

**Australian Catholic University (ACU)
Submission to COAG Health Council
Discussion Paper:**

**“Independent Review of Accreditation
Systems within the National Registration
and Accreditation Scheme for health
professionals”**

May 2017

ACU Submission to the Review of Accreditation Systems

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Executive Summary

Australian Catholic University (ACU) welcomes the COAG Health Council discussion paper, *Independent Review of Accreditation Systems with the National Registration and Accreditation Scheme for health professions*, and appreciates the opportunity to respond.

ACU is a truly national university, with seven campuses in five states and territories. Moreover, as the largest educator of nursing students in Australia,¹ ACU has a strong interest in effective accreditation arrangements. Consequently, ACU supports the 2014 Harmonisation project² and efforts towards achieving greater consistency, transparency and reduction of duplication in accreditation processes.

In terms of specific accreditation issues raised in the discussion paper, ACU believes that:

- Outcome-based standards rather than input or process standards should define the accreditation system (see response to issue #8). While in some circumstances input measures can provide assurance on key discipline knowledge, ACU is of the strong view that input measures such as the minimum 800 hours of workplace experience for the accreditation of Registered Nurses are mostly arbitrary and not evidence based. Any use of input measures requires a greater evidence base and should be subsidiary to outcome measures (i.e. the competence displayed by the graduate).
- Healthcare priorities should be embedded in accreditation standards (see response to issue #14). For example, mechanisms to expand the location of clinical placements as well as measures to reduce their escalating cost should be established and enforced. Australia's health workforce will suffer in quantity and quality if this does not occur.
- Accreditation standards do have a role to play in improving contemporary education practices in curricula and clinical experience (see response to issue #15). Greater recognition of simulation as a component of clinical experience, and greater incentives within professions to supervise students (such as in the nursing profession) are improvements that can and should be embedded in accreditation standards.
- ACU advocates a national focus on advice and reform, and greater national coordination of the health workforce (see response to issue #30). A national advisory body devoted to this purpose, such as the previous Health Workforce Australia, should be incorporated into health accreditation architecture.

ACU focuses on these issues as an education provider but we provide brief comment on other general issues raised in the discussion paper, including: greater consistency and commonality in accreditation standards (issue #1); common health profession elements in accreditation standards (issue #11); and interprofessional education and inter-disciplinary practice (issue #13).

¹ Hobsons, *The Good Universities Guide 2015 to Universities and Other Higher Education Providers*. p. 131.

² M. O'Keefe, A. Henderson, et al, (2014), *Harmonising higher education and professional quality assurance processes for the assessment of learning outcomes in health*, Office for Learning and Teaching, 2014; 1-72

Introduction

In Australia, the health profession has national accreditation unlike, for example, the teaching profession, which is primarily regulated at a state level. Yet this national system is also disjointed, operating as 14 largely autonomous, profession-based entities which include the:

- Aboriginal and Torres Strait Islander Health Practice Accreditation Committee
- Australasian Osteopathic Accreditation Council
- Australian and New Zealand Podiatry Accreditation Council
- Australian Dental Council
- Australian Medical Council
- Australian Nursing and Midwifery Accreditation Council
- Australian Pharmacy Council
- Australian Physiotherapy Council
- Australian Psychology Accreditation Council
- Chinese Medicine Accreditation Committee
- Council on Chiropractic Education Australasia
- Medical Radiation Practice Accreditation Committee
- Occupational Therapy Council
- Optometry Council of Australia and New Zealand

These 14 national boards have the power to decide whether their accreditation functions are exercised by an external accreditation entity or an internal committee established by the board.

Health accreditation allows health graduates to practise in their chosen profession in Australia. The accreditation of higher education programs occurs separately to the registration of students and ACU respects the role that national boards and associated accreditation authorities play in ensuring higher education providers deliver programs in line with accreditation standards.

The accreditation system is also meant to help shape the future health workforce to meet the needs of the community. In this respect, ACU sees the current arrangements as failing, particularly in coordinating supply and demand of future workers.

Increasing numbers of students are choosing to pursue careers in the health sector, contributing to the Faculty of Health Sciences being the largest faculty at ACU (see Appendix A).

ACU's Health Sciences students are aware of many of the forces that will drive growth in the health workforce in Australia into the future. These include:

- A larger population that, by definition, requires more health care. Australia's population will be almost 40 million in 2054-55, up from 24 million today.³

³ Australian Government. *2015 Intergenerational Report: Australia in 2055*. (March 2015)

- An ageing population that will require a disproportionately higher level of health care due to more complex and chronic health problems. The number of Australians aged 65 and over is projected to more than double by 2054-55, including around 40,000 people aged over 100. By contrast, there were only 122 Australian centenarians in 1974-75.⁴
- Chronic health conditions increasing the demand for treatments and consequent care. Chronic disease is the leading cause of illness, disability and death in Australia with the cost of the four most expensive chronic diseases equating to around 36 per cent of all health expenditure.⁵ Notably, Australia has among the highest rates of adult obesity in the world at 28.3%.⁶
- As incomes rise, so too does the consumption of greater or higher quality health care services while the emergence of new, more effective treatments also increases the demand for these treatments.⁷
- More health care workers will be needed as more individual health care workers elect to work fewer hours. Many nurses, doctors and other health professionals are choosing to work fewer hours, partly for work-life balance or family commitments but also due to the rising intensity of care required for patients.

Despite the overwhelming evidence that more healthcare workers will be needed in Australia in the future, there is a lack of coordination and planning for their training. This is particularly evident in the arrangement of clinical experience and student placements, where rising costs and narrowing opportunities have the potential to erode Australia's future health workforce. Insufficient coordination and foresight, including in terms of accreditation, mean that young health care graduates may be lost to the system just when Australia needs them most.

In this submission, ACU draws attention to the inefficiencies and inadequacies in the requirements made by national boards and their accreditation authorities. ACU also notes the role these organisations can and should play in protecting and developing the future health workforce.

⁴ *ibid*

⁵ These four being cardiovascular diseases, oral health, mental disorders, and musculoskeletal. Australian Government. *Reform of the Federation White Paper, Issues Paper 3: Roles and Responsibilities in Health*. (Dec 2014)

⁶ OECD, *Health at a Glance 2013*. <http://www.oecd.org/australia/Health-at-a-Glance-2013-Press-Release-Australia.pdf>

⁷ Australian Government. *2015 Intergenerational Report: Australia in 2055*. (March 2015)

Issue #1 – Greater consistency and commonality in standards

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

The benefits of greater consistency and commonality in standards would significantly outweigh any costs.

Health accreditation systems should pursue and promote consistency, transparency and reduction of duplication where possible so practices are similar across all registration boards. Greater efficiency would benefit students through lower registration fees and also benefit universities through lower compliance costs.

While ACU recognises that compliance with accreditation standards is important and necessary, it is also costly and time consuming. The inefficiencies in the current accreditation process have become a burden on universities that should be reduced.

For example, some accreditation agencies require universities to provide multiple copies of the same appendices for double degrees in both hard and soft format. This requirement consumes considerable faculty staff time and cost in printing, compiling, binding and mailing the thousands of pages of the same volumes of appendices. This is an example of duplication and inefficiency imposed by agencies that are involved in the accreditation of only one component of a double degree.

The burden of university accreditation load can be eased by moving to self-assessment for generic standards at a university and/or faculty level (similar to TEQSA processes). This would involve stating where information is available, eliminating the requirement to provide large volumes of documents and substantially similar information to multiple organisations in differing formats.

Recommendation: That greater consistency and commonality be pursued in the development and application of accreditation standards.

Issue # 8 – Outcome-based or input or process-based standards

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

There may be circumstances where input and process standards are required but, in most cases, input standards are unjustified. For instance, the hours some disciplines prescribe for clinical learning are not justified by research and are quite arbitrary, and do not allow simulation to be a recognised adjunct to clinical supervision.

One example relates to nursing graduates, who can register only if their program of study has been approved by the Nursing and Midwifery Board of Australia (NMBA). The Standards developed by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and approved by the NMBA articulate the core competencies required for registered nurses in Australia.

Section 3.6 of the Accreditation Standards for Registered Nurses (2012) requires “a minimum of 800 hours of workplace experience, not inclusive of simulation activities, incorporated into the program and providing exposure to a variety of health-care settings.”⁸ At the same time, section 3.7 of ANMAC requires that a course of study “prepares students for workplace experience and, wherever possible, incorporates opportunities for simulated learning”.

In other words, the value of simulation learning is recognised but it does not count in any way towards the 800 hours of mandated experience.

Similarly, in some allied health disciplines (such as occupational therapy), a minimum of 1,000 clinical placement hours are required,⁹ while others (such as physiotherapy) have no specified minimum number of hours but require students to achieve competency in key clinical areas across a range of settings.¹⁰

Providing coordination, learning support and appropriate supervision for students whilst on clinical placements places a huge cost burden on universities. ACU’s Faculty of Health Sciences organises approximately 1.9 million hours of clinical placements a year, of which 1.1 million hours are for its nursing students. This activity engages approximately 30 staff and consumes approximately one-fifth of the faculty’s entire budget.

While students value exposure to the workplace during their courses, there is little evidence to support a fixed number of hours of supervised practice for any health discipline. The crucial element is the overall outcome of the learning experience that occurs within a course of study rather than the input measure that is the proxy for this outcome. Despite this, many

⁸ Australian Nursing and Midwifery Accreditation Council (ANMAC). *Registered Nurse Accreditation Standards 2012*. (October 2012).

⁹ Occupational Therapy Council (Australia & New Zealand) Ltd. *Occupational Therapy Accreditation Standards*. (December 2013).

¹⁰ Australian Physiotherapy Council. *Accreditation Standard for Physiotherapy Practitioner Programs*. (December 2016)

accreditation bodies for health disciplines taught by ACU insist on strict input measures. Besides nursing, these include:

- *Occupational Therapy Council (Australia & New Zealand)* – a minimum of 1,000 hours is required of fieldwork/practice education experiences (December 2013).
- *Australian Psychology Accreditation Council* – 1,000 hours of supervised practice, with a minimum of 400 hours of direct client contact for AQF Level 9 programs, or 1,500 hours of supervised practice with a minimum of 600 hours of direct client contact for AQF Level 10 programs (Proposed Accreditation Standards, June 2016).
- *ANMAC Midwife Accreditation Standards* – 100 antenatal episodes of care; primary *accoucheur* for 30 women who experience a spontaneous vaginal birth; direct and active care to an additional 10 women throughout the first stage of labour and, where possible, during birth; caring for 40 women with complex needs across pregnancy, labour, birth or the postnatal period; attendance at 100 postnatal episodes of care with women and, where possible, their babies; 20 full examinations of a newborn infant (2014).

The requirement of health accreditation authorities for specific inputs, such as hours of workplace experience, needs to be reconsidered for three main reasons:

- 1) There is no evidence to justify the minimum hours requirement for clinical placement experiences, or models of supervision such as ratio of supervisor to student.
- 2) There is no uniformity in the application of this requirement among universities or across disciplines. It may be reasonable that differing amounts of clinical placement hours are required for different disciplines but there is no evidence to support this.
- 3) There is growing evidence that simulation learning can be an effective adjunct to learning during clinical placements. Simulation learning has always been a feature of healthcare training but advances have progressed to such an extent that simulation-based learning is equivalent to physical placements.

A landmark 2014 study completed in the United States found no statistically significant differences in clinical competency, comprehensive nursing knowledge or pass rates between students who had:

- (a) traditional clinical experiences;
- (b) 25% of their traditional clinical hours replaced by simulation; or
- (c) 50% of their traditional clinical hours replaced by simulation.¹¹

Further, in the first six months of their working life, no differences were found in manager ratings of overall clinical competency and readiness for practice. The results indicate that substituting up to half of traditional clinical hours with high-quality simulation experiences

¹¹ Hayden, J.K., et al (2014). 'The NCSBN National Simulation Study.' *Journal of Nursing Regulation*. Vol 5, Issue 2, July 2014.

produces “comparable end-of-program educational outcomes and new graduates that are ready for clinical practice”.¹²

This study suggests that high-quality simulation learning can be just as effective as learning on clinical placements. Consequently, all disciplines should recognise the value of this form of learning, without necessarily mandating it.

The context for the United States study was similar to that in Australia in terms of competition for clinical placement sites. However, simulation is not necessarily a cost-effective substitute for clinical placement. Simulation is not cheap if done properly and this form of learning must also have minimum standards surrounding it to safeguard and ensure its quality.

