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

APC Response
PART 1, APRIL 2017
# Table of Contents

Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions ................................................................. 4

1. Australian Pharmacy Council (APC) ........................................................................................................ 4
   1.1. History of the Australian Pharmacy Council .................................................................................. 5
   1.2. Accreditation Activities – our journey ......................................................................................... 5
   1.3. Collaborations ................................................................................................................................ 5
   1.4. International Benchmarking ......................................................................................................... 6

2. International Perspectives on Health Professional education Quality Assurance and Workforce Development ........................................................................................................ 6
   2.1. International Pharmaceutical Federation (FIP) ............................................................................ 6
       2.1.2. Transforming Pharmacy Education – Nanjing Statements and Workforce Development goals .... 7
   2.2. World Health Organisation (WHO) ............................................................................................... 7
       2.2.1. Guidelines on Education and Training Institutions ............................................................... 8
       2.2.2. Guidelines on Accreditation ................................................................................................ 9
   2.3. The National Academies of Sciences, Engineering and Medicine .................................................. 9
       2.3.1. Varying Views on Accreditation ............................................................................................. 10
       2.3.2. Competency-based Accreditation and Collaboration ........................................................... 11
       2.3.3. Engaging new partners in Accreditation ................................................................................. 11
       2.3.4. Moving forward .................................................................................................................... 11
       2.3.5. Summary of the workshop ................................................................................................... 12
   2.4. Relevance to the Australian context ................................................................................................. 13

Responses to questions within the Discussion Document .............................................................................. 14

1. Improving efficiency ............................................................................................................................. 14
   1.1. Accreditation standards ............................................................................................................... 14
   1.2. Training and readiness of assessment panels ............................................................................... 17
   1.3. Sources of accreditation authority income ................................................................................... 18

2. Relevance and responsiveness ........................................................................................................... 19
   2.1. Input and outcome based accreditation standards .......................................................................... 19
   2.2. Health program development and timeliness of assessment ......................................................... 21
   2.3. Interprofessional education, learning and practice ........................................................................ 24
   2.4. Clinical experience and student placements .................................................................................. 24
   2.5. The delivery of work-ready graduates ........................................................................................... 26
   2.6. National examinations ................................................................................................................. 29

3. Producing the future health workforce ................................................................................................. 31
   3.1. Independence of accreditation and registration ............................................................................ 31
3.2. Governance of accreditation authorities .......................................................................................... 31
3.3. Role of accreditation authorities .................................................................................................... 32
3.4. What other governance models might be considered? ................................................................... 33
3.5. Accountability and performance monitoring .................................................................................. 37
3.6. Setting health workforce reform priorities .................................................................................... 37
3.7. Specific governance matters ........................................................................................................... 38
    3.7.1. The roles of specialist colleges and post-graduate medical councils ........................................ 38
    3.7.2. Assessment of overseas health practitioners ............................................................................ 38
    3.7.3. Grievances and appeals ............................................................................................................ 40
4. References ........................................................................................................................................... 41
5. Appendices .......................................................................................................................................... 43
Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions

1. Australian Pharmacy Council (APC)

The Australian Pharmacy Council Ltd (APC) is the independent accrediting authority for pharmacy education and training. APC plays a key role in protecting public safety by ensuring high standards of pharmacy education, training and assessment.

APC welcomes the release of the Independent Review of Accreditation Systems (ASR) within the National Registration and Accreditation Scheme (‘NRAS’, or ‘the Scheme’) for health professions. The questions raised by the Review team allow all of us to reflect on how we continue to meet the objectives and guiding principles of the NRAS scheme. At APC, we are committed to consultation and collaborative working to ensure continuous improvement of: the accreditation of pharmacy education programs, the examination of interns, and the assessment of overseas qualified pharmacists. This will ensure that the profession has the skills and knowledge to deliver effective health care to meet the evolving needs of the community and professional practice.

APC processes encourage innovation in education and training. APC acknowledges the balance between regulatory controls and voluntary action in achieving system and cultural change. Responsive regulation is an approach that values trust, transparency and professionalism.

APC also cooperates with international bodies and maintains a strong presence in the International pharmacy space, to ensure best world practice and innovation are introduced in the Australian environment.

Diagram of the life cycle of APC activities
1.1. History of the Australian Pharmacy Council

The Australian Pharmacy Council (APC) has been operating in various forms for 35 years. In 1982, the Australian Pharmacy Examining Council (APEC) was formed to assess and examine overseas trained pharmacists, alongside the Association of Pharmacy Registering Authorities (APRA), which was the national body for the State and Territory Pharmacy regulators. The New Zealand and Australian Pharmacy Schools Accreditation Committee (NAPSAC) was formed in 1998 to accredit pharmacy programs under APRA. In 2001, APRA became the Council of Pharmacy Regulatory Authorities (COPRA), and in 2006 APC Inc. was established as an incorporated society, merging the activities of both APEC and COPRA.

In 2009, in anticipation of NRAS, and to meet the Australian Health Workforce Ministerial Council requirement that the accreditation function be independent of government the Australian Pharmacy Council Ltd was formed as a company limited by guarantee with the State and Territory Pharmacy regulatory boards as members. On 1 July 2010 a new constitution and membership of APC Ltd commenced, with members from the Pharmacy professional bodies, pharmacists, educators and community members.

1.2. Accreditation Activities – our journey

APC accreditation functions since the commencement of the modernised national regulatory system for health professionals under the National Registration and Accreditation Scheme (NRAS).

For a timeline of our journey, please see Appendix 1.

1.3. Collaborations

APC works with other professional bodies and accreditation councils at a national and international level to ensure that our processes are evidence informed and that we are efficient and effective. As an active member of the Health Professions Accreditation Councils’ Forum (‘HPACF’ or ‘the Forum’) we are committed to working collaboratively to facilitate consistency in approach, while maintaining our individual profession-specific requirements. This includes sharing innovations, policies and procedures.

APC connections and collaborations in this field include the following:

- As a facilitator of conversations with stakeholders; from 2013 – 2015 APC held an annual series of Colloquia on topics including outcomes-based standards, experiential placements [1]
- APC has a close relationship with the Pharmacy Council of New Zealand, as a valued partner, to whom APC provides all accreditation services [2]
- APC acts as an active member of the Health Professions Accreditation Councils’ Forum (the Forum), and an elected member of the Accreditation Liaison Group.
- As a member of the standards-development working group for the Physiotherapy Council, APC contributed to the development of the new physiotherapy degree standards, and will use this background to assist in the review of the upcoming pharmacy degree standards
- APC is seen as a leader in quality assurance in the international pharmacy arena – APC was invited to give a plenary speech at the International Pharmaceutical Federation Global Education conference in Nanjing, China in 2016. [3], and
- In 2017 APC moved offices to be located within an “accreditation precinct” in Canberra with the Australian Nursing and Midwifery Council and the Australian Medical Council to facilitate continuing collaborative work.
1.4. International Benchmarking

APC accreditation processes are informed by the best available evidence and international benchmarks to ensure the most appropriate and relevant standards for our local needs. This includes both local accreditation councils for health professions within Australia and, internationally, within the pharmacy sector.

Our connections and benchmarking include the following:

- As a member of the International Pharmaceutical Federation, APC contributes to policy documents, reports and the development of guidelines
- Under a Memorandum of Understanding with the Accreditation Council on Pharmaceutical Education (US counterpart), APC shares processes and standards
- Under a Memorandum of Understanding with Royal Pharmaceutical Society (UK), APC shares processes and standards
- Regular annual meetings with the General Pharmaceutical Council (UK) are held, in which we share processes and standards
- APC invites prominent International guests to bring their advice, experience and knowledge in its Colloquia and research developments.

2. International Perspectives on Health Professional education Quality Assurance and Workforce Development

2.1. International Pharmaceutical Federation (FIP)

The International Pharmaceutical Federation (FIP) is the global federation for pharmacy that represents three million pharmacists and pharmaceutical scientists worldwide. The Education division of FIP, called FIPEd, is working to stimulate transformational change in pharmaceutical education and engender the development of science and practice, towards meeting present and future societal and workforce needs around the world. APC is well recognised by this group to be at the forefront of innovation.

FIPEd advocates for the use of needs-based strategies where pharmacy education is socially accountable, where practice and science are evidence-based and where practitioners have the required competencies to provide the needed services to their communities.

FIPEd aims are to:

- Provide a global platform for exchange, mentoring and learning for leaders and academics, focussing on the development of leadership skills and academic management and pedagogic skills;
- Build, advocate for, and disseminate evidence-based guidance, consensus-based standards, tools and resources for educational development for both organisations and practitioners.

The FIPEd aims align strongly with the WHO guidelines, and there is a strong connection between the two organisations and their missions.

2.1.1. Quality Assurance of Pharmacy Education; the FIP Global Framework, 2nd Edition

In 2008 the first version of the FIP Global Framework for Quality Assurance of Pharmacy Education Version 1, was adopted and published by the International Pharmaceutical Federation (FIP). In 2014 this was updated to the current framework Quality Assurance of Pharmacy Education; the FIP Global Framework, 2nd Edition. These guidelines, which have been validated by a number of member organisations, include the following sections:
• Section A provides the context for quality assurance of pharmacy education and the important role that it plays not only to assure quality but to support initiatives that aim to expand and advance pharmacy education at the national level
• Section B provides quality criteria and quality indicators for pharmacy education
• Section C provides a framework for a national quality assurance system, either governmental or non-governmental
• Section D provides a glossary of terms, explaining how they are used in the document

We, at APC, have contributed to the development and validation of this Global Framework leadership through membership of the FIPEd Quality Assurance Domain.

2.1.2. Transforming Pharmacy Education –Nanjing Statements and Workforce Development goals

In 2016 the FIP convened an inaugural Global Conference on Pharmacy and Pharmaceutical Education in which pharmacy leaders and educators from around the world came to consensus on a strategy to create a shared vision to improve health through transformative pharmacy and pharmaceutical sciences education. The results of the conference were the development of the Nanjing Declaration, Statements and workforce development goals. APC contributed to the development of these strategic goals through our membership of FIP and FIPEd.

2.1.2.1. APC Leadership in Quality Assurance

Australia is seen as a leader in pharmacy education accreditation in the international pharmacy arena. Our APC CEO was invited to give the plenary speech on Accreditation, entitled “Quality, accreditation and regulation of Education and Training” to the international audience at this Global Conference on Pharmacy and Pharmaceutical Education. [3].

This presentation is in Appendix 2.

2.1.2.2. Pharmaceutical Workforce Goals

FIP have agreed on 13 Workforce Development Goals, which are grouped into three clusters. Of these, the Goals of Academic Capacity and Quality Assurance are particularly relevant to the APC’s work. [5]

2.1.2.3. Nanjing Statements

The Nanjing Statements on Pharmacy and Pharmaceutical Sciences Education were agreed across the member organisations of FIP in November 2016 at the Nanjing Conference. [3]

As an FIP Member, and key member of the FIPEd Quality Assurance Domain, APC was involved in the development of these goals and they reflect our practices and policies within Australia and New Zealand.

2.2. World Health Organisation (WHO)

In 2013 the World Health Organisation issued its guidelines for “Transforming and Scaling up Health Professionals’ Education and Training. [6]. These guidelines are to address the “political commitment to reform of health professionals’ education; formal collaboration and shared accountability between ministries of health, education and other related ministries; linkage to a national planning process; and the creation or strengthening of national and sub-national institutions.”
The report includes a set of recommendations that are evidence-based, practical and relevant to ensure a global health workforce that meets the needs of the 21st century.

The authors state that the “primary beneficiaries of these Guidelines are policy and decision-makers in the health and education sectors, educators, and future and current health professionals. However, the Guidelines are conceived for the ultimate benefit of users of health services, whose needs should determine the quantity, quality and relevance of the education of health professionals. The Guideline recommendations can be strong or conditional depending on the quality of the supporting evidence, the balance of benefits and harms, resource use, feasibility and acceptability”.

The WHO Guidelines are broken into five domains: Education and training institutions, Accreditation and regulation, Financing and sustainability, Monitoring, implementation and evaluation, and Governance and planning.

These guidelines are a relevant source for consideration in the reform of health professional education, workforce development and accreditation in Australia. The interactive e-platform contains easily accessible tools to support implementation of these goals. [7]

Transformative scaling up of health professionals’ education and training is defined as:

“the sustainable expansion and reform of health professionals’ education and training to increase the quantity, quality and relevance of health professionals, and in so doing strengthen the country health systems and improve population health outcomes.”

2.2.1. Guidelines on Education and Training Institutions

The need to achieve national and global health objectives has focussed attention on Global Health workforce education. The Lancet Commission has identified a series of reforms of education processes needed for health systems to effectively answer population needs. [8]. These reforms aim to develop competencies in a workforce that is responsive to local needs, but connected globally.

The authors also define three generations of reform over the past century; science-based, problem-based and systems-based, and the WHO guidelines are aimed at assisting this reform. See diagram below. [8]

---

[8] The WHO Guidelines address the following issues; faculty development, curriculum development, simulation methods, admissions and interprofessional education.
2.2.2. Guidelines on Accreditation

The Recommendation for Accreditation within the WHO guidelines is “National governments should introduce accreditation of health professionals’ education where it does not exist and strengthen it where it does exist.”

The commentary provided within the guidelines states that there is limited literature on advantages and disadvantages of the different systems of accreditation that may be performed by government, independent organisations, professional associations or private companies, or on the impact of accreditation on quality improvement.

“Nevertheless, it is generally considered that accreditation can have a significant positive effect on the quality and relevance of the health workforce in that it can guide professional education in addressing the priority health concerns of the community. A global strategy that incorporates the best of all practices with clear targets and outputs could encourage regions to create and reinforce national accreditation systems. In order to be effective, such a global system should be based on standards developed and accepted by all stakeholders. The process of accreditation should be independent and transparent so as to be a stamp of quality (Baumann and Blythe 2008). Accreditation status should be time-limited, and the accreditation system itself should be periodically evaluated.”

And furthermore:

“The lack of evidence and studies assessing the impact of health professionals’ accreditation as part of regulation does not mean that there should be no regulation. Indeed, in spite of the low quality of evidence, the panel decided to issue a strong recommendation because a very high value was placed on an uncertain but potentially important impact on both the quality and relevance of the health workforce.”

As stated within this “the process model that includes: self-evaluation based on agreed standards; a peer review that usually includes a site visit; and a report indicating the outcome of the accreditation (full accreditation, conditional accreditation and no accreditation). A ministry, a professional regulatory body, a national accrediting body or a professional society may carry it out.”

Looking further into the literature, there is the question of how social accountability can be built into the curriculum, as well as responding to global harmonisation challenges. “The importance of global principles with context specificity is ever more relevant for professional education in our mobile and interdependent world. Global principles would bring consistency, transparency, and open accountability to the accreditation process, while easing the emergence of communities of knowledge and practice. Uniformity across countries could have, however, the unintended consequences of helping with professional migration across national boundaries. Local adaptation would be necessary to adjust and implement global trends in specific settings for clinical practice, pedagogy, gaining of credentials, and evaluation, while maintaining sufficient flexibility for innovation and reform.”[8]

The online tool for these guidelines poses questions for the use of the guidelines for policy makers and stresses the importance of ensuring the system is context-specific and relevant for the population. [9]

2.3. The National Academies of Sciences, Engineering and Medicine

In April 2016, members of the Global Forum on Innovation in Health Professional Education, (of the Health and Medicine Division of the National Academies of Sciences, Engineering and Medicine), convened a workshop entitled “Exploring the role of accreditation in enhancing quality and innovation in health professions education” [10]
The aim of the workshop was to explore global shifts in society, health, health care, and education, and their potential impact on general principles of program accreditation across the continuum of health professional education (foundational, graduate, and continuing professional development).

The workshop engaged health professional educators, accreditors, and others to explore such topics as:

- Improving the efficiency and cost of accreditation (e.g., harmonisation of competencies across professions, joint accreditation, etc.)
- Engaging new partners in accreditation (e.g., individuals, communities, and populations)
- The role of accreditation as an element in achieving quality health care delivery and quality health professions education
- Challenges and opportunities for accreditation (e.g., accrediting non-traditional educational models, countries with no or inadequate accreditation systems).

The Global Forum had previously explored topics including interprofessional education (IPE) and training, trans-disciplinary professionalism and health professional education. This workshop aimed to build on these to explore the implications of introducing innovations into the health professions’ accrediting process.

The report of the workshop outlines the discussions that were held, but is not a consensus study report. As stated in the introduction, “Unlike consensus study reports that offer in-depth reviews of the evidence on somewhat narrowly defined topics, workshops at the National Academies are designed to bring different voices together to illuminate topics and inspire creative thinking across professions and sectors.” [10]

Despite this, the report is stimulating reading and illustrates that the challenges faced in the US are similar to those we face in Australia with the balance of regulation/accreditation and innovation weighed up with costs and outcomes for the public.

This workshop report contains a considerable amount of information and ideas relevant to the current review, and some key messages from the report are outlined below:

### 2.3.1. Varying Views on Accreditation

A summary of the discussion on accreditation processes overall included the following key messages:

- While accreditation of professional preparation programs can ensure that students are receiving educational content considered necessary by the profession for entry into practice, accreditation alone cannot decide what those standards are.
- The interests and concerns of government and regulators are broader than those of individual professions. This context presents a critical set of challenges for accreditation.
- Each profession's dialogue addressing innovation within accreditation will vary depending on the culture of the individual profession.
- The trend in accreditation is moving from a focus on structure and content to a focus on process and outcomes.
- To improve quality of education in a particular area, it is not enough to identify a particular topic of education to be addressed through accreditation standards. There are issues that surround the topic—such as the accreditor’s role in implementation and whether the accreditor provides guidance on quality improvements or a pathway to implementation—that also need to be considered.

### 2.3.2. Competency-based Accreditation and Collaboration

A summary of the debates on competency-based accreditation and collaboration included the following key messages:
Accreditation bodies could be incentivised to work more collaboratively with individuals and groups outside of their professional siloes in an attempt to lighten the administrative burden on accredited institutions or programs who must answer to multiple accrediting agencies.

When encouraging interprofessional training and practice, it is important to first start with the process of building a vision and engaging the community, and then work backward into competencies, including interprofessional competencies.

Competency-based professional standards could be incorporated across the continuum of education, from the pre-service degree level to residency programs, continuing education, and certification.

Accreditors could develop competency-based professional standards using evaluations from both a quality assurance and quality improvement perspective.

There are many benefits of greater collaboration among stakeholders, including cost savings and efficiencies through economies of scale, as well as developing a common understanding of what each entity or group does to add meaning to processes.

2.3.3. Engaging new partners in Accreditation

A summary of the discussion held on engaging patients and clients with a more person-centred approach to accreditation included the following key messages:

- A person-centred philosophy [involves] a strong survey process and collaborative partnerships for enhancing the life of the individual who is being served through accredited programs
- Accreditation can stimulate innovative models, and accreditation can be part of this
- The ability to work effectively across national and regional borders requires time, trust, relationships, understanding, respect for other’s professions, an awareness of societal and professional needs, and sufficient resources to address challenges and create opportunities
- There must be a single language used for an accreditation system. A challenge will be the moving of the accreditation system from multidisciplinary into interdisciplinary through to trans-disciplinary
- Breaking the barriers is difficult when some of the professionals work in silos or interact with more ease amongst their own domain. Such barriers can be linked to time or resource scarcity and prioritisation that does not favour interprofessional cooperation.

2.3.4. Moving forward

This session focused on how accreditation could facilitate the advancement of core competencies including IPE and social determinants of health, with the following key messages:

- For accreditation standards to be in a position to include core competency concepts, there first needs to be agreement on what those core competencies should be; in order to achieve this, collaboration across disciplines and a linkage between education and practice has to exist.
- One Health and the social determinants of health are two examples where stakeholders are changing curricula and their approaches in order to incorporate these topics into education and improve health outcomes.
- Institutions could start with a focus on the needs of the patients and communities, and then move their focus toward what competencies faculty require in order to train or mentor their students in how to address these needs.
- Accreditation expectations of continuing education providers can be adjusted in order to incentivise groups and institutions to provide interprofessional continuing education.
Innovation in accreditation begins with new perspectives. By bringing people together with different perspectives one can see the problem in a different way, and devise more robust and more exciting solutions.

The operational elements of accreditation and the strategic thinking processes are important, but the discussion should be framed around social accountability, specifically health and well-being, instead of health care alone.

There is an increasing sense of urgency to transform health professional education; while the movement to adopt core competencies across professions and address common educational issues among professions is underway, it is moving too slowly relative to the rapid changes in the health care system.

2.3.5. Summary of the workshop

A final summary of the workshop included the following points:

- **Vision is (almost) everything**
  - Social accountability: health, wellness rather than health care
- **Aligning clinical accreditation and educational accreditation is critical**
  - Social accountability: patient-centred care
- **Conceptual models of accreditation are generative**
  - Recognise the tension between profession, accreditors and regulators
- **Collaborative partnerships diminish tensions and drive change**
- **Team-based care and IPE can be used to leverage change**
- **The need for change is ubiquitous, but implementation strategies are scarce**
  - “The what is clear, the how is much less so”
- **Enhanced outcome measurement (and validated toolkits) is much in demand**
  - Distal outcomes (related to individual and population needs) should take precedence over proximal (learning) outcomes
- **Blueprints can be helpful but context may dominate!**
  - Clashing cultures often bedevil innovation
- **Resource redistribution is essential!**
  - It’s a “zero sum game”
- **Leadership, leadership, leadership**
- “The main task of leadership is to manage uncertainty and foster collaboration”

![Figure of Illustration of health and education systems](11)

The full workshop program and presentations are available online. [12]
2.4. Relevance to the Australian context

The discussions and outcomes of this workshop have considerable relevance to the Australian context of health professions education and accreditation. Despite the differences in the health care policy framework between the USA and Australia, the issues that are raised mirror those being considered within the Discussion Document, and the Scheme as a whole.

The US accrediting agencies are predominantly private bodies, and these organisations are independent organisations, not government authorities. Nationally recognised accrediting authorities in the USA are sometimes, but not in all cases, members of the Council for Higher Education Accreditation (CHEA), which is the primary national voice for accreditation and quality assurance to the U.S. Congress and U.S. Department of Education. [13]
Responses to questions within the Discussion Document

1. Improving efficiency

APC is committed to continuous quality improvement and are constantly working to improve the efficiency of our operations. This has included the following:

- **2012**
  - Consultation on new outcomes-based degree program standards

- **2013**
  - Consultation on and production of the evidence guide for the outcomes-based degree program standards

- **2014**
  - Implementation of outcome-based standards for degree programs

- **2015**
  - Revision of our Constitution, reduced size of our Board and reduced number of sitting days
  - Revision of APC standing committees – removed Examining Committee
  - Completion of an organisational restructure and reduction in FTE by 10%
  - Transition of all examinations to computer-based delivery across the world

- **2016**
  - Revision of the governance of accreditation to ensure better responsiveness and more efficient process
  - Implementation of a smaller skills-based Accreditation Committee with more frequent meetings
  - Reduction in the size of our Accreditation Site Evaluation Teams (SETs) from 6 to 5 members
  - Revision and implementation of a risk-based accreditation decision making framework
  - Signed an Memorandum of Understanding (MoU) with TEQSA

- **2017**
  - Revision and streamlining of reporting times for monitoring/conditions following feedback from Schools of Pharmacy
  - Further reduction of the size of Accreditation SETs (panels) from 5 to 4 members
  - Further reduction of APC FTE by 15%

For a diagram of timeline of APC activities, please see Appendix 1.

1.1. Accreditation standards

Question 1. What would be the benefits and costs of greater consistency and commonality in the development and application of accreditation standards?

It should be recognised that currently each profession within the Scheme is at a different point along the continuum of implementation of accreditation standards and processes. Some professions did not have national accreditation standards prior to 2010 (or 2012 for the more recently added professions) whereas others such as pharmacy and medicine have been operating for over 35 years. Therefore, at the beginning of the Scheme, some professions had standards already in place which required adaptation to the Scheme, and others started from scratch.
Prior to NRAS, the pharmacy accreditation standards in place had been set in 2005. Post – NRAS pharmacy was one of the first professions to review accreditation standards and developed outcomes-focused standards in 2012. These standards were approved by the Pharmacy Board of Australia (PharmBA) in December 2012 and became effective from 1 January 2014. At this stage, very few of the professions had reviewed or implemented outcome-based standards, and we benchmarked the new standards against those in medicine and international pharmacy standards; the result of this was a set of standards that were contemporary and reflected good practice at the time.

Accreditation standards are generally reviewed every five years within the Scheme – this has been the case for all the professions. Development of standards must be compliant with the AHPRA Procedures for the development of accreditation standards framework, http://www.ahpra.gov.au/Publications/Procedures.aspx which includes consultation requirements and a regulatory impact assessment through the Office of Best Practice Regulation.

The PharmBA has agreed that we will review the standards in 2018, which will allow new standards to be developed within the five-year window and implemented in 2019.

In preparation for this next standards review:

- We support having a common structure and terminology of language within standards, and will implement this for the next round of standards development
- We have met with the Australian Nursing and Midwifery Accreditation Council (ANMAC) and agreed to share a shortened process, and be on their Review Committee
- We will endeavour to develop standards that are in line with the Higher Education Standards Framework standards that the Dental and Optometry Councils have recently implemented
- We have advised the PharmBA of this proposed methodology

We support a greater consistency in data collection and sharing amongst the accreditation authorities. The next stage of enhancement of our IT Customer Relationship Management (CRM) system is to develop an accreditation portal, and we suggest that this could be implemented to specifications agreed between the Councils within the Health Professions Accreditation Council’s Forum and Universities Australia.

We are already progressing a greater consistency and does so through two means: Strengthening relationships with other Councils and professions, and developing a modern IT system to underpin such developments

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

TEQSA’s role predominantly concerns the student experience whereas the role of APC, as a professional accreditor, is that of public safety; hence these responsibilities are complementary. Our standards and processes recognise those of TEQSA, and more than 95% of what we assess is profession-specific.

As our standards were written in 2012, effective 2014, the reference to TEQSA that is made within the standards was contemporary at the time, due to the continuing evolving role of TEQSA and the Higher Education standards framework.

In our standards, education providers are able to provide evidence for the pharmacy–specific components. For example, the ability of a School of Pharmacy to have and to be able to demonstrate the appropriate autonomy with respect to financial accountability is a profession-specific requirement, and is articulated in our standards. Similarly, the Governance standard is related to ensuring that the School of Pharmacy is well governed within the whole university structure.
In 2016 we signed a Memorandum of Understanding with TEQSA, which outlines how we will share information between each other’s agencies. This facilitates dialogue with education providers if deemed appropriate.

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

There are benefits with a risk-based accreditation process and at APC we have adopted such an approach. We have implemented a risk-based cyclical approach; a hybrid approach of determining the length of the cycle dependant on a number of risk factors. This framework is based on a review of the literature.

We define an accreditation risk as:

‘A risk is any potential or actual event, decision, action or inaction that could affect a program or education provider’s compliance with the Standards.’

The period of accreditation awarded to a program is determined by the risk factors, including numbers of conditions and/or monitoring requirements. The maximum period of accreditation is six years and is available to programs that are determined to have a low risk. Moderate and high risk programs are required to demonstrate progress and improvements for certain standards to reduce their risk rating and increase their accreditation period up to the maximum of 6 years.

*The APC Risk Decision-making Framework is in Confidential Attachment 1*

Our experience is that over a period of accreditation there is likely to be evolution of the program to meet the changing demands of graduates and a cyclical review is therefore of value. Whether there could be an open-ended cycle is yet to be proven in professional accreditation for health professions with a high level of risk – there is no precedent for open-ended accreditation in the profession of pharmacy across the six countries compared in the ALG paper “Comparisons of international accreditation systems for registered health professions” [13].

Additionally there are continuous changes in curriculum with new modalities and modifications to scopes of practice (e.g. genomics, vaccinations, prescribing) as well as new approaches to educational delivery that need to be considered.

Our Risk Decision-making Framework gives the PharmBA confidence in the process of determining whether the applications of conditions/monitoring or a reduced cycle of accreditation are appropriate and necessary to ensure the outcomes of the program.

In 2016, after extensive consultation with our stakeholders, we extended the maximum period of accreditation to six years, dependent on the risk profile.

Our view is that continuous monitoring without an accreditation cycle could indeed result in a greater burden for education providers, due to an apparently continuous requirement for change reporting; this could be an unintended consequence.

“Regulation can be a barrier to innovation if it is too rigid, excessive or not responsive to evolving needs. Rules and norms can also be too costly to implement and therefore deprive institutions of resources that could be devoted to improving their performance. A balance between flexibility and effectiveness needs to be found. For example, a recommendation to regulate the creation of schools and programmes should ensure that the conditions for doing so do not generate disincentives and subsequently hinder the expansion of the supply of educational opportunities.

When there is no mechanism to ensure that students in the same profession receive the same quality of education, some form of regulation is needed; but to what extent should there be standardization of curricula and teaching strategies, without limiting space for innovation and adaptation to changes in the environment or allowing for cultural variations between countries or regions within countries? There is no easy answer to
the question of the extent of regulation. Each country has its own cultural and legal traditions and specificities, and what is acceptable in one country may not be in another. However, the criterion that policymakers should use is the same everywhere: which regulation will contribute more to improving the quantity, quality and relevance of health professionals?" [6]

1.2. Training and readiness of assessment panels

Question 4. What changes could be made to current accreditation processes (such as selection, training, composition and remuneration of assessment teams) to increase efficiency, consistency and interprofessional collaboration?

APC processes for training and selection of Site Evaluation Teams (SETs) are well established and seen as leading practice across the health professions.

We provide SET members with a comprehensive manual, templates and application materials to support them through the process of reviewing a university program.

In 2012 we published 4 online training modules which we also made available to other professions. The descriptions of each module are outlined below:

**SET Module One** provides you with an overview of the APC accreditation framework which ensures the quality, consistency and rigor of standards and audit processes. You will learn about the role of the SET and its unique value to the process and your roles and responsibilities within the SET. The module provides you with a timeline of the typical process and what to expect at each stage.

**SET Module Two** focuses on how to prepare for a SET audit and undertake an initial assessment of an application, ready for the site visit.

**SET Module Three** outlines methods and tips to conduct an on-site audit which focuses on evidence-gathering against the APC guidelines and standards.

**SET Module Four** *(optional)* provides you with techniques and tools to enable you to contribute to the development of an evidence-based report against the APC guidelines and standards. (SET Chairs may find this module very relevant).

We include accreditation SET members from across professions when this is necessary; for example, for the New Zealand Pharmacy Prescriber program accreditation that we conduct on behalf of the Pharmacy Council of New Zealand, we used Medical Practitioners as part of the Evaluation team. See https://www.pharmacycouncil.org.au/education-providers/prescribing-programs/

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

The importance of consumer involvement in accreditation, as the ultimate “recipients” of the products of accreditation, is a principle that APC works towards. In 2014, the Josiah Macy Jr. Foundation in the USA held a conference called “Partnering with Patients, Families, and Communities to Link Interprofessional Practice and Education” which then recommended a summit of education accreditors and professional certification bodies with education leaders, clinicians, patients, families, and communities be convened to produce a framework and a position statement to set a commitment and action plan for incorporating partnerships with patients, families, and communities into accreditation and certification of health professionals. [14]

The outcomes of the conference further reflected; “Large-scale transformation of education for healthcare professionals will not occur without the commitment of educational organizations and program leaders, who are heavily influenced by their respective accrediting bodies and the professional requirements for
certification. Therefore accreditation and certification standards can catalyze the incorporation of partnerships with patients, families, and communities into both educational curricula and the clinical practice experience. Redesigned accreditation standards and certification competencies will speed dissemination of the structure and process elements needed to foster partnership in education and training processes. They will also encourage organizations to change more rapidly towards the professional culture, attitudes, and behaviors necessary for genuine partnership with patients, families, and communities." [14]

APC governance of accreditation includes the use of appropriately constituted Site Evaluation Teams (SET), trained auditor accreditation staff as support, and final consistent decision-making from the APC Accreditation Committee. The SET itself makes recommendations to the Accreditation Committee, which then makes the accreditation decision.

The Accreditation Committee has delegated decision-making powers from the Council, and is a skills-based committee constituted with pharmacists, other health professionals and consumers. The Accreditation Committee By-Law was established in 2016. [15] This committee makes consistent decisions within a decision-making framework, approved by the PharmBA.

Our view is that the consumer is best placed on the decision making Accreditation Committee. We do, under some circumstances, include a member of another profession within the team - as outlined above for the New Zealand Pharmacist Prescriber course accreditation.

1.3. Sources of accreditation authority income

Question 6. What should be the key principles for setting fees and levies for funding accreditation functions, including how the respective share of income provided from registrants and education providers should be determined?

We consider that all users should contribute to the Scheme, that is, registrants, education providers, and, recognising the public benefit of safe and competent health practitioners, public funding.

Prior to the commencement of the Scheme, each state and territory pharmacy registration board paid a per-registrant fee to APC. Since the Scheme began, National Boards have funded accreditation authorities according to historic relationships, and not according to any specific model. This has not proved to be a satisfactory funding approach and has resulted in different fee structures for each profession.

AHPRA and the National Boards have not been able to agree on funding principles. We have been keen to advance the work commenced on this in 2016 to define such principles, but, to date, these discussions have not progressed and the principles have not yet been agreed.

In 2010, the PharmBA initially informed APC it would not contribute any funding to the APC for accreditation. Based on that tenet, APC set fees for education providers; these were recalculated once the funding was agreed for the PharmBA to make a contribution based on historical precedent, and reduced to the levels commensurate with those of today, plus some CPI increments.

As demonstrated in the Accreditation Liaison Group (ALG) costings paper we have consistently received one of the lower per-registrant amount of accreditation funding from a National Board when compared to other professions, with 3 – 6% of the per-registrant income being expended on accreditation over the three year period quoted. [16]

Question 7. Should fees charged for the assessment of overseas qualified practitioners and assessment of offshore competent authorities be used to cross-subsidise accreditation functions for on shore programs?

As the threshold standards for registration of both domestic and overseas trained pharmacists are the same, there are obvious commonalities in the assessment and accreditation functions. An overseas trained
pharmacist is required to demonstrate equivalency of competence to an Australian graduate in order to be eligible to gain provisional registration with the PharmBA and enter an internship. Therefore the development work in examinations and assessments is closely interlinked with that of accreditation of domestic programs.

There are potential advantages to cross-subsidisation for education providers under the current process, in the same way that some education providers benefit from the income from international students. However, this is subject to government migration policy and other economic factors, which are both out of APC’s control.

For these reasons, there has been, and will continue to be, a level of cross-subsidisation of the examinations functions with accreditation functions of APC. However, APC does not allocate registrants’ (PharmBA) income to the accreditation functions. Without a change in the agreements for the funding formula, as described in 6, above, then any proposed or suggested change may not be possible.

