National Registration and Accreditation Scheme (NRAS) – Accreditation Systems Review

NT Submission

The Northern Territory supports the view expressed by the Independent Reviewer at the Darwin consultation forum that the national system is functioning reasonably well. Overall it is strongly recognised that the professional competency of health professionals and the delivery of safe health services to the public are of critical importance in the accreditation of programs and the registration of health practitioners.

IMPROVING EFFICIENCY

Accreditation standards

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

The Northern Territory (NT) agrees that efficiencies in the operation of accreditation systems could be identified to streamline accreditation processes. However, the complexity of accreditation systems is acknowledged, noting that educational institutions undergo multiple accreditation processes by various bodies with variations between:
- levels of study, e.g. professional entry, post-graduate and specialist
- programs of study within the same profession
- education providers – internal accreditation requirements and external assessment processes
- training positions/placements.

Streamlining of accreditation systems may benefit from:
- A clear distinction between the role of each accreditation process to help avoid overlap and duplication.
- Development of common terminology and formats for accreditation. There should be a concerted effort to remove duplication where it is obvious.
- The more experienced accreditation authorities may have capacity to assist the smaller/newer accreditation bodies to implement streamlining and improvements in a move to more consistent accreditation processes.
- A process for recognition of previous accreditation assessments for facilities for one course should apply for other courses that make use of the same facilities. For example, the NT Medical Program (NTMP) had to complete the full accreditation process for the first two years of program when it was offered in Darwin even though the facilities and staff had already been accredited for the final two years of program. The time that was taken to have GP placements accredited for NTMP students was also significant.
- The Health Practitioner Accreditation Councils’ Forum (HPACF) could review or investigate the possibility of creating consistencies. Indications are that the HPACF has taken positive steps towards identifying common elements of accreditation and streamlining processes, with more work to come on this.
Educational providers may be able to streamline processes by coordinating accreditation assessments with regular timeframes and a broader scope to account for a range of programs. There is general agreement that the accreditation of common competencies across professions may be possible e.g. anatomy, diagnosis, pharmacology and communication skills. This in itself could lead to efficiencies in the accreditation processes for education providers if supported by a common standard of accreditation. However it is also noted that the breadth and depth of functional knowledge in these areas may vary. Communication is a common requirement across health professions; however the application of this skill will vary. Communication by a community pharmacist in a public space is quite different to the detailed discussions undertaken in a GP’s private room. This is likely to be the case for a number of competencies that may be considered common across professions.

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

Tertiary Education and Quality Standards Authority (TEQSA) requirements cover both the education provider and the program of study, and are generally considered reliable and rigorous processes. It is understood that TEQSA has done some work towards common elements of accreditation. TEQSA requirements could form the basis for accreditation of providers and programs, providing some consistency and recognition of common elements. This would allow the accreditation authority to focus on their expertise on professional practice, standards, outcomes and minimising risk to the public specific to the individual professions. Recognition of registration with TEQSA could be used as an enabling requirement for accreditation such as the approach adopted by Australian Pharmacy Council.

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

The NT notes that approved accreditation standards must adhere to the key priority of public safety and therefore be risk averse. A risk-based approach is unlikely to be acceptable to the public and has not proven to be a fail-safe system in the past. Such an approach would need a way of identifying issues when they occur and quick responses to avoid an issue escalating or a practitioner slipping through the system undetected. There would need to be different levels of risk with associated triggers for action. However, risk may not be the only trigger for action, particularly if prevention is the key focus for protection of the public.

A risk management approach could be based on self-assessment and should involve the right quality information, supported by evidence, consistent triggers for action and reliable application. The Australian Nursing and Midwifery Accreditation Council (ANMAC) recently launched a risk based approach based on TEQSA with significant benefits to be gained by nursing and midwifery. In practice, there is a lengthy process to gain accreditation as an education provider for curriculum prior to the ANMAC process, therefore timing is an issue. A risk-based approach is appealing due to less work required. However, it would need the ability to identify
issues involving small cohorts of students or graduates and for determining whether an issue before a board can be linked to accreditation of the associated program of study. Under a risk based approach, the triggers should also be able to allow or stimulate innovative change and should not delay implementation.