In summary, there may be some circumstances where input and process standards are warranted. These requirements can provide assurance that the key domains of discipline knowledge have been addressed (which will vary across disciplines). Nevertheless, ACU strongly believes that:

- i) greater evidence should inform these inputs; and
- ii) competency-based measures should be the key driver for the standards that are developed.

Recommendation: That input measures, such as the minimum 800 hours of workplace experience for the accreditation of Registered Nurses, be re-assessed for their validity and if there is no evidence to justify their inclusion, that they be removed. (A recommendation regarding simulation is contained in our response to issue #15).

¹² *ibid.*

Issue # 11 – Common elements in accreditation standards

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

ACU agrees with the 2014 Harmonisation Project's recommendation that accreditation standards be made as general as possible. Specific elements should only be included where necessary to take into account discipline-specific requirements.

ACU agrees with the Discussion Paper's observation that "given the apparent consistency in domains and roles across professions, including communication, ethical behaviours, leadership and collaboration, there is an opportunity to consider the application of the TLOs [threshold learning outcomes] and commonality more broadly".

The risk that general standards could ignore specific discipline requirements can be managed by individual disciplines having input into the process so that any documentation contains discipline specific information. In ACU's view, the benefits in terms of reduced duplication and cost outweighs this risk.

Recommendation: Accreditation standards with common health profession elements / domains should be pursued with appropriate discipline input.

Issue # 13 – Interprofessional education

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?

Interprofessional education (IPE) is a valuable mode of learning, however it is not a panacea for all health practitioner training. IPE, which requires students to learn with other disciplines, should not be mandated in standards or accreditation requirements, as there are great differences in how this can be implemented across institutions that teach different disciplines.

Disciplinary knowledge and learning should remain the priority, delivered in the context of a multidisciplinary health team.

Recommendation: IPE should not be mandated in standards or accreditation requirements.

Issue # 14 – Improvement of curricula and clinical experiences

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

The increasing number of students choosing to pursue careers in the healthcare sector has not been matched by an equivalent growth in the availability of clinical placements. In some instances, this increase in demand for places has forced up the price sought by some health providers for the limited places available. Moreover, the variability in cost across settings is unworkable, urgently requiring a national price benchmark for large disciplines.

The Discussion Paper correctly observes that “access to clinical placements and, in some cases, the fees charged by some health services for hosting these placements, impact upon the diversity of settings and experiences available to students to adequately achieve the skills and attributes required for professional practice”.

Clinical placements are still predominantly undertaken in public, metropolitan hospitals despite health service progressively moving away from acute (i.e., hospital) care to community care. ACU believes more placements should be made available in private, community based and preventative health care locations, not only to expand the supply of placements but to ensure that students’ experience matches real practice settings.

What was once a knowledge partnership between universities and health providers to train the future health workforce has become a more transactional relationship, where many providers seek to charge universities the full cost of – or even profit from – providing clinical placements. This marks a significant shift from former arrangements, whereby health providers used to pay apprentice wages to trainees in recognition of the direct clinical services they provided.

Benefits which flow to providers from training students include the value of their labour (e.g. caring for patients, general administrative tasks etc.) and the identification of individuals who can be offered work in the future.

Of course, these benefits are balanced by costs, as good providers take the time to explain procedures and convey knowledge to trainees. But any net costs are more than outweighed by the payments sought by health providers.

Further, notwithstanding anecdotal comments that students create increased workload for industry staff, evidence suggests that educator-student teams can actually achieve greater productivity for health services.¹³

¹³ See, for example, Susan Ash et al (2015), “Student and supervisor productivity change during nutrition and dietetic practice placements: a cohort study,” *Nutrition and Dietetics*, 72 (2):163-169; Ladyshewsky, R. K., et al. (1998), “A comparison of productivity and learning outcome in individual and cooperative physical therapy clinical education models,” *Phys Ther* 78 (12): 1288-1301.

In this context, it is inequitable for health providers, all of whom receive public funds, to shift the full burden of the cost of clinical placements to universities at the same time as receiving the benefit of the student's labour.

This cost-shifting also creates a deterrent for universities to offer certain health sciences courses, particularly where they may involve smaller or niche enrolments. If the current cost shifting model continues unchecked, it has the potential to negatively affect Australia's health workforce supply in the future.