2. Relevance and responsiveness

APC is well-connected with policy and the profession, and open to discussion with consumers and indigenous health groups, and has achieved the following:

- **2014**
  - implementation of outcome-based standards for our degree programs
  - identification of the need for standards for pharmacists to administer vaccinations and commencement of wide consultation

- **2015**
  - publication of accreditation standards for training courses for pharmacists undertaking vaccinations
  - accreditation for two new, innovative pharmacy degree programs “BPharm Management” and “MPharm International”
  - completion of a pilot to recognise Advanced Practice Pharmacists (Non-NRAS)
  - worked with Australian Medical Council (AMC), Australian Nursing and Midwifery Accreditation Council (ANMAC) and Council on Chiropractic Education Australasia (CCEA) on an Interprofessional Workshop to agree on IPE Competencies

- **2016**
  - commencement of a project for the PharmBA to review the Intern Year summative assessments – the Intern Year Blueprint Project
  - presentation of our IPE work at the International OTTAWA and ANZHPE Conference with AMC
  - consultation with Indigenous Allied Health Australia in the review of the National Competency framework for pharmacists

- **2017**
  - commencement of a review of the standards for vaccination training for pharmacy students

2.1. Input and outcome based accreditation standards

Question 8. Should accreditation standards be only expressed in outcome-based terms or are there circumstances where input or process standards are warranted?

Our current accreditation standards for degree programs are outcome-based. They were introduced in 2014 and are based on the international guidelines for the pharmacy profession. [4]

These standards are fit for purpose for pharmacy because:
- Our standards were developed following extensive consultation both within and outside the pharmacy profession
- Our universities worked with us in the development of the accompanying evidence guides [17]
- We use a National Examination which tests the competence and knowledge of our graduates within the intern training year.

APC degree standards do not stipulate input hours for in-program clinical placements. See Case Study Three: Expansion of Experiential placements and sites

In contrast, our Intern Training Program accreditation standards contain some input-based requirements. The ITP standards stipulate a small minimum number of face-to-face training hours in addition to the workplace-based training within the intern supervised practice year. This was seen as necessary to enable reflection by interns who are predominantly in dislocated training sites, to allow the support and collegiality that can most effectively be achieved by group sessions.

Our view is that a combination of both outcomes-based standards and a National Examination is the most effective process. See answers to Question 9 and Question 18.

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

Our experience is that the current assessment processes against the standards are effective for the pharmacy profession. This is due to our processes of accreditation, which are based on evidence, transparency, robust process and collaboration.

In addition, we have the National Examinations (Intern Written Examination and Oral Examination), and the Intern Training Program with supervised practice, which all intern pharmacists must successfully complete to fulfil general registration requirements.

Supervised practice is a period of workplace training and assessment that all graduates must complete as part of the registration pathway in Australia. It can be undertaken in a community or hospital pharmacy.

The Intern Training Program (ITP) provides competency-based training for a graduate to progress from student to competent pharmacist through the application of academic knowledge alongside practical experience. The ITP’s are accredited by the APC as a special project for the PharmBA. Through the course of the ITP an intern is expected to develop and demonstrate the required knowledge, skills and attributes defined in each of the eight functional areas of the National Competency Standards Framework for Pharmacists in Australia 2010 and this is assessed by both formative and summative assessments.

The Intern Written Examination is delivered by the APC across Australia by computer-based delivery. https://www.pharmacycouncil.org.au/interns/prepare-for-an-exam/. It is a 125-question 3-hour multiple choice competency examination which assesses an intern’s ability to apply the knowledge, skills and competency gained in the undergraduate course and during supervised practice, to current pharmacy practice.

The Oral Examination delivered by the PharmBA (AHPRA). http://www.pharmacyboard.gov.au/Registration/Internships.aspx . This is a 45-minute, four question oral assessment. The examination covers:

- Part 1 Medication Knowledge and Counselling (10 minutes)
- Part 2 Primary Healthcare (10 minutes)
- Part 3 Legal and Ethical Practice (5 minutes)
- Part 4 Problem Solving & Communication (20 minute time limit & open book)
2.2. Health program development and timeliness of assessment

Question 10. Should there be a common approach to the development of professional competency frameworks and to the inclusion of consumers and possibly others in that development?

The first competency standards in pharmacy were developed in the 1994 following the processes set for all professions. [18]. Since then a number of iterations of the framework have been developed.

Competency frameworks form the “policy” and direction for a profession which must be part of the health workforce that can deliver future health care needs, adopt new roles and deliver integrated services. The current system doesn’t have a clear mechanism for this to be articulated for each profession; the loss of Health Workforce Australia (HWA) has impacted on this policy direction, which is now less clear from the Department of Health.

The pharmacy profession has developed the National Competency Standards Framework for Pharmacists in Australia through a collaborative group of all the professional bodies formed expressly for this purpose, called the Pharmacy Practitioner Development Committee (PPDC). [19]

Of the 11 member organisations of the PPDC, the PharmBA and the APC are the only two members who have acting in the public interest as their mandate; this potentially reinforces the suggestion in the discussion paper that the competencies should be developed for professions with the inclusion of consumers, employers and indigenous health groups who could provide the perspectives of community need and broader workforce reform. For the most recent review of the pharmacist competencies, we encouraged the PPDC to consult with Indigenous Allied Health Australia, the peak body for Indigenous allied health professionals, and NACCHO, the national peak body on Aboriginal health, as well as the Consumers Health Forum, to ensure that these perspectives were included.

The current review of the framework will result in standards that will integrate the Advanced Pharmacy Practice Framework to produce a single competency standards framework. [20]

The suggestion that these competencies should be developed in a more consistent manner across the professions is one that we would support. Outcome-based accreditation standards rely on these competencies for the description of the graduate outcomes, and our view is that this makes a compelling case for competency standards being developed by the profession-specific standards-setting bodies - which are the accreditation authorities operating under the same rules of the National Law, i.e. the AHPRA guidelines: keeping all standards development within one standards-setting body for each profession, and using the accreditation authority, with oversight from an over-arching body.

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

The development of accreditation standards that have common health profession elements/domains overlaid with profession-specific requirements is already underway within the scheme, as evidenced by the recent work of some professions (Australian Dental Council, Optometry Council of Australia and New Zealand) as well as the accreditation committees. APC, with the agreement of the PharmBA, will follow a similar process at the next review of the accreditation standards in 2018.

The benefits of developing standards in this way include more clarity for the education providers with respect to terminology and frameworks, and also the provision of clear expectations of what is required for professional accreditation as compared with education provider (student experience) requirements for TEQSA. Examples of specific standards include Interprofessional Education (IPE), Quality Use of Medicines and prescribing, cultural competence and ethics. Collaborative partnerships diminish tensions and drive change. [12]
The risks of developing accreditation standards that have common health profession elements/domains include the possibility of a “lowest common denominator” approach, which would be detrimental to ensuring the best outcomes for a particular degree program. Some professions such as pharmacy have additional post-graduation assessments such as National Examinations; these are aspects that would need to be added and incorporated into the whole framework.

Greater commonality in standards could potentially result in a lack of ownership within each profession, which could lead to a more “tick box” approach to accreditation. Our current processes require education providers to demonstrate evidence against the standards, but as these are minimum standards, the process encourages innovation, excellence and gives commendations when this is demonstrated. The current process for the development of standards is prescribed strictly and more common standards may also most likely involve a different, broader kind of development process. They could possibly take longer to develop, due to the need to gain consensus across the professions, which could delay responsiveness to health needs.

A key facilitator to the effectiveness and efficiency of accreditation standards assessment is the clarity by which the evidence requirement for each standard is expressed. At APC we have worked with our education providers to develop Evidence Guides [17] for our accreditation standards. These assist education providers to determine what evidence can be provided for each standard, and what further assessment will be made during the SET visit to verify the evidence.

Question 12. What changes in the accreditation system could improve the timeliness and responsiveness of processes to ensure education programs are delivering graduates who have the knowledge, clinical skills and professional attributes required of the current and future workforce?

The currency of accreditation standards is influenced by a number of factors. First, changes in standards are instituted to reflect changes in education, health care and technology, as well as to improve standard quality and fill gaps. For example, a subset of standards may be affected by external factors, such as legislation or a review of the organisation, or the Accreditation authority’s own judgment of a need for change. These changes to standards are enacted as soon as the required consultation on the proposed changes has been completed. As new standards are effective immediately, education providers are notified of the changes. From that point onwards, the annual progress report monitors whether programs of study reflect changed standards. The net effect is that changes in workforce, education or external environment can be reflected in education priorities within two or three years.

The use of outcomes-based accreditation standards, competence standards that undergo regular review, and summative assessment of graduates by way of National Examinations has allowed pharmacy to be agile and responsive to the changing needs of the community.

In some instances, expansion to scopes of practice within professions can require accreditation authorities to act expediently to meet the needs of the workforce. This can include both changes to student graduate outcomes and additional requirements for the registered workforce through continuing professional development (CPD).

Pharmacy is a profession that has seen some significant changes in scope of practice since the introduction of NRAS, and APC has been a facilitator to enable this change. The expansion of the scope of practice of pharmacists to administer vaccines to patients, and our development of standards for courses for pharmacists and intern pharmacists, is an example of how we used our CPD accreditation functions for public safety.
Case Study One: Pharmacists as Vaccinators

The implementation of pharmacists as vaccinators presented a significant change in practice for pharmacists, and required new knowledge, clinical and patient-centred skills, in addition to professional attributes, to ensure the safety of the public.

Following the determination by the PharmBA in December 2013 that vaccination was within the scope of practice of a pharmacist with appropriate additional training, APC commenced the development of vaccination accreditation standards for registered pharmacists and intern pharmacists.

In 2014, Queensland Health implemented a Queensland Pharmacist Immunisation Pilot (QPIP) Phase 1 trial in 80 pharmacies which saw 10,889 influenza vaccines delivered, demonstrating that community pharmacy is well placed to improve vaccination rates. Almost one in five people vaccinated in the QPIP Phase 1 trial had indicated that they would not otherwise have been vaccinated and one in seven said it was the first time they had been vaccinated for influenza.

In 2014, APC commenced consultation to develop the APC Standards for the accreditation of training programs to support pharmacist administration of vaccines. This process consisted of two rounds of public consultation and included extensive involvement from State and Territory Departments of Health. We also invited a Canadian Regulatory Expert as a keynote speaker at our Colloquium to share his experiences of pharmacists as vaccinators in the provinces of British Columbia and Ontario.

In 2015 our vaccination standards were published, and made publicly available for APC Accredited CPD Accrediting Organisations to use.

By 2017 pharmacists who had completed courses accredited against the APC Standards were able to provide influenza vaccinations in all states and territories across Australia.

In 2017 we are commencing consultation on a review of the standards to facilitate the training of pharmacy students in accredited degree courses.

Case Study Two; New models of pharmacy degrees – Blended Learning, BPharm(Hons) MPharm, We have a commitment and the processes in place that enable us to be responsive and receptive to new pedagogy and innovative methods that education providers propose.

Prior to the NRAS implementation, we were approached by a university with a request to consider accreditation of a new blended learning pharmacy degree. The program was proposed to have two cohorts of students, with one cohort who would be predominantly off-campus as distance education students, with an intensive residential course each semester. The complexities of accreditation of this type of pharmacy program, to ensure that both on-campus and off-campus students were able to complete a degree that would meet the standards, was one that we were able to meet. The degree remains as an accredited course and is producing graduates who meet the standard set in the National Examination.

Another university approached us with an innovative model of pharmacy degree, which required us to consider how we could be flexible to incorporate this model into our current structure. Working with the School from an early stage, we identified how that the proposed programs could meet the standards while being in a different format to the current model of a BPharm (Hons) and separate accredited Intern Training Program.

1 APC Standards of the Accreditation of Programs to support pharmacist administration of vaccines
Two years later the new program commenced, using new formative assessments that were trialled prior to implementation and APC was updated throughout the process. This program is able to meet the standards with monitoring as for a new program.

2.3. Interprofessional education, learning and practice

Question 13. 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 is quite widely reflected in health education accreditation standards in Australia. [21]. However, as outlined in the discussion document, the implementation of standards is not universal, and is constrained by a number of factors.