For some of the health professions accreditation processes have been streamlining over the years and are often based on a cycle of assessments, e.g. every five years, with annual reports and/or reporting when significant changes to a program occur. Common cycles may work where there are a number of health profession courses offered by one university, particularly for the higher level or common requirements, thereby minimising the disruption incurred by education providers and health services in accommodating accreditation assessment panels, sometimes multiple panels within short periods of time. A risk management approach without a cycle of accreditation would need a mechanism for monitoring the quality of graduates. NT stakeholders raised the issue of which health professions are actually considered ‘low-risk’ given they are all involved in treating or consulting with the public.

Training and readiness of assessment panels

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

Accreditation is a specific skill in itself and may require standards for members if the composition of assessment panels were to be broadened. Some National Boards have more sophisticated accreditation standards and processes e.g. well-established accreditation authorities, whereas some have accreditation committees. Occupational Therapy Australia has developed accreditation standards for occupational therapy that meet international and National Board requirements. Physiotherapy now has the practice thresholds that cover both Australia and New Zealand and form the basis of the mutual recognition process. Some non-registered allied health professions also have their own accreditation standards and overseas assessment processes.

Accreditation is also impacted by other legislative requirements, particularly the accreditation of placements such as work health and safety requirements and disability legislation. The uncapping of student numbers in the education sector has also increased demand for accreditation of new programs of study further exacerbating duplication, costs and other accreditation requirements. While there is little capacity to influence these factors, the impact they have had must be recognised and possibilities for minimising them explored.

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

In the NT consultations it was deemed unnecessary by the majority of stakeholders to include consumers as part of the accreditation assessment teams due to the complexity of assessments and the profession specific aspects. Accreditation authorities incur various costs including travel
associated with assessments, site visits and training of accreditation panel members. Costs would increase if additional members were required such as consumer representatives. Assessment teams often hold interviews with education staff, placement providers, clients and local consumers as part of the accreditation process. The definition of ‘consumer’ can also vary significantly depending on the input required. For example, consumers could also be the health services.

Sources of accreditation authority income

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

The capacity to find efficiencies in accreditation processes would vary between National Boards. For example, the Aboriginal and Torres Strait Islander Health Practice Board of Australia is not yet self-funded by registrants but has achieved cost savings by reducing the number of board meetings and by performing its own accreditation function. Each National Board should be encouraged to review and identify further efficiencies related to accreditation.

As previously mentioned the more experienced accreditation authorities could facilitate the smaller or newer accreditation bodies to achieve more streamlined and consistent accreditation processes, which may reflect in economies for accreditation. The different professions entered the national scheme at very different starting points for the accreditation of their programs of study. The last five years have seen a process of maturation and some standardisation. Opportunity exists for the Boards and Councils with well-established processes to provide support for other Boards.

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

It was noted that this situation may exist currently in medicine accreditation. If there are surplus funds within the processes of assessment of overseas qualified practitioners and assessment of offshore competent authorities it is acceptable to see these funds used to cross-subsidise accreditation functions for on shore programs?

RELEVANCE AND RESPONSIVENESS

Input and outcome based accreditation standards

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

The focus of accreditation should be on student outcomes as opposed to specific hours of practice and the level of commitment to input/processes/resources, particularly for smaller/newer professions. It would be appropriate for accreditation authorities to reconsider
the value of the amount of hours spent in clinical placements related to the quality of student outcomes. Accreditation can be granted with conditions to address any system issues within specified timeframes rather than the standards setting the operational benchmarks.

The requirement for minimum clinical placement hours could be considered an arbitrary approach. For the NT this can directly affect the ability to provide placements, attract students back for employment, develop necessary professional skills and deliver health services rather than applying a quality based approach. For example, the Nursing and Midwifery Board of Australia’s requirement for 5,000 hours of full-time experience (or equivalent) at the clinical advanced nursing practice level, required for endorsement as a Nurse Practitioner, effectively rules out the conduct of this program in the NT.

Inconsistencies in other standards, such as scores needed for admission and pass levels for progression, affect the quality of graduate produced. Education providers need an effective mechanism to prevent students from progressing if results do not meet required standards.