Location

In Australia, as elsewhere, there has been a focus on primary (or non-hospital) rather than acute care and an investment in early intervention. However, this has not seen a complementary change in clinical training, which is still largely operating under an apprenticeship model (without the apprenticeship pay), focused on public hospitals.

In 2012 (the latest year for which national data is available), for example, about three-quarters of the almost 35 million health training hours in Australia were provided by public health services.¹⁴ The national figures also show that the proportion of training provided by the private sector declined by 7% between 2011 and 2012.¹⁵ As a University of Sydney study observed, "the shift to primary and community based care and to private provision has not been matched by a proportionate or significant increase in clinical placements in those settings".¹⁶

The public and not-for-profit sectors provide much of the clinical training yet many graduates end up working for private providers. The distribution of training and supervisory load is not well managed and clinical experience often does not match real practice settings.

It is not best practice for a large share of students to end up working for private providers and in community primary care health settings despite never having trained in these settings. A more coherent system would allow training to better reflect the locations where more health workers will work.

Efforts should be made to enable clinical placements to be expanded to smaller health providers. Many smaller providers have little or no experience in hosting placements and often do not see themselves as competent supervisors of students so appropriate resources and support should be made available to these smaller providers to allow them to offer clinical placements.

At the same time, smaller groups of students at smaller facilities would make it more labour intensive for universities to negotiate placements and more difficult for them to monitor and support these students. While primary health care networks are an ideal training environment, it is currently far simpler for a university to secure 100 placements with a hospital than to approach GP surgeries to seek placements for individual students. This is largely why only

¹⁴ Health Workforce Australia (HWA). (2013). *Clinical Training 2012: Survey Results June 2013*. p.9. 2012 is the last year that national data of this type was available from HWA.

¹⁵ *ibid.*

¹⁶ Buchanan, J., et al. *Student Clinical Education in Australia: A University of Sydney Scoping Study* (2014), p.10 & 29

half of one percent of ACU's placement hours occurs in GP clinics, despite such clinics growing in size and number in Australia.

To enable better penetration of clinical placements into private providers and local primary health care settings, accreditation agencies have a role to play in facilitating access to new clinical training arrangements. Adequate support and resources should be provided to assist new providers to offer placements. This would expand the number of clinical places whilst not unnecessarily increasing the burden on universities or new providers.

Cost

Medicine and nursing account for half of all health enrolments in Australian universities yet they take up two thirds of all clinical placement hours in Australia (36 and 30 percent respectively). They also experienced the largest total increase in training hours between 2011 and 2012 (the latest year for which national data is available).¹⁷

Shortages and consequent price hikes have emerged in response to this growth. In public providers, some jurisdictions have set a cost recovery approach (e.g. Victoria) but costs can be double in other jurisdictions that adopt a different approach. Private health providers have no limitations on the amount they charge for supervision of student placements yet universities have to utilise private providers to ensure sufficient placements are available for all students.

There is already intense competition among higher education providers vying to get the placements they need. Some private health providers have seen this competition as an opportunity to profit, offering placements to the highest bidder, as at an auction. There is no national cost benchmark that private providers have to abide by, even though these private providers receive public funds to operate.

The multiplicity of charging arrangements around clinical placements reflects the diverse circumstances that have evolved in different jurisdictions and different provider settings over decades. Many of these relationships have proven to be robust. But costs are rising and the different arrangements that existed in the past, as well as expensive new agreements, have led to a highly uncoordinated and increasingly unviable approach to the training of Australia's future health workforce.

Recommendation: Cost and location issues should be factored into accreditation standards so that Australia's future health workforce is not compromised. Mechanisms to expand the location of clinical placements as well as measures to reduce their escalating cost should be established and enforced.

¹⁷ Health Workforce Australia (HWA). (2013). *Clinical Training 2012: Survey Results June 2013*. p.8

Issue # 15 – Contemporary education practices

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

Simulation

Simulation-based education and training should be better incorporated into accreditation standards but should not be mandated.

As mentioned in the response to issue #8 above, high fidelity simulation is not cheap if done properly. In fact, it is very expensive for some disciplines and can even be more expensive than traditional models of clinical experience.

Simulation, however, can alleviate the extreme demand for clinical places by providing high quality training and has the benefit of exposing students to a broader range of experiences and cases than might be possible in a clinical setting.

ACU is strongly committed to high quality simulation and the ways in which simulation can be designed to represent authentic learning environments. Uniquely among Australian universities, ACU employs a Faculty Simulation Coordinator, who coordinates ACU's Graduate Certificate in Clinical Simulation and Education.

ACU supports rigorous quality assurance regimes to ensure sufficient standards of simulation learning. In regard to nursing specifically, ACU believes, as mentioned above, that ANMAC should build accreditation for simulation into existing program accreditation. ANMAC should recognise and regulate the role of simulation as an appropriate component of learning for clinical practice, without necessarily making it mandatory.

Clinical facilitators

The job of supervising student nurses is formally undertaken by clinical facilitators. Clinical facilitators are registered nurses (RNs) whose roles focus on clinical supervision and assessment and who facilitate learning for approximately eight nursing students at a time in a clinical setting.

In some jurisdictions (e.g. Victoria), the health service predominantly employs the facilitator ('in-house facilitation') but in other jurisdictions (e.g. NSW), the university is required to employ the facilitator on a contract basis, which is more expensive (due to on-costs and added administration) and also less effective because the facilitator may not have a pre-existing relationship or familiarity with the health setting where the placements occur. In practice, other RNs do most of the supervision but the clinical facilitator is the most significant cost.

Section 8.7 of the ANMAC Standards requires that "assessment of nursing competence within the context of the workplace experience is undertaken by an appropriately qualified registered nurse".¹⁸ These other RNs are authorised to complete students' clinical

¹⁸ Australian Nursing and Midwifery Accreditation Council (ANMAC). *Registered Nurse Accreditation Standards 2012*, section 8.7. (October 2012).

assessments but often do not because they view it as the facilitator's responsibility to make that assessment.

One of the main reasons NSW Health resists "in-house" facilitation is the view that it will add to nurses' already overstretched workloads. Health providers approached by universities regularly state that their staff are stretched to capacity and are unable to formally take on any more load. While this requirement forms part of the ANMAC Competency Standards, there is no incentive for RNs to supervise student nurses. The status quo in Australia is that supervising student nurses is an unrecognised, undervalued burden rather than a core competency in need of development.

In other allied health disciplines, hospital and industry based staff from the same discipline are frequently responsible for the clinical assessment of students' competency. This has now been accepted as part of the professional responsibility and role.

An obvious opportunity exists in Australia to recognise this undervalued training aspect of RNs' work via credentials provided by registration bodies that would be recognised by employers. This already occurs in the United Kingdom, where facilitators (or "mentors") play a central role in delivering clinical training. In the UK, the role of mentor is considered an important step in a nurse's career development. RNs are keen to become mentors because it is a requirement to gain promotion in the National Health Service.

In the UK, mentors undertake all clinical training and assessment of students when on clinical placements, which constitutes half of any pre-registration program.¹⁹ Universities deliver courses and annual updating training that RNs are required to complete in order to become and continue as a mentor. Such broad coordination and recognition of clinical placement work does not exist in Australia, where cost and placement variability is widespread.

The debate in the UK has moved on to whether all nurses should become mentors (the generic position) or whether it should be a separate career pathway for a few (the specialist position).²⁰ This is a very different debate from what is occurring in Australia, where facilitators may not even be employed by health services but rather on a casual basis by the university.

In Australia, there are no national standards for clinical facilitators. There is no definition for what the role is or what it entails, or what support is required to maintain competence through relevant knowledge and attributes. ACU urges national boards and their associated accreditation agencies to clarify the clinical facilitator role through credentials that would make more RNs want to be facilitators.

Recommendation: Accreditation standards should recognise but not mandate simulation as a component of clinical experience, and provide greater incentives for professions to supervise students through appropriate recognition and reward.

¹⁹ Levett-Jones, T. et al (2009). p. 13.

²⁰ King's College London. 'Should all nurses be mentors?' (Oct 2013).

Issue # 30 – National focus on advice and reform

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

ACU believes there is a need for a more holistic approach to the future health workforce.

The current, highly uncoordinated approach to the training of Australia's health workforce creates unnecessary costs for universities as well as a broad risk for the community by failing to ensure Australia's future health workforce needs are met.

