers.

[Training and readiness of assessment panels](#)

Q4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and interprofessional collaboration?

AOAC supports robust processes, policies and procedures in place around selection, education and the composition of assessment teams to ensure efficiency, fairness and consistency. AOAC has since inception included other health professionals with expertise in education and accreditation in its accreditation teams and utilises inter-professional expertise when required in other activities. For example a senior medical educator facilitated the 2017 question writing workshop for the examination of overseas practitioners. The accreditation committee includes personnel who have served on other accreditation committees and teams.

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AOAC does not believe in re-invention when robust frameworks already exist within other professions. We recognise the contribution of AHPAC members who have offered their existing frameworks to inform and improve the training and selection of AOAC team members. In particular, we plan to review assessor training which is being developed by ANMAC to see if this can be adapted for AOAC.

It is important that collaboration occurs in our approach to recruiting, training and retention of assessment panel members as the inclusion of other professional groups within assessment teams increases interprofessional collaboration e.g. a nursing professional on the assessment team for an osteopathy degree and vice versa.

A pool of personnel with accreditation and assessment expertise from within the health professions and consumer groups which accreditation councils could draw upon when selecting team personnel would foster inter-professional understanding and consistency of process.

At present remuneration is arranged by individual councils and within AOAC are set well below the income these individuals would normally earn in their usual employment. A benchmarking exercise may be useful to inform discussions around remuneration strategies.

Q5. Should the assessment teams include a broader range of stakeholders, such as consumers?

The focus of AOAC when selecting assessment teams is to achieve the desired range of expertise in education, practice and health service management within the minimum possible team size. Since inception, AOAC teams have included personnel from outside and within the profession to achieve these objectives typically within teams of three assessors with an administrator. AOAC believes that there are a number of issues to be considered prior to including consumers in assessment teams, such as clarity of role; how will they be able to assess the curriculum against the standards and weighing the value of inclusion against costs in efficiency and financial terms?

The constitution of AOAC ensures that there is community representation on the Board and committees which manage accreditation and assessment processes. Development of standards involves wide ranging consultation including with the public. There is potential to enhance community representation via inclusion of organisations representing community interests in stakeholder consultation.

[Sources of accreditation authority income](#)

Q6. 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?

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AOAC generally supports the continuation of the existing funding model that shares the cost of accreditation between a grant from the National Board and fees from individual education providers. Notwithstanding this general support, AOAC will be reviewing its fee structure in the next financial year. ANMAC is undertaking an activity based costing project later this financial year and AOAC will participate in this project.

It would be useful to have a consistent approach for funding of accreditation from each of the National Boards using a best practice principle basis. In the past, some components of accreditation have been funded separately and differently by the National Boards. For example, the development of accreditation standards has been funded separately in some cases and in others it is part of the overall grant.

Q7. 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?

AOAC believes that the funding model should be transparent and consideration be given to the potential impact of cross-subsidisation upon skilled migration. As a council which assesses a relatively small number of candidates each year, the AOAC is aware of the considerable costs involved in developing and implementing a robust assessment process and the burden that this would result in if a user pays principle was strictly applied or if fees from candidates were also required to cross-subsidise other costs of accreditation.

AOAC assesses candidates to provide advice to the National Board about their capacity to meet the requirements for registration and for the purposes of recognition for skilled migration in the category of Osteopathy. The Capabilities of Osteopathic Practice (2009) is used as the benchmark for both assessing the standards of overseas trained graduates and for assessing programs of study. In this regard, there are synergies which produce efficiencies both for the candidates in a single assessment process and more broadly in undertaking accreditation functions.

AOAC has established two pathways for assessment of candidates: a Competent Authority Pathway which involves a desktop assessment and e-based examination and a Standard Pathway which includes written and clinical examinations. Fees from the assessment of candidates who meet the criteria for the Competent Authority Pathway in part subsidise the considerably higher costs of assessing graduates from other countries using the Standard Pathway.

There are significant costs in developing assessment processes, question banks and undertaking clinical examinations. These are currently met by fees paid by candidates and subsidised in part by the National Board. Without this support, the costs of assessment of overseas trained practitioners would become a significant obstacle to the flow of skilled migration as the substantial set-up and maintenance costs of the assessment process would be recouped from a small number of applicants.

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Relevance and responsiveness

Input and outcome based accreditation standards

Q8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

AOAC endorses the commentary about the rationale for including both input and outcome based standards in accreditation provided in the AHPAC submission and notes that a mix of both is usual practice including within TEQSA standards. The challenge is to frame inputs or processes in ways that ensure the primary goals of the Scheme —safety and quality— are achieved without undue burden for education providers or stifling innovation.

The AOAC completed a comprehensive review of accreditation standards for osteopathy in 2016 through a process of consultation with key stakeholders. The resulting standards are output focused with inputs/processes framed in language which asks the education provider to demonstrate how the objective of producing suitably qualified graduates that meet the standards is achieved. For example, in relation to staffing requirements, AOAC requires that the education provider demonstrates that they have:

- 1.3.3 The number of teaching staff allocated to the program necessary to deliver a program that provides graduates with the knowledge, skills, and professional attributes to practise osteopathy in Australia
- 1.3.4 Allocated to the program teaching staff who are equipped with the skills and experience to effectively deliver the program

The only prescribed inputs within the AOAC Accreditation Standards for Osteopathic Courses in Australia (AOAC 2016) are that the institution is a registered Higher Education Provider recorded on the National Register of higher education providers (TEQSA), and that the program of study is taught at AQF level 7 or higher.

Q9. Are changes required to current assessment processes to meet outcome-based standards?

Please see response to Q8

Health program development and timeliness of assessment

Q10. 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?

Requiring a common approach to competency frameworks depends on the purpose and outcome of this approach. Some of the potential benefits of a common approach to the development of accreditation processes discussed in Q1 may also flow from adopting a

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common approach in the development of competency frameworks. This can be achieved using best practice methodologies with extensive consultation with stakeholders such as the boards, councils and professions. AOAC sees value in including consumer groups as part of routine stakeholder engagement processes in development and review of accreditation standards and Capability frameworks to keep the public interest central to the process.

AOAC supports exploration of a common approach to development and endorsement of professional competency frameworks with a view to efficiency, quality and fairness, stakeholder engagement and transparency of the process.

Currently different Boards use different methodologies and funding strategies in developing competency frameworks. As an example of one contemporary process, AOAC commenced comprehensive reviews of both the AOAC Accreditation Standards (2010) and, on behalf of the National Board, the Capabilities for Osteopathic Practice (2009). The projects commenced simultaneously in 2014 with wide-ranging stakeholder consultation involving the regulators, professional and educational providers in Australia and New Zealand, the peak international body and AHPRA and were then release for public consultation. Both projects were finalized and submitted to the Osteopathy Board of Australia in August 2015. After minor amendments were made, final reports was accepted by the Osteopathy Board of Australia in March 2016 who after consultation with AHPRA staff, commenced a further round of consultation with a similar group of stakeholders. The board has recently tendered for further work to be done to incorporate this feedback with a view to delivering a final report in early 2018.

There are concerns that the additional consultation represents duplication of effort causing unnecessary delays in the release of the revised Capabilities. This delay has a flow-on effect as reviews of AOAC assessment processes have been awaiting release of the revised Capabilities to which the assessment will be mapped. Education providers are also impacted as they await the revised Capabilities to form the basis of curriculum reviews and blue-printing of assessment.

Q11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?

AOAC supports a best practice approach to developing accreditation standards that takes account of the commonalities between the professions and supports the Review's suggestion that "accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements" may be a useful way to achieve harmonization while ensuring that specific professional requirements are not either lost or reduced to a minimum.

Production of contemporary, comprehensive, clearly articulated competency standards relevant to each profession are essential as benchmarks against which graduates and candidates for assessment are measured in output focused accreditation processes.

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Where there is a need for health professions to learn and deliver similar care, then AOAC supports a consistent approach to standards based on evidence. An example of this could be the adoption of the prescribing standards as developed by Health Professionals Prescribing Pathway under the auspices of The National Strategy for the Quality use of Medicines.

Interprofessional education, learning and practice

Q12. 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?

AOAC considers that contemporary accreditation and competency standards are the key to ensuring education programs reflect the requirements for a contemporary workforce. Establishing best practice processes for the review and adoption of accreditation and capability standards may streamline processes, reduce duplication and improve transparency and responsiveness. Q10 describes the current process of review of the Capabilities of Osteopathic Practice and questions whether efficiencies might be gained by reducing duplication.

A formal review of AOAC's accreditation standards for Osteopathic education programs in Australia generally occurs every five years (recent major reviews were published in 2010 and 2015) with interim reviews triggered by feedback from stakeholders occurring on an as needs basis. An example of an interim change was streamlining the definitions of major change and enhanced flexibility in dealing with major changes which enabled the AOAC to respond in a more risk based way.

Changes to Capabilities standards have occurred less frequently – the current standards were developed in 2007-2009 and have remained unaltered despite considerable changes to contemporary practice triggered by evidence and changing practice contexts.

Clinical experience and student placements

Q13. How best could interprofessional education and the promotion of inter-disciplinary practice be expressed in accreditation standards that would reflect the priority accorded to them?

Further development of inter-professional education (IPE) across the professions would require a shared standard with a clear definition for the term IPE together with criteria to ensure consistency. The standard needs to be sufficiently broad to enable innovative approaches by education providers to meet the standard while taking account of the structural constraints education providers face in delivering interprofessional learning. This could be done by reviewing the work that Professor O'Keefe has done through

Collaborating across Boundaries – A framework for an integrated interprofessional Curriculum. Professor O’Keefe developed a number of interprofessional competencies that could with some work translate to interprofessional standards.

Q14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?

Healthcare priorities are evolutionary and contextual and embedding them within curricula and clinical experiences is complex. AOAC considers that this is best accomplished through setting standards that require students to be exposed to the healthcare priorities without naming the actual content that is to be included to enable the current priorities to be assessed during the life of the standards.

Q15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

AOAC considers that contemporary accreditation and competency standards are the key to ensuring education programs incorporate innovative educational practices. AOAC Standards of Accreditation are an example of contemporary standards: they are output focused and describe inputs in ways that encourage innovation (include recognition of simulation and other delivery methods). For example the standards for clinical education require the program:

2.4.2 (iv) Incorporates simulation-based learning, where necessary, to ensure students develop a comprehensive range of diagnostic and examination skills.

This is in recognition that simulation supports and prepares students for situations in practice. The range of simulation contributes to the learning of most practitioners. Simulation is already incorporated into many professions practice as demonstrated at the HPAC work shop held in June 2015 Collaborating for Patient Care – Interprofessional Learning for Interprofessional Practice

http://www.healthprofessionscouncils.org.au/files/7c4d0b610f2d2161ec0828fcd57372350ef0f6f0_original.pdf

The Forum agreed to the outcomes of the Report and have also developed position statements on Interprofessional Learning and on Simulation based education.

The level and range of simulation differs across education providers and the quality of teachers in simulation also differs as there are no standards to support the practice. AOAC understands that Health Workforce Australia were developing standards and we support this work to guide practice in this area. In working with ANMAC at this time AOAC understands that the organisation is keen to develop standards for the use of simulation with other professions.

[The delivery of work-ready graduates](#)

Q16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?

AOAC processes for the accreditation of courses and assessment of overseas graduates do not include requirements for periods of supervised practice following graduation or successful completion of assessment respectively. Approved courses of study do include clinical practice requirements within the program of study to enable students to practice and develop clinical skills.

The Osteopathy Board has stipulated a period of supervised practice for overseas qualified osteopaths who have been assessed using a “light touch” Competency Authority Pathway, presumably on the basis that in the absence of a formal clinical assessment, the period of supervision is a valid harm minimisation strategy.

The need for supervised practice appears to increase with the capacity to harm. Whether this strategy is warranted might be better evaluated if notifications, complaints and other public safety data were analysed.

Q17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

Within osteopathy, work readiness could be defined as meeting the minimum standards for independent practice as articulated in the Capabilities of Osteopathic Practice (2009). Osteopaths tend to work in private practice and are prepared for independent practice. Employer training, development and induction responsibilities have not been widely canvassed within the osteopathy profession.

[National examinations](#)

Q18. 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?

AOAC believes that robust accreditation processes negate the need for further national assessment to gain registration. Internationally, many countries with national examinations also have accreditation processes e.g. New Zealand has national exams for nursing and midwifery and accreditation. Accreditation and examinations perform different functions. Accreditation examines the quality of programs and education providers while examinations provide a snapshot of the individual student’s capabilities under set conditions at single points in time. National examinations are costly and have poor predictive value for work readiness. They are not conducive to assessing an individual’s performance as a member of a team in a clinical setting.

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Alternative strategies to assist in benchmarking graduate quality include utilisation of common assessment strategies and external examiners in exit clinical assessments. These assessments and examiners could conceivably also form part of the assessment strategy of overseas trained graduates.

Producing the Future Workforce

Independence of accreditation and registration

Q19. 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?

