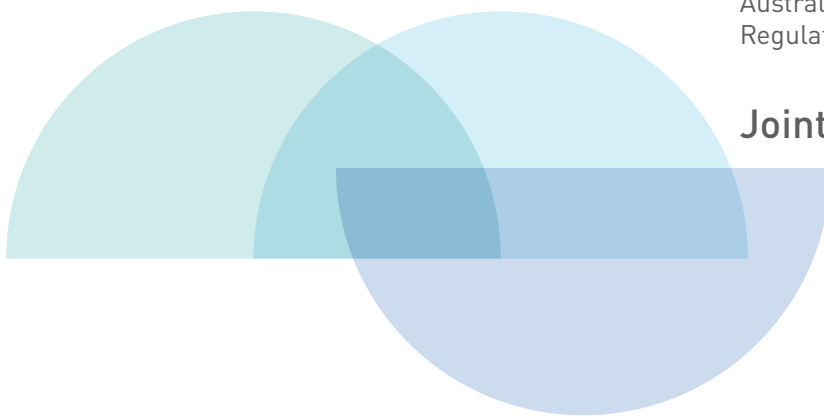


National Boards and  
Australian Health Practitioner  
Regulation Agency

## Joint submission to **NRAS review**

**October 2014**



Aboriginal and Torres Strait  
Islander health practice  
Chinese medicine  
Chiropractic  
Dental  
Medical  
Medical radiation practice  
Nursing and Midwifery

Occupational therapy  
Optometry  
Osteopathy  
Pharmacy  
Physiotherapy  
Podiatry  
Psychology

Australian Health Practitioner Regulation Agency

# Executive summary

## Preamble

AHPRA and the National Boards have prepared this submission in response to the *Review of the National Registration and Accreditation Scheme for health professions* public consultation paper (Snowball, 2014) (the consultation paper) developed by Independent Reviewer Mr Kim Snowball and published on the Australian Health Ministers' Advisory Council (the Ministerial Council) website on Friday, 28 August 2014.

We understand that this submission from National Boards and AHPRA will be made publicly available and will be used to inform the final report made by the Independent Reviewer to the Ministerial Council.

## Introduction

The purpose of the National Registration and Accreditation Scheme (the National Scheme) is to deliver consistent, proportionate and timely regulatory outcomes in the public interest, ensuring that risks to public and patient safety are identified, assessed and mitigated in the most cost-efficient and effective way possible. The National Scheme has also been designed to facilitate workforce mobility across Australia and reduce red tape for practitioners. This is consistent with the legislation within which we are established and operate.

National Boards and AHPRA believe the fundamental tenets of ministers' original vision for the National Scheme are in place, are working and should be preserved. We do not support further fragmentation of nationally consistent arrangements, particularly in relation to notifications management. We recognise that there are areas that require ongoing improvement and many of these improvements can and are being made within the existing National Law framework.

The National Scheme is the product of an important national health workforce reform.<sup>1</sup> It is internationally significant in its scale and ambition.<sup>2</sup> Information on the provenance of the Scheme and initial implementation challenges are well documented.<sup>3</sup> These issues are largely historic and there have been recent measurable improvements in performance.<sup>4</sup> AHPRA is continuing to mature rapidly, but on any international and national regulatory comparison it is still a relatively young organisation at four years of age.<sup>5</sup>

## Achievements

The National Scheme has delivered important benefits for the health system in each state and territory and for health practitioners and the community. National registration means national mobility for all registered health practitioners, underpinned by consistent national standards within and increasingly across professions.

The National Registers provide a single clear reference point for the community with information about the registration status of all registered health practitioners in Australia. This includes information about any current restrictions on their registration. Ensuring the accuracy and completeness of information on the National Registers is one of the most important accountabilities of National Boards and AHPRA. There

<sup>1</sup> [Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions dated 6 March 2008](#).

<sup>2</sup> In the four years to May 2014, National Boards and AHPRA have to date hosted delegations from the Government of Vietnam; the Health and Care Professions Council of the United Kingdom; the Singapore Ministry of Health; the Chief Medical Officer from Iceland; the United Kingdom General Medical Council; the Health Professions Council of South Africa; and, more recently, the Kazakhstan Ministry of Health.

<sup>3</sup> 2012 Parliament of the Commonwealth of Australia, House of Representatives Standing Committee on Health and Ageing, [Report Lost in the labyrinth: on the registration processes for international medical graduates](#). 2014 Parliament of Victoria, Legal and Social Issues Legislation Committee, Inquiry into the performance of the Australian Health Practitioner Regulation Agency.

<sup>4</sup> See Section three: our performance.

<sup>5</sup> 2014 Parliament of Victoria, Legal and Social Issues Legislation Committee, Inquiry into the performance of the Australian Health Practitioner Regulation Agency.

is still an important community debate to be had about whether further information about proven disciplinary history should be published on the National Registers in the public interest.<sup>6</sup>

The self-funded<sup>7</sup> National Scheme has clearly identified the actual cost of statutory regulation for Australia's health practitioners. After rebuilding appropriate levels of reserves since the transition to the new Scheme, and setting fees required to meet implementation costs, there is a trend of stable or reducing fees for professions over time. Most National Boards (11 of the 14) posted surpluses in 2013-14.<sup>8</sup>

This is in part due to the reduced 'red tape' associated with moving from 97 different regulators in the past, to one common service provider (AHPRA) for practitioners, the public, employers, other regulators and governments to interact with about registration. The self-funded model has also provided a single payment for national registration, which includes the fees for co-regulatory authorities in NSW since 2010 and from July 2014 for Queensland. This further reduces the red tape associated with administering multiple fee collections.

**Table 1: Headline achievements**

Headline achievements
<ul style="list-style-type: none"> <li>• Online register with 619,509 registered health practitioners in Australia on 30 June; a growth of 89,394 since 1 July 2010 in registrant numbers in all professions<sup>9</sup>.</li> <li>• More than 120,459 students are registered and studying to be health practitioners in Australia.</li> <li>• Stable and reducing fees.</li> <li>• Quality Framework for activities and performance reporting for accreditation authorities.</li> <li>• More than 97 per cent of registrants now renew their annual registration online – setting an international benchmark.</li> <li>• 96 per cent of registrants complete the workforce survey, creating invaluable data for workforce planning and reform.</li> <li>• 75 per cent of immediate actions taken by National Boards for the most serious notifications about registrants led to restrictions on practitioners' registration.</li> <li>• There has been a 16 per cent increase in notifications lodged overall<sup>10</sup> and a 9 per cent increase in mandatory notifications.</li> <li>• Of the matters decided by tribunals, 88 per cent resulted in disciplinary action.</li> <li>• Of the 139 appeals that were finalised during the year, 81 per cent resulted in no change to the original decision made under the National Law.</li> <li>• Multi-profession policy and standard development.</li> <li>• Key performance indicators introduced supporting improved notifications management.</li> <li>• Data-exchange partnerships in place (e.g. the Australian Institute of Health and Welfare, Medicare Australia, National E-health Transition Authority and the Commonwealth of Australia Department of Health).</li> <li>• Enabler of eHealth policy, contributing to efficiencies in other government agencies.</li> <li>• Electronic documents for all meetings, increasing savings and document security.<sup>11</sup></li> </ul>

The large-scale single database of practitioners has enabled much greater online transaction rates and secure information exchange with employers and health funders than ever before in Australia, or likely the world. This is becoming a very efficient, scaled model after the significant initial development cost. It is the subject of international interest.

<sup>6</sup> Moynihan, R [2012] 'A watchdog to bite the giants' *The Medical Journal of Australia*; 196 (1): 15.

<sup>7</sup> Note: Aboriginal and Torres Strait Islander health practitioners are currently subsidised by governments.

<sup>8</sup> Refer to the *AHPRA and National Boards Annual Report 2013/14* for more information.

<sup>9</sup> There were 530,115 registered practitioners as at 30 June 2011 [*Australian Health Practitioner Regulation Agency – Annual Report 2010/11*; page 41] and 619,509 as at 30 June 2014. This increase includes the addition of four new professions to the Scheme.

<sup>10</sup> Includes NSW data.

<sup>11</sup> In 2013-14, there were 1,828 meetings of national, state, territory and regional boards and committees. Refer Appendix 8 of the *AHPRA and National Boards Annual Report 2013/14* for details.

National registration has also meant more accurate and complete health workforce data. These data are a fundamental enabler of health workforce reporting, policy and eHealth priorities.<sup>12</sup> Reliable and comparable workforce data makes a significant contribution to the health workforce reform priorities of governments and National Boards. Analysis of national data on notifications is informing the development of risk-based approaches to regulation to identify important issues and address them.

## Accreditation

The National Scheme has established a common statutory framework for accreditation of health profession education and represents a significant change from the previously diverse profession-specific models. Implementation of the model of independent accreditation functions within the Scheme as agreed by the Ministerial Council is stimulating collaboration and accountability while delivering on the objectives. Over the past four years, much has been achieved through collaboration of the National Boards and AHPRA with the accreditation authorities.

The National Boards and AHPRA have worked with the accreditation authorities to develop a common understanding of the National Scheme and its accreditation functions and promote accountability for these functions through regular reporting by accreditation authorities against the *Quality Framework for the Accreditation Function*.<sup>13</sup>

The National Boards, AHPRA and the accreditation authorities have increasingly worked collaboratively to identify opportunities for improvement, aspects of accreditation that need some consistency of approach (such as reporting of accreditation decisions), as well as areas within accreditation that lend themselves to cross-professional approaches. Steady progress continues and further cross-profession initiatives such as work on inter-professional learning and embedding models for simulated learning environments in clinical training are being implemented or are planned, with the aim of further demonstrating good practice in health profession accreditation.

## Multi-profession approaches

There are 14 National Boards in the National Scheme working in partnership with AHPRA to regulate more than 619,500 health practitioners. Each National Board deals with health professions of differing size, volume of notifications, complexity and risk profile. This is summarised in Table 2 below:

<sup>12</sup> Relationships have been established with multiple data-exchange partnerships, for example with Health Workforce Australia and the Australian Institute of Health and Welfare, Medicare Australia, National E-health Transition Authority, Health Identifiers' Service – Commonwealth of Australia Department of Human Services.

<sup>13</sup> Click here for the [Quality framework for the accreditation function](#).

**Table 2: National Boards of differing size, volume, complexity and risk profile**

Profession	Risk Profile (Deloitte analysis 2013)	Registrants (2013-14)	Proportion of total registrants	Notifications (2013-14) <sup>14</sup>	Proportion of total notifications	Notifications per '000 practitioners (2013-14)	Monitored Registrants <sup>15, 16</sup>
Medical	5	99,379	16.0%	5,585	55.6%	56.2	1,654
Nursing and Midwifery	4	362,450	58.5%	2,010	20.0%	5.5	1,228
Psychology	3.5	31,717	5.1%	487	4.8%	15.4	187
Pharmacy	3.5	28,282	4.6%	514	5.1%	18.2	234
Dentistry	3.5	20,707	3.3%	951	9.5%	45.9	190
Podiatry	3	4,129	0.7%	54	0.5%	13.1	22
Physiotherapy	2.5	26,123	4.2%	134	1.3%	5.1	93
Occupational Therapy	2.5	16,223	2.6%	43	0.4%	2.7	101
Chiropractic	2.5	4,845	0.8%	111	1.1%	22.9	49
Chinese Medicine	2.5	4,271	0.7%	26	0.3%	6.1	870 <sup>17</sup>
Osteopathy	2.5	1,865	0.3%	11	0.1%	5.9	9
Medical Radiation Practice	2	14,387	2.3%	28	0.3%	1.9	135
Optometry	2	4,788	0.8%	66	0.7%	13.8	12
Aboriginal and Torres Strait Islander Health Practice Board of Australia	1	343	<0.1%	6	<0.1%	17.5	9
Totals (five higher volume and risk professions)	n/a	542,535	87.6%	9,547	95.0%	n/a	3,493
Totals (nine lower volume and risk professions)	n/a	76,974	12.4%	479	4.8%	n/a	534
Total (all professions)	n/a	619,509	100%	10,047 <sup>18</sup>	100%	n/a	4,027

A key strength of the National Scheme has been the regular interaction between all National Boards, particularly through their Chairs. This has facilitated cross-profession approaches to common regulatory issues and cross-profession consultation and collaboration. Cross-profession collaboration, to the extent that is currently being achieved on regulatory issues, did not exist before the National Scheme.

While the National Scheme is a multi-profession scheme operating within a single statutory framework and supporting agency, there needs to be scope for a range of regulatory approaches which are tailored to professions with different risk profiles and professional characteristics. For example, five National Boards

<sup>14</sup> Includes NSW data.

<sup>15</sup> Imposed conditions and undertakings from notifications and registration applications.

<sup>16</sup> Data is at 30 September 2014 and includes conditions and undertakings from NSW notifications being monitored by the HPCA.

<sup>17</sup> Of the 870 Chinese medicine practitioners, 766 of the 'Monitored Registrants' relate to an English language condition. The condition requires suitable arrangements to be in place should the practitioner and the patient not share a common language.

<sup>18</sup> Total includes 21 notifications received where the profession was not yet identified.

– medicine, nursing and midwifery, dental, pharmacy and psychology – accounted for 95 per cent of all notifications received in 2013-14.<sup>19</sup>

National Boards and AHPRA recognise that one-size regulation cannot fit all. Contemporary approaches to regulation are risk-based and proportionate.<sup>20</sup> We are actively examining how to support more risk-delineated, flexible and sustainable regulatory approaches, within the framework of the National Law. This will see a clearer delineation between the five professions that account for much of the regulatory risk – dental, medicine, nursing and midwifery, pharmacy and psychology – and the nine professions that face different volumes in regulatory workload and risk profiles, including the sustainability of the costs of statutory regulation. Some of these approaches are discussed in more detail at question 4.

## Notifications

The management of notifications has, not surprisingly, attracted considerable stakeholder comment.<sup>21</sup> This level of public scrutiny accompanies many health practitioner complaints systems internationally.<sup>22</sup> We recognise that ministers and the community need to have confidence in the systems for dealing with concerns about the conduct, performance or health of health practitioners. We welcome this as an important area of focus for the review, in particular the opportunity to examine the current model in the context of international leading practice and the public protection objectives of the National Law.

The National Boards and AHPRA believe that the current model of notifications management in the National Scheme is viable and performance has recently improved measurably. Four of the five professions with the greatest volume of notifications and greatest regulatory risk (dental, medicine, nursing and midwifery and psychology, which account for 90 per cent of notifications to the Scheme<sup>23</sup>), there is essentially local management of notifications in a national standards framework. For these professions, there are state, territory and regional boards making decisions about local practitioners, as part of a local health complaints management network. This includes collaboration with a local health complaints entity, referral of serious matters to a local tribunal and support to local boards and committees through an AHPRA office in each state and territory. National Committees also link into this local network. This keeps the best aspects of previous arrangements and involves locally relevant and timely decision-making about individual cases.

In making decisions about notifications, Boards have a primary focus on public safety and professional standards.<sup>24</sup> The National Scheme has not been established with powers as a complaints resolution agency, such as the powers reserved solely by health complaints commissioners to conciliate on financial matters in privileged proceedings. National Boards therefore do not have any powers relating to general health complaints; however, this is not always well understood by the general public. These issues are not isolated to Australia and we note a recent article citing the public in the United Kingdom does not appear to understand the National Health Service complaints processes or the role of the General Medical Council.<sup>25</sup>

These issues highlight the ongoing importance of close working relationships with health complaints entities and the joint consideration processes, as well as clear communication with notifiers.

<sup>19</sup> Data provided is at 30 June 2014 and excludes NSW data. Earlier data is available within AHPRA annual reports.

<sup>20</sup> Sparrow, MK (2008) *The Character of Harms – Operational Challenges in Control* ISBN 9780 5218 72102

<sup>21</sup> 2013 AHPRA submission to the Victorian Parliamentary Inquiry into the performance of the Australian Health Practitioner Regulation Agency and the 2013 AHPRA submission to the Queensland Minister for Health in relation to strengthening health complaints management in Queensland.

<sup>22</sup> Duff, E (2014) 'Health Care Complaints Commission in Crisis', *Sydney Morning Herald* 19 June 2014.

<sup>23</sup> Dental, medicine, nursing and midwifery, and psychology all have state, territory and/or regional boards/committees that make decisions about local practitioners. The Pharmacy Board of Australia has a national committee that makes decisions about practitioners from across Australia. Refer to Appendix 1 of the *AHPRA and National Boards Annual Report 2013/14* for more information on National Board structures.

<sup>24</sup> *Health Practitioner Regulation National Law Act 2009*, Part 5, Division 2, Section 35, 'Functions of National Boards'.

<sup>25</sup> [Moberly](#) (*BMJ Careers*, 21 July 2014).

Relationships with health complaints entities are working increasingly well across jurisdictions, although are not always well understood by the community.<sup>26</sup>

It is acknowledged that there are areas that can be improved. This includes the time an investigation might take; the experience of notifiers, including AHPRA's communication with them; the experience of practitioners who are subject to a notification; and ensuring that matters which ultimately do not require board intervention are dealt with as quickly as possible. While every notification is assessed and considered by the relevant board, a significant percentage of notifications received do not require any action because they do not meet the risk threshold under the National Law, and do not pose sufficient risk of harm to the public or to patient safety to warrant regulatory action.<sup>27</sup>

National Boards and AHPRA have made significant changes to improve the timeliness of our management of notifications, including adding substantial resources to the assessment and investigation of notifications. AHPRA has robust processes to swiftly identify and manage serious risk to the public and has built consistent national operational processes and introduced a range of performance measures to better manage, improve and report on our work. National Boards and AHPRA have adopted a set of regulatory principles<sup>28</sup> to guide our work and the decision-making across the National Scheme, to guide regulatory decision-making that is proportionate, risk-based and effective.

Options for possible change to the existing complaints and notifications system under the National Scheme are included in section one, and data on our performance and management of notifications is included in section three.

### Governance and accountability

The design of the governance and accountability arrangements of the National Scheme has also attracted considerable stakeholder comment. National Boards and AHPRA recognise that there are perceptions that the National Scheme is complex and difficult to navigate.<sup>29</sup> This initial concern is, in part, a result of establishing a new national co-operative scheme that relies on state and territory legislative powers in the absence of any referral of powers to the Commonwealth to legislate.

Overall accountability rests with health ministers collectively, through the Australian Health Workforce Ministerial Council. Primary accountability for regulatory policy, standards and regulatory decision-making about health practitioners rests with National Boards. Primary accountability for the operation and performance of the National Scheme within participating jurisdictions rests with the Agency Management Committee. To improve clarity, an Accountability Framework setting out who does what, and who is responsible for what in the Scheme, has been documented and approved (Attachment H).

Community understanding of regulation is critical to public confidence and trust.<sup>30</sup> Greater local accountability can be achieved within current administrative and legislative arrangements. For example, ministers could mandate a set of key performance indicators (KPIs) for regulatory performance through a policy direction or minor legislative amendment to their adopting legislation. This could require reporting on our performance to parliaments, through ministers and parliamentary committees.

This year we are producing state- and territory-specific reports, which profile our work in each jurisdiction over the past year. These reports will include state-specific data with national comparisons, and reports from chairs of state, territory and regional boards, and state and territory managers. These will complement the national annual report. Both National Boards and AHPRA are committed to

<sup>26</sup> 2013 AHPRA submission to the Victorian Parliamentary Inquiry into the performance of the Australian Health Practitioner Regulation Agency.

<sup>27</sup> Of the matters closed following assessment, around 57 per cent require no further action and of matters closed following investigation (page 135), about 51 per cent require no further action (page 140). These rates of taking no further action on notifications is consistent with NSW and internationally. Our [Guide for notifiers](#) explains more about making a notification. Page 11 of the guide explains why the Boards do not always take action as a result of a notification.

<sup>28</sup> Refer section two: our achievements or <http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>.

<sup>29</sup> 2013 AHPRA submission to the Victorian Parliamentary Inquiry into the performance of the Australian Health Practitioner Regulation Agency; KPMG 2014, Australian Health Practitioner Regulation Agency – organisational review final report.

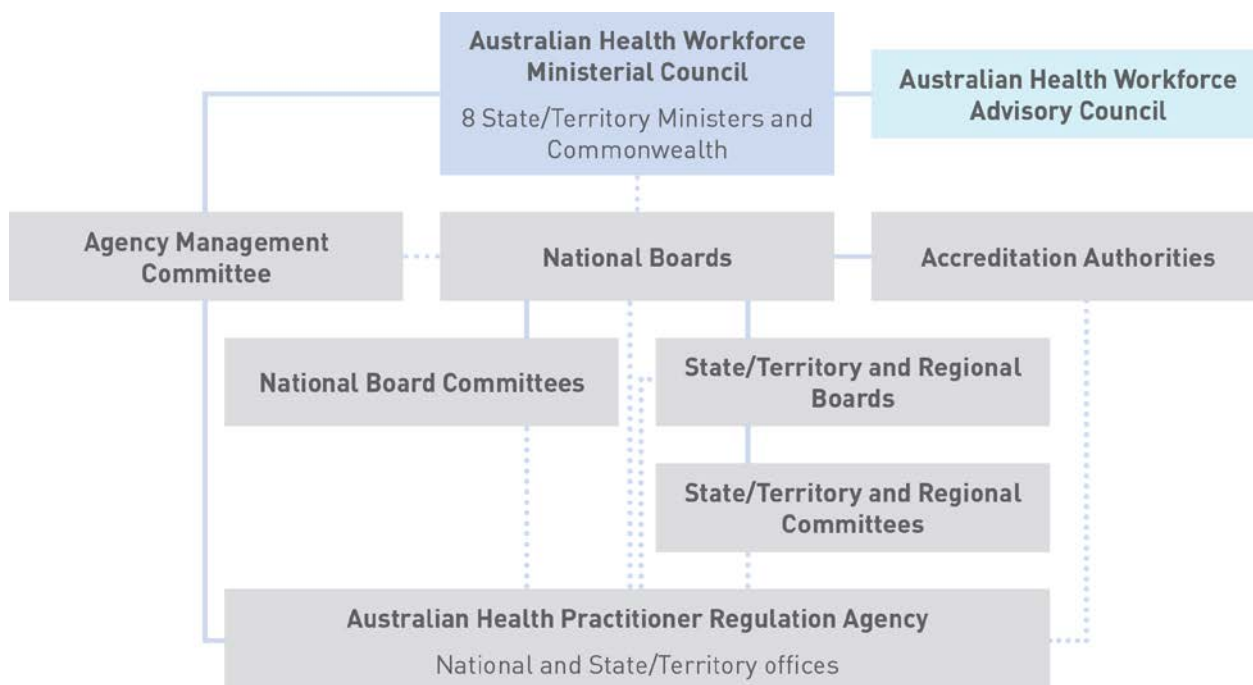
<sup>30</sup> Onora Oneill Reith Lecture 2002.



strengthening their accountability to each parliament and to report in more detail on our performance, particularly as this relates to our regulatory performance. These issues are important areas and we note they are being explored as part of the Review.

National Boards and AHPRA have addressed the questions relating to the reconstitution of the Australian Health Workforce Advisory Committee (AHWAC) in part one of this submission.

A snapshot of the governance arrangements is outlined in Figure 1 below.



**Figure 1: Structures and governance**

### Workforce reform

National Boards are primarily focused on making sure that regulatory measures do not constrain workforce reform, except when needed to ensure public safety. The National Scheme has already contributed to workforce reform through national registration and mobility, underpinned by national standards. The availability of more accurate and complete workforce data is also a key contribution of national registration. More than 96 per cent of registrants complete the workforce survey associated with their annual renewal, creating invaluable data for workforce planning and reform.

The National Scheme is not the main driver of workforce reform, but should be responsive to government and other agreed priorities. The National Law is based on a title protection model and imposes very few restrictions on the practice of registered health practitioners. Perceived regulatory barriers to workforce reform in Australia now may be more historic perception than reality, as well as a number having an industrial rather than regulatory basis.

We have established mechanisms to engage with governments on these issues across Boards and intend to work closely with Australian Health Ministers' Advisory Council (AHMAC) and the Health Workforce Principal Committee to ensure a clear understanding of government priorities. The National Boards are actively considering the Ministerial Council approved guidance on criteria for future consideration of specialist recognition and endorsement of *Approval of specialties under section 13 of the Health Practitioner Regulation National Law Act – Guidance for National Board submissions to the Australian Health Workforce Ministerial Council*.

National Boards and AHPRA work closely with major stakeholders, including Commonwealth and state and territory health departments, to contribute to strategic developments in health workforce reform. Our focus is on regulatory responses and ongoing work with professions and we believe there is an



opportunity in the Review to take action to remove current barriers created by variation in jurisdictional law (e.g. drugs and poisons, regulation of radiation equipment and use). We believe that accreditation standards and processes are also important levers to prepare the health workforce for future practice needs and have addressed this in more detail in our submission.

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## Scope of this submission

This submission provides our response to the questions and issues raised in the consultation paper and detailed information about our achievements and performance to date.

**Section one** outlines our responses to the questions raised in the consultation paper.

**Section two** outlines our achievements after four years of multi-profession regulation under the National Scheme.

**Section three** outlines our performance across four core areas.

**Section four** includes detailed appendices and further information when we think this will assist the review team.

## Section 1: Responses to the questions raised in the consultation paper

This section responds to questions raised by the Independent Reviewer in parts one and two of the consultation paper, and outlines opportunities for improvement identified by National Boards and AHPRA.

### a) Accountability

National Boards and AHPRA agree the existing governance entities defined in the National Scheme must be accountable for their performance against the National Law objectives and guiding principles at a national level, to individual state and territory health ministers who have ultimate responsibility for the safe practice of health professionals in their jurisdictions, and to parliaments and the people of Australia.

**Question 1: Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?**

**Question 2: Should the Australian Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?**

**Question 8: Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?**

National Boards and AHPRA **do not support** a reconstituted AHWAC assuming responsibility for annual, independent reporting on the operation of the National Scheme. Instead it is most appropriate for the Agency Management Committee to retain the primary accountability to health ministers individually and collectively for performance reporting on the operation of the Scheme. However, there may be merit in a reconstituted AHWAC providing independent advice to health ministers on complex or contentious policy issues that cannot be resolved using current processes and providing expert advice on threshold measures for entry of professions into the National Scheme.

Clarification of its role and mandate, administrative support, membership, and the real potential for an additional layer of regulatory governance that may be seen as increasing complexity and cost to governments and/or registrants are important factors that need to be appropriately considered prior to final proposals being submitted to Australian Health Ministers for consideration.

We understand the three main functions for a reconstituted AHWAC as proposed in the consultation paper to be:

1. Provide *independent reporting* on the operation of the National Scheme
2. Consider any unresolved *cross-professional issues*
3. Provide expert advice on *threshold measures for entry* to the National Scheme.

Each of these is considered in turn below.

## Independent reporting

National Boards and AHPRA **do not support** a reconstituted AHWAC assuming responsibility for annual, independent reporting on the operation of the National Scheme. Instead it is most appropriate for the Agency Management Committee to retain the primary accountability to health ministers individually and collectively for performance reporting on the operation of the Scheme.<sup>31</sup> The [Agency Management Committee](#) has established a [Performance Committee](#) to oversee its governance responsibility in relation to performance measurement and reporting.

There is significant potential for confusion and unnecessary duplication of resources and function with the Agency Management Committee and additional costs and resources to support a reconstituted AHWAC were it to assume responsibility for an annual assessment of 'regulators' (not defined) based on established performance measures with the Scheme.<sup>32</sup>

National Boards and AHPRA agree it is important to have clear measures of performance agreed with government and regular reporting of performance. Key performance indicators (KPIs) for notifications have been set by the Agency Management Committee and implemented by National Boards and AHPRA. Registration KPIs have also been agreed to by National Boards and AHPRA and reporting is set to commence in October 2014.

National Boards and AHPRA agree there needs to be direct accountability for what we and other entities established under the National Scheme do – at a national level, to individual state and territory health ministers who have ultimate responsibility for the safe practice of health professionals in their jurisdictions, and to parliaments and the people of Australia.

Greater clarity from governments about desired levels of performance is welcome and AHWAC may play a role in providing independent advice to governments and the National Scheme on appropriate measures. A reconstituted AHWAC could also have a role in advising on any future independent review of the operation of the Scheme in three to five years' time if ministers decide that this is desirable.

## Cross-professional issues

There may be merit in a reconstituted AHWAC providing independent advice to health ministers on complex or contentious policy issues that cannot be resolved using current processes.

As part of its advisory role, there may be merit in a reconstituted AHWAC providing independent advice on complex or contentious proposals for changes in standards proposed to the Ministerial Council. It is good regulatory practice for registration standards (and accreditation standards), codes and guidelines to be reviewed on a regular basis, for example three to five years or earlier if the need arises. Not all proposed changes are complex, or contentious, or warrant independent advice beyond what is already provided through consultation as required under the National Law and using procedures published on our website which take into account COAG best practice regulation principles.

If there were complex or contentious policy issues that cannot be resolved using current processes, then it may be beneficial for these exceptional proposals to be referred to a reconstituted AHWAC for independent advice to health ministers. This approach would be more consistent with the requirements which require engagement with the Office of Best Practice Regulation in the Commonwealth and compliance with the COAG best practice regulation guidelines requiring impact studies only for specific high-impact proposals.

<sup>31</sup> AManC currently has a statutory responsibility under the National Law to ensure that AHPRA performs its functions in a proper, effective and efficient way. The Ministerial Council can give AManC any other function under the Law. AManC is appointed by the Ministerial Council, was expanded to 8 members, has a regular meeting plan and its administrative and operational support is met by AHPRA within current funding arrangements.

<sup>32</sup> The AHWAC has not been active since 2011. At that time, the AHWMC comprised 7 members, including a Chair. Secretariat support was provided (as needed) by governments (though the former Health Workforce Australia). The AHWAC met on an 'as needed' basis and did not have a regular work plan.

The National Scheme has a specific role to play in workforce reform, driven by government priorities, with due consideration given to our regulatory role and our mandate to ensure the public is protected. National Boards are the key determiner of the appropriate competencies and qualifications that provide for a safe and competent registered health practitioner with the professions they regulate.

### Threshold measures for entry

There may be merit in a reconstituted AHWAC providing expert advice on threshold measures for entry of professions into the National Scheme.

A reconstituted AHWAC could provide expert advice on threshold measures for entry of professions into the Scheme. In August 2011, health ministers identified the need for work on unregistered professions, and future directions for national registration (see [AHWMC Communiqué - 5 August 2011](#)). Although the Intergovernmental Agreement (IGA) sets out the *AHMAC Criteria for assessing the need for statutory regulation of unregulated health occupations*<sup>33</sup>, what has been missing is a formal process for submissions from professions seeking regulation under the Scheme to be lodged, independently assessed, and advice and recommendations brought to the Australian Health Workforce Ministerial Council (the Ministerial Council).

A reconstituted AHWAC may perform this function well. Ultimately, decisions on these matters must continue to rest with the Ministerial Council for the Scheme.

### Implementation

If it was to be reconstituted, AHWAC would need to operate in a way that does not add unnecessary complexity, duplication, cost or other burden to the National Scheme and does not detract from the direct accountability of National Boards and AHPRA to the Ministerial Council. Its role would be to provide independent, expert and strategic advice to ministers on matters relevant to the Scheme, with members appointed by the Ministerial Council, and remuneration of members and administrative costs and secretariat support provided by governments as stated in the IGA for establishment of the Scheme.<sup>34</sup>

The very limited number of referrals by health ministers to AHWAC to date, combined with a lack of clarity around its advisory mandate, provides effectively no data to draw on to measure whether its membership was fit for purpose, that the secretariat and administrative arrangements were appropriate, that remuneration and funding was adequate, or how the AHWAC could most effectively provide independent and informed advice to health ministers while operating independently within a government framework.

## b) The future for regulation of health practitioners in Australia

The purpose of the National Scheme is to deliver consistent, proportionate and timely regulatory outcomes in the public interest, ensuring that risks to public and patient safety are identified, assessed and mitigated in the most cost-efficient and effective way possible. This is consistent with the legislation within which we are established and operate.

<sup>33</sup> Attachment B of the Intergovernmental agreement for a national registration and accreditation scheme for health professions provides guidance on the inclusion of other health professions signed on 26 March 2008, including the *AHMAC Criteria for assessing the need for statutory regulation of unregulated health occupations*.

<sup>34</sup> The IGA for the national scheme clearly considered the role of AHWAC to be an independent advisory body that would assist the AHWMC to exercise its functions by providing authoritative advice on a broad range of policy issues. Appointments and remuneration were decided by the AHWMC. COAG agreed that the AHWAC would be funded directly by governments according to the AHMAC cost-sharing formula (section 12, Attachment 1, IGA) – not through registrant fees. Part 3 and Schedule 1 of the National Law set out the functions of the AHWAC, its membership and broad operation.

**Question 3: Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost savings \$11m per annum.**

The option to establish a single Health Professions Australia Board **is not the preferred option** for National Boards and AHPRA, however, we recognise that a similar model works successfully for the Health and Care Professions Council (HCPC) in the United Kingdom (UK), and this question seeks to understand whether it could work in Australia.

## Introduction

National Boards and AHPRA do not support the establishment of a single Health Professions Australia Board as our preferred option.

A single Health Professions Australia Board has the potential to deliver benefits to both to the public and the National Scheme. Consistency in policies and standards and their application may both facilitate operational efficiencies and mirror the community's expectations of health practitioners. In practice there is more commonality between health professions than differences, and the National Boards and AHPRA have worked steadily over the past four years to develop greater consistency of standards and guidelines between professions within the current model. A single Health Professions Australia Board could enhance this process; however, it is potentially too early into the Scheme to propose 'wholesale' changes.

National Boards and AHPRA do support the consolidation of the notifications and registration functions through a single mechanism outlined in question four. A Multi-Profession Working Group<sup>35</sup> has been convened by National Board Chairs and representatives from AHPRA. This work undertaken by the Working Group has canvassed, considered and evaluated a variety of governance and structural changes to the way these nine boards and AHPRA work. Option 2 provides an opportunity for AHPRA and the National Boards to fully realise the potential benefits of this work and deliver improvements in quality and efficiency as well as cost effectiveness. Some of these options are discussed in more detail at question four.

## Costs

The cost comparison in the consultation paper acknowledges that, on the basis of the comparison made, the unit cost of regulation is cheaper in Australia, at \$278 per registrant, compared with \$301 in the UK.<sup>36</sup> This is a significant achievement for the Scheme after only four years of operation. National Boards and AHPRA are acutely aware of the obligation to operate in an efficient way, and are continuously working together to improve our efficiency.

It is important to understand the cost of regulation in Australia versus the cost comparison in other countries. On a unit cost by profession-specific basis when comparing Australia and the UK, of the nine professions that have been proposed for inclusion in a single Health Professions Australia Board:

- two<sup>37</sup> professions are currently cheaper to regulate in Australia
- five<sup>38</sup> are cheaper to regulate in the UK, and
- two<sup>39</sup> are only regulated in Australia and not the UK.

<sup>35</sup> Comprising the chair of each of the nine professions that have been proposed for inclusion in a single Health Professions Australia Board and senior AHPRA representatives.

<sup>36</sup> Note these are based on the costs included in the consultation paper and are based on an exchange rate of AUS\$1.81.

<sup>37</sup> Chiropractors and osteopaths.

<sup>38</sup> Optometrists; medical radiation practitioners; occupational therapists; physiotherapists; and podiatrists.

<sup>39</sup> Aboriginal and Torres Strait Islander health practitioners and Chinese medicine practitioners which attract, for example, unique challenges including cultural aspects (and may include a reliance on experts including Chinese speakers), grandparenting scheme and diverse qualifications.



National Boards and AHPRA understand there are further cost reductions that might be achieved across the other five professions.

The proposition in the consultation paper of generating potential savings in the vicinity of \$11 million is attractive to the National Scheme. However, we strongly support the need for further detailed analysis that also incorporates costs associated with accreditation. It is unclear, due to the absence of information around cost estimates from external accreditation authorities, what potential savings could be achieved by the accreditation authorities working cooperatively to reduce costs.

National Boards and AHPRA consider any potential savings to be generated predominantly from sitting fees, which are intrinsically linked to the number of board or committee members and in turn reflect regulatory workload; meeting frequency; and location (which may require travel and accommodation). AHPRA has undertaken initial modelling based on a single Health Professions Australia Board to quantify the proposed savings of \$11 million as estimated in the consultation paper. **Our initial modelling has identified a saving in the vicinity of \$800 thousand to \$2.5 million.** However, it is important to note that these are estimated figures and further detailed analysis would be required.

While it is accepted that a single Health Professions Australia Board would likely result in improved efficiencies for the Scheme and potentially, over time, a lower single registration fee for (some) practitioners from these nine professions, some National Boards are concerned there may be unintended financial consequences affecting the remaining five professions.

National Boards operate on a cost allocation basis, which means each cost is assigned to the activity that is most responsible for the generation of that cost. Some costs can be easily identified and attributed to Boards or AHPRA cost centres. Others need to be shared using accepted cost allocation methodologies. More detail on the cost allocation principles can be found in each Health Profession Agreement located on the AHPRA website under publications.<sup>40</sup> Any further analysis of this option should consider this possibility in more detail.

The National Scheme belongs to the states and territories. Enshrined in the original Intergovernmental Agreement and the National Law is the requirement to establish at least one office in each state and territory, which brings associated costs.

The consultation paper suggests the proposed single Health Professions Australia Board should cost \$18.7 million, making the unit cost of regulation in Australia \$243 per registrant. If a single registration fee was applied for those nine professions, and to ensure the sustainability of the Board, this is the minimum amount at which the fee could be set. The 2014-15 registration fees for three of the nine professions proposed for inclusion are lower than this amount, including Occupational Therapy and Physiotherapy,<sup>41</sup> which together constitute approximately 55 per cent of the total registrants in this group. This would indicate that fees for these three professions might in fact increase by between 50-140 per cent respectively, unless a net benefit is realised for each profession.

We note the consultation paper proposes exploring how the policy position of no cross-subsidisation could be relaxed to reduce costs. It is unclear if the proposal is to apply to all 14 professions or just the nine professions proposed for inclusion in a single Health Professions Australia Board. Further clarity would be necessary to allow informed commentary.

Accurate comparisons between the HCPC and National Scheme are inherently difficult due to the wide differences in the structure and governance arrangements, functions and environments. It is noted that the overall aggregate risk profile of the professions regulated by HCPC is lower than that of the nine professions being considered for this option within the National Scheme. National Boards and AHPRA acknowledge that accurate financial contrasts are therefore difficult. We recognise our colleagues in the UK have been extremely successful in refining their methodology and are keen to continue discussions to obtain more precise and achievable savings should this be the preferred model following the review.

<sup>40</sup> <http://www.ahpra.gov.au/Publications/Health-profession-agreements.aspx>.

<sup>41</sup> \$160 and \$159 respectively.

Should this option be the preferred option following the review, National Boards and AHPRA will work collaboratively to identify and deliver achievable benefits of a single Health Professions Australia Board.

### **Profession-specific input**

A single Health Professions Australia Board may enhance consistency of decision-making across the professions on most matters, but in some instances, profession-specific leadership, input and understanding is necessary, including the workforce reform objectives of the National Law. The current National Boards structure provides sufficient professional skill and expertise, balanced with community input, so does not require additional profession-specific input to decision-making on most matters.

There are potentially viable mechanisms such as profession-specific decision-making committees, liaison groups, professional officers and/or obtaining independent advice that could provide the expertise required to adequately support profession-specific decision-making at many levels; however this will come at a cost. These would be additional costs that are not clearly identified in the current costing methodology.

#### *Podiatry Board of Australia*

The Podiatry Board of Australia (PodBA) is particularly concerned that although they have lower volumes of registrants, the profession brings a unique level of complexity and risk because of the endorsement for scheduled medicines, a specialist register and a large section of the workforce being in small private practice. The PodBA is concerned that despite assurances that professional input will be available and not diluted, this is not likely to be the operational reality in a new single Health Professions Australia Board model.

#### *Occupational Therapy Board of Australia*

The Occupational Therapy Board of Australia (OTBA), in partnership with the NSW Occupational Therapy Council, has recently commissioned a project to obtain an in-depth qualitative analysis of notifications to date. Analysis of the notifications will focus on building our understanding about profession-specific issues that are of concern to members of the public and any patterns of practice that are posing risks or problems. The OTBA intends to use this to inform targeted and proportionate regulation, identify any issues relevant to student training which may also inform future review of accreditation standards, and to share the findings with the profession to help targeting of CPD and other strategies to strengthen practice across the profession.

In this respect, the OTBA is of the belief their work differs from the HCPC, and accordingly may need to be considered in comparisons. As options for multi-profession regulation and changes in board structure are assessed, it is essential to consider the potential benefit of this type of work and how it could be maintained in alternative models. The relationship between National Boards and the professions is an important link for capitalising on this type of approach and consideration should also be given to how to leverage the necessary professional support for this work if it is to be continued.

#### *Medical Radiation Practice Board of Australia*

Similarly, the Medical Radiation Practice Board of Australia (MRPBA) is initiating a research report into rates of notifications in medical radiation practice. Notification rates are relatively low for the profession and the MRPBA is concerned that there may currently be under-reporting within the profession, due to inadequate understanding of the regulatory requirements under national registration and confusion about the respective roles of the MRPBA and licensing authorities.

The object of the research is to compare actual notifications with adverse events reported to licensing and radiation safety authorities as well as within health facilities and then analyse the proportion of these that potentially should have been notified. The results may indicate a need for additional focus on education for practitioners on notification thresholds as well as enhanced information sharing with state and territory licensing authorities.

#### *Chiropractic Board of Australia*

The Chiropractic Board of Australia (ChiroBA) is concerned that even though it has lower volumes of registrants, it received the third highest number of notifications per thousand registered practitioners in 2013-14. Also, a significant number of notifications referred to the ChiroBA were serious professional conduct and performance breaches and included the largest and most expensive tribunal matter that the Scheme has been involved with. Profession-specific input has been critically important in dealing with these issues and the ChiroBA has serious concerns that this input will be significantly diluted with a single Health Professions Australia Board.

To overcome some of the perceived cost barriers of entry into the National Scheme, it may be appropriate to consider the establishment of a single Health Professions Australia Board to include any new professions that meet the agreed risk threshold and are approved for future entry into the National Scheme.

**Question 4: Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost savings \$7.4m per annum.**

National Boards and AHPRA support the option to consolidate the notifications and registration functions through a single mechanism. National Boards and AHPRA recognise our obligation to ensure operations are carried out efficiently, effectively, and economically<sup>42</sup> and are continuously working together to explore multi-profession approaches to all our core regulatory functions within the Scheme.

## Introduction

National Boards and AHPRA prefer the option to use common regulatory mechanisms and continue to consolidate and integrate regulatory functions, while retaining the existing National Board governance arrangements. This approach is most consistent with the work we have undertaken in exploring and implementing multi-profession approaches to all of our core regulatory functions within the scheme to date.

It is important to acknowledge that National Boards and AHPRA have already overcome a number of challenges to the quality and effectiveness of the Scheme and a number of professions have begun to deliver fee reductions<sup>43</sup>. Achieving economies of scale and maintaining regulatory outcomes for relatively low-risk professions with lower regulatory volumes does remain a challenge.

It is unclear how the \$7.4 million forecast in the consultation paper could be achieved without further analysis of the basis of the costs; however, National Boards and AHPRA agree that further savings and efficiencies are possible without sacrificing the quality of regulatory decision-making. National Boards and AHPRA recognise that one-size regulation cannot and does not fit all. Modern approaches to regulation are risk-based.<sup>44 45</sup> There needs to be scope for a range of regulatory approaches which are tailored to professions with different risk profiles and professional characteristics.

The Multi-Profession Working Group has been exploring potential options around these different regulatory approaches since mid-2013. Through this work, the boards of the nine professions represented on the working party have demonstrated their commitment to strengthening the National Scheme in addition to their own efficiency and effectiveness. Within the current regulatory model, scope exists for a range of different approaches to be adopted which encompass varying multi-profession characteristics and share the overarching objectives of consistent, proportionate and timely regulatory outcomes as well as managing risk in the most efficient and effective way possible.

## Actions underway or being considered include:

<sup>42</sup> Section 212 of the National Law.

<sup>43</sup> Six National Boards reduced their fees in 2014-15, one as much as 30 per cent.

<sup>44</sup> National Boards and AHPRA have been working with Professor Malcolm Sparrow [see footnote 19 and AHPRA initiative 'Increase the use of data for evidence-based regulation and policy' in the *Business Plan*].

<sup>45</sup> Australian National Audit Office: Administering Regulation – achieving the right balance (better practice guide: June 2014).

1. Combining immediate action committees into fewer cross-profession committees: this has the potential to produce cost and process efficiencies but also to lead to improvements in quality regulatory outcomes. All nine Boards now have consolidated or combined registration and notification committees already.
2. Piloting joint immediate action committees: this has the potential to improve the public perception of objectivity and independence as well as reducing delays or inefficiencies and allowing for the development of regulatory expertise in this low-volume, highly standardised but higher-stakes regulatory process. Of the 474<sup>46</sup> immediate action cases where action was taken by National Boards in 2013-14, 358 resulted in some form of restriction on registration. Of the 474 immediate action cases, 18<sup>47</sup> belonged to the nine lower regulatory volume and risk professions, and 14 of those resulted in some form of restriction in registration.<sup>48</sup>
3. Reducing governance committees: Most professions have several board committees in place outside the notifications and registrations functions (for example finance and governance committees) and consolidating some of these committees has the potential to reduce board-related expenses without affecting regulatory outcomes. While there are efficiencies to be gained by reducing the number of board committees, separate committees can allow potential for greater specialisation and a greater focus on patient safety. This may lead to some minor cost efficiencies.
4. New ways of working: Board and committee meetings can represent a significant expense for some professions and not all Boards and committees may need to meet with the same frequency, or be face-to-face. Considering alternative options including the number of members, meeting frequency and location could reduce Board-related expenses and reduce the burden on Board (and committee members). Conducting more meetings via tele/video conference (e-meetings), for example, has the potential to reduce costs and the individual burden on members through reduced travel and time away from their practice or business. A number of Boards are already doing this.

## Operational

The creation of a single AHPRA registration and notifications team for these nine professions could potentially lead to cost efficiencies while increasing regulatory quality through process expertise and consistency through specialisation. Potential benefits include improved regulatory quality through familiarity; more consistent material provided to registration and notification committees; and the possibility of overcoming the perception that matters relating to low-volume professions are not treated with appropriate priority.

Currently, certain registration functions are already delegated to AHPRA (particularly renewals) and by further increasing the level of registration decision-making delegation it may be possible to reduce board-related expenses through reduced committee involvement. Greater regulatory expertise would also develop within AHPRA, leading to better quality outcomes as well as improvements to timeliness and efficiency.

Potential exists for the introduction of a triage team within AHPRA for professions with lower volumes of notifications. Unlike the option for a dedicated registration and notification team, the scope of work for this team would only extend to matters of notification, not registration. If introduced, this team could receive all notifications relevant to those nine professions with lower risk profiles and regulatory volumes, then conduct the initial assessment stage (in conjunction with the relevant committees) before handing cases to local-based AHPRA investigators to conduct required on-ground activities and investigations.

## Other issues

<sup>46</sup> Excluding NSW data.

<sup>47</sup> Chinese medicine practitioner (2); chiropractor (6); medical radiation practitioner (1); occupational therapist (2); osteopath (1); physiotherapist (3); and podiatrist (3).

<sup>48</sup> Chinese medicine practitioner (2); chiropractor (4); occupational therapist (2); physiotherapist (3); and podiatrist (3).

A related issue is to consider minor changes, or policy guidance from ministers, to address the current challenges of board member ratio requirements that can create barriers to succession planning and inhibit merit-based appointments. The Osteopathy Board of Australia, for example, is faced with the challenge of 80 per cent of registrants being geographically concentrated in two states within Australia. This equates to fewer registrants in the smaller jurisdictions and thus fewer osteopaths in the available pool of potential applicants.<sup>49</sup> Increasing flexibility for the composition of boards to reflect the characteristics and needs of individual professions would be consistent with recommendation three of the Senate inquiry.<sup>50</sup>

National Boards and AHPRA would support further analysis of this option to obtain more precise and achievable cost savings as we are of the view the implementation of one or more of the options discussed above is still unlikely to deliver savings in the vicinity of those proposed in the consultation paper.

**Question 5: Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**

Any savings realised through options one or two should be returned to registrants through lower fees.

It is a feature of the maturation of the National Scheme that several National Boards are now able to commence reducing the fees<sup>51</sup> paid by registrants. Currently the fees required to be paid under the Scheme are to be 'reasonable' having regard to the efficient and effective operation of the Scheme and the fees set by each National Board reflect the regulatory workload borne by the Scheme on behalf of that profession. It is reasonable that once savings are realised by National Boards, implementation costs satisfied and equity targets reached that fee reductions would be applied where possible.

As part of the further detailed analysis of the potential savings for options one and two that may seek to include trends over several years, reasonable transition and implementation costs should be considered and factored in.

**c) For professions seeking entry to the National Scheme**

**Question 6: Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?**

It would **not** be considered acceptable to remove the fundamental basis for the assessment of net public benefit when considering future proposals for statutory regulation of further professions through the National Scheme. The Council of Australian Governments-endorsed [Principles of Best Practice Regulation](#) require a regulatory impact assessment prepared for consideration by Ministerial Council as decision-makers in relation to the inclusion of further professions within the Scheme.

It is a matter for governments to determine which professions are regulated within the National Scheme. The role of the National Scheme is not to decide which professions should enter the Scheme, but to ensure there is a sustainable model of regulation in place to accommodate any new professions governments decide require regulation.

Existing criteria guide the current approach to assessing the need to regulate a profession.<sup>52</sup> National Boards and AHPRA support the focus on evidence of risk of harm to the health and safety of the public as a core focus of these criteria.

<sup>49</sup> See separate submission from the Osteopathy Board of Australia (October 2014).

<sup>50</sup> Recommendation 3 (paragraph 2.178) of [the Senate: Community Affairs Legislation Committee inquiry into the National registration and accreditation scheme for doctors and other health workers, Commonwealth of Australia, ISBN 978-1-74229-160-4](#).

<sup>51</sup> Six National Boards reduced their fees in 2014-15, one as much as 30 per cent.

<sup>52</sup> Pursuant to the Intergovernmental Agreement for a National Registration and Accreditation Scheme for Health Professions of 26 March 2008, it was agreed that Ministerial Council will determine additional professions that should enter the Scheme using the criteria for assessing the need for statutory regulation of unregulated health occupations.

The introduction of the '2012 professions'<sup>53</sup> was successful and efficient. We have learned from this and initial experience in regulating these professions suggests that new professions take time to prepare for the transition into the National Scheme. Lead times need to allow for the profession to fully prepare for regulation. This is particularly true of only partially regulated or currently unregistered professions.

The work the National Scheme is undertaking on more flexible approaches to regulate lower-risk professions with smaller regulatory volumes at lower cost may be an important element for the entry of new professions. Our objective in this work is to deliver consistent and proportionate regulatory outcomes; to ensure that risk is being identified and mitigated in the most efficient and cost-effective way possible.

If alternate approaches to regulation in the National Scheme are being considered (refer question seven), then arguably this would not preclude other professions from inclusion in the National Scheme.

#### **Question 7: Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?**

AHPRA and the National Boards are of the view that there needs to be a uniform, cross-jurisdictional, regulatory protection mechanism for the health-related services provided by unregistered health practitioners to the Australian community. We support a change in the National Law to recognise professions that provide adequate public protection through other regulatory means and note the United Kingdom (UK) has a similar approach through the Assured Voluntary Registers Scheme that could potentially be adapted to the Australian context.

The National Boards and AHPRA acknowledge that a significant amount of healthcare is delivered to the Australian community by practitioners with limited statutory regulatory oversight, although there may be protection through other mechanisms such as employment relationships. Inclusion in the Scheme currently requires achievement of a threshold based on risk of harm to the health and safety of the public. The National Boards and AHPRA support this approach, but that does not preclude the introduction of other models of health and social care regulation under the umbrella of the National Scheme where the level of regulatory burden applied is proportionate to the regulatory risk posed to the public.

Other regulatory approaches such as negative licensing or voluntary registration have been successfully employed both domestically and internationally as tools to provide formal risk-appropriate level regulatory systems. Voluntary registration models provide a system that provides recognition of qualifications, minimum entry standards, assurance of practice standards, a code of conduct and ethics, and an avenue for complaints. Negative licensing models provide for the enforcement of codes of conduct to all persons practicing in the health area.

The *Options for regulation of unregistered health practitioners*<sup>54</sup> final report released by the Australian Health Ministers' Advisory Council in April 2013 reflects a need for strengthened regulatory protections for consumers who use the services of unregistered health practitioners. The report considers a number of options including government-monitored complaints handling; government-monitored voluntary registers; a voluntary national register; a national statutory Code of Conduct; and statutory registration extended to all unregistered health professions. The final report suggests some of these options need to be administered by existing state and territory bodies, or potentially by a national body.

The National Scheme already has a presence in each state and territory, as well as the expertise and organisational infrastructure to manage the inclusion of other regulatory models and would be well placed to play a role in strengthening regulatory protections.

Models such as the Assured Voluntary Registers Scheme administered by the Profession Standards Authority (PSA) in the UK could be integrated into the National Scheme. This system formally accredits

<sup>53</sup> Four professions joined the Scheme on 1 July 2012 including Aboriginal and Torres Strait Island health practitioners; Chinese medicine practitioners; medical radiation practitioners; and occupational therapists.

<sup>54</sup> Australian Health Workforce Ministerial Council [2013] *Options for regulation of unregistered health practitioners - final report*.



the existing voluntary self-regulation mechanisms employed by a professional body. To achieve accreditation a professional body must meet the accreditation criteria set by the PSA, which covers areas such as governance, standing, education, training, standards, complaints handling, etc. The Scheme is funded on a cost-recovery basis by the professional associations applying for accreditation.

The model in the UK also provides the PSA with the authority to make a risk-based recommendation on the appropriateness of the model of regulation for a profession should they feel that their current model of regulation is inappropriate for their level of risk. The PSA may make recommendations to raise or lower the level of regulation for a profession: for example, a self-regulated profession may be recommended for individual statutory regulation and vice versa.

The inclusion of unregistered health practitioners in the National Scheme will provide opportunities for cross-professional development, growth and improvement in those professions as well as the potential for better workforce planning opportunities across the Country.

The proposal for a single National Code of Conduct with enforcement powers for breach of the Code is the most likely to deliver the greatest net public benefit to the community. While the National Scheme may be well placed to manage such a program, it would need to be funded externally by the states and territories.

## d) Complaints and notifications

National Boards and AHPRA believe that the current model of notifications management in the National Scheme is viable and working. We support option 1 to retain the existing configuration of notifications handling but improve the process via a range of administrative changes, in response to the problems outlined in the consultation paper. Some minor technical amendments to the National Law may also be helpful.

### Introduction

The management of notifications has, not surprisingly, attracted considerable stakeholder comment.<sup>55</sup> This level of public scrutiny accompanies many health practitioner complaints systems internationally.<sup>56</sup> We recognise that ministers, the community and the regulated professions need to have confidence in the systems for dealing with concerns about the conduct, performance or health of registered health practitioners. We welcome this as an important area of focus for the review, in particular the opportunity to examine the current model in the context of leading practice internationally and the public safety objectives of the National Law.

Comprehensive information about the management of notifications is published in the *Annual Report 2013/14*.

The National Scheme includes state, territory and regional boards and committees making decisions about local practitioners as part of a local health complaints management network that includes collaboration with a local health complaints entity, referral of serious matters to a local tribunal and support to local boards and committees through an AHPRA office in each state and territory. National Committees also link into this local network through local AHPRA staff members and assigned committee members as required. These local boards and committees operate under powers delegated by each of the national boards.

These arrangements have aimed to maintain and build on the best aspects of previous arrangements and ensure locally relevant and timely decision-making about individual cases. For the professions with the greatest volume of notifications and greatest regulatory risk (dental, medicine, nursing and midwifery and

<sup>55</sup> For example, the Chair's foreword in the recent report of the Inquiry into the performance of the Australian Health Practitioner Regulation Agency (AHPRA) by the Victorian Legal and Social Issues Legislation Committee perceived there were a number of problems with the existing health complaints process in Victoria including time delays, inadequate communication and responsiveness, confusion over the roles of AHPRA, the Boards and the Health Services Commissioner, inadequate rights of notifiers, and inadequate ministerial and parliamentary accountability and oversight.

<sup>56</sup> Duff, E (2014) 'Health Care Complaints Commission in Crisis', *Sydney Morning Herald* 19 June 2014.



psychology, which account for 90 per cent of notifications to the Scheme), this ensures local management of notifications in a national standards framework. These standards are also underpinned by a common set of regulatory principles which have been agreed with all National Boards and AHPRA.<sup>57</sup>

While we recognise that there is more to do to educate the community about the role of regulation, it is important to note that notifications from members of the community account for approximately 64 per cent of the notifications we receive annually.<sup>58</sup> This is against a backdrop of a significant increase in notifications each year since the commencement of the National Scheme, with an overall increase of 16 per cent in the past year alone.<sup>59</sup>

### Relationships with health complaint entities (HCEs)

The relationship between the National Scheme and HCEs is the foundation of the system for managing notifications and complaints. It needs to be based on a clear understanding of common goals; distinct but complementary roles and responsibilities, and some jurisdictional differences in legislation.

In making decisions about notifications, Boards have a primary focus on public safety and professional standards. The National Scheme has not been established with powers as a complaints resolution agency. However this is not always well explained or understood by notifiers. It highlights the importance of close working relationships with health complaints entities and the joint consideration processes under the National Law. These are working well in all jurisdictions although are not always well understood by the community.<sup>60</sup> These issues are not isolated to Australia and we note a recent article citing the public in the United Kingdom does not appear to understand the National Health Service complaints processes or the role of the General Medical Council.<sup>61</sup>

Management of notifications under the National Law supports a clear delineation between the role of the National Boards (supported by AHPRA) and the health complaints entity (HCE) in each jurisdiction. The National Law sets out that under Part 8, the National Boards (supported by AHPRA) are responsible for the investigation and management of notifications about the health, performance and conduct of regulated health practitioners. There are clear definitions of 'unprofessional conduct' and 'professional misconduct'.

Currently, the functions of HCEs are determined by the laws of the state or territory in which the HCE is established and guided by the current Memorandum of Understanding (MoU) with AHPRA as executed on 27 October 2010. The day-to-day operation of each HCE varies between jurisdictions in a similar fashion to the jurisdictional-based practitioner regulation that existed prior to the National Scheme.

An examination of the current model of HCE operation with a view to moving to a more standardised, nationally consistent model would bring their role in overall health practitioner regulation into line with the operation of the National Scheme. A change of this nature would require legislative amendment but could bring benefit to both notifiers and practitioners through a more consistent approach to the handling of complaints.

We will also be reviewing the current MoU (within scope of current legislation) to introduce more currency to the partnership, consistency across the operations of HCEs and to build on the formal interaction between both entities.

It is noted that NSW and Queensland are both currently co-regulatory jurisdictions and it is not anticipated that this will change as a result of the three-year review of the Scheme.

<sup>57</sup> Refer section two: our achievements or <http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>.

<sup>58</sup> From 1 July 2013 to 30 June 2014, a total of 4,324 of the 6,811 notifications received came from HCE (1,995); member of the public (308); patient (1,529); and relative (492).

<sup>59</sup> Includes NSW data.

<sup>60</sup> 2013 AHPRA submission to the Victorian Parliamentary Inquiry into the performance of the Australian Health Practitioner Regulation Agency.

<sup>61</sup> [Moberly](#) (*BMJ Careers*, 21 July 2014).

## Question 9: What changes are required to improve the existing complaints and notifications system under the National Scheme?

National Boards and AHPRA support a principle-based approach to implementing changes to the existing model of managing notifications, based on a clear understanding of the role of regulation and the clear identification of shortcomings of the current model and opportunities for improvement.

Articulated below are a number of principles of a leading practice notifications management model, much of which can be achieved within the current model of management of notifications and the existing legislative framework. These principles could equally apply to entities within the National Scheme, including in co-regulatory jurisdictions and to local HCEs. The areas where legislative amendment/clarification may be appropriate are also identified.

### Principles

#### Clear entry point for lodging notifications

Notifiers need to have a clear pathway to raise concerns about a registered health practitioner. In the current arrangements in all jurisdictions except NSW and Queensland, notifications can be lodged either with AHPRA or the jurisdictional HCE. The National Law mandates a process whereby every notification lodged about a registered health practitioner is jointly considered by AHPRA and the relevant HCE to determine the appropriate body to deal with the matter. This means that it does not matter where a person lodges a notification, as there is a process to determine the most appropriate body to deal with their concerns.

For further detail see our response to question 11.

#### The notifier is an important participant in the regulatory scheme

The current application of the notifications provisions of the National Law essentially treats the notifier as an informant. This generally does not accord with the expectations of notifiers.

A report from the Health Issues Centre (HIC) [\*Setting Things right: Improving the consumer experience of AHPRA\*](#) (June 2014) (the HIC report) commissioned by AHPRA, identified that community notifiers can experience the notification process as difficult to access, delayed, impersonal and opaque. Further, the 2014 Victorian Parliament *Inquiry into the performance of the Australian Health Practitioner Regulation Agency*<sup>62</sup> (the inquiry) found, in summary, that scope existed to improve the experience of the notifier.

Leading practice in notifications management would recognise that the participants in the notification process are the National Board, the practitioner and the notifier. The notifier provides information to the Board but often also has expectations about how their concerns should be addressed by the Board.

While a notifier is an important participant, the notifier cannot determine the action that should be taken. However, there are simple elements of engagement with the notifier that would involve them more closely in the management of the notification. For example: improved initial explanation of the notifications process and what the notifier can expect; AHPRA has undertaken to examine the sharing of practitioner responses with notifiers; and seeking the notifier's comments prior to the National Board considering the matter.

#### Regular and more complete communication with notifiers and practitioners

Regular communication with both the notifier and practitioner involved is an important element of the notifications management process. AHPRA sends notices and other correspondence on behalf of the

Boards and their committees to practitioners, notifiers or others involved in a notification. AHPRA and the National Boards also publish individual information sheets about each step in the notification process that are sent to the practitioners and notifiers at the relevant stage. The information sheets for practitioners are published on the AHPRA website.

We recognise the need to communicate clearly with consumers and practitioners about our work, their part in the notification process and the purpose of the Scheme more broadly. For example, the HIC report highlighted that many consumers did not understand the written communication they received. AHPRA has commissioned an independent writer and established a review team to revise our correspondence with notifiers. While this work is progressing well, we are consistently reviewing and improving the information we provide on our website, supported by advice from the Community Reference Group.

National Boards and AHPRA are also sensitive to practitioners that have a notification made about them. The notification process does take time and this can cause a great deal of stress for practitioners going through the process. We are also taking steps to improve the experience for practitioners who are subject to a notification.

There is scope to improve transparency of communicating with notifiers. The confidentiality provisions of the National Law restrict the information that can be disclosed to notifiers (section 192(4)). Under previous legislation, boards in most states were able to give notifiers more information about the status, progress, and outcome of their notification than is currently permitted under the National Law.

In line with the guiding principles of the National Law, and our own regulatory principles,<sup>63</sup> transparency is critical. Greater clarity about the extent of the information that can be provided to the notifier and the practitioner at the end of the proceedings is necessary.

Further detail relating to transparency is available within the response to question 13.

### Timeliness of notifications management

The length of time it can take to complete a notification has been an area of concern for National Boards and AHPRA, as well as major stakeholders. While some notifications are complex and require significant interagency liaison (for example with police and coroners) the general view is that the notification process has been taking too long.

There are a number of important elements of timeliness including:

- initial triage and risk assessment, especially if any form of immediate action may be required to ensure public safety
- ensuring matters that do not meet the risk threshold for regulatory action under the National Law are dealt with and closed as quickly as possible
- prompt progress of matters that require further assessment and investigation to determine whether regulatory action is needed, and
- the response of tribunals in determining final regulatory action in the most serious matters.

We are committed to transparency and accountability through better performance reporting. During the year, key performance indicators were developed jointly by National Boards and AHPRA and implemented to better measure and therefore manage notifications.

It is important to note that timeliness is one measure of the quality of notifications management. It is important to also have a focus on other dimensions of quality, including the effectiveness of regulatory decision-making.

<sup>63</sup> Refer section two: our achievements or <http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>.

See response to question 12 for further information.

### Effective management of complex notifications

Some of the most complex notifications are referred to the relevant Board during or after initial investigations by an employer (e.g. a hospital) or the coroner/police. A leading practice model of notifications management would enable early co-ordination of activities by multiple agencies to assist the experience of the notifier, avoid duplication of effort and improve timeliness.

The National Law does not create barriers for National Boards to utilise investigations completed by other agencies or indeed the employer's own internal processes (as far as feasible) or to split matters between entities, particularly between Boards and HCEs and progressed concurrently. However, there may be issues in relation to the legislation which underpins health complaints entities in each jurisdiction. This approach is likely to be more immediately responsive to notifier expectations while enabling Boards to explore issues of risk to public safety.

Leading practice would include an opportunity for conciliation, even when a matter is initially managed by a National Board. This could be achievable within current legislation, depending on cooperation between Boards and HCEs. Such a model could be achieved by:

1. referral from a National Board to the HCE (without specification of action to be taken) and
2. request from a National Board to the HCE (specifically to conciliate/mediate)

National Boards undertaking conciliation/mediation would require a change to the National Law and could also represent a departure and/or compromise from their role as regulators. As such, this option is not supported. See our response to question 14.

### Like risk dealt with consistently nationally and underpinned by national standards

While recognising differences of practice context, individual circumstances and procedural fairness, the principle that a similar level of risk should be dealt with in a similar way across Australia is important. There should be no geographical differences when it comes to a consistent regulatory response to practitioners.

The response to concerns about conduct, performance and health must be underpinned by consistent national standards set by National Boards, with supporting codes and guidelines. National registration and mobility will become meaningless if it is not underpinned by national standards.

### All regulatory outcomes feed into national registers

The National Registers are an invaluable public protection measure for the community. This means they must contain complete information about the registration status of all registered health practitioners. Whatever the route by which restrictions are placed on a practitioner, they must all feed into the Register.

Conditions on registration need to be clearly monitored to ensure ongoing public safety wherever the practitioner may be in Australia and truly comparative data is essential if the National Scheme is to demonstrate that regulatory objectives are achieved.

### Expanded range of outcomes

#### 1. Counselling

Leading practice would be enhanced by making legislative change to the National Law to include provisions for the National Boards to require counselling of practitioners as a notification outcome. Counselling is an outcome available to NSW Health Professional Councils under Part 8 of the NSW National Law and is considered to be a powerful regulatory response, particularly when there are concerns about practitioner insight into the essence of the notification. There is potential for express incorporation of counselling arrangements along the lines in place in NSW.

As an alternative, the National Law gives wide scope to the National Boards to set conditions on registration that could include counselling or peer interview arrangements. Under the current model, Boards may be able to achieve this through the use of conditions on registration, as appropriate for the particular matter.

## 2. Reprimands

In the current legislative framework, only panels or tribunals may reprimand a practitioner. Both panel and tribunal proceedings are costly and extend the timeframe for finalising a notification. Ideally, panels should be reserved for matters where there is a need to test evidence, but where it is not clear that the threshold for professional misconduct has been reached. Enabling Boards to reprimand practitioners when that appears to be the appropriate response and the evidence is already sufficiently clear would be useful and would support retaining this more distinct role for panels.

### Question 10: Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all states and territories?

National Boards and AHPRA believe that the desired principles informing a strengthened approach to dealing with notifications can be achieved within the existing model via a range of administrative and legal changes, in response to the problems outlined in the consultation paper. Our response to question 9 identifies ways in which this could be achieved. National Boards and AHPRA do not support the adoption of the co-regulatory arrangements in Queensland across all states and territories as these have only been in place for three months and the model is still evolving. There is also a concern to minimise any further fragmentation of the National Scheme.

While National Boards and AHPRA recognise the reasons for implementing a new co-regulatory approach in Queensland, we do not support its adoption across all jurisdictions.

### Background

1. **Improvements can and are being achieved within the existing model:** National Boards and AHPRA believe that the desired principles informing a strengthened approach to dealing with notifications can be achieved within the existing model via a range of administrative methods and specific technical legal changes.
2. **Increased risk of fragmentation:** Objectives in relation to efficiency and continuous improvement are more difficult to achieve in a highly differentiated environment. Introducing additional co-regulatory arrangements would risk fragmentation of the National Scheme, compromise the achievement of the objectives of the National Law and potentially introduce inconsistent handling of 'like' notifications.
3. **Ongoing and transition costs:** [There would be] significant costs and disