AN ACCREDITATION SYSTEM FOR RURAL GENERALIST EDUCATION AND TRAINING FOR THE ALLIED HEALTH PROFESSIONS

6 July 2018

Accreditation System

This document proposes an accreditation system for adoption by a new accreditation entity.

Note: A governance system, business model and associated resources for a new entity have been drafted in a parallel process for consideration by stakeholders involved in its establishment.

Prepared by the Australian Healthcare and Hospitals Association

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This document proposes an accreditation system for rural generalist education and training for the allied health professions in Australia. It has been prepared by the Australian Healthcare and Hospitals Association, on behalf of Queensland Health, drawing on existing profession-specific and inter-professional frameworks, outcomes from previous stages of the rural generalist strategy, and extensive consultation with stakeholders in the education and health care sectors and wider community.

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Introduction

What is a rural generalist in the allied health professions?

Allied health professionals are integral to the delivery of high quality multi-professional services that address the health needs of rural and remote communities.

The term 'rural generalist' refers to an allied health professional that can respond to the broad range of healthcare needs of a rural or remote community. These practitioners require a broad skill-set and commonly have a strong reliance on teamwork, multi-disciplinary and inter-professional practice and use a range of service delivery strategies that optimise access for consumers. Services are delivered for a wide breadth of clinical presentations and to people across the age spectrum, and usually in a variety of healthcare delivery settings e.g. inpatient, ambulatory care, community (SARRAH 2017).

Rural generalists have a primary health professional qualification. They practice under the regulatory instruments relevant to the individual's specific allied health profession and the policies of their employer (SARRAH 2017).

Health services have increasingly recognised that rural generalism can be considered an area of practice with a definable skill set. This skill set includes clinical and non-clinical capabilities that, although not unique to rural and remote practice, are important for these settings. The skill set is strongly influenced by the context of rural and remote practice, with the ability to design and deliver accessible, effective, efficient and acceptable services to geographically dispersed populations as part of small multi-disciplinary and inter-agency teams being the hallmark of a good rural generalist practitioner.

Advancing rural generalist practice in the allied health professions

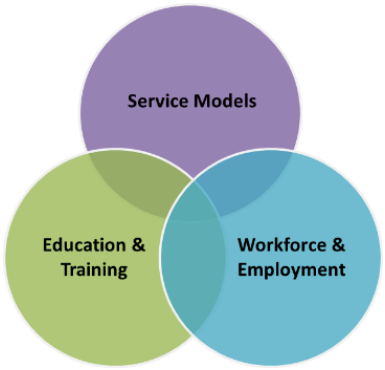
The concept for a national Allied Health Rural Generalist (AHRG) Pathway has been advancing since 2013. It is a workforce and service development initiative pursued through a cross-jurisdictional collaboration that includes state and territory health services from across Australia, and is led by Services for Australian Rural and Remote Allied Health (SARRAH). Development of the AHRG Pathway recognises the disproportionate burden of illness and poorer access to health services in rural and remote communities compared with metropolitan areas, maldistribution of the health workforce, difficulties recruiting and retaining staff and limited training that is relevant to rural practice.

The AHRG Pathway has the aim of addressing some of the known challenges of small allied health workforces delivering services to widely dispersed populations, including professional isolation and difficulty accessing supervision and peer learning, problems sourcing training of adequate breadth to meet the needs of generalists with a wide scope of practice, and professional recognition and career pathways that are not aligned to generalist practice.

There are three components to the AHRG Pathway, each critical to the implementation of the Pathway by health services and commissioning agencies. These are:

- *Service delivery strategies and models* that ensure equitable access to high quality multi-disciplinary services for rural and remote communities, using telehealth, delegation to allied health assistants, extended scope including skill sharing between professions, and partnerships between service providers that bring care 'closer to home' for rural and remote consumers;

- *Workforce/employment structures* that support recruitment and retention, and facilitate progress from graduate level through to a proficient rural generalist in the relevant allied health profession and into extended scopes of practice, as required and supported by the health service (including appropriate supervision and clinical governance); and
- *Education and training*, supporting the development of skills and capabilities of the allied health professional in order to meet the challenges of delivering services in rural and remote areas (SARRAH 2017).



These three components are reflected in the continuum from commencing independent practice in the individual's profession through to becoming a proficient rural generalist, and into extended scope and complex practices where this is required by the local service. (See Figure 1)

Figure 1. Allied Health Rural Generalist Pathway

For background on the AHRG Pathway, please visit https://www.health.qld.gov.au/ahwac/html/rural-remote

For resources to support implementation of AHRG positions by health services and commissioning agencies, please visit https://www.sarrah.org.au/ahrgp

The accreditation system

Purpose of the accreditation system

The primary purpose of the accreditation system for education programs in rural generalist practice for the allied health professions is to support health services and commissioning agencies implementing the AHRG Pathway to identify education programs that address the learning and development needs of allied health professionals in rural generalist practice.

It is neither 'professional accreditation' nor 'academic accreditation'.

Health service partners involved in developing the AHRG Pathway have identified the need to have a benchmark for rural generalist education and training programs. A common understanding of the capabilities and competencies developed in rural generalist education and training programs is required to allow health services to integrate the qualification into industrial instruments, employment models and business/commissioning processes. Accreditation standards for rural generalist education programs will provide quality assurance for health services, commissioning agencies and for potential participants that a program meets the published standards, and by extension that a graduate of an accredited program possesses the competencies described in the standards.

For allied health professionals with a passion for rural and remote practice, accreditation will support selection of an education program that will meet their development requirements. An accredited program may also support engagement with employers and commissioning agencies by providing an indicator of proficiency in rural generalist practice.

Accreditation will also support tertiary education providers to develop rural generalist programs that meet health sector requirements and funding schemes for trainees. The standards will assist education providers to map existing post-graduate offerings and identify opportunities to target gaps through developing education offerings or forming relationships with other institutions.

Scope of the accreditation system

The scope of the accreditation system for education programs in rural generalist practice for the allied health professions is for:

- The seven professions included in the current scope of the AHRG Pathway: nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, podiatry, radiography and speech pathology.
- Post-graduate education and training. The AHRG Pathway has been designed to support the workforce that possess a primary qualification and meet the entry requirements for one of the seven professions. Entry-level education and competencies are not in scope of this work.
- These seven professions in relation to their role in providing care in a health service setting in rural and remote areas. This care may be delivered in state/territory health services, the non-government sector or the private sector. The scope does not currently include other allied health professions or other service settings (e.g. disability, social services, health promotion or public health). However, it is acknowledged that there are allied health professionals providing services in these other sectors in rural and remote areas. There may be future opportunities to examine expanding the focus of the AHRG Pathway, but other professions and sectors are not in scope of this proposed accreditation system.
- Only the education and training component of the AHRG Pathway, i.e. the education program delivered by an education provider. It does not extend to accreditation of other components of the

AHRG Pathway, such as the employment conditions or workplace supervision implemented by the employer. While critically important, these are considered the responsibility of the health service employing the allied health professional who is enrolled in the education program. Education programs may be associated with Level 1 and/or Level 2 training and development stages in the AHRG Pathway. Training requirements of proficient rural generalist practitioners (Level 3 in the AHRG Pathway) include some extended scope (complex practice) clinical training, management and leadership, and education and research. Existing post-graduate education programs, and profession and work-based programs can meet the development needs of many individuals at this level, and so this accreditation system does not extend to Level 3.

Principles applied in the accreditation system

The principles applied in the proposed accreditation system are consistent with current theory and practice, and include:

- **The focus is professional competencies and learning outcomes**
  There should be a specific and detailed set of contemporary competency statements (ADC 2014a). The professional competencies and learning outcomes at graduation should be a focus (UA & PA 2016).
- **Accreditation standards are outcomes-focused**
  Adoption of outcome-based approaches for accreditation standards enables relevant and responsive health education programs (AHMAC 2017). Both education and health are highly dynamic environments. To enable innovation in the education of (and service delivery by) health practitioners, processes, methods and resources should be considered in terms of the outcomes and results achieved and functions fulfilled (HPAC 2016). However, it is recognised that a complete separation of process/structure and outcome in education program design and delivery is artificial, and may not be measurable in an accreditation system. As such both process/structure and outcomes need to be considered (HPAC 2016).
- **Criteria for accreditation are evidence-based**
  Criteria are based on relevant Australian and international benchmarks and are demonstrably based on available research and evidence (UA & PA 2016) and robust peer review (ADC 2014a). There should be a rationalisation of evidence requirements to maximise benefit and minimise the burden on education providers, including considering information from other review processes as providing evidence towards meeting the accreditation standards (ADC 2014a).
- **The higher education environment is taken into account**
  Accreditation must be distinguished from the TEQSA monitoring of adherence to the Higher Education Standards Framework, and not duplicate effort or process (UA & PA 2016). There needs to be broad applicability across all education settings, not only universities (ADC 2014a).
- **There is flexibility in evidence requirements**
  Diverse institutional circumstances must also be accounted for (UA & PA 2016), with flexibility in evidence requirements to take account of the differences between education providers in their teaching and learning approaches and their clinical experience arrangements, as well as new and emerging educational trends (ADC 2014a).
- **Stakeholders are engaged in the development and review of the accreditation system**
  Stakeholders include students, governments, education providers, industry, the professions and consumers/community (UA & PA 2016). They may be consulted through feedback mechanisms, workshops to discuss good practice and representation in accreditation committees, expert groups and policy development (HPAC 2016)

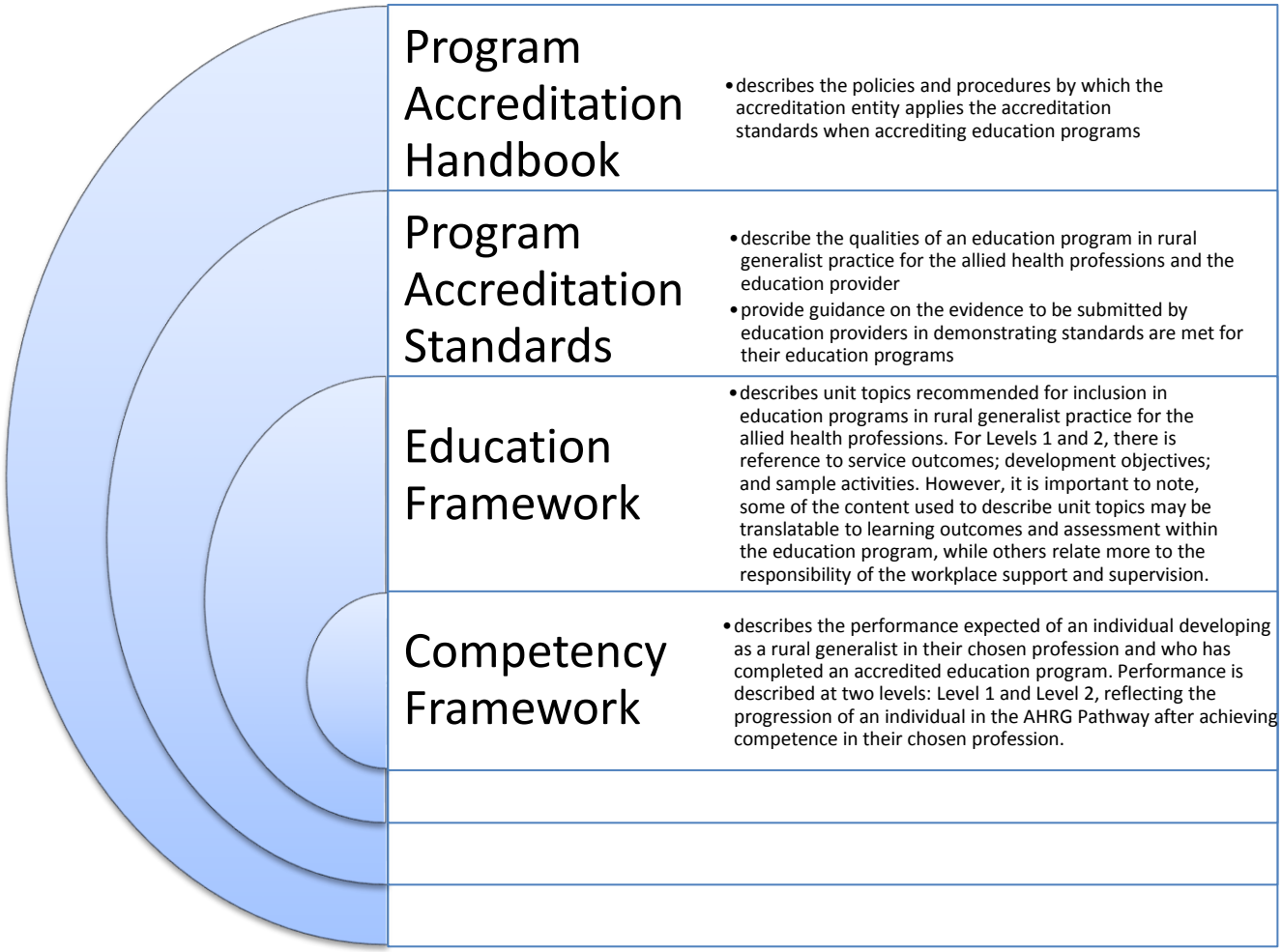
Resources to support the accreditation system

The resources to support the proposed accreditation system include:

1. Competency Framework for rural generalist practice in the allied health professions (AHRG Competency Framework)
2. Allied Health Rural Generalist Education Framework (AHRG Education Framework)
3. Program Accreditation Standards and Evidence Guide
4. Program Accreditation Handbook.

These resources are complementary and inter-linked. (See Figure 2.)

Figure 2. Resources to support the accreditation system



Glossary

Accreditation, academic	Evaluation of a course of study (either by TEQSA or by a self-accrediting provider such as a University) against course requirements specified in the Higher Education Standards Framework (UA & PA 2016).
Accreditation, professional	A course of study meets essential criteria in the training and education of its students in the relevant professional discipline, and that graduates from that discipline achieve the professional competencies and learning outcomes necessary for entry into the relevant level of professional practice (UA & PA 2016).
Competency	The ability to apply knowledge, skills and attitudes to the standard of performance required in the workplace. It embodies the ability to transfer and apply skills and knowledge to new situations and environments (adapted from ASQA 2018).
Capability	The extent to which individuals can adapt to change, generate new knowledge, and continue to improve their performance (Fraser & Greenhalgh 2001).
Delegation	The process by which an allied health professional delegates activities to an AHA who has appropriate education, knowledge and skills to undertake the activity safely (Western Australia Country Health Service 2009). It has also been identified that delegation involves the conferring of authority on an AHA to perform activities that would otherwise be performed by an allied health professional (Queensland Government 2010).
Expanded scope of practice	Optimising full scope of practice, extending scope of practice to include tasks that fall outside of the recognised scope of that profession (under the right circumstances), and delegating specific tasks to the support workforce to enable full and extended scope (Queensland Health 2017).
Extended scope of practice	A discrete knowledge and skill base additional to the recognised scope of practice of a profession and/or regulatory context of a particular jurisdiction (Queensland Health 2017).
Full scope of practice	Includes the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorised to perform. The full scope of a profession is set by professional standards and, in some cases, legislation.
Student	An individual commencing a course of study in a particular year with an education provider. This term is used in the Program Accreditation Standards, reflecting that the accreditation system is applied to education providers and the programs they deliver, and this is the relationship the individual has with the education provider. Other terms, such as trainee, have not been used in this context, so as not to be confused with the individual's employment relationship with a health service or workplace. Such terms may be used in the context of the AHRG Pathway.

Resource 1.

Competency Framework for rural generalist practice in the allied health professions

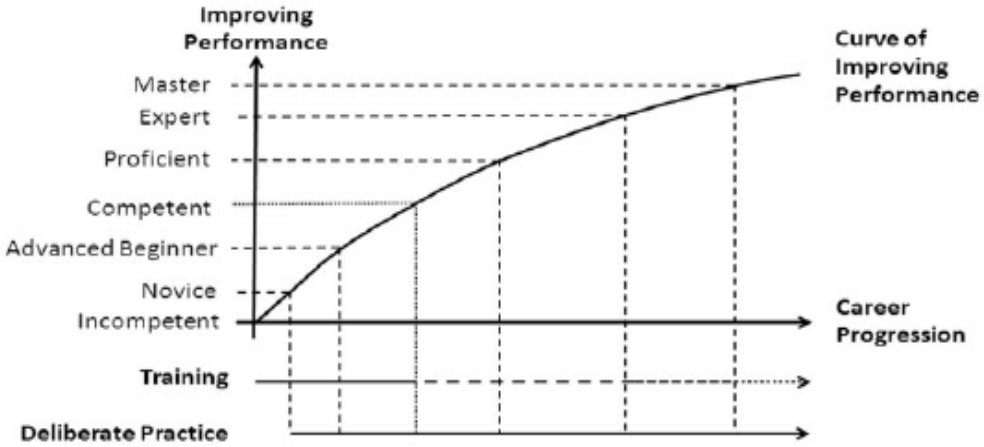
The Competency Framework describes the performance expected of an individual, at the completion of an accredited education program, practising as a rural generalist in their profession. Performance is described at two levels: Level 1 and Level 2, reflecting the progression of an individual in the AHRG Pathway after achieving competence in their chosen profession.

Background

Competency standards are an important basis by which professions in Australia define the attributes of the competent practitioner. Competency frameworks (or equivalent) exist for each of the seven allied health professions that are in the scope of this work, describing the knowledge, skills and other attributes that are to be attained for entry to the profession.

The Competency Framework for rural generalists in the allied health professions has been developed based on the modified Dreyfus model (Khan & Ramachandran 2012), a current model for explaining the relationship between competence and performance. This model identifies seven levels of performance along a continuum (see Figure 3).

Figure 3. Curve of improving performance adapted for health care – modified from Dreyfus and Dreyfus (1980) and ten Cate et al (2010) (Khan & Ramachandran 2012)



In this model, individuals move along the curve of improving performance through a combination of training and deliberate practice.

The AHRG Competency Framework for rural generalist practice in the allied health professions assumes that entry-level competence, as defined in profession-specific standards, has been achieved at the point of entering a profession and prior to commencing rural generalist training, and is one point on a curve of improving performance.

The AHRG Competency Framework describes the performance expected of an individual, at the completion of an accredited rural generalist practice education program and who is applying this training in their profession in a rural or remote practice setting. Performance is described at two levels: Level 1 and Level 2, reflecting the progression of an individual in the AHRG Pathway (see Figure 1). It reflects the integration of the knowledge, skills and attitudes attained, i.e. the outcome of education and experience, as the individual enters the transition to the next level in the Pathway, with performance at Level 1 assumed for those at Level 2. A 'Level 3' is also identified in the AHRG Pathway in Figure 1, reflecting the scope of a 'Proficient Rural Generalist' in the individual's profession.

The AHRG Competency Framework has been developed from the AHRG Education Framework.

Structure of the Standards

The AHRG Competency Framework identifies five competencies to be developed and assessed through education and training in the AHRG Pathway, underpinning the ongoing and progressive development of an individual's capability to respond to varied, familiar and unfamiliar circumstances in the rural and remote health service setting. These competencies are that an Allied Health Rural Generalist:

1. Upholds professional and ethical standards in the rural and remote setting.
2. Collaborates to plan and develop rural health service delivery models, strategies and policies to better meet the needs of the community.
3. Implements rural health service delivery models, strategies and policies to better meet the needs of the community
4. Evaluates services to improve quality and contribute to the evidence base for service provision in the rural and remote setting.
5. Applies their professional knowledge and skills to provide services to better meet the needs of the community in rural and remote settings.