The Osteopathy Board of Australia is constituted of osteopaths selected by representation from the States and Territories. Board appointments are made by Ministers who should be cognisant of the need to appoint Boards with the range of skills required to undertake Board functions effectively. AHPRA has a separate accreditation policy area that provides advice on matters to do with accreditation. It appears that National Boards are increasing their use of AHPRA to inform accreditation functions which appears to support the notion that the National Boards are not ideally constituted for purpose.

AOAC advocates that the Terms of Reference for each National Board should demonstrate that the Boards are constituted in a way that provides the necessary expertise to support robust discussion and decision making when considering accreditation standards and decisions. We support the principle of appointment from within and outside the profession to achieve the expertise required to discharge functions effectively throughout the governance structure of the NRAS scheme. The AOAC constitution recognises this principle and appointments achieve the desired expertise on the board, committees and assessment teams by recruiting from outside and within the profession.

Challenges in recruiting appropriate expertise should not be constrained by representation by jurisdiction or limited to a specific profession especially in professions such as Osteopathy where pre-professional programs exist in two jurisdictions. Osteopathy has a small pool of appropriately skilled practitioners and academics to draw from and AOAC has successfully augmented this pool with expertise from other health professions and consumer representatives in the appointment of assessment teams.

Q20. 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?

AOAC supports greater independence of accreditation authorities in the development and approval of accreditation and competency standards and programs of study. AOAC supports

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the separation of standards setting and the approval of the education program for regulatory purposes. The separation of powers makes for a more robust system of checks and balances between education and regulation. Greater independence would assist in the alignment of education and training and in meeting consumer needs particularly if the governance model was structured as per our response to Q25. The issue for Accreditation authorities is that while the accreditation councils try to work collaboratively with stakeholders, the approval process is then determined through the National Board. Accreditation standards are developed through comprehensive consultation processes and are then reviewed again by the National Board who may make unilateral changes. AOAC understands the regulatory requirements for separation of development and approval of standards. However, as discussed in Q19, personnel with appropriate expertise are required to inform effective decision making and the Scheme may benefit from a best practice statement to ensure efficiency, accountability and transparency throughout the process.

Governance of accreditation authorities

Q21. Is there adequate community representation in key accreditation decisions?

Consumers should have input into accreditation and that input should be directed to the areas where it is most beneficial. Consumers may be of most benefit as stakeholders in the development and review of accreditation processes and practice standards to ensure public interest remains central to all functions.

Within osteopathy, community representation is enshrined in the AOAC constitution for its Board and the committees that manage accreditation and assessment processes but are not generally included on assessment teams which are made up of a small number of clinical education professionals from within and outside Osteopathy. Development of standards involves wide ranging consultation including with the public. There is potential to enhance community representation via inclusion of organisations representing community interests in stakeholder consultation.

The AOAC constitution requires that the board and committees are appointed to achieve the desired range of expertise with personnel appointed from within and outside the profession. AOAC Board and committees have community members and the AOAC Board Chair 2011-2016 was filled by a community member.

We support similar processes throughout NRAS governance. The limitations of current National Board selection processes and benefits of revised processes and the inclusion of other personnel is discussed in Q19.

Q22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

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AOAC is constituted as a not-for-profit company with robust processes, policies and procedures in place around selection. Training for health professionals' role in accreditation is provided to ensure integrity and mitigate the possibility of conflicts of interest. Board directors, members of accreditation committees and assessment teams understand the ethical and legal obligations of their role and policies for identifying and managing conflicts of interest are outlined in relevant AOAC publications.

Q23. 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?

Meeting the requirements of registration as a not-for-profit company under Australian law ensures sound and ethical governance. AOAC is structured as Not-for-Profit Company Limited by Guarantee and governed by Australian company law, as well as the *Charities Act 2013*. AOAC is registered with the Australian Charities and Not for Profit Commission (ACNC) and the Australian Securities and Investment Commission (ASIC) the company directors have a duty to ensure that the company continues to conform to the definition of a charity within the legislation, and to act appropriately should that no longer be the case.

AOAC has a service agreement with ANMAC to provide the administrative functions for the Council. AOAC stipulated that it was to remain an independent entity managed by a Board of Directors remaining as a Not-for-Profit Company limited by Guarantee registered through ACNC and ASIC. ANMAC receives a fixed amount for services which is reviewed each year. This arrangement works well because of the exchange of Interprofessional information and processes while maintaining a separate identity.

AOAC has been engaged with ANMAC over the last two years and sees the benefit of two professional organisations working together. AOAC sees the advantage of the affiliation with ANMAC rather than continuing with a non-health professional secretariat lie in the ability to clearly see where they are opportunities for Interprofessional collaboration and sharing of information. This has been further enhanced through the development of a central location in Canberra for the Australian Medical Council, Australian Pharmacy Council and ANMAC/AOAC.