A focus on health professions’ accreditation processes has been seen as some as a key facilitator for interprofessional education and the potential readiness for interprofessional practice. In 2012, a review was conducted of the content of 10 health professions’ accreditation standards to assess the accreditation mandate for IPE in the USA, identify best practices of incorporating IPE standards into US accreditation processes, and identification of common themes in IPE accreditation standards across US health professions. [22].

The authors recommend that the accrediting bodies representing the US health professions collaborate to create a common IPE standard. They concluded that “Should the current uniprofessional approach to IPE accreditation persist, accrediting bodies are encouraged to reference the nursing and pharmacy accreditation documents as models of accountable IPE language use. Either approach would certainly address the observed lack of “deep intellectual roots in the commitment to IPE,” as well as barriers to its progress.” [22]

This report has influenced the incorporation of interprofessional experiences before graduation for US health education programs. For pharmacy, while revising its standards in 2014, the Accreditation Council for Pharmacy Education (ACPE) noted that all health care professionals should attain certain competencies during their education. At the top of the list were patient-centred care and collaboration with others on the health care team. ACPE added a new standard on Interprofessional Education to accomplish this goal. Beginning in fall 2016, every ACPE-evaluated school must incorporate didactic and experiential learning on interprofessional teams. https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf

As referred to in the discussion document, in 2015, APC, AMC, ANMAC and CCEA worked together to develop a workshop on interprofessional learning and practice, which we implemented to seek agreement on some interprofessional definitions and competencies. This was funded by the respective accreditation authorities themselves, and the question was raised at the time as to how such cross-professional activities could be funded in the future.

There is a considerable willingness for the accreditation authorities to encourage interprofessional learning within accreditation standards and processes, but the funding for cross-professional work in this sector is neither uniformly nor widely available.

The Governance suggestions in Question 25 address a possible mechanism for accountability of this.

2.4. Clinical experience and student placements

Question 14. How could the embedding of healthcare priorities within curricula and clinical experiences be improved, while retaining outcome-based standards?
Ensuring that graduates were able to practice across the range of changing pharmacy practice areas was a key strategic intention of the revised accreditation standards in 2012. In the previous pre-NRAS standards, Schools of Pharmacy were “encouraged” to provide student exposure to clinical placements across the range of pharmacy practice settings.

The revised accreditation standards from 2014 now require Schools of Pharmacy to ensure all students will experience a range of placements, including both hospital and community pharmacy.

Pharmacy is one of the few professions with an additional supervised practice post-provisional registration intern year. Each graduate is provisionally registered and undertakes a year of internship, while completing an APC Accredited Intern Training Program and completing the two National Examinations. As the internship is a paid position, it is predominantly completed in one sector only; either community or hospital pharmacy.

Our 2015 APC Colloquium was focused on experiential placements, and allowed stakeholders to discuss placement methodologies and tools and the clinical experiences gained by students. This included our invited guest speaker, Mr Ravi Sharma from the UK, describing the implementation of intern and clinical pharmacy placements within medical general practice. [1]

**Case Study Three: Expansion of Experiential placements and sites**

In preparation for the development of outcome-based standards, in 2012 we appointed a Clinical Placements working party, to assist us in developing standards that would be evidence based, contemporary and flexible.

The aim of the working party was to facilitate the experiences of students in different settings along the continuum of care and to allow them to learn in a variety of settings. The secondary aim was to determine what evidence there was for mandated “hours” of clinical placement within the degree.

The group comprised pharmacy educators, clinicians, a medical educator and APC staff.

After a literature search, and benchmarking, the group made recommendations to the Council to include a standard within the new standards that would require Schools of Pharmacy to provide experiential placements in both primary and secondary care to all undergraduate students. The new requirements were tested in the rigorous public consultation process used to develop the degree standards in 2012.

This new requirement was implemented in the 2014 degree standards, and has resulted in students now having the opportunity to see practice in community, hospital and (in some cases) primary care clinics and aged care facilities. Given the lack of evidence, the mandated hours for placements were removed and emphasis placed on the quality of each placement which should have clear learning outcomes informed by the curriculum to ensure the theoretical base has been laid so that students can experience the placement within the relevant context. Appropriate assessment methods appropriate to the learning outcomes is also emphasized.

The outcomes of this change will assist to ensure that new pharmacists will have a firm grounding in wider range of aspects of care, and are better prepared for future practice in a variety of settings.

*A copy of the presentation poster given at the International Pharmacy Education Conference in 2015 is in Appendix 3.*
Question 15. How best could contemporary education practices (such as simulation-based education and training) be incorporated into the curricula and clinical experience?

As the technologies underpinning simulation-based education mature, there is widespread growth in the use of simulation as an efficient way to develop and practice skills, techniques and patient interactions before using them in real clinical situations.

We support innovation in education and pedagogy, and our standards do not stifle innovation. Internationally, other accreditation authorities also support this as well. [23]

Schools of Pharmacy use simulations as a key part of pharmacist education, and we recognise the importance of this. Our standards rightly state that simulation can support the placement experience, but not fully replace this. In particular, simulation has a role in first experiences in pharmacy. [24]

Some of the innovations in the simulation space used in Australia in pharmacy education include:

- Case histories and cases – written and online
- Pharmatopia [http://www.monash.edu/pharm/innovative-learning/technologies/pharmatopia](http://www.monash.edu/pharm/innovative-learning/technologies/pharmatopia) - an online tableting module
- Pharmacy Simulator [https://www.pharm.utas.edu.au/sim_platform/?page_id=15](https://www.pharm.utas.edu.au/sim_platform/?page_id=15) - a simulated community pharmacy
- Pharmville [https://www.youtube.com/watch?v=BuJGxdhe6YU](https://www.youtube.com/watch?v=BuJGxdhe6YU) - an online community for pharmacy students to practice with
- MyDispense [https://info.mydispense.monash.edu/](https://info.mydispense.monash.edu/) – an online pharmacy simulation for practising dispensing skills
- Aesclepia [https://www.youtube.com/watch?v=0R78AZebuNQ](https://www.youtube.com/watch?v=0R78AZebuNQ) – a patient bot developed for interprofessional learning between pharmacy and medical students

The 2015 APC Colloquium also highlighted the use of simulations in pharmacy programs, and demonstrated that APC accepts simulation as complementary and additional pedagogy to that of clinical placements.

2.5. The delivery of work-ready graduates

Question 16. Is there a defensible rationale for a period of supervised practice as a pre-condition of general registration in some professions and not others?

The education of pharmacists shares the characteristic that students progress through various levels of supervised practice towards registration. Clinical experiential learning is greater towards the end of the training, allowing education providers to place more emphasis on development and assessment of work readiness before graduates enter the profession. The need for a formal period of supervised practice increases as the student transitions from observing to increased responsibility for direct patient care with resultant increased capacity to cause harm, the need for integration of complex skills, and the requirement for competence in institutional and team-based environments.

In Australia the Intern Year is the final year of supervised practice for an Australian or New Zealand pharmacy graduate, or overseas trained pharmacist from a Stream A country seeking registration as a pharmacist in Australia. In pharmacy, the intern year comprises:

- 1824 hours of Supervised practice in an approved site with an approved preceptor
- Completion of an APC Accredited Intern Training Program (ITP)
- Completion of the Intern Written Examination administered by APC on behalf of the PharmBA
Completion of the Oral Examination administered by AHPRA on behalf of the PharmBA.

Interns must hold provisional registration with the PharmBA and complete the ITP whilst working in a pharmacy site under an approved preceptor. The ITPs are accredited by the APC according to the requirements described in the Accreditation Standards for Australian Pharmacy Intern Training Programs 2010. There are currently six accredited ITPs in Australia including university and professional body providers.

Four of the ITP providers (Monash University, University of Queensland, University of South Australia and University of Sydney) are members of the National Alliance for Pharmacy Education (NAPE) and offer the opportunity to obtain a Graduate Certificate in Pharmacy Practice by completing additional units of study (above the ITP requirements). Interns completing the PSA’s ITP will be awarded a Graduate Certificate in Applied Pharmacy Practice without undertaking additional units or assessments. From 2021, interns with a Bachelor of Pharmacy (Hons) from Monash University, who complete the Monash University ITP, will be able to meet the requirements for the awarding of a Master of Pharmacy.

As well as developing generic professional attributes such as communication, teamwork, problem solving and professional and ethical conduct, the role of the ITP is to provide opportunities for interns to integrate academic training into professional practice, and develop the competencies required for initial registration. ITP providers must ensure effective and validated formative assessment measures are employed throughout the program, to ensure interns successfully complete all learning objectives.

Supervised practice/ internship in some form are universally a part of the education and training of pharmacists across the globe. [13] See Pharmacy excerpt from this paper here:

**Activities leading to general registration Pharmacy**
The European Union directive (2005/36/EC) stipulates that the minimum training requirement for recognition of a pharmacist’s qualifications must include at least a six-month traineeship. The International Pharmaceutical Federation’s (FIP) 2013 Global Education Report found that at least 25 out of 94 countries globally (27%) support a post-degree preregistration internship system of six to 12 months. [25].

The United Kingdom and Ireland require a pharmacy intern year (or preregistration period) of one year, as with Australia. More recently, the General Pharmaceutical Council in the United Kingdom has set standards that allow the implementation of an integrated five year degree without a separate internship. However, only three universities (out of 30 accredited programs) have implemented this, with two implementing this only for international fee-paying students, who have an incentive to complete the full program due to visa restrictions. [26]

In North America, and some parts of Asia, the pharmacy degree for registration is a Doctor of Pharmacy program – a PharmD. This is generally a six year program of education, with multiple experiential placements incorporated within the degree itself. These multiple shorter placements are spread throughout study years and give pharmacy students the opportunity to gain practical experience in different areas of practice.

The current internship system in Australia is both cost-effective for government (as the sector funds most placements through private community pharmacies) and also allows employers to prepare and support graduates in their first role in pharmacy. As the scope of practice of pharmacy is wide, and specialisation is not regulated through endorsement on the Register, a newly registered pharmacist can work in any sphere of pharmacy practice.

A full description of the internship and assessments within this period both in Australia and internationally is in Confidential Attachment 2.

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

As outlined in the discussion paper, “in any business or service it is never expected that new graduates will be immediately able to demonstrate in full the capabilities and knowledge of experienced practitioners”.

What constitutes “work-readiness” for each profession may differ, depending on the perspective from which it is measured, and the expectations of graduates, employers and patients. An Australian study into the perceptions of pharmacy students and preceptor pharmacists between 2011 and 2014 indicated that there were many similarities between pharmacists’ and students’ perceptions, both emphasising transferable skills. Knowledge was seen as secondary to experience, practice skills, and personal attributes, and more recently (in 2014) pharmacy employers’ focus shifted towards graduates’ management skills, ability to grow business, and implement novel pharmacy services. [27] Interestingly the authors reflected that “Both groups reasoned that these skills could not always be ‘learnt at university’, but could sometimes to be gained through experience or were, in some cases, simply an individual’s personality trait that turns out to be favourable for employment.”

The intern year for pharmacy is positioned to allow development and assessment of a graduate within a safety net of supervised practice. Both the safety of the graduate and the safety of the public must be taken into account within this framework.
2.6. National examinations

Question 18. Does a robust accreditation process negate the need for further national assessment to gain general registration? Alternatively, does a national assessment process allow for a more streamlined accreditation process?

As evidenced in the Accreditation Liaison Group (ALG) International Comparisons Paper, every pharmacy jurisdiction in the comparison group assesses their graduates with a national examination process prior to full registration.

A National examination, as a summative assessment, can be used as one of the outcome measures of accreditation. The Pharmacy examinations process complements the outcome-based accreditation system.