Each competency consists of a number of enabling competencies, and each of these is associated with a number of performance criteria.

Performance criteria focus on key aspects of performance, expressing what a competent professional would do in terms of observable results or behaviours at a specified performance level. The performance levels reflect a continuum of development where the focus on one's own professional activities shifts to focus on the individual's role within a team, and to those beyond the team, within the rural and remote context. The performance criteria allow the Competency Framework to serve as an external measure of expected performance against which actual performance can be assessed.

Consistent with the Education Framework, only performance at Level 1 and 2 development stages have been specified in the Competency Framework. Articulation through to Level 3 was considered when drafting the Education Framework, including specific extended scope clinical pathways, management and leadership pathways, and education and research pathways. Similarly, it is expected that the Competency Framework would also articulate with existing programs and frameworks for extended scope and advanced practice.

Competency Framework

1. An Allied Health Rural Generalist upholds professional and ethical standards in the rural and remote setting.

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework reference point**
1.1. Practises professionally and ethically	• Applies professional and ethical standards in responding to ethical challenges common in rural and remote settings	• Promotes adherence to professional and ethical standards in responding to ethical challenges common in rural and remote settings through the design or revision of processes	• Domain 2. Core unit 5. Ethical practice
1.2. Promotes cultural safety	• Collaborates with the community, senior staff and cultural experts to develop a comprehensive picture of cultural needs for the local community • Communicates effectively in a culturally safe manner • Proposes changes to own and team practice to enhance cultural appropriateness and outcomes for the local community	• Incorporates cultural competence principles into local service planning • Identifies and utilises resources to support culturally appropriate and safe service delivery for the local community • Actions changes to enhance cultural appropriateness and outcomes for the local community	• Domain 2. Core unit 3. Cultural competence
1.3. Promotes evidence-based professional practice	• Sources and incorporates evidence into practice	• Leads the incorporation of evidence in the design, implementation and evaluation of services in rural and remote settings	• Domain 1. Core unit 2. Evidence-based decision making

2. An Allied Health Rural Generalist collaborates to plan and develop rural health service delivery models, strategies and policies to better meet the needs of the community.

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework primary reference point**
2.1. Engages with the community	• Recommends appropriate and relevant community engagement mechanisms in rural and remote settings • Participates in community engagement activities in rural and remote settings	• Initiates and leads effective community engagement activities in relation to local service • Uses findings from community engagement activities to define community needs or contribute to broader community needs analysis	• Domain 2. Core unit 4. Community engagement
2.2. Analyses available information	• Interprets community demographic and health information in relation to the local service • Integrates knowledge of service evaluation results into service planning and development • Integrates knowledge of health prevention/promotion programs into service planning and development	• Leads analysis of community profile and service evaluation information	• Domain 1. Core unit 3. Service development and planning

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework primary reference point**
2.3. Establishes partnerships within and outside the health sector	• Recognises implications of health system structure, funding and organisation on local service delivery • Recognises the influence of inter-sectoral relationships on the delivery of healthcare in rural and remote communities • Consolidates, applies and extends entry level knowledge, skills and abilities to collaborate in practice	• Promotes awareness of rural generalist service delivery models, strategies and policies • Collaborates with those in the broader health system and inter-sectorally to plan and develop service delivery models relevant to local service need	• Domain 2. Core unit 1. Health care systems and rural service models • Domain 1, Core unit 2 Primary health care
2.4. Compares and contrasts rural generalist service delivery models, strategies and policies to meet local need	• Identifies the main forms of rural generalist service delivery models, strategies and policies • Identifies strengths, challenges and requirements for successful implementation for the main forms of rural generalist service delivery models, strategies and policies • Participates in the scoping and development of a rural generalist service delivery model, strategy or policy for the local service	• Identifies impacts and opportunities of rural generalist service delivery models, strategies and policies for local services • Proposes recommendations for rural health service delivery models, strategies and policies	• Domain 2. Core unit 1. Health care systems and rural service models

3. An Allied Health Rural Generalist implements rural health service delivery models, strategies and policies to better meet the needs of the community.

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework reference point**
3.1. Implements rural generalist service delivery models safely, effectively and efficiently	• Participates in the implementation of a rural generalist service delivery model, strategy or policy for the local service	• Leads and manages the implementation of a rural generalist service delivery model, strategy or policy for the local service, with support of senior colleagues	• Domain 1. Core unit 1. Project management and leading change
	For example:	For example:	
	• Participates in the implementation, expansion or review of telehealth service delivery	• Leads (with support) the implementation, expansion or review of telehealth service delivery as part of the model of care	• Domain 2. Optional unit 1. Telehealth
	And/or • Participates in the implementation, expansion or review of delegation to clinical support workers in accordance with delegation frameworks	And/or • Leads (with support) the implementation, expansion or review of delegated practice as part of the model of care	• Domain 2. Optional unit 2. Delegation

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework reference point**
	And/or • Participates in the implementation, expansion or review of skill sharing, including training, monitoring and governance processes	And/or • Leads (with support) the implementation, expansion or review of a model of care that includes skill sharing • Leads (with support) the implementation, expansion or review of a model of care that includes extended scope of practice	• Domain 2. Optional unit 3. Extended scope including skill sharing
	And/or • Participates in the development or review of partnerships with agencies in other sectors to bring 'care closer to home', including local service providers and rural-urban partnerships	And/or • Leads (with support) the implementation, expansion or review of partnerships that deliver new or expanded services for local communities and bring 'care closer to home'	• Domain 2. Optional unit 4. Partnerships and new services
3.2. Implements primary health care initiatives in collaboration with partners	• Participates in the integration of the key principles and features of primary health care in local service delivery	• Leads (with support) the integration of a primary health care initiative in collaboration with other partners	• Domain 2, Core unit 2 Primary health care
3.3. Manages rural generalist service delivery models	• Participates in the management of finances and resources within the service	Performance may be extended beyond that achieved after completing Level 1 education and training such that the AHRG: • Undertakes (with support) the management of finances and resources within the service	• Domain 1. Optional unit 1. Management skills

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework reference point**
	• Participates in workforce management activities within the service to improve performance and drive change	• Undertakes (with support) workforce management activities within the service to improve performance and drive change	• Domain 1. Optional unit 1. Management skills
	• Participates in identifying, documenting and proposing solutions to presenting operational risks and service management issues	• Undertakes (with support) operational risk reporting, monitoring and management, presenting service management issues and proposed solutions to managers and executive	• Domain 1. Optional unit 1. Management skills
3.4. Promotes education and supervision	• Participates in the education and formal clinical/professional supervision of students and staff	• Undertakes (with support) the education and formal clinical/professional supervision of students and staff	• Domain 1. Optional unit 2. Education and supervision

4. An Allied Health Rural Generalist evaluates services to improve quality and contribute to the evidence base for service provision in the rural and remote setting.

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework reference point**
4.1. Manages clinical risk	• Identifies and reports clinical risks, hazards and opportunities for improvement in the practice context	• Reviews clinical risks in the local service/team and develops recommendations to prevent or mitigate identified risk	• Domain 1. Core unit 4. Quality improvement and clinical risk management
4.2. Implements quality improvement initiatives	• Contributes to quality improvement initiatives within the team/service	• Leads quality improvement initiatives for the team/service	• Domain 1. Core unit 4. Quality improvement and clinical risk management
4.3. Engages in research	• Participates in research or knowledge translation activities associated with rural generalist service development or quality improvement, leading or managing (with support) specific components	Performance may be extended beyond that achieved after completing Level 1 education and training such that the AHRG: • Leads or manages (with support) research or knowledge translation activities associated with rural generalist service development or quality improvement	• Domain 1. Optional unit 3. Applied research in rural and remote contexts

5. An Allied Health Rural Generalist applies their professional knowledge and skills to provide services to better meet the needs of the community in rural and remote settings.

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework reference point**
5.1. Provides services to client groups across the lifespan and continuum of care, with a broad range of clinical conditions*	• Consolidates, applies and extends entry level knowledge, skills and abilities in practice, including a specific focus on clinical presentations and conditions highly relevant to the local service setting • In the provision of care, plans and prepares, performs/delivers, monitors and evaluates, and modifies as necessary • Assertively communicates advice and recommendations for patient/client care relevant to the scope of the profession and level of expertise	• In the provision of care, demonstrates clinical decision-making capability with a high level of independence in increasingly complex situations • Assertively communicates advice and recommendations for patient/client care relevant to the scope of the profession and level of expertise	• Domain 3. Core clinical practice (profession-specific)
5.2. Implements effective, high quality, evidence-based care relevant to own profession using rural generalist service delivery strategies and networks	• Applies and extends knowledge, skills and abilities in delivering clinical care using rural generalist service delivery strategies and inter-agency and professional networks	• Delivers clinical care using rural generalist service delivery strategies with a high level of proficiency • Effectively collaborates with other services and agencies relevant to client care including establishing and maintaining networks	• Domain 3. Clinical focus areas (profession-specific)

Enabling competencies	**Performance criteria** After completing Level 1 education and training, an AHRG:	**Performance criteria** After completing Level 2 education and training, an AHRG:	**Education Framework reference point**
5.3. Extends scope of practice (complex practice) and/or dual qualification role*	• Is exposed to practice that extends scope of practice or provides a dual qualification role in the team service model	• Implements extended scope (complex practice) and/or dual qualification role identified in the team service model with appropriate safety, evaluation, governance and reporting processes in place • Demonstrates adherence to safety, evaluation, governance and reporting processes	• Domain 4. Extended scope (complex practice) and dual qualification
5.4. Implements skill sharing#	• Delivers extended scope (skill sharing) tasks identified in the team service model • Demonstrates adherence to safety, evaluation, governance and reporting processes		• Domain 4. Extended scope (skill sharing)

*****Profession-specific clinical focus areas and extended scope and dual qualification role, beyond core clinical practice, as identified in the AHRG Education Framework, are listed in Table A1.1. Clinical focus areas cover the clinical capabilities most commonly identified as being required in rural generalist practice in the relevant profession. However, they have some service specificity and should be selected to align to health needs of the local community and service model of the team.

Skill sharing task clusters can potentially be implemented by a range of professions. Those identified in the AHRG Education Framework are listed in the table below. Performance criteria associated with skill sharing task clusters are not divided into Level 1 and Level 2 development stages. Refer to the AHRG Education Framework for details relating to tasks determined to be potentially appropriate for skill sharing in rural or remote service settings, given appropriate clinical governance, training and competency assessment and monitoring are implemented.

Table 1.1. Profession-specific clinical focus areas and extended scope and dual qualification tasks, beyond core clinical practice, as identified in the AHRG Education Framework. Refer to the AHRG Education Framework for details relating to the areas and tasks identified.

Profession	Clinical focus areas (client group or category of clinical presentation) for each profession	Extended scope (complex practice) and dual qualification scope prioritised by rural or remote services*
Nutrition & Dietetics	• Generalist dietetics practice • Paediatrics • Food service management • Diabetes • Prevention & self-management	• Comprehensive diabetes management including Credentialed Diabetes Educator (dual qualification) and advice on insulin dose • Gastrostomy management
Occupational therapy	• Paediatrics • Oedema & lymphoedema • Hand therapy • Rehabilitation • Home modification & equipment prescription • Prevention & self-management	• None currently prioritised
Podiatry	• Foot morbidity in high risk groups • Wound management • Oedema management • Musculoskeletal • Prevention & self-management	• Endorsement for scheduled medicines
Pharmacy	• Quality use of medicines, including medication safety • Distribution activities • Specific practice areas (e.g. renal, oncology, palliative care) • Prevention & self-management	• None currently prioritised
Physiotherapy	• Musculoskeletal/orthopaedics • Paediatrics • Continence & women's health • Sub-acute/step-down rehabilitation • Prevention & self-management	• Primary contact – neuromusculoskeletal/orthopaedic (complex practice)
Radiography (medical imaging)	• Commenting • Radiographic advice for remote area operators	• Sonography (dual qualification)

Profession	Clinical focus areas (client group or category of clinical presentation) for each profession	Extended scope (complex practice) and dual qualification scope prioritised by rural or remote services*
Speech pathology	• Paediatric speech and language • Paediatric feeding • Adult rehabilitation • Adult neurology • Adult dysphagia • Aboriginal and Torres Strait Islander ear health • Prevention & self-management	• None currently prioritised

* Other extended scope (complex practice) has been identified but not prioritised for inclusion in the AHRG Competency Framework currently. Most commonly this is due to regulatory barriers and/or limited implementation of the scope in practice in jurisdictions.

Table 1.2. Skill sharing task clusters that can potentially be implemented by a range of professions, as identified in the AHRG Education Framework. Refer to the AHRG Education Framework for details relating to tasks currently determined to be appropriate for skill sharing.

For all professions	**Extended scope (skill sharing) tasks** **Refer to the AHRG Education Framework for details relating to tasks currently determined to be appropriate for skill sharing.**
Core skill shared tasks	• High risk foot screen • Falls risk screen • Psychosocial screen • Carer strain index • Mental health first aid • Subjective screening assessment of pressure area risk including Waterlow (pressure risk screen) • Malnutrition risk screen (using MST)
Skill share clinical task clusters	Assessment and intervention tasks in the following clinical areas: • Activities of daily living and function • Mobility and transfers • Cognition, perception and memory • Developmental and child health • Diet and nutrition • Musculoskeletal • Foot care (high risk groups) • Pressure care, scars and wounds • Social and psycho-social • Swallowing • Communication

Resource 2.

Education Framework for rural generalist practice in the allied health professions

The Education Framework describes unit topics recommended for inclusion in education programs in rural generalist practice for the allied health professions. Structured to reflect the levels in the AHRG Pathway, for Level 1 and Level 2 there are detailed descriptions of service outcomes; development objectives; and sample activities/outputs to guide the development of education programs.

Background

The **Allied Health Rural Generalist Education Framework** was developed in 2015–16 through a two-stage project sponsored by Queensland Health and managed by the Cunningham Centre, Darling Downs Hospital and Health Service and the Greater Northern Australia Regional Training Network.

The Education Framework describes the development requirements of rural generalists in seven allied health professions, and aligns with the AHRG Pathway to reflect the continuum from commencing independent practice in the individual's profession through to becoming a proficient rural generalist. (See Figure 1.) The frame of reference is the service need, i.e. what the health service/team needs to do to deliver a rural generalist service that addresses demand and health needs of the community, rather than the training of an individual health professional in isolation from their work role.

A substantial component of the Education Framework is not profession-specific, including service development, education and training, cross-cultural service delivery, rural and remote health context and service delivery strategies.

The Education Framework drew on a range of information sources including (AHPOQ 2018):

- Stage 1 of the AHRG Pathway strategy:
  A comprehensive mapping of clinical tasks and functions for six professions across five rural and remote services (public and community-controlled) in three jurisdictions. This resulted in a detailed description of rural generalist clinical requirements, including identification of profession-specific clinical tasks and tasks potentially appropriate for skill sharing between professions or delegation to support workers, where training, supervision and governance processes were available in the team (GNARTN 2013).
- Stage 2 of the AHRG Pathway strategy:
  A stakeholder review and validation of the skill-shared tasks identified in Stage 1.
- Stage 3 of the AHRG Pathway strategy:
  A trial of designated early career (Level 1) rural generalist AHRG training positions in Queensland hospital and health services. Work-place generated development plans informed the drafting phase of the Education Framework. The evaluation conducted by Southern Cross University of the 2014 AHRG Trainee cohort identified that the lack of formal rural generalist education programs was a key barrier to progressing the AHRG concept (Nancarrow et al. 2015). This finding initiated the development of the Education Framework as the foundation step for the development of training options for health services.
- Extensive consultation with rural and remote allied health professionals and professional leaders in Queensland and interstate (SARRAH 2017)
- Review of documents relevant to rural and remote practice for the seven professions including the WACHS allied health competency frameworks, Queensland Health HP3-HP4 Rural Development Pathway, HealthLEADS, profession-specific standards/frameworks and published literature.

Following drafting of the Allied Health Rural Generalist Education Framework in 2015, GNARTN oversighted an expert review. Finalisation of the document was undertaken by Kristine Battye Consulting in 2016. Reviewers included senior academics from Australia and New Zealand in each of the seven professions. Feedback was integrated into the Education Framework, which was then provided under a one-year exclusive license period to James Cook University. This university, working in partnership with

QUT was contracted in late 2016 by Queensland Health to translate the Education Framework into a formal, two-level rural generalist training program to support the multi-jurisdictional trial of rural generalist training positions 2017–19.

Education Framework

The Education Framework can be downloaded from https://www.health.qld.gov.au/ahwac/html/rural-remote

Resource 3.

Program Accreditation Standards and Evidence Guide

The Program Accreditation Standards describe the qualities required of an education program in rural generalist practice for the allied health professions.

They are based on a template set of accreditation standards currently being used in the accreditation of education programs for a number of different health professions, including for entry-level programs and for post-graduate programs leading to endorsement or other recognition.

Background

The development of an accreditation standards template based on common domains, for use across professions, was identified as a mechanism for improving efficiency in the accreditation process (AHMAC 2017). In 2014, the Australian Dental Council (ADC), in partnership with the Dental Council – New Zealand, developed a set of accreditation standards that could be used for a range of dental practitioners: dentists, dental specialists, dental hygienists and dental therapists, and dental prosthetists/clinical dental technicians (ADC 2014b).

Each of the dental practitioner groups has a separate set of competencies and professional attributes required of graduates. These are used as a key reference point in the accreditation process.

Since the release of the ADC Accreditation Standards, a number of other health professional accreditation agencies for entry-level allied health professional education programs have adopted this common set of Accreditation Standards through their own stakeholder review processes, albeit with some minor edits:

- Optometrists (OCANZ 2016)
- Chiropractors (CCEA 2017)
- Physiotherapists (APhysioC 2016)
- Psychologists (APAC 2017).

The Occupational Therapy Council (Australia and New Zealand) and three accreditation committees (Aboriginal and Torres Strait Islander Health Practice, Medical Radiation Practice, Chinese Medicine) are also considering options to commence with this format when next reviewing and updating their standards (AHMAC 2017).

There is also experience applying the ADC Accreditation Standards to post-graduate education programs for students who are registered or recognised in their chosen profession, e.g.:

- Programs in ocular therapeutics for optometrists (OCANZ 2017)
- Programs for specialist registration for dentists (ADC 2018)
- Programs for endorsement for conscious sedation for dentists and dental specialists (ADC 2018).

The template was therefore considered appropriate for accreditation of education programs in rural generalist practice for the allied health professions.

Structure of the Standards

The Program Accreditation Standards comprise five Domains, each with a descriptive Standard Statement (ADC 2014b):

1. Public Safety
2. Academic Governance and Quality Assurance
3. Program of Study
4. The Student Experience
5. Assessment.

Each Standard Statement is supported by multiple criteria. The criteria are indicators that set out what is expected of an accredited program in order to meet each Standard Statement.

The criteria are not sub-standards that will be individually assessed. However, when assessing a program regard will be given to whether each criterion is met, taking a balanced view of the whole Standard, including the criteria, to determine whether the evidence presented by an education provider clearly demonstrates that a particular Standard is met.

Presenting evidence against the Accreditation Standards

Education providers seeking accreditation of education programs in rural generalist practice for the allied health professions will be required to submit current documentary evidence for review by an accreditation team, in accordance with the policies and procedures outline in the *Program Accreditation Handbook*.

Experiential evidence may also be obtained, e.g. through discussions with the education provider, students, staff, supervisors, graduates and employers. Video-enabled interviews will be used wherever possible.

Evidence acquired elsewhere may also be used in the accreditation process, e.g. from the Tertiary Education Quality Standards Agency (TEQSA), from the accreditation authorities responsible for accrediting for entry-level education programs, from professional associations endorsing post-graduate education programs. Any external evidence used in the accreditation process will be shared with the education provider for comment and review of factual accuracy.

The onus is on the education provider to present evidence that demonstrates how the Standards are met. For guidance, examples of evidence have been listed against the Program Accreditation Standards. Separate evidence need not always be submitted against each criterion. The education provider is expected to explain the purpose for presenting any piece of evidence in the context of a particular Standard and its criteria.

Using the Competency Framework and Education Framework in accreditation

In accreditation in Australia and internationally, there is a continuing emphasis on outcome-based standards, partly from recognition that prescriptive input standards such as curriculum inhibit innovation.

However, it is also well-recognised that both input and outcome-based standards are necessary for assessment and accreditation of an education program. A purely input-based accreditation cannot provide confidence that graduates have achieved the desired competencies, while a purely output-based approach will provide no hint of where to look for improvement when graduate performance varies (HPAC Forum 2017).

It is expected that the Competency Framework forms a core part of an outcome-focused approach to accreditation. Education providers are expected to provide evidence of how their program learning outcomes map to the relevant level in the Competency Framework.

However, with defined rural generalist training roles for the allied health professions being relatively new in Australia, education providers developing programs will see a greater emphasis initially on inputs in the accreditation process. At least initially, education programs will be expected to be developed with strong reference to the specifications in the Education Framework, which describes the service and practice requirements of rural generalists at the conclusion of education (i.e. more input-based). Accreditation teams will consider the specifications in the Education Framework, but in doing so, it is recognised that some of the content used to describe unit topics may be translatable to learning outcomes and

assessment within the education program, while others may relate more to the health service's responsibility for workplace support and supervision.

Over time, as familiarity with the AHRG concept increases, the emphasis in accreditation is expected to shift further towards education programs meeting the performance requirements defined in the Competency Framework, rather than the specifications in the Education Framework.

Program Accreditation Standards

These Program Accreditation Standards have been adapted, with permission, from the Australian Dental Council Accreditation Standards for Dental Practitioner Programs (ADC 2014b).

Domain 1. Public safety

Standard Statement	Criteria	Examples of evidence
Public safety is assured.	1.1 Protection of the public and the care of patients/clients are prominent amongst the guiding principles of the educational program, work-integrated learning and student learning outcomes.	• Documentation showing the program eligibility criteria and description of the processes used to assess eligibility to enrol • Documentation detailing the management of complaints or breaches of ethical and professional conduct of staff and students • If work integrated learning is a formal (assessed) component of the program: ○ Documentation showing the relevant learning outcomes to be achieved through work-integrated learning within the education program ○ Policies and procedures on work integrated learning and supervision ○ Register of agreements between the education provider and external entities relevant to work-integrated learning ○ Professional indemnity insurance arrangements for students undertaking work-integrated learning *May be requested* • *Evidence of service models, regulatory environments, business/funding models and governance structures for health*
	1.2 Students continue to meet the requirements to practice independently in their profession in Australia.	
	1.3 Students meet all requirements for practice in the location and organisational context in which work-integrated learning will be undertaken.	
	1.4 Students undertaking work integrated learning as a formal (assessable) component of the education program are supervised by suitably qualified health practitioners, who meet the requirements to practice independently in their profession in Australia.	
	1.5 Health services providing work-integrated learning as a formal (assessable) component of the education program have robust quality and safety policies and processes and meet all relevant regulations and standards.	
	1.6 The provider holds students and staff to high levels of ethical and professional conduct.	

		services providing work-integrated learning experiences

Guidance

This Standard addresses public safety and the care of patients as the prime considerations.

Student registration documentation

Education providers are responsible for ensuring that all students enrolled in the education program meet the requirements to practice without conditions in their profession in Australia i.e. current registration or meets the eligibility requirements for practice in a self-regulated profession.

Work-integrated learning

The scope of the accreditation system for education programs in rural generalist practice for the allied health professions relates only to the formal education and training component of the AHRG Pathway, i.e. the education program delivered by an education provider. This includes any work-integrated learning (WIL) undertaken as part of an individual's course of study, which, as noted in the TEQSA Guidance Note on WIL, may vary considerably in nature and scope (TEQSA 2017).

It is expected that individuals enrolling in education programs in rural generalist practice for the allied health professions will be employed in health services in rural and remote settings. This will support the application of learnings from the course of study in practice. However, the scope of the accreditation system does not extend to accreditation of the organisation in which a student is employed. Employment conditions and operational and professional supervision in the workplace are considered the responsibility of the health service implementing the AHRG Pathway. They will only be considered as part of the accreditation process if the education provider explicitly uses experiences gained through employment as part of the education program. In this case, the accreditation process will consider these experiences in the same way any other WIL experience is evaluated.

Education providers will be expected to provide documentary and experiential evidence to show how:

- WIL experiences have clearly defined objectives, with arrangements and assessment clearly defined and known to both students, the health service and supervising practitioners
- Supervising practitioners have the professional and supervisory skills, qualifications and registration status required to supervise the student for the WIL experience in a health service setting
- WIL experiences are supported in the health service by appropriate service models, regulatory environments, business/funding models and governance structures
- Feedback from patients/clients, students and supervisors are monitored to inform the educational experience.

Domain 2. Academic Governance and Quality

Standard Statement	Criteria	Examples of evidence
Academic governance and quality assurance processes are effective.	2.1. The provider has robust academic governance arrangements in place for the program of study that includes systematic monitoring, review and improvement. 2.2. Quality improvement processes use student and other evaluations, internal and external academic and professional peer review to improve the program. 2.3. There is relevant external input to the design and management of the program, including from representatives of rural and remote health services. 2.4. Mechanisms exist for responding within the curriculum to contemporary developments in health professional education and practice.	• Evidence of registration with TEQSA as a higher education provider OR • Key academic governance policies and procedures AND • Evidence of arrangements relating to partnerships between education providers to deliver the program • Terms of reference for program governance committees/reviews • Evidence of effective consultation and/or formal partnerships with health services, allied health professions, community and other health professions to deliver program *May be requested* • *Role statements for senior positions in the program* • *Records of governance meetings showing participation, decisions made and implemented* • *Copies of forward plans for program which include assessing and mitigating program opportunities/risks* • *Examples of student, employer and/or graduate surveys/reviews and outcomes* • *Copies of external or internal reviews and outcomes* • *Arrangements which enable students and/or staff to respond to contemporary developments in health professional education theory and practice* • *Records of other stakeholder consultation or engagement activities showing participation, decisions made and implemented*

Guidance

This Standard addresses the organisation and governance of the education program.

The focus is on the overall context in which the program is delivered, specifically the administrative and academic organisational structure which supports the program and the degree of control that the academics managing and delivering the program, health services, allied health professions and other external stakeholders have over the relevance and quality of the program to produce graduates who achieve the defined competencies.

A strong understanding of the AHRG concept and link to practical rural generalist service requirements is expected to be seen.

Third party, agent or partnership arrangements

Academic partnerships may be formed between education providers, including for the purpose of course delivery, articulation, student mobility or general academic collaboration.

Where an academic partnership is formed to deliver an education program, education providers will be expected to provide documentary and experiential evidence of the partnership, including the purpose, roles, responsibilities, contractual or other arrangements, and monitoring and quality assurance arrangements. A single accreditation application may be submitted jointly by the academic partners, with evidence provided about the contributions of each education provider, as appropriate. Depending on the type of partnership and the education providers involved, evidence of registration with TEQSA as a higher education provider may be relevant as documentary evidence. Also see the TEQSA *Guidance Note: Third Party Arrangements* (TEQSA 2017a).

Alternatively, each education provider may wish to submit a stand-alone accreditation application for the particular competencies achieved within their education program. See the *Program Accreditation Handbook* for further information about part-program accreditation applications.

Domain 3. Program of study

Standard Statement	Criteria	Examples of evidence
Program design, delivery and resourcing enable students to achieve the required competencies.	3.1. A coherent educational philosophy informs the program of study design and delivery. 3.2. Program learning outcomes address all the relevant competencies. 3.3. The quality and quantity of work-integrated learning is sufficient to produce a graduate competent to practice with a rural generalist scope. 3.4. Learning and teaching methods are intentionally designed and used to enable students to achieve the required learning outcomes. 3.5. Principles of inter-professional learning and practice are embedded in the curriculum. 3.6. Teaching staff are suitably qualified and experienced to deliver the units that they teach. 3.7. Learning environments support the achievement of the required learning outcomes. 3.8. Facilities and equipment are accessible, well-maintained, fit for purpose and support the achievement of learning outcomes. 3.9. The program has the resources to sustain the quality of education that is required to facilitate the achievement of the necessary competencies.	• Statement of overall educational philosophy/design for the program • Curriculum map including program learning outcomes and alignment to the relevant competencies • Assessment matrix or other consolidated and comprehensive assessment design documentation to demonstrate alignment to the relevant competencies • Program/course/subject approval documentation • Staffing profile for the program, including numbers, professional qualifications, areas of expertise, teaching and supervision responsibilities, and if applicable, registration status. • Summary of work-integrated learning delivered in the program *May be requested* • *Subject guides for students detailing how the program of study is structured and enacted at each stage* • *Examples of learning and teaching materials and approaches using a range of delivery methods* • *Student and employer feedback on program of study* • *Sample staff position descriptions* • *Documentation on recruitment, support, workload and/or professional development of staff teaching in the program* • *Examples of staff engagement with learning and teaching initiatives to support (innovative, contemporary and evidence based) teaching approaches*

Guidance

This Standard focuses on the way the educational outcomes of the program are achieved and how consistent they are with the AHRG Competency Framework and AHRG Education Framework.