ANMAC's administrative staff have achieved efficiencies by aligning the reporting of the two organisations.

[Role of accreditation authorities](#)

Q24. 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? What other governance models might be considered?

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The agreements could be improved to reflect sound business practice with performance indicators and by being aligned to the objectives of NRAS and the accreditation functions. AOAC believes that the quality report should be replaced with a performance report linked to the objectives for which funding is provided and which adds value to the function of the scheme. The information within the Quality Report is often a replication of information provided through the year and other information that does not provide value.

[What other governance models might be considered?](#)

Q25. 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.

Accreditation has limited power to effect change without having a strategic informed policy regarding the health workforce. It is relatively easy to include national policy decisions and strategic health priorities into accreditation standards, particularly with a move to more outcome based standards. AOAC builds its accreditation standards on evidence and consultation as prescribed by the National Law and therefore any governance structure needs to be within the scope and remit the scheme.

AOAC is also a member of the Health Professionals Accreditation Collaborative which now includes the four AHPRA Committees and AOAC does not believe that this is the appropriate forum to develop into a governance role.

The AOAC supports the Forum response which is reproduced below:

“one potential solution to the challenge of carrying out the accreditation functions provided in the National Law while progressing cross-profession issues is a coordination group building on the existing Accreditation Liaison Group, giving that group enhanced remit and expanded membership. It would need representation from all three major types of organisation within accreditation roles in NRAS: national boards; accreditation authorities; and AHPRA, as well as community representatives, education providers and possibly also policy advisors. Such a group would be able to reflect the requirements for intra- and inter-professional coordination by nature of its representation. It would have accountability for progressing cross-profession issues in accreditation standards, and would be accountable to the AHPRA Agency Management Committee, and thus to ministers through a transparent process. Some of the key points to ensuring the success of such a group would be:

- That such a group should be a committee and report directly to the Agency Management Committee (which may need revised terms of reference and membership)
- That it be a committee not a board;

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- That the committee be responsible for monitoring the performance of accreditation authorities, AHPRA and national boards in delivering on their accreditation functions under the national law
- That the committee have capacity to identify priorities for cross profession work, and to provide resources for agreed work
- That such a committee be sufficiently resourced to undertake policy work, but otherwise be as lean and efficient as possible;
- That the committee should be fully funded within NRAS;
- That the committee membership be restricted to a number consistent with agile decision-making but enable appropriate representative from the professions (small, medium and large defined by registrant numbers, for example) in the Scheme and an independent chair;
- That it should have a formal and clear channel of communication with ministers;
- That it should be both accountable, and able to enforce accountability, in areas of responsibility.

The Forum considers this is the type of solution that stands the best chance of addressing policy, cross-professional coordination, and accountability gaps while preserving the best aspects of the current system. However it is worth considering other possible models for the purposes of comparison and perspective.

The Review suggests that AHPRA's Agency Management Committee might be a logical vehicle for managing cross-profession issues. This committee's job is to manage AHPRA, and it has the sorts of business, administrative, legal and health sector skills to perform that role. However it does not necessarily make sense to ask such a group to take on the additional task of coordinating cross-profession activities in accreditation and ensuring responsiveness to community health needs. A committee charged with that task needs to be fit for purpose, and include the appropriate skills to fulfil that purpose. AHPRA is a key part of the NRAS structure and should be represented. However accreditation authorities and national boards should also be represented to contribute cross-profession perspectives and accreditation expertise. Education providers and community representatives also need to be on the committee if objectives of relevance to health education and responsiveness to community need are to be met."

Q26. How best in any governance model could recognition and accreditation of cross-professional competencies and roles be dealt with?

AOAC supports the development of mechanisms for recognising and accrediting cross-professional competencies and roles in health. One such mechanism is The Health Professionals Prescribing Pathway (HPPP)¹⁰ which provides a nationally consistent approach to the prescribing of medicines by health professionals (other than medical practitioners) registered under the NRAS. The principles outlined in the document underpin standards for prescribing for nurse practitioners and endorsed midwives. There is need for a governance framework that determines and monitors cross professional competencies to ensure the regulated profession continues to meet the scope of practice and mandated competencies.

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Accountability and performance monitoring

Q27. 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?

AOAC supports the need to be accountable for the delivery of the accreditation functions across NRAS. As in Q24 we suggested that a proper business agreement with performance indicators be applied in the contract format. The current system with a quality report does not provide a mechanism for quality improvement. The Accreditation Authorities are independent companies and any reporting should be based on performance indicators related to the functions of accreditation, rather than information that is relevant to managing the company.

AOAC would like to see that the indicators are relevant and measurable rather than being requested to provide policies and governance documents. AOAC would be delighted to be part of a process that developed meaningful reporting that is transparent and can be shared with our stakeholders.

Setting health workforce reform priorities

Q28. What role should the Ministerial Council play in the formal consideration and adoption of proposed accreditation standards?

The current role is sufficient as Ministers determine the macro level of health and education. AOAC is aware of broader health policy and the health and workforce issues that face Australia and particularly those affecting the Osteopathy profession. And recommends that the structure proposed in question 25 is considered as a high level governance structure

Q29. 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?

See question 28

Q30. 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?

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

Please see response to question 25

AOAC has developed a stakeholder engagement framework that supports its consultation process for the development of accreditation standards which includes a wide range of stakeholders from education, regulators and the profession in Australia and New Zealand, AHPRA and the peak international body for osteopathy. There is scope for formalising inclusion of peak consumer bodies in its consultation processes.

[Specific governance matters](#)

[The roles of specialist colleges and postgraduate medical councils](#)

Q31. Not relevant to AOAC

[Assessment of overseas health practitioners](#)

Q32. **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?**

AOAC is gazetted to undertake the skilled occupation assessment and has undertaken this role for over five years. There is no reason why the two processes cannot be completed at the same time. AOAC already provides a single process for candidates requiring assessment for both accreditation and recognition of qualification for skilled migration purposes.

Q33. **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?**

AOAC supports accreditation authorities undertaking both these functions of accreditation. Accreditation councils have access to educational expertise which equips them to construct and administer appropriate assessment of qualifications. It is a role that AOAC currently undertakes and sees no reason for the process to be done elsewhere.

Q34. **Should there be consistency across the National Boards in assessment pathways, assessment approaches and subsequent granting of registration status for overseas trained practitioners?**

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AOAC supports the perspective that assessment of the internationally educated osteopaths must be relevant, fair and transparent. Applicants whose educational preparation meets the Australian standards and capabilities should be eligible for registration. There are opportunities to explore this if the assessment of internationally qualified osteopaths is linked to the National Training Centre (NTC), however, the practice requirements of each profession should not be lost. Assessment must be fit for purpose and could be expected to vary depending upon the skills, attributes and knowledge to be assessed and the practice context of the particular profession. Common skills worthy of exploration to develop consistent approaches in assessment for all professions include their ability to work in a multidisciplinary team and how well they communicate patient information.

Q35. 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

AOAC has established two pathways for assessment of candidates: a Competent Authority Pathway which involves a desktop assessment and e-based examination and a Standard Pathway which includes written and clinical examinations. AOAC does not require supervised practice. However, the Osteopathy Board of Australia does require candidates who have successfully completed the Competency Authority Pathway to undertake a period of supervised practice.

The need for supervised practice appears to increase with the capacity to harm. Whether this strategy is warranted might be better evaluated if notifications, complaints and other public safety data were analysed and the quality assurance framework of the supervision was assessed.

Q36. Does the AHPRA/HPACF guidance document on the management of accreditation-related complaints resolve the perceived need for an external grievance/appeal mechanism?

AOAC processes for managing complaints is based on the AHPRA/HPACF Guidance process for managing complaints regarding accreditation matters and is designed to be rigorous, fair and responsive. See Q37 for more information.

Q37. If 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 complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

AOAC supports the need for robust review of the decisions made by accreditation authorities and utilises an approach to appeals from education providers regarding decisions which emphasises the independence of the appeal process. AOAC has not received any appeals regarding its accreditation process to date. This may be because of the open channels of communication between education providers and AOAC.

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If an external entity is considered necessary AOAC supports the National Health Practitioner Ombudsman as an appropriate channel for grievances and appeals. AOAC further supports the scope of complaints to encompass all accreditation functions including fees and charges.

References:

AOAC Accreditation Standards for Osteopathic Courses in Australia AOAC July 2016

Health Workforce Australia, The Health Professionals Prescribing Pathway (HPPP)
O'Keefe M 2015 Collaborating across boundaries: A framework for an integrated interprofessional curriculum Office for Learning and Teaching Australian Government pp 1-29

UTS Capabilities for Osteopathic Practice 2009