The Organisation for Economic Co-operation and Development (OECD) has observed that Australia is experiencing a substantial expansion of its medical workforce that will improve access to health care but is placing stress on current training capacity.²¹

A lack of national vision and coordination is opening up cracks in the quality of the training provided. The escalating costs of clinical placements that are one result of this misalignment impacts universities directly and, ultimately, the health workforce as a whole.

Better accreditation arrangements may help rectify this problem. Embedding within the accreditation architecture a body such as the former Health Workforce Australia would help by reviewing education and training requirements and pulling together relevant information and future projections in the context of health workforce reforms. In its absence, there is likely to be duplication of effort with less informed outcomes and no-one providing an umbrella overview.

Recommendation: A national advisory body devoted to health workforce reform such as the previous Health Workforce Australia to be incorporated into health accreditation architecture.

²¹ OECD, *Health at a Glance 2013*. <http://www.oecd.org/australia/Health-at-a-Glance-2013-Press-Release-Australia.pdf>

Conclusion

ACU's submission outlines some of the inefficiencies and inadequacies in the current disjointed structure of health accreditation. These include:

- the duplication of onerous compliance regimes imposed by agencies that have authority over different components of the same double degree;
- process-based accreditation requirements that are generally unsupported by evidence and that take precedence over outcomes-based assessments of a graduate's competence; and
- contemporary practices, such as simulation training, that are not, or are insufficiently, incorporated into accreditation standards.

A number of ACU's concerns, however, are based not on the requirements imposed by national boards and their associated accreditation agencies, but rather on the functions they do not currently perform.

At its broadest level, health accreditation must facilitate the creation of the future health workforce that Australia needs. ACU believes the current system fall short in this regard by failing to foster what is arguably the most important aspect of health education, a student's clinical training.

The national boards do not provide incentives for professions to supervise students, nor do they coordinate supply, mandate cost, or put in place structures that allow a variety of clinical experiences in different settings to occur.

National boards and their associated accreditation agencies have focused on imposing requirements without appropriate regard to the increasingly unbalanced market for clinical training or facilitating the conditions where their requirements can be realistically met. Continuing to push the problem down to education providers that do not have the power or capacity to influence the supply of clinical placements is a recipe for compromising both the quantity and quality of the future health workforce. This has the potential to compromise the fundamental objective of any professional accreditation regime: to protect and develop its workforce, which is especially crucial in the case of a workforce so central to the future welfare of the Australian community.

For this reason, ACU also recommends the reinstatement of a body, such as the previous Health Workforce Australia, which can serve as a national source of analysis and evidence-driven reform of the health workforce and which should be incorporated into future health accreditation architecture.

APPENDIX A: ACU Faculty of Health Sciences

ACU is the world's largest English speaking Catholic university with more than 32,000 students and over 2,200 staff at seven campuses in five states and territories.

The Faculty of Health Sciences is the largest faculty within ACU, with over 16,000 students and almost 700 staff, and has a significant role in shaping the identity and reputation of ACU.

The Faculty prepares highly qualified graduates in the areas of:

- biomedical science,
- clinical education,
- clinical exercise physiology,
- counselling,
- environmental science,
- exercise science,
- health administration,
- healthcare simulation education,
- high performance sport,
- mental health,
- midwifery,
- nursing,
- occupational therapy,
- paramedicine,
- physiotherapy,
- psychology,
- public health,
- rehabilitation,
- social work and
- speech pathology

ACU has established a particularly strong reputation for producing high quality nurses to serve the Australian health sector, and continues to enrol more undergraduate nursing students than any other university in Australia. Currently, ACU has over 7,200 students enrolled in undergraduate nursing and midwifery courses.

The Faculty of Health Sciences operates on six of ACU's seven campuses (Brisbane, North Sydney, Strathfield, Canberra, Melbourne and Ballarat). Executive Dean Professor Michelle Campbell has overall responsibility for leadership and management of the faculty nationally.

The Faculty of Health Sciences has experienced an average annual enrolment increase of 15 per cent over the 2009-2015 period, primarily as a result of the introduction of the demand driven system. This growth has plateaued in recent years in line with overall growth in the higher education sector; however, the consolidation of this period of rapid growth is reflective of the continuing high demand for ACU Health Science courses.