A strong understanding of the AHRG concept and link to practical rural generalist service requirements is expected to be seen.

The accreditation entity expects education providers to be cognisant of:

- the needs of adult learners who have already met the entry-level requirements for their respective allied health profession, and who are living and working in a rural or remote setting;
- service models for implementing clinical activities, regulatory environments relevant to these clinical activities, supportive business/funding environments, and appropriate governance structures required within implementing health services.
- the *Aboriginal and Torres Strait Islander Health Curriculum Framework* (Commonwealth of Australia 2014);
- developments in inter-professional learning and practice; and
- relevant profession-specific frameworks.

For components of an education program that require approval (or equivalent) by other entities in order for allied health professionals to meet any associated regulatory requirements, education providers will be expected to apply for recognition of those aspects through existing mechanisms. Evidence of such approval will be accepted by the accreditation entity, and those components of an education program will not be subject to further evaluation. Examples include:

- Qualifications for endorsement of registration, e.g. scheduled medicines endorsements for podiatry
- Programs to support credentialing by a recognised entity, e.g. Australian Diabetes Educators Association accredited post-graduate courses for recognition as a Credentialled Diabetes Educator.

Levels of qualification have not been defined for accreditation of education programs. The accreditation entity will consider the learning outcomes and their alignment with the Competency Framework and Education Framework. Consideration will be given to whether the volume of learning is sufficient for graduates to achieve the learning outcomes identified. However, it is then expected that any qualification awarded will be consistent with the criteria (including 'volume of learning' descriptor) in the Australian Qualifications Framework.

Domain 4. The student experience

Standard Statement	Criteria	Examples of evidence
Students are provided with equitable and timely access to information and support.	4.1 Course information is clear and accessible. 4.2 Admission and progression requirements and processes are fair and transparent. 4.3 Students have access to effective grievance and appeals processes. 4.4 The provider identifies and provides support to meet the academic learning needs of students. 4.5 Students are informed of and have access to personal support services provided by qualified personnel. 4.6 Students are represented within the deliberative and decision making processes for the program. 4.7 Equity and diversity principles are observed and promoted in the student experience.	• Evidence of registration with TEQSA as a higher education provider OR • Student admission and progression policies and procedures for the program • Copies of program information handbook and link to website • Copies of policies and procedures relevant to the student experience • Description of the range of academic and personal support services available to students and the qualifications required of the staff providing the services • Details of student representation within the governance and curriculum management processes of the program • Policies and procedures on equity and diversity, with details of implementation and monitoring *May be requested* • *Use of student satisfaction data or other feedback to improve program* • *Examples of the provision of academic and/or personal support services* • *Sample of admission and progression decisions*

Guidance

This Standard focuses on how the provider delivers a student experience that is equitable and respectful of all students' development, wellbeing and rights. The accreditation entity expects a provider to be cognisant of the needs of adult learner practitioners in shaping the experiences of students in a postgraduate program for qualified health practitioners.

Domain 5. Assessment

Standard Statement	Criteria	Examples of evidence
Assessment is fair, valid and reliable.	5.1 There is a clear relationship between learning outcomes and assessment strategies.	• Assessment matrix/blueprint which details assessment methods and weightings and demonstrates alignment of assessment to learning outcomes and AHRG Competency Framework • Qualifications, registration/professional membership status (if applicable) and responsibilities of markers of assessment and supervisors involved in assessment AND • Evidence of registration with TEQSA as a higher education provider OR • Policies and procedures on assessment strategy, assessment and marking, credit for prior learning and progression • Processes for identifying, using and evaluating input of external experts (if applicable) to assessment • Examples of assessment moderation/benchmarking including the outcomes • Sample certification for graduates *May be requested* • *Samples of student assessment and feedback provided to students* • *Sample of student log books/portfolios* • *Examples of assessment statistical data and how it is reviewed/used to improve program/course/unit outcomes and assessment approaches*
	5.2 Scope of assessment covers all learning outcomes relevant to the competencies.	
	5.3 Multiple assessment tools, modes and sampling are used including direct observation in a clinical setting (including telehealth or simulated).	
	5.4 Program management and co-ordination, including moderation procedures, ensure consistent and appropriate assessment and feedback to students.	
	5.5 Suitably qualified and experienced staff assess students	
	5.6 All learning outcomes are mapped to the required competencies, and assessed.	

Guidance

This Standard focuses on the assessment strategies and methods used in the program in giving assurance that every student who graduates from the program has achieved the required competencies.

The accrediting entity expects education providers to use fit for purpose and comprehensive assessment methods and formats to assess the intended learning outcomes, and to ensure a balance of formative and summative assessments occur throughout the program. It is expected that assessors are suitably qualified and experienced to assess students. A 'team' assessment approach, e.g. involving experienced academics, assessment design experts and rural and remote practitioners, may be helpful in some circumstances.

Resource 4.

Program Accreditation Handbook

The *Program Accreditation Handbook* describes the policies and procedures by which the accreditation entity applies the accreditation standards when accrediting education programs.

Note: Adoption of the policies and procedures included within the *Program Accreditation Handbook* are dependent on a new entity being established, and the intent expressed by stakeholders (funders, Members and Directors) through the establishment process. AHHA has proposed (separately to this handbook) a governance system, business model and associated resources to establish this new entity.

1. Guiding principles

The policies and procedures outlined in this *Program Accreditation Handbook* are guided by the following principles:

- **A clear purpose.** Accreditation exists to identify education programs that address the learning and development needs of allied health professionals in rural generalist practice. This will support health services and commissioning agencies implementing the AHRG Pathway, developing allied health professionals in the delivery of high quality multi-professional services that address the health needs of rural and remote communities.
- **Objective, transparent and responsive processes.** All components of the accreditation system will be based on the available research and evidence base. Stakeholders will be involved in the development and review of standards through wide-ranging consultation. The accreditation processes will be sufficiently flexible to recognise programs across the vocational education and training (VET) and higher education sectors; they will support diversity, innovation and evolution in education.
- **Fostering continuous quality improvement.** It is the responsibility of education providers to demonstrate how their program meets the Program Accreditation Standards. Accreditation processes will be conducted in a positive, constructive manner based on collaboration and peer review.

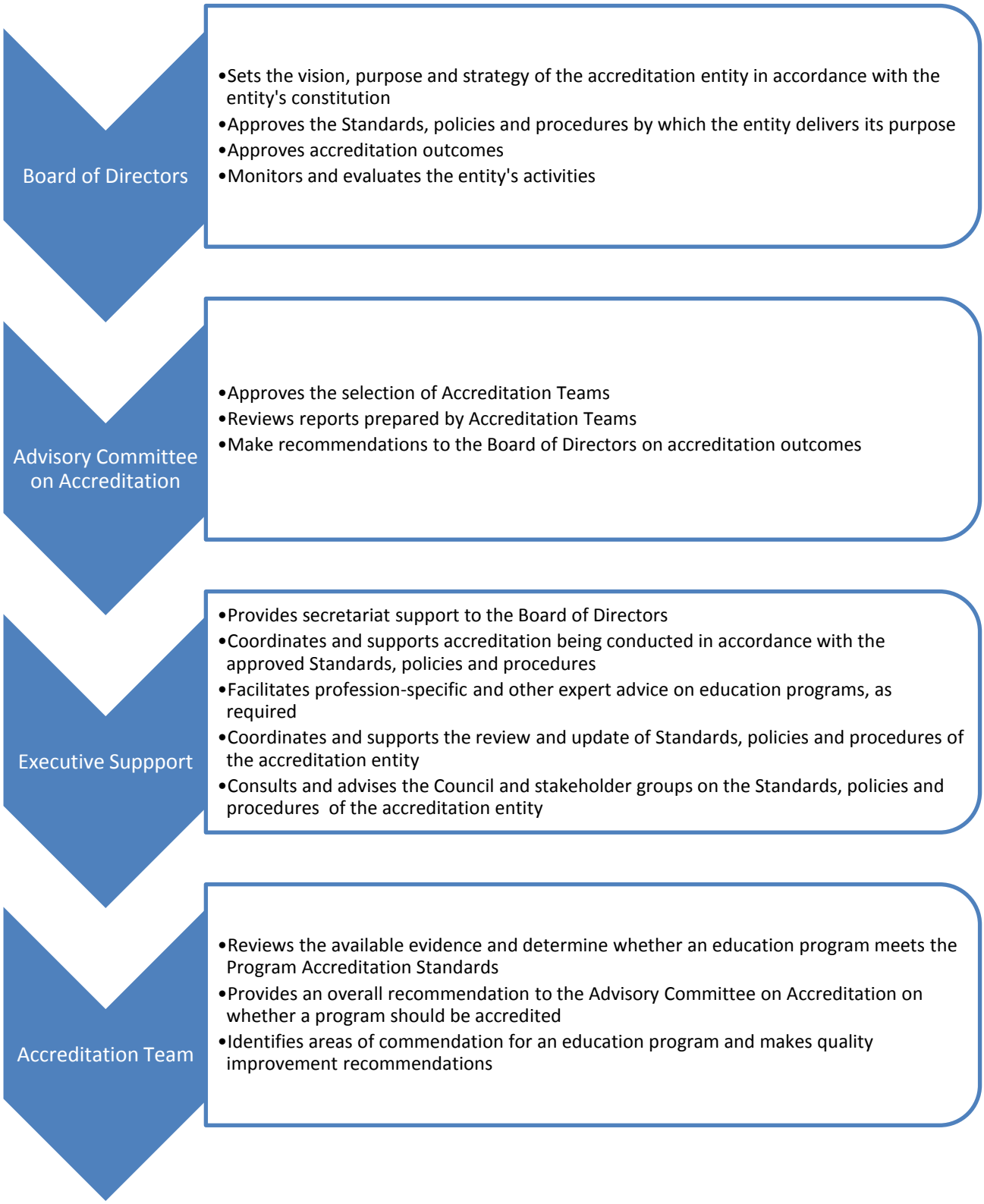
The policies and procedures outlined in this *Program Accreditation Handbook* have been developed with consideration of the current context of rural generalist practice in the allied health professions in Australia. While the accreditation system is in its infancy, in particular, and a review of the Education Framework underway, commitment to continual monitoring, consultation and review of the accreditation system will be built into business activities.