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

The height of the bar for standards in each profession needs to be of a sufficient level to provide a safe service to the public but not so high as to prevent the education providers from meeting regulatory requirements. Scope is needed within the system to cover broader issues such as health economics training in curriculum, skills to aid patient outcomes and credentialing to ensure quality student outcomes.

Health program development and timeliness of assessment

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

There is consensus across NT stakeholders that there are areas of commonality across the 14 health professions that would lend themselves to common standards and processes. This is generally for the higher level functions of universities including:

- Governance, structure and administration
- Risk and quality management
- Financial management and sustainability
- Student support and representation.

The individual accreditation of the profession specific components is seen as critical so that the education system delivers ‘work ready’ and safe health profession graduates. Current accreditation requirements mostly include that universities should engage with consumers on a variety of matters such as student placements and curriculum development through mechanisms such as consumer representation on course advisory groups. This type of involvement in the accreditation process is preferable to participation on accreditation assessment panels that require specialised skills.
11. What are the risks and benefits of developing accreditation standards that have common health profession elements/domains, overlayed with profession-specific requirements?

Core common competencies would provide foundation skills but profession specific skills remain vitally important and should not be undervalued. Accreditation looks at the macro requirements for skills development while providing the flexibility for education providers to address profession specific requirements at a detailed level. The communication requirements of health professionals has shifted over the years from communication between clinicians and records to now a greater focus on communication, with patients as the centre of the interaction, multidisciplinary team management and appreciation of cultural background, needs and preferences.

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

The process for development of accreditation standards could be streamlined to reduce the number of committees that endorse them and to clearly identify the mechanism for initiating a review of existing or development of a new standard. It is understood that the current process requires a standard to be requested by the relevant National Board.

The university system can be an onerous one when making significant changes to curriculum e.g. up to 24 months lead in time is required.

The current accreditation system allows flexibility to address profession specific requirements as they change. As mentioned above, communication requirements have shifted over the years to a greater focus on communication with patients and appreciation for cultural background. This will be an essential element in future workforce development and innovative models of care. The development of further extended scopes of practice and even the larger concept of ‘new’ health professions needs to be enabled into the future with technology changing so rapidly.

What was once considered advanced practice in has now become standard practice for some professions in areas such as scheduled medicines and vaccinations. Optometry has upskilled their professionals in ocular medicines in response to the need for advanced professional skills, and this is now standard for new graduates.

Interprofessional education, learning and practice

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

Multi-disciplinary teams tend to currently be focussed on health space and would benefit from being broadened to other settings such as child protection, environmental health and education. This would enable students to learn about other professions and carry this multi-disciplinary approach to a broader number of workplaces. Broadening graduate skills further to incorporate
quality improvement processes may also assist in achieving service-level improvements. The concept of student exchanges as part of broadening skills and experiences, particularly between regional and remote areas has the potential to produce graduates with an appreciation for other professions and working as effective members in multi-disciplinary teams.

It was noted that health professions outside of the National framework also need to function in multi-disciplinary teams e.g. the working relationship between nursing and social work. Also core competencies would ensure that even health professionals who may not work in multi-disciplinary teams would still have the basic diagnostic skills and understanding of the scope of other professions to know if they can help or need to refer on.

Clinical experience and student placements

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

Healthcare priorities will vary across jurisdictions. NT education providers understand local requirements/environments such as the challenges of working in remote locations. Interstate education providers also need to understand the NT context as many students in the NT are from interstate, particularly in nursing, and many do placements in the NT especially for allied health, where courses are not taught in the NT. Student exchanges may help develop the experience and skills of students for remote practice.

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

Simulation is a valuable method of learning that needs to be developed and managed well. It would be useful to improve current examples and evidence about the value of simulated learning, particularly across multidisciplinary training, preparation for placements and specific acute level skills. There is a need to review simulation based training as a contribution to clinical practice hours, especially in the cases of emergency situations. Simulation training is a worthwhile education practice that not only incorporates emergency situations but also students working as a multidisciplinary team.

The delivery of work-ready graduates

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

It was noted that intern years exist for pharmacy and medicine to strengthen competencies in the workplace, while other professions in the NT offer new graduate programs. The requirement for supervised practice leading to general registration is appropriate for high risk activities undertaken within certain professions to manage risk and uphold the principle objective of providing for the protection of the public.
17. How should work readiness be defined, and the delineation between registration requirements and employer training, development and induction responsibilities be structured?

Employers should be able to have a level of confidence in the baseline level of graduate skills and then assess for work readiness appropriate for that specific workplace. When boards deal with performance issues, they are issues of today. Even if work ready today, a graduate may not be ready for ‘future’ work. There needs to be a focus on lifelong learning with health professionals possessing the skills and capacity to learn, to deal with technological change and changing scopes of practice.

It is noted that it is challenging for the accreditation system to address the diversity in ‘work readiness’ requirements of employers across Australia. The concept of ‘work readiness’ will vary across Australia and it is specific to employer requirements. It is not clear if work readiness is solely an issue of student training and graduate outcomes or a health service/employer issue as work-ready is not only centred on professional skills. The quality of graduate may depend on the quality of the program and the university. Further development of a graduate is specific to the workplace. For example, are internships primarily educational or more about learning about the workplace and the Australian health system. Graduate competencies are important but also topics such as cultural competency and location-specific health literacy.

In medicine, work readiness generally focuses on working in hospitals as interns whereas a large portion of graduates go on to work in other locations e.g. 50% GPs, 5% remote in NT. Similarly the NT needs to provide midwives with the opportunity to work in hospitals to get the required skills (i.e. number of births) but would also like to provide graduates experience in the primary health care setting and the remote team environment in which they are likely to work.

National examinations

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

There was not support in NT for the concept of a national assessment to gain registration. However it is very desirable for a reliable level of knowledge and skills on graduation to be assumed.

PRODUCING THE FUTURE HEALTH WORKFORCE

Independence of accreditation and registration

19. Do National Boards as currently constituted have appropriate knowledge, skills and incentives to determine accreditation standards and programs of study which best address the workforce needs of a rapidly evolving health system?
It is acknowledged that ten National Boards have been in place for six years and four National Boards have only been operational for four years. The boards and AHPRA have worked hard to settle down functions, standardise requirements and streamline processes, and may now be in a position to place a greater focus on workforce reform.

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

The accreditation system needs to work closely with National Boards and jurisdictions to ensure the workforce is the right workforce for future health care. A mechanism is needed to identify if the system is constraining change or supporting development of new service delivery approaches. Decisions on health workforce reforms need to be objective, impartial, consistent, expert and transparent. It was expressed that the current system does have to capacity to achieve this.

Governance of accreditation authorities

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

With regard to involving consumers in the governance of the accreditation system and workforce development, it has proven difficult to find consumer representatives and advocates in the NT, in particular Indigenous representatives. However, a number of Aboriginal controlled medical services are involved in the NT and offer clinical placements and employment for medical graduates.

As previously discussed consumer engagement is a requirement of accreditation for universities including consumer representation on a course advisory group. This type of involvement in the accreditation process is preferable than for participation on accreditation assessment panels that require specialised skills. The definition of ‘consumer’ can also vary significantly depending on the input required. For example, consumers could also be the health services.

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

Current governance arrangements draw on specific skills relevant to the profession and should have the ability to address potential conflicts of interest including by varying the composition of assessment panels. As a small jurisdiction, the potential for conflicts of interest arise regularly and are managed through clear guidelines and the requirement to seek advice from the regulator. The role of expert clinicians is important as well as academics.
23. In the case of councils, what governance arrangements are necessary to allow them to separate accreditation activities from their commercial and other obligations as legally constituted companies?

The funding agreements between AHPRA and the accreditation councils should provide the direction and key performance indicators to guide decisions around business and accreditation functions.

Role of accreditation authorities

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

The standard clause in AHPRA funding agreements could be strengthened to require regular reporting against the NRAS objectives as specified in the agreement. It is acknowledged that accreditation relates more to the objectives that align with core business such as facilitating the provision of high quality education and training of health practitioners (s.3(2)(c)) and the rigorous assessment of overseas trained health practitioners (s.3(2)(d)). However, the Health Professions Accreditation Councils’ Forum should have capacity to support the objectives relating to health workforce reform, which would ensure the councils remain relevant to the health sector.

There is already sufficient flexibility in course curriculum to respond to changing requirements e.g. in relation to expanded practice and technological advancements, which do not necessarily require reaccreditation. Changes are likely to be in profession specific requirements, while retaining the more common elements such as business operations and learning/teaching approaches of the education providers.

What other governance models might be considered?

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

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

The Australian Health Practitioner Regulation Agency is a multi-million dollar agency with specific business and operational functions under the National Registration and Accreditation Scheme including support for the functions of National Boards. It could easily be seen as a conflict of interest if the AHPRA Agency Management Committee also had responsibility for accreditation over the boards. National Boards have the professional expertise and community representation, to oversee accreditation functions and have the ability to require additional
requirements like supervised practice and exams, if concerns about the quality of a program are identified.

One national assessment process may assist in minimising the requirement for individual accreditation assessments while still addressing the quality and standards expected of a profession. However, it would be extremely challenging for one national accreditation body to adequately address all relevant standards across 14 health professions. The complex nature of the professional and technical skills required would be extensive including the supply of sufficient professionals to ensure assessment for each profession could be undertaken to the required standard.

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

Indications are that the Health Professions Accreditation Councils’ Forum has taken positive steps towards identifying common elements of accreditation and streamlining processes, with more work to be done on this. The National Boards should consider cross-professional competencies and the prevalence of working multi-disciplinary teams, when reviewing all standards, not just accreditation standards. Accreditation authorities that are more advanced in cross-professional competencies may be able to assist the smaller/newer bodies to incorporate this thinking into their accreditation processes.

Accountability and performance monitoring

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

National Boards, as the approving authority for accreditation standards, should be responsible for monitoring the performance of accreditation authorities in collaboration with AHPRA. Regular reporting by accreditation authorities against the key performance indicators in AHPRA funding agreements could be a first indicator of performance. National benchmarking that allows education providers to compare their performance against other providers, as in the case for the Physiotherapy program of study providers, might be beneficial for incentivising improved performance.

Setting health workforce reform priorities

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

The Ministerial Council members could not embrace the breadth of professional knowledge and technical skills required for dealing with accreditation standards for all 14 health professions and would need to rely on the advice of National Boards and jurisdictions to determine the appropriate positions. Development of standards currently requires extensive stakeholder
consultation, including at a jurisdictional level, to ensure National Boards are well informed when making decisions.

The Ministerial Council has a higher level responsibility for ensuring adequate supply of the health workforce now and into the future. Subsections 11(3)(d) and (4) of the National Law, provide scope for the Ministerial Council to give direction to a National Board on matters that are deemed to have a substantive and negative impact on the recruitment or supply of health practitioners.

It is also noted that, on establishment of the National Scheme, stakeholders strongly objected to accreditation being subject to Ministerial Council approval.

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

The objectives and guiding principles are considered broad enough covering issues from the quality of training programs, access to services in the public interest, facilitation of workforce mobility and the inclusion of innovation in education and service delivery. This should allow the directions of Ministerial Council under s11(3)(d) to be made in response to most anticipated negative or restrictive impacts.

30. How best can a national focus on advice and reform be provided, at least for the delivery of accreditation functions, that:
   • As part of a broader workforce reform agenda, regularly addresses education, innovative workforce models, work redesign and training requirements?
   • Has regular arrangements for engagement with key stakeholders such as the regulators, educational institutions, professional bodies, consumers and relevant experts?

AHPRA and National Boards have increased their efforts in raising public awareness of the National Scheme and existing mechanisms for providing feedback including on accreditation processes. Educational campaigns have been held across Australia, stakeholder forums are held regularly and communication with notifiers and jurisdictional contacts are in the process of being formalised e.g. National Law amendments, alert notices and regulatory compacts. There needs to be an effective mechanism for health services to raise concerns and complaints about the accreditation system concerning all stages of the assessment process. Student feedback in relation to multi-professional learning using existing frameworks is useful. Regular analysis of available data could identify potential issues with a particular program or education provider e.g. where data shows a trend or pattern of issues/complaints.

Jurisdictions play a key role in identifying and advising the Ministerial Council on changes to technology and models of care that require responses through advancements in education and practice of the health workforce. For example, the National Disability Insurance Scheme reforms
will widen the focus, skill sets and requirements for the allied health workforce including multi-disciplinary teams, and will likely draw the public workforce to the private sector.

A significant issue for the NT is maldistribution of the workforce with clusters of certain professions in certain areas not necessarily related to demand. The focus needs to be on keeping people out of hospital. In order to address this maldistribution and issues of equity of access, we need to look at new models of care, strive for equity in numbers and location of service providers and encourage, facilitate and support health professionals to choose to work and stay in non-hospital settings.

It needs to be determined if maldistribution is a health services issue, independent of accreditation and regulation, or if it should be addressed throughout the education and training continuum. The emerging NT workforce will need to manage interactions with disadvantaged and Indigenous patients in rural and remote settings. To develop consistency of the workforce, that is retain health providers in remote communities, they have to ‘want to be there’ and need to stay long enough to immerse themselves into community life. There is evidence that ‘growing our own’ doctors through the NT Medical Program is working with doctors staying in the NT after bonded periods of service are completed.

Specific governance matters

The roles of specialist colleges and post-graduate medical councils

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

It is acknowledged that the Medical Board has been in place for six years and there is recognition that the board and AHPRA have worked on its functions, as well as standardisation of requirements and processes. Accreditation for medicine is known to be unique with the specialist programs and post-graduate councils. It is noted that there is a separate review of the performance of the specialist medical colleges in relation to the assessment of specialist international medical graduates.

The NT Department of Health works closely with the various medical accreditation bodies to ensure the processes occur as smoothly as possible for registration and employment of doctors across NT. It is noted that there is inconsistencies observed in the calibre and readiness to practice in graduates which requires some dedication of time and work place training to avoid an impact on patient safety.

Assessment of overseas health practitioners

32. Are there any reasons why processes for having qualifications assessed for skilled migration visas cannot be aligned with those for registration that are conducted under NRAS?
Alignment could be achieved as in the case of Dentistry. Competency of practice remains vitally important as is the guiding of good supervision.

33. Is there is a defensible justification for the bodies who have been assigned responsibility for accreditation of Australian programs not being assigned the function to assess overseas trained practitioners?

No - the two functions marry together to allow alignment of standards and competencies which gives efficiencies in the functions of the accreditation bodies. Flow on effects of the responsive development of the standards is more likely to occur if these two processes are conducted by the same body.

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

Indications are that the Health Professions Accreditation Councils Forum has taken positive steps towards identifying common elements of accreditation and streamlining processes, with future work planned.

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

With regard to assessment of overseas qualified practitioners who come through the competent authority pathway, the quality of practitioner could depend on whether recognition was awarded to graduates from a particular country or graduates from a particular education provider within a recognised country, such as the case with overseas teachers. Given the view that education providers within Australia can produce a wide range of quality of student outcomes, the latter approach would be preferable, e.g. education providers within the UK are assessed for equivalence with Australian qualifications.

Grievances and appeals

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

An educational campaign is suggested as an effective way to ensure that health services and employers are clearly aware of existing feedback mechanisms for accreditation processes, clinical placements issues and the quality of graduates. There is also scope for students to provide multi-professional feedback using existing frameworks.

There needs to be an effective and consistent mechanism for health services to raise concerns about the quality of graduates and for feeding complaints into the accreditation system from all stages of the assessment process. Regular analysis of available data could identify potential
issues with a particular program or education provider, e.g. where data shows a trend or pattern of issues/complaints.

37. If an external grievance appeal process is to be considered:
   - Is the National Health Practitioner Ombudsman the appropriate entity or are there alternatives?
   - Should the scope of complaints encompass all accreditation functions as defined under the National Law, as well as fees and charges?

It would be considered appropriate for the National Health Practitioner Ombudsman to deal with external grievances related to accreditation matters, on the basis of having the appropriate skills and resources to investigate matter, as required. Alternatively, AHPRA could deal with complaints regarding accreditation on the basis of having responsibility for funding agreements with accreditation authorities and for measuring their performance against those agreements. National Boards could then draw on the advice of AHPRA when reconsidering accreditation standards. It is acknowledged that the capacity to conduct investigations and access information of an external entity would be limited, if not totally restricted.

Health services and employers need to be aware of the appropriate mechanism for raising concerns about the quality of graduates and for feeding complaints into the accreditation system.