As part of continuous improvement and benchmarking, in 2016 APC approached the PharmBA to commence a project to review the summative assessments (National Examinations) for the pharmacy intern year. The project (due for completion in 2017) is called the Intern Year Blueprint (IYB), and has the following four phases:

Phase 1 – Initiation
This phase will see the background research and analysis undertaken. The outcome of this phase will be a formal report to the PharmBA via the Intern Year Blueprint Steering Group (IYBSC) including:

a) The literature review findings
b) A detailed report into the strengths and weaknesses of the current assessment structures

Phase 2 – Development of IYB and assessments framework First Draft
This phase will centre on the development of a draft intern year blueprint (and assessment frameworks) against the new National Competency Standards.

Phase 3 – International review of IYB and assessments framework Second Draft
In this phase, the IYB First Draft (with assessment frameworks) will be reviewed by an international expert and Second Draft (version 2) will be prepared and sent out to open public consultation.

Phase 4 – Development of final IYB and assessment frameworks
This is the final phase where public consultation is integrated into the final IYB and assessment framework, endorsed by the IYBSC and sent to the PharmBA for endorsement.

The first stage of this project is due May 2017, and a confidential draft literature review is attached in Confidential Attachment 2.

As one of the few professions with a national examination, APC has considerable experience in delivery of MCQ examinations. The APC Intern Written Examination is a 3-hour, 125-question multiple-choice competency assessment, and is a highly validated and effective tool which is delivered to approximately 1800 intern pharmacists each year across Australia. The processes are best-practice to ensure validity and reliability.

Below is a description of the life cycle of the APC examination development process.
APC analyses the results of the Intern Written Examination and uses this as part of the accreditation process; it is complementary but not exclusive. The Accreditation Committee considers these results as part of quality assurance of the program. While these results are a “lag indicator”, they nevertheless provide feedback in an objective way as to whether the graduate is able to meet requisite graduate outcomes set for the program.

Such a methodology allows the accreditation process to be more accountable, especially with outcome-based accreditation standards. Each education provider (both university and Intern Training Program) receives their results annually in an anonymous form and can use this in a benchmarking and quality improvement exercise. The Committee can also identify inconsistencies or poor performance, and require the university to reflect on what modifications in curricula or delivery of the program may be required to meet any prescribed monitoring or conditions.

A copy of a report on examination benchmarking is in Confidential Attachment 3.

An analysis of the pass marks, practice placements and future trends in the Intern Written Examination are conducted regularly to further inform the delivery of the intern year.

A sample analysis report is in Confidential Attachment 4.

As the publication of this material is not approved by the PharmBA, education providers are not able to share these results publicly, as outlined in the APC Accreditation Marketing Policy.
3. Producing the future health workforce

3.1. Independence of accreditation and registration

Question 19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?

The PharmBA and APC relationship is an excellent one, being respectful and complementary. The PharmBA has confidence in APC’s abilities, and relies on the expertise of APC, to deliver a world-class accreditation service.

The APC is able to bring issues to the PharmBA for consideration, and vice versa, and this has led to many innovations and quality improvement initiatives since the Scheme began. A recent example is the Intern Year Blueprint project described in Question 8 above.

We believe that the PharmBA, which determines and enforces registration standards, has the knowledge and capabilities to evaluate accreditation standards and should remain the location for determining those standards. The PharmBA have approved the processes of the APC, and receive six-monthly reports against the quality framework to be assured that proper processes have been followed.

However, we note that the National Board appointment process is reliant on jurisdictional appointments, not skills-based appointments. This could potentially lead to the composition of a National Board with minimal experience in education. A review of the requirements of the composition of National Boards to consider the skills mix within their composition could lead to improved outcomes for some professions.

Question 20. Would greater independence of accreditation authorities, in the development and approval of accreditation standards and/or approval of programs of study and providers, improve alignment of education and training with evolving needs of health consumers?

In many professions and industries, separation between standard setting and regulatory oversight is considered essential in ensuring credibility and transparency. Furthermore, allowing an accreditation authority to set its own standards without connections to National Boards could arguably weaken accreditation responsiveness to government policy.

For these reasons, as outlined above, we believe that National Boards, which determine and enforce registration standards should remain the location for determining those standards. However, to strengthen the policy responsiveness of standards, the Government may wish to consider requiring Boards to include health care policy representatives on any committee that approves accreditation.

Alternatively, the governance structure as proposed under Question 25 may assist with this.

3.2. Governance of accreditation authorities

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

The APC is committed to having community representation in key accreditation decisions. We have two Community members as Directors on the Council Board, and one on the Accreditation Committee. These positions are stipulated within the Constitution and selected on merit against a skills selection framework.

Our governance of accreditation includes the use of appropriately constituted Site Evaluation Teams (SET), which include academic and practising pharmacists, supported by APC trained audit staff. The SET itself makes recommendations to the Accreditation Committee, who then makes the accreditation decisions. The
Accreditation Committee is a skills-based committee constituted with consumers, academics, pharmacists, other health professionals.

Question 22. What changes are required to current governance arrangements to allow accreditation authorities to source professional expertise without creating real or perceived conflicts of interest?

The APC has a skills-based board, and Constitution requires two community Directors. The Directors are appointed on merit and are not nominees or representatives of any organisations. Current APC governance arrangements facilitate requisite professional expertise and input without real or perceived conflicts of interest. The APC board currently includes number of pharmacists, a director from another health profession (Medicine) and two community directors. Additionally, the majority of current APC directors are graduates of the AICD Company Directors course.

The APC Conflict of Interest policy follow best-practice guidelines from the Australian Institute of Company Directors (AICD) and is strictly adhered to. [https://www.pharmacycouncil.org.au/media/1220/g-04-conflict-of-interest-policy.pdf](https://www.pharmacycouncil.org.au/media/1220/g-04-conflict-of-interest-policy.pdf). This policy ensures director independence and impartiality of decisions.

Question 23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

APC has separated activities from commercial obligations by way of a delegation framework; the Directors approve the policies under which the Accreditation Committee and Examination group work, and appoint the members of those groups based on the relevant By-Law.

The APC Accreditation Committee By-Law was reviewed in 2016 and the Council delegates the decisions on accreditation to the Accreditation Committee, with some exceptions. It is a skills-based committee constituted from academics, pharmacists, other health professionals and consumers.

The Committee makes consistent decisions within a risk evaluated decision-making framework with input for all committee members, and these decisions have universally been approved by the PharmBA.

The members of all APC committees are selected on a skills basis with transparent processes using an expression of interest process. APC Council and Committee roles are highly sought after, with interest far exceeding the positions available at each selection round.

3.3. Role of accreditation authorities

Question 24. Is the standard clause in AHPRA funding agreements with accreditation councils sufficient to ensure that the delivery of accreditation functions is aligned with, and is adequately responding to, the objectives of the NRAS?

APC provides a statement on this standard clause (to “increase cross profession collaboration and innovation, support IPE and encourage alternative learning environments”) in each report.

The current legal and governance framework between AHPRA and the accreditation authorities is still evolving, with ongoing work needed between the accreditation authorities and AHPRA in 2016 to clarify timelines and negotiation of agreements. APC believes there is scope for more explicit performance indicators and for a more substantial dialogue regarding the performance of accreditation against those indicators.

The governance arrangements suggested in Question 25 could assist with this.
3.4. What other governance models might be considered?

Question 25. What is the optimal governance model for carrying out the accreditation functions provided in the National Law while progressing cross-profession development, education and accreditation consistency and efficiency? Possible options include:

- Expanding the remit of the AHPRA Agency Management Committee to encompass policy direction on, and approval of, accreditation standards;
- Establishing a single accreditation authority to provide policy direction on, and approval of, accreditation standards.

Accreditation authorities currently work at the intersection of education and training and health professional practice, having close and ongoing engagement with the education providers and the professionals in pharmacy. By virtue of this relationship, APC is able to engage the expertise of educators and the profession to ensure that accreditation standards reflect contemporary educational practice and future professional practice.

Our view is that this engagement represents an important factor in the acceptance of accreditation as a performance improvement opportunity, and thereby not simply acting as an exercise in regulatory compliance. Retaining a profession-specific authority for pharmacy to facilitate this activity is crucial. We would suggest that an amalgamation approach at this point could hinder the work that a profession-specific authority such as pharmacy, with 30 years of history, has been able to achieve. Such an amalgamation would also be expensive and slow and would involve the dismantling of the current structures of the accreditation authorities, some of which have highly sophisticated systems and processes in accreditation as well as examination and assessments. With over 100 expert pharmacists and subject matter experts engaged annually in activities for APC, many of whom fit this contribution around their exciting and ongoing professional commitments, our ability to attract and retain these people cannot be underestimated. Recent experience in the amalgamation of health related entities as seen in regulatory affairs suggests there will be a substantial attrition of profession specific engagement resources that will come at significant financial and intellectual costs. Reasons for such a development are obviously many and varied but certainly two contributing factors are a sense of disengagement that comes with dealing with a much larger national organisation as well as a loss of commitment in contributing to less focused broader health discipline related matters.

Having said this, APC has been providing services to a number of the accreditation authorities within the Scheme for many years. This includes delivery of examinations within and outside of Australia, and conducting assessments of overseas trained practitioners. See Case Studies below

**Case Study Four: APC services to the Chiropractic Accreditation authority**

In 2013 the Council of Chiropractic Education Australasia (CCEA) approached APC to provide services to assist their assessments of overseas trained practitioners, and as the registered office of CCEA. As a small accreditation authority, CCEA saw the benefits in using the expertise of APC, who have expert staff and contemporary systems to support their assessments.

In 2014 APC implemented the assessment services into the APC processes, using the CCEA standards.

In 2017 these services were renewed, and APC now provides an enhanced service to CCEA with electronic applications. The registered office of CCEA remains with APC, and CCEA staff and Council members use APC offices for meetings.
Case Study Five: APC “Clearing House” Examination delivery across the health professions

Fifteen years ago APC began an operation to deliver professional examinations assessments of overseas trained practitioners for health and other professions within Australia and across the globe. This function of APC business was called the “Clearing House”.

The registered health professions who joined the Clearing House included Australian Dental Council, Australian Physiotherapy Council, Australian Osteopathic Accreditation Council and the Pharmacy Council of New Zealand. Other professions include the Australian and New Zealand Society of Nuclear Medicine, Australian Institute of Medical Scientists, Australasian Veterinary Boards Council and Dietitians Association of Australia.

Since 2002 APC has offered these examinations in each capital city in Australia and in venues across 10 countries internationally; in all over 35 venues. Coordination for the conduct of these examinations is undertaken in the APC office and follows a rigorous and robust process to ensure the security of examination material and processes is maintained at all times.

Each of these professions maintains their own material and standards, and APC manages the process of delivery through a contractual arrangement with each Council.

In 2014 the APC Clearing House activities were transitioned into a “trading-as” arm of APC called Independent Assurance Solutions.

APC has also been working closely with the New Zealand pharmacy regulator (up until 2004, the Pharmaceutical Society of New Zealand, and since 2004 the Pharmacy Council of New Zealand. See Case Study below:

Case Study Six: APC and the Pharmacy Council of New Zealand (PCNZ)

A close relationship between the Australia and New Zealand pharmacy regulators has been in place for decades and APC has been providing accreditation services to the New Zealand pharmacy regulator since the 1990’s. The predecessor to the current APC Accreditation Committee was the New Zealand and Australian Pharmacy Schools Accreditation Committee (NAPSAC).

The relationship between APC and PCNZ has always been a close partnership, such that in 2010 APC invited PCNZ to be a member of the APC, and to nominate a dedicated position on the APC board.

The APC services delivered to PCNZ include accreditation of education programs (both degree and Intern training programs) and examinations for both overseas trained pharmacists and New Zealand intern pharmacists. In 2010 APC was asked to undertake accreditation of the New Zealand Pharmacist Prescriber qualification for PCNZ, which is a scope of practice for independent prescribers that is not in place in Australia.

PCNZ has also contributed to the development of accreditation standards that bridge Australia and New Zealand, and this close alignment works in the spirit of the Trans-Tasman Mutual Recognition Arrangement. APC is grateful to the many New Zealand academics and pharmacists who contribute to APC work in both sides of the Tasman, including as SET chairs and examination Subject Matter Experts.

One area which the discussion paper raises is the effectiveness of the mechanism by which health policy is articulated and influences accreditation standards, particularly with respect to government policy and cross-professional work. Without Health Workforce Australia (HWA), and a clear link to National Boards and accreditation authorities, there has not been a mechanism for the professions to be adequately briefed on the reform agenda for health policy. APC agrees that this needs further development.

The discussion paper suggests that AHPRA’s Agency Management Committee might be a suitable place for managing cross-profession issues; however our view is that this is not a suitable place. AHPRA is currently...
set up through the Health Profession Agreements largely to provide support to NRAS boards, and to require the Agency Management Committee to become more involved in policy matters has the potential to pull accreditation authorities away from their links to National Boards, and accreditation standards may drift away from registration standards.

The discussion paper also suggests the UK model of the Health and Care Professions Council (HCPC). Our research, including discussions with our UK counterparts, suggests that this model is not fit-for-purpose for a profession such as pharmacy with the inherent risks to the public of pharmacist practice. [28] Having recently been introduced to the HCPC for predominantly cost-saving reasons, UK social workers are due to leave the HCPC by 2020 and set up their own accreditation/ regulation body again. This validates our views that pharmacy needs a profession-specific accreditation body.

The discussion paper also refers to examples of the Australian Health Service Safety and Quality Accreditation (AHSSQA) scheme, which provides national coordination of accreditation processes against the National Safety and Quality Health Service (NSQHS) standards. This is a very large and expensive scheme, and would be separate from the National Board.

However, as stated earlier, we would not support the link of accreditation being removed from the National Board. We believe the power of accreditation to effect changes in pharmacy when accreditation is acting alone would be diminished. We agree that this could be further enhanced if activities within NRAS are coordinated, through health policy, with those of education and health care providers. Our view is that such coordination is possible in a reformed system, and this would produce the best outcomes.

A possible structure

APC would support a potential solution of a policy coordination group with representation from all three major types of organisation within NRAS: National Boards, accreditation authorities, AHPRA, and education providers and community representatives. This 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 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, not a board;
- 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 committee membership be restricted to a number consistent with agile decision-making;
- That it should have a formal and clear channel of communication with ministers;
- That is should be both accountable, and be able to enforce accountability, on accreditation decisions.

This has some similarly to the current Accreditation Liaison Group (which it would likely replace) but with an expanded policy and performance remit. Our view is this structure could address policy, cross-professional coordination, and accountability gaps while preserving the best aspects of the current system.
The role of this new Committee could include requiring reviews of standards to consistent structures, facilitating the sharing of information across education providers (with the Forum and (potentially) Universities Australia) and instituting consistent approaches to aspects of the Scheme.

We also see that the Health Professions Accreditation Councils’ Forum, which in our view has been a successful venture for quality improvement and cross-professional dialogue, could be better placed to take a more active role within this structure. The Forum is already established and with some funding it could assist this new Committee in setting KPIs and providing accountability for the performance of each of the accreditation authorities. What currently holds the Forum back from this role is the lack of authority and funding. It also demonstrates how the professions have voluntarily come together to collaborate on matters of mutual interest to advance accreditation functions and activities.

Aligning the processes and structures of standards, as well as nomenclature and risk-based processes, could be implemented across the various current accreditation authorities as described.

In 2016 we made an active decision to relocate our offices to an “accreditation precinct” in Majura Park, Canberra, next to AMC, ANMAC and Australasian Osteopathic Accreditation Council (AOAC). The relocation took place in early 2017, and is already allowing us to share and collaborate more on our processes, and we envisage will lead to considerable efficiencies without reducing effectiveness. Such mechanisms will drive and facilitate collaborations without inhibiting natural learnings and efficiencies.

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

The current Health Professions Accreditation Councils’ Forum has made progress to continue to progress cross-professional issues, and has the potential to progress this work further with a funding model in place. As expressed in Question 25 above, we see that the Health Professions Accreditation Councils’ Forum, is best placed to take this work forward; it is already established and with some funding it could assist this new Committee in setting KPIs and providing accountability for the performance of each of the accreditation authorities.
What currently holds the Forum back from this role is the lack of authority and funding. It also demonstrates how the professions have voluntarily come together to collaborate on matters of mutual interest to advance accreditation functions and activities.

The discussion paper cites prescribing as a potential cross-professional opportunity. The Forum began work in 2016 to develop a standard for all the professions, led by APC President Debra Rowett, and this is further evidence of what the Forum is able to achieve.

3.5. Accountability and performance monitoring

Question 27. What should be the standard quantitative and qualitative performance measures for the delivery of the accreditation functions across NRAS and who should be responsible for, firstly, reporting against these measures and, secondly, monitoring performance?

The Quality framework for the accreditation function was agreed between accreditation authorities and AHPRA in 2010, and has been used by all Councils to report to AHPRA and National Boards since this time. However, it appears that the feedback on these reports varies across the professions, and we would support the introduction of a more standardised set of data, and template report, for this into the future.

The monitoring of these reports could potentially sit with the Committee proposed under Question 25, or could be delegated from this Committee to a mechanism within the Forum.

We welcome a discussion as to what KPI’s would be appropriate and how they could be measured.

3.6. Setting health workforce reform priorities

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

The role of the Ministerial Council is to ensure that appropriate standards are set but not to constrain by encouraging innovation and responsiveness to changing and emerging demands.

The APC experience in consulting health jurisdictions regarding proposing changes to accreditation standards is that we can receive different responses. Examples include pharmacists as vaccinators prior to 2016, and the recent Victorian Health Department Pharmacist Chronic Disease Management pilot https://www2.health.vic.gov.au/health-workforce/reform-and-innovation/pharmacist-chronic-disease-management. A mechanism that allowed all accreditation authorities to navigate these different priorities and responses across jurisdictions would be welcomed.

We suggest that the Committee referred to in Question 25 could be a mechanism for this.

Question 29. Is the requirement that the Ministerial Council may only issue directions under s11(3)(d) if it considers a proposed accreditation standard may have a substantive and negative impact on the recruitment or supply of health practitioners, too narrow to encompass all the National Law objectives and guiding principles, and if so, how should it be modified?

The current law only allows the Ministerial Council to intervene when a proposed standard may have a “substantive or negative impact on the recruitment or supply of health practitioners”. We have had no experience on the use of this clause.

Question 30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:
As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?

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

Without HWA, and a clear link of policy to National Boards and accreditation authorities, there has not been an effective mechanism for professions to be adequately briefed on the reform agenda.

We attend, present and participate in national pharmacy conferences where policy is discussed, and while this assists to inform our work, this is in isolation to our specific work in accreditation.

We believe that the Forum has been a facilitator for driving the workforce agenda, including the work on interprofessional education and prescribing, without any legislative agenda. We see considerable potential in the Forum to develop and drive this further, with a stronger governance structure and support from within the Scheme. If, as part of the Scheme, it took on the role of articulating policy and collaborating with all the elements of the Scheme that have a role on accreditation – accreditation authorities, National Boards and AHPRA, (such as described in Question 25) the Forum could provide added value as a negotiation and coordination mechanism.

3.7. Specific governance matters

3.7.1. The roles of specialist colleges and post-graduate medical councils

Question 31. Do the multi-layered assignment arrangements involving the National Boards, specialist colleges and post-graduate medical councils provide mechanisms for sufficient scrutiny of the operations and performance of these functions?

N/A

3.7.2. Assessment of overseas health practitioners

Question 32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?

APC performs both the Skilled Migration assessments for the Department of Immigration and Border Protection, and assessments for registration as a pharmacist for the PharmBA.

The two processes are very similar, however the assessment for skilled migration can include additional assessment of:

- the equivalent AQF level of the overseas qualification
- relevant skilled employment
- English language ability (if applicable registration standard applies that differ to the requirement under the visa category)

Despite the above, there is duplication in the existing arrangement between assessment for skilled migration and assessment for registration functions. We cannot see why these are not aligned for all professions, as there is considerable overlap for some of the requirements. Alignment for all professions to the accreditation authority could reduce regulatory burden and costs.
Question 33. Is there a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

Our view is that most efficient and robust model is that the accreditation authority should be responsible for both these functions. In our experience, our expertise and close understanding of the educational and practice requirements of overseas trained pharmacists, makes APC the most appropriate place for these assessments to occur.

The close relationship that most accreditation authorities have with their respective professions has been built up over many years. Separation of these functions is therefore likely to result in a less efficient economic outcome.

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

As evidenced in the Accreditation Liaison Group (ALG) International Comparisons Paper, each profession internationally has developed their processes and requirements separately. As the practice of some health professionals in countries outside of Australia can vary considerably, it is important to consider each profession on its own merits.

The APC processes are very similar to those for the countries compared, and are seen as necessary for pharmacy in each of these countries.

Question 35. Should there be a greater focus on assessment processes that lead to general registration for overseas trained practitioners without additional requirements such as supervised practice and how might this be achieved?

The need for uncompromising standards to ensure public protection is a foundation of the Scheme, due to the high-stakes nature of the potential harm to patients. The public attention when these assessments are not robust or fit for purpose is generally one of outrage. [http://www.abc.net.au/news/2017-03-07/doctors-identity-allegedly-stolen-and-used-in-nsw-hospitals/8332812](http://www.abc.net.au/news/2017-03-07/doctors-identity-allegedly-stolen-and-used-in-nsw-hospitals/8332812)

Assessments of overseas trained practitioners must be fit for purpose. As practice across the professions is diverse, as are the levels of risks of each profession, consistency of assessment processes is unlikely to be achievable, let alone desirable.

Pharmacy is a profession in which supervised practice and examinations are required in each of the six countries compared in the International Comparisons Paper.

It is necessary to ensure that the public is protected and that only those pharmacists who meet the standards for practice in Australia are able to practice. However, it is important to consider internationally the range of practice of a profession as pharmacy has considerably different contexts of practice with respect to competencies, legislature, practice settings and cultures within the profession across the world.

APC has recognised this context in our assessment processes that vary in their requirements dependent on the skills and competencies of the practitioner based on their original practice environment. [https://www.pharmacycouncil.org.au/pharmacists/overseas-trained-pharmacists/am-i-eligible/](https://www.pharmacycouncil.org.au/pharmacists/overseas-trained-pharmacists/am-i-eligible/)

In 2012 APC developed standards to ensure that the processes for pharmacists from overseas countries are implemented in an efficient and effective way; Stream B countries (UK, Ireland, US and Canada) have a shortened route for registration based on these standards, which reduces burden while maintaining standards. Our international equivalents in the UK, Ireland, US and Canada do not provide such processes
Pharmacists from non-Stream B countries (with accreditation, competencies and practice environments that are not sufficiently aligned with Australian practice) need to undertake additional assessment and supervised practice compared to Stream B pharmacists.

The report on Stream B standards is in Confidential Attachment 5.

3.7.3. Grievances and appeals

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

We have used this guidance to develop our own processes, but to date have not had any instances where we have tested the process.

We would be open to improvements that might increase transparency, and it may be perceived as fairer for all for an external body to become involved. This would align with international standards such as ISO 10002.

Question 37. 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?

One of the strengths of the Scheme is the independence of accreditation authorities (with reporting and accountability requirements). That means that Authorities are able to make decisions free of undue influence of stakeholders such as the professions, National Boards, and education providers. If there is to be a complaints mechanism external to the accreditation entities then it could be similar to the National Health Practitioner Ombudsman (NHPO).
4. References


5. Appendices
Appendix 1 – APC timeline
<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1982-2005</td>
<td>Pre-NRAS</td>
</tr>
<tr>
<td>2006-2008</td>
<td>Pre-NRAS Year 1</td>
</tr>
<tr>
<td>2009</td>
<td>(NRAS Year 0)</td>
</tr>
<tr>
<td>2010</td>
<td>(NRAS Year 1)</td>
</tr>
<tr>
<td>2011</td>
<td>(NRAS Year 2)</td>
</tr>
<tr>
<td>2012</td>
<td>(NRAS Year 3)</td>
</tr>
<tr>
<td>2013</td>
<td>(NRAS Year 4)</td>
</tr>
<tr>
<td>2014</td>
<td>(NRAS Year 5)</td>
</tr>
<tr>
<td>2015</td>
<td>(NRAS Year 6)</td>
</tr>
<tr>
<td>2016</td>
<td>(NRAS Year 7)</td>
</tr>
</tbody>
</table>

**Governance**

- COPRA (Council of Pharmacy Registering Authorities)
- APEC (Australian Pharmacy Examining Committee)
- NAPSA (New Zealand and Australian Pharmacy Schools Accreditation Committee)
- Combined to Australian Pharmacy Council (APC) Incorporated 2007

**Standards**

- Accreditation Criteria for degree programs set 2005
- Intern Training Program (ITP) Standards set
- Intern Training Program Standards set
- Development of Stream B Standards (Overseas Pharmacists)
- Review of Degree standards
- Development of Evidence Guides for new degree standards
- CPD Accreditation Standards approved
- Vaccination standards development commenced
- Advanced Practice Credentialing standards developed (non-NRAS)
- CPD Accreditation Guidelines published
- Vaccination accreditation Guidelines standards published
- Review of Vaccination accreditation cycle to 6 years
- Increased degree accreditation cycle to 6 years
- Increased degree accreditation cycle to 6 years

**Processes**

- Consultation with all Pharmacy bodies to establish APC Inc
- Consultation on Accreditation Fees
- Consultation on Intern Training Program (ITP) Standards
- Consultation with pharmacy bodies to establish APC Ltd Post-NRAS
- Pharmacy Board discussions re funding and services
- Implemented ITP and CPD accreditation programs
- CPD Accreditation Standards working party – profession-wide
- Wide consultation on new degree standards
- International – APC Accreditation visit to GPhC in UK to inform new accreditation processes
- Wide consultation on Vaccination standards
- Heads of Schools workshop External moderation/cultural competence
- International – APC CEO invited speaker at FIP International Pharmacists Conference on Quality Assurance
- International – APC signs MoU with Royal Pharm Society (UK)
- 2nd APC Colloquium, Brisbane – Mysteries of Time and Space
- 2nd APC Colloquium, Melbourne – Innovation: drivers to quality education
- 3rd APC Colloquium, Canberra – The secret ingredient
- Interprofessional Workshop with AMC and ANMAC
- APC signs MoU with TEQSA
- International – APC CEO invited plenary speaker on Accreditation at FIP Global Pharmacy Education Conference
- APC awarded hosting rights for International Life Long Learning in Pharmacy Conference 2018
- Setting up Accreditation Special Interest Groups across ANMAC/AMC/APC
- Moved offices to "Accreditation Precinct" with ANMAC and AMC

**Engagement**

- Review of APC Constitution – reduced size of Board, streamlined APC Committees
- Review of Accreditation Committee - implemented skills-based and smaller Committee

**Consultation Intern**

- Intern Written Exam (IWE) delivered nationally by computer-based delivery to 9 centres, 2000 interns
- Intern Training Program (ITP) Standards set
- Development of Stream B Standards
- Finalised Approved Stream B Standards
- Change of constitution of SET teams – additional academic member
- Development of online modules for IWE examination preparation
- New AIMS Item bank for examination material implemented
- Pharmacy Council of New Zealand (PCNZ) IWE delivery commenced
- Upgrade of online SET training modules
- Commence accreditation of degrees against new accreditation standards
- Transition of all APC accreditation standards
- New Online web portal implemented for assessment and examination candidates
- Staff organisation structure (reduced FTE and management structure)
- New APC Website
- Increased degree accreditation cycle to 6 years
- Implemented risk-based decision making for accreditation of programs
- Further enhancements to Web Portal for exam candidates
- Updated APC website

**Degree accreditation processes implemented**

- Funding models developed
- ITP Accreditation processes developed
- Intern Written Exam (IWE) delivered nationally by computer-based delivery to 9 centres, 2000 interns
- Development of online Site Evaluation Team (SET) training modules
- Change of constitution of SET teams – additional academic member
- Development of online modules for IWE examination preparation
- New AIMS Item bank for examination material implemented
- Pharmacy Council of New Zealand (PCNZ) IWE delivery commenced
- Upgrade of online SET training modules
- Commence accreditation of degrees against new accreditation standards
- Transition of all APC accreditation standards
- New Online web portal implemented for assessment and examination candidates
- Staff organisation structure (reduced FTE and management structure)
- New APC Website
- Increased degree accreditation cycle to 6 years
- Implemented risk-based decision making for accreditation of programs
- Further enhancements to Web Portal for exam candidates
- Updated APC website
Changing today and tomorrow’s workforce

With our ageing population, and increasing technologies, we have

• increasing patients with co-existing conditions, and
• more demand for increased and complex therapies
• a demand for quality workforce of pharmacists and pharmaceutical scientists.

Context of our practice
How do we assure quality for transformation?

- Competency Standards & Frameworks
- Accreditation standards & processes
- Registration/ Licensure Examinations
- Continuing Professional Development (CPD)
- Expanding scopes of practice
- Emerging professional/student
- Practising advancing professional

Australian National Registration and Accreditation Scheme

Established in 2010 – now 14 health professions

Six key objectives:
- protection of public safety
- facilitation of workforce mobility
- facilitation of high-quality education and training
- facilitation of assessment of overseas-trained health practitioners
- promotion of access to health services
- development of a flexible, responsive and sustainable workforce

Quality Assurance – foundation component

- Competency Standards and Frameworks
- Accreditation standards & processes
- Registration/ Licensure Examinations
- Continuing Professional Development (CPD)
- Expanding scopes of practice
- Emerging professional
- Practising professional
Competency standards & Frameworks

- Describe knowledge, skills, attitudes and values
- Relevant to need and context
- Both “Entry to practice” and aspirational
- Underpin accreditation and assessments

Quality Assurance – Undergraduate and pre-registration

Emerging professional

Accreditation standards & processes
Registration/Licensure Examinations
Continuing Professional Development (CPD)
Expanding scopes of practice

Practising professional

Accreditation standards for Schools of Pharmacy

- “Outcome-based” standards
- Not prescriptive
- Encourage innovation in program delivery
Accreditation processes and systems

Accreditation standards & processes

APC Cycle of re-accreditation

Quality Assurance – Registration

Emerging professional

Practising professional

Competency Standards and Frameworks

Accreditation standards & processes

Registration/Licensure Examinations

Continuing Professional Development (CPD)

Expanding scopes of practice
Underpinning principles for Registration exams

- National registration examinations are high-stakes
- Defensibility is based on the ability of exam items to distinguish between candidates who can demonstrate competency and those that cannot
- Exam items are developed and reviewed by contemporary practising pharmacists
- Examination results can assist to “triangulate” results for other quality assurance components
Examination Quality Assurance

- The better the items, the better the examination
- Review by item, examination and cohort basis
- Contemporary psychometrics
- Engagement with contemporary practitioners is key

Resources for examination preparation


Quality Assurance – Life Long Learning
Continuing Professional Development – CPD Accreditation

- Learning Needs Accreditation
- Program Accreditation
- Program Study Accreditation
- Learning Module Accreditation
- Continuing Professional Development (CPD)

Quality Assurance

- Competency Standards and Frameworks
- Accreditation standards & processes
- Registration/Licensure Examinations
- Continuing Professional Development (CPD)
- Expanding scopes of practice
- Emerging professional
- Practising professional

Expanding scopes of practice - workforce transformation
Examples of quality assurance as an enabler of practice change

- Building and maintaining relationships for collaborative practice
- Inter-professional education and learning
- Building and maintaining relationships with people
  - Embedding Cultural competence
- Expanding scopes of practice
  - Vaccinations, Prescribing

Interprofessional education and training

- Learning together to practice together

Embedding cultural competence

APC Accreditation Standards:

Effective partnerships or engagement with individuals, their communities or networks of Aboriginal and Torres Strait Islander people in Australia and Māori in New Zealand is important for gaining an understanding of the unique challenges faced by indigenous people that impact on their health status and for securing relevant expertise for assisting program development.

Australian Aboriginal and Torres Strait Islander people and New Zealand Māori have a unique contribution to make to the education of future health professionals. Their contribution is essential for developing cultural competence and cultural sensitivity in students but also to assist students’ understanding of the significant gaps in health indices of these groups in comparison to the population as a whole.
Expanding scopes - vaccinations

Expanding scopes of practice
Competency Standards & Frameworks
Accreditation standards & processes
Continuing Professional Development (CPD)

Conclusion - Continuing Cycle of workforce development

- Iterative process
- Embed the emerging practice into general competencies
- Quality assurance is an enabler of innovation

Competency Standards & Frameworks
Accreditation standards & processes
Continuing Professional Development (CPD)
Registration/Licensure Examinations

Thank you - Xièxiè

www.pharmacycouncil.org.au
An evaluation of clinical placement requirements in pharmacy and the role of Australian Pharmacy Council in monitoring quality

Australian Pharmacy Council Clinical Placement sub-committee of the Accreditation Committee.

“The experiential placement program develops the foundation communication and clinical skills for professional practice. Experiential learning should start early in the program, with increasing decision-making and level of responsibility over the course of the program. Each placement should have clear learning outcomes.”

Background

Review of Accreditation Standards for Pharmacy Degree Programs

In December 2011, the Pharmacy Board of Australia (PBA) directed the Australian Pharmacy Council (APC), as the independent accrediting body for pharmacy, in accordance with the Health Practitioner Regulation National Law Act 2009 Section 47(5) to review the Accreditation Standards for Pharmacy Degree Programs with the review to be completed by November 2012.

While the PBA may direct that the review cover only certain aspects of the Standards it did not do so on this occasion. The review therefore was wide-ranging while building on the current Accreditation Standards for Pharmacy Degree Programs.

The development of the standards must comply with Australian Health Practitioner Regulation Agency (AHPRA) procedures for the development of accreditation standards.

Through the initial consultation period with key stakeholders and benchmarking with relevant national and international standards, a number of contentious issues were identified which included clinical placements.

Experiential placements were regarded as an extremely important part of a pharmacy program by all stakeholders. A wide range of structural models for placements exist varying from university to university, and across student year levels.

Aim

To identify specific clinical placement requirements for pharmacy programs to inform the review of the accreditation standards.

Methodology

The Australian Pharmacy Council convened a sub-committee of the Accreditation Committee to undertake an analysis of current clinical placement requirements in pharmacy.

This sub-committee was tasked with considering a comparison of clinical placement requirements among Australian health professions and pharmacy education internationally, as well as details of the clinical placement reports provided to Health Workforce Australia by the Australian accredited pharmacy schools. A detailed literature review was also undertaken.

Figure 1. The contribution of different methods of learning to achieving defined learning outcomes needs to be recognised.

Outcomes

A key focus of experiential placements is to apply theory to the complexities involved in meeting individual patient needs in real life situations. This necessitates exposure to the workplace, to patients, and to people working in other health professions. Developing professionalism and transitioning from student role to a practising professional.

A balance of open-ended and more structured situations was considered valuable building across each year level. A wider range of experiential learning opportunities, including health education programs through Medicare Locals, interdisciplinary clinics, medication management services, aged care services and professional organisations.

There was little evidence to support determination of an optimal duration of experiential placement during a pharmacy program. Early exposure to pharmacy practice through experiential placement is considered important in the first and second year.

In the UK, practical experience is required, but no hours specified, only that it should increase year on year. The UK also requires 52 weeks practical experience pre-registration.

The contribution of different methods of learning to achieving defined learning outcomes needs to be recognised. (Figure 1)

Conclusion

While the findings of the sub-committee were used to inform the development of the standards relating to clinical placement requirements in APC accredited programs, the broader analysis will continue to be built upon to inform the ongoing development of quality guidelines for pharmacy simulation, experiential learning and clinical placements.