2. Governance and decision-making framework

The decision-making framework for accreditation is summarised in Figure 4.

(Note: the governance and decision-making framework is dependent on the governance system, business model and associated resources adopted when establishing the new entity. In addition to the Board of Directors and Advisory Committee on Accreditation, the proposed governance system includes a Council of member representatives to provide strategic and policy advice to the Board and to advocate to the Board on behalf of constituencies. This component of the governance system is not reflected in Figure 4, as the Council is not involved directly in the decision-making for accreditation.)

Figure 4. Summary of in decision-making framework for accreditation



2.1 Executive Support

An individual or entity will be engaged to provide executive, operational, finance and administrative support to the accreditation entity.

Role

Roles in providing support to the Board of Directors include:

- Developing and managing business plans and budgets
- Providing administrative support, such as taking meeting minutes, circulating papers
- Ensuring compliance with legal obligations
- Communicating and consulting with stakeholders.

Roles in supporting accreditation activities include:

- Liaising with the education provider regarding the AHRG concept and pathway, their application and interviews;
- Providing advice to the Accreditation Team on the interpretation of the Program Accreditation Standards; and
- Ensuring the Accreditation Team report has appropriately addressed the Program Accreditation Standards and is within the scope of the accreditation entity's functions.

Selection

Skills required to provide Executive Support include:

- Project and financial management skills
- Effective stakeholder engagement skills
- A sound understanding of the Allied Health Rural Generalist concept and pathway;
- Knowledge and skills in accreditation;
- Experience in supporting a not-for-profit Board.

A policy on Executive Support is provided in the proposed Governance Charter. (Note: this is dependent on the governance system, business model and associated resources adopted when establishing the new entity.)

2.2 Accreditation Team

Role

Accreditation Teams are established by the Executive Support according to the approved policies and procedures to:

- Review the available evidence and determine whether an education program meets the Program Accreditation Standards
- Provide an overall recommendation to the Board of Directors on whether a program should be accredited
- Identify areas of commendation for an education program and make quality improvement recommendations.

Selection

Teams shall be comprised of three or four individuals, who collectively have expertise and experience:

- In rural and remote allied health service delivery in Australia
- As an academic with experience in tertiary health professional education in Australia
- In interprofessional learning, assessment or accreditation

- As a practising allied health professional (at least two of those professions covered by the education program)
- In accreditation processes.

Once a preliminary team has been selected, the education provider will be given the opportunity to consider the team members and identify any perceived or real conflicts of interest that may exist. In the event that a conflict is identified, the Executive Support will consider alternative members.

A Chair will be appointed to lead the Accreditation Team through the accreditation process. This will include chairing teleconferences with the team, allocating evaluation and reporting writing tasks to team members, leading the questioning of interviewees, leading the writing of the report, and taking the lead in formulating the overall recommendation.

Expectations and training

All Accreditation Team members will be expected to:

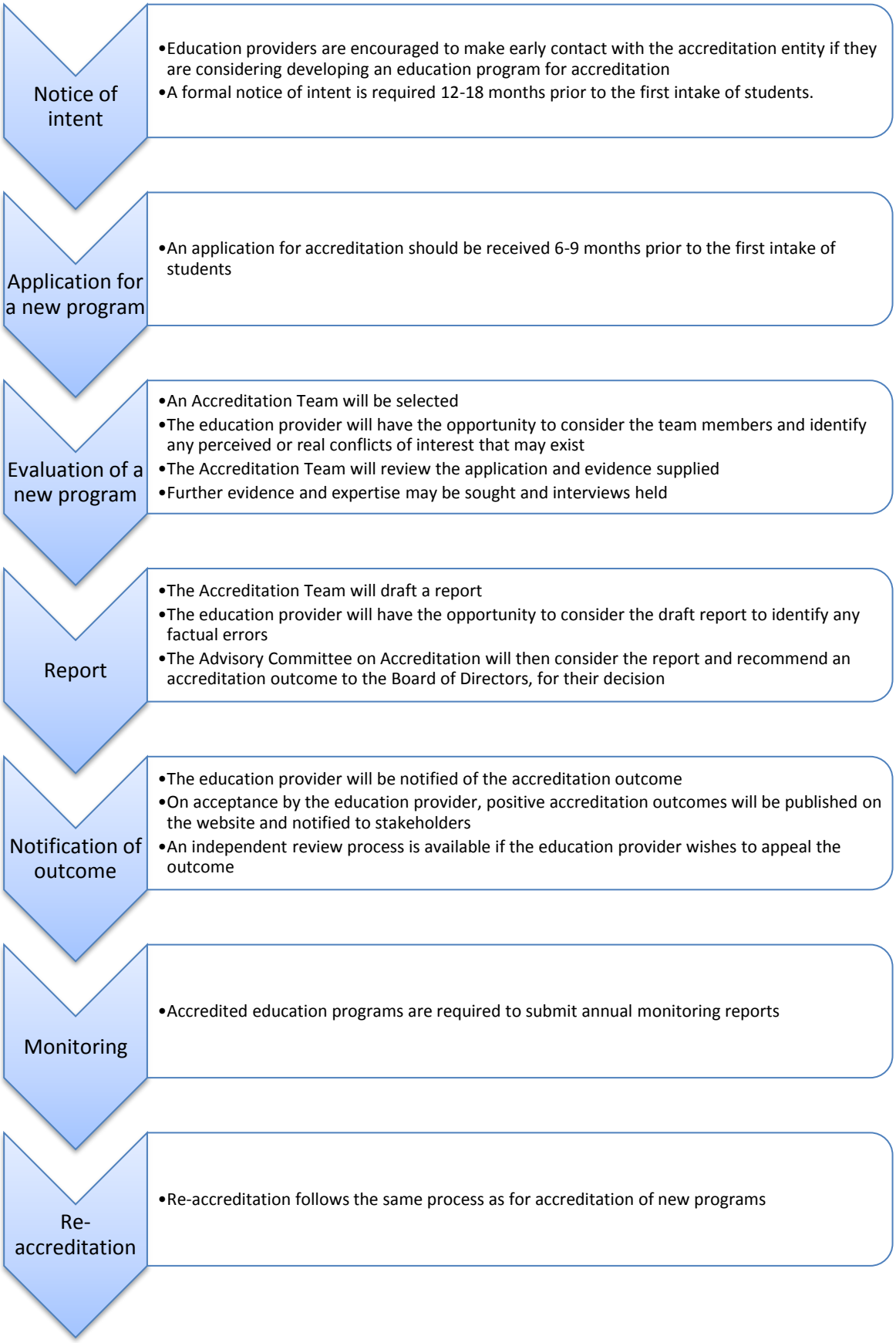
- Have a sound understanding of the Allied Health Rural Generalist concept and pathway;
- Apply honesty, integrity, independence and confidentiality as a team member;
- Disclose any interests and declare confidentiality prior to appointment to a team;
- Apply the Program Accreditation Standards, policies and procedures when evaluating evidence from multiple sources;
- Have access to information and communication technology (ICT) to support a desktop review of evidence provided electronically and to participate in video-enabled conferencing; and
- Collaborate with the team and the Executive Officer to record findings in a standard format and provide a recommendation based on these findings.

Training will be provided. Collaborative training with other accreditation entities will be pursued and supported. (Note: details are dependent on the governance system, business model and associated resources adopted when establishing the new entity.)

Accreditation Team members will be provided an honorarium in acknowledgement of their professional contribution. (Note: this is dependent on the governance system, business model and associated resources adopted when establishing the new entity.)

3. Accreditation process

3.1 Overview of the accreditation process



3.2 Notice of intent

Education providers considering developing an education program for accreditation are encouraged to make early contact with the accreditation entity to support a clear understanding of the AHRG concept and pathway, as these drive the purpose for the education.

Once a decision has been made by the education provider to develop an education program for accreditation, a notice of intent should be submitted to the accreditation entity. This should be submitted 12-18 months prior to the first intake of students. This submission should include a business plan, covering the process and timeline for the development of the program through to delivery of the full program to the first cohort, demonstrating how the Program Accreditation Standards will be met.

The accreditation entity will confirm the process and indicative timelines, working closely with the education provider in the development of a new program to reduce risk to students, health services implementing the AHRG Pathway and the education provider.

3.3 Application for a new program

An application for accreditation of a new program should be submitted 6-9 months prior to students being admitted to the program. This will facilitate an accreditation decision being made prior to the intake of students. (It is acknowledged, however, that as there is no regulatory requirement for the program to be accredited, any program developed can still be delivered regardless of accreditation status.)

The education provider should prepare a comprehensive submission against the five Program Accreditation Standards for evaluation by the Accreditation Team. The accreditation entity is mindful of the need to keep the administrative burden of accreditation to a minimum:

- An application template is available for providers to guide the application process.
- The application should be submitted electronically.
- Guidance on the types of evidence that may be provided is included as part of Resource 3. Education providers are encouraged to submit documentation in its original format or as prepared for other purposes (e.g. TEQSA audit), and not to spend time unnecessarily reformatting it for this accreditation process.
- Hard copies of information are not required. Documentary evidence may be provided as attachments to the application or through hyperlinks to key documents that may be publicly available.
- In the application, education providers are asked to map the documentary evidence to the Program Accreditation Standards, with reference to the relevant Criteria, in order to ensure it is clear what evidence was provided to demonstrate each Standard has been met.

3.4 Evaluation of a new program and reporting

On receipt of an application, the Executive Support will undertake a preliminary review to confirm the application appears complete. They will liaise with the education provider if any evidence, on face value, appears missing.

The Chair of the Accreditation Team will then undertake a preliminary review to allocate evaluation and writing tasks to team members based on their expertise and experience.

Applications will be distributed electronically to Accreditation Team members, with allocations identified for evaluation and writing tasks. An initial teleconference will be held to discuss allocations, and confirm expectations and timeframes.

When evaluating a submission for a new program, the Accreditation Team will be cognisant that the program is being evaluated in a planning phase. The team would want to be assured that:

- The curriculum framework and design of the program are sufficiently developed;
- There are detailed plans for the development and delivery of curriculum content and assessment, including plans for staffing, physical facilities and educational resources;
- The staff expected to implement the program understand the AHRG concept and their role; and
- Any work-integrated learning experiences that the education provider intends to include in the program have been planned and are feasible to implement.

The reports prepared individually by team members will be collected and collated by the Executive Support into a single report. The draft report will be circulated to the Accreditation Team for discussion at a second teleconference. The purpose of this teleconference is to discuss any uncertainties in findings and confirm further evidence, expertise required for evaluation and/or interviews required to complete the evaluation against the Program Accreditation Standards.

The Executive Support will liaise with the education provider and Accreditation Team members to schedule and conduct interviews. The Executive Support will obtain further expertise required for evaluation, as required.

Following receipt of further evidence, evaluation and/or conduct of interviews, Accreditation Team members will make amendments to the draft report. These will again be collected and collated by the Executive Support into a single report. The draft report will be circulated to the Accreditation Team for discussion at a third teleconference. The purpose of this teleconference is to confirm the final report and a recommendation on the accreditation outcome.

The Accreditation Team may also identify Commendations, areas of the program that are considered to significantly exceed the minimum requirements for accreditation, and Recommendations, areas where an opportunity has been identified to further improve the quality of the program as part of the provider's commitment to continuous quality improvement.

The education provider will be given an opportunity to review and comment on the factual accuracy of the draft report (with the recommendation on the accreditation outcome omitted) before it is provided to the Advisory Committee on Accreditation for consideration and recommendation of an outcome to the Board of Directors.

The Board of Directors will make a final decision on the accreditation outcome and report it to the education provider. On acceptance of the accreditation outcome by the education provider, positive accreditation outcomes will be published on the accreditation entity's website and notified to stakeholders. The removal of accreditation or addition of conditions will also be published and notified to stakeholders.

3.5 Monitoring requirements

Education providers with an accredited education program (with or without conditions) are required to submit annual monitoring reports. Again, the accreditation entity is mindful of the need to keep the administrative burden of accreditation to a minimum. An annual monitoring report template is available for providers to guide the submission. The report should be submitted electronically.

In the report, education providers are asked to:

- Report against any conditions;
- Identify any major changes planned to the program (see below);
- Summarise any evolutionary changes made to the program in the preceding year, and identify any changes anticipated or planned for the future; and
- Report against indicators of program quality or risk, where identified (see below).

The Executive Support will review annual monitoring reports, seek advice from the Accreditation Team chair, Council members and other individuals identified with suitable expertise and experience depending on the contents of the report. A recommendation will be prepared with the Advisory Committee on Accreditation regarding acceptance of the report, for consideration by the Board of Directors.

The Board of Directors will make a final decision on acceptance of the annual monitoring report and any change to accreditation status and report it to the education provider. Any changes to accreditation outcomes will then be published on the accreditation entity's website and notified to stakeholders.

Definition of major change

A major change to an accredited education program may affect its accreditation status and is subject to a more comprehensive evaluation by an Accreditation Team.

For the purposes of accreditation, it is any change that may actually or potentially affect any of the *Program Accreditation Standards* being met, including a:

- Change in education provider or settings for delivery of the program
- Change in the allied health professions covered by the program
- Change in whether the program covers all or part of the competencies in the Competency Framework
- Significant change in educational philosophy
- Change in the length of the program
- Significant change in the format or overall sequence of subjects in the program
- Significant change in teaching strategies or assessment methods
- Significant change in student numbers relative to available resources
- Significant change in staffing profile
- Any conditions imposed on the provider by an education regulatory agency.

The gradual evolution of a program in response to initiatives in the education and health sectors is encouraged, and not necessarily considered a major change. If an education provider is unsure whether changes being considered a major change, they should consult with the accreditation entity.

Indicators of program quality or risk

There is growing interest and experience in risk-based approaches to accreditation in Australia. Such approaches require an availability of risk parameters/indicators, e.g. knowledge of the probability of occurrence and extent of damage. Such data are unlikely to be achieved with the number of education providers and size of cohorts in education for rural generalist practice in the allied health professions. However, as experience with risk-based approaches increases over time and intelligence about risk-based indicators grows, annual monitoring reports may include such indicators, developed in consultation with stakeholders.

3.6 Re-accreditation

An application for re-accreditation of a program should be submitted 6-9 months prior to the end of the accreditation period. This will facilitate an accreditation decision being made prior to accreditation expiring.

The education provider should prepare a comprehensive submission against the five Program Accreditation Standards for evaluation by the Accreditation Team. This should follow the same process as for an application for a new program (see 3.3 and 3.4).

3.7 Fees

Fees may be payable for accreditation. (Note: this is dependent on the governance system, business model and associated resources adopted when establishing the new entity.)

4. Outcomes

Accreditation outcomes that may be applied to education programs are listed in Table 4.1.

Table 4.1. Accreditation outcomes that may applied

Accreditation granted	Accreditation is granted when the program meets the Program Accreditation Standards. Retention of this outcome is subject to ongoing monitoring.
Accreditation with conditions is granted	Accreditation with conditions is granted when the program substantially meets the Program Accreditation Standards but the program has a shortcoming in one or more Standard. The shortcoming is considered to be of such a nature that it can be addressed within a reasonable time period. Retention of this outcome is subject to ongoing monitoring, with evidence required of conditions being met within the timeframes stipulated to the education provider.
Accreditation not granted	Accreditation is not granted when there are significant deficiencies in the program such that it does not meet the Program Accreditation Standards, and that the education provider does not have the capacity to remedy them or does not accept the need to do so.

Where accreditation is granted (with or without conditions), a time period for accreditation will also be specified up to five years.

5. Policies

5.1 Confidentiality

A Confidentiality policy has been proposed as part of the governance system, business model and associated resources, for adoption by the Board of Directors when establishing the new entity.

5.2 Conflict of interest

A Conflict of interest policy has been proposed as part of the governance system, business model and associated resources, for adoption by the Board of Directors when establishing the new entity.

5.3 Complaints and appeals

Grievances arising out of accreditation processes should be raised in the first instance with the Executive Support. Issues and concerns, in most instances, may be resolved informally through these discussions. The Executive Support will report to the Board of Directors on all grievances raised and the actions taken to resolve them.

If the issue or concern cannot be successfully resolved informally, a formal complaint can be made in writing to the Chair, Board of Directors.

If an education provider wishes to appeal an accreditation outcome, they may seek an independent review of the accreditation outcome by writing to the Chair, Board of Directors. The appeal must:

- Be received within one month of the notification of the accreditation outcome being received by the contact identified by the education provider
- Specify the grounds on which an independent review is sought.

An appeal may be based on one or more of the following grounds:

- An error occurred in the process leading to the accreditation outcome being determined
- Relevant and significant evidence was not properly considered, or was incorrectly interpreted, in the process leading to the accreditation outcome being determined
- Inappropriate weighting was given to evidence used in the accreditation outcome being determined
- The reasons provided for the accreditation outcome are inconsistent with the evidence upon which that decision was made.

On receiving an appeal, an independent review panel of up to three members will be established by the accreditation entity:

- The panel will not include any member of the original Accreditation Team
- The panel will be selected to ensure the expertise and experience necessary for reviewing the particular area of focus in the education provider's appeal
- The panel will review the provider's application and evidence in the context of the particular area of focus in the education provider's appeal
- The panel will have the discretion to conduct further interviews as deemed necessary to make an informed judgement
- The panel will prepare a report, which will be provided to the education provider and the accreditation entity.

The direct cost of the review will be met by the education provider.

The Board of Directors will make a final decision on acceptance of the annual monitoring report and any change to accreditation status and report it to the education provider. Any changes to accreditation outcomes will then be published on the accreditation entity's website and notified to stakeholders.

5.4 Accreditation Marketing Policy

Education providers may use the following statements when marketing education programs that have been accredited by the accreditation entity:

Accreditation

This program has been granted accreditation by [insert name of accreditation entity] as a Level [insert 1 or 2] program for rural generalist practice in the allied health professions. The program is available to the following professions: [insert professions included in the program].

Accreditation with conditions

This program has been granted accreditation with conditions by [insert name of accreditation entity] as a Level [insert 1 or 2] program for rural generalist practice in the allied health professions. The program is available to the following professions: [insert professions included in the program].

5.5 Review of Program Accreditation Standards and associated resources

Program Accreditation Standards and associated resources will be subject to a substantive review with broad stakeholder consultation every five years.

While the accreditation system is in its infancy, in particular, and a review of the Education Framework underway, commitment to continual monitoring, consultation and review of the accreditation system will be built into business activities.

Between substantive reviews, stakeholders may submit a recommendation for amendment. If there is a need for a recommendation for amendment to be considered other than during a substantive review, the recommendations must be accompanied by evidence to support why the amendment should be pursued as a priority.

The Executive Support will review recommendations for amendment, seek advice from the Accreditation Team chair, Council members and other individuals identified with suitable expertise and experience, depending on the recommendation. The recommendation will be considered by the Advisory Committee on Accreditation, together with this advice, and a recommendation on the action to be taken provided to the Board of Directors for a decision.

6. Templates

6.1 Application template

An application template is provided as Attachment 1 (not published).

6.2 Reporting template

A reporting template is provided as Attachment 2 (not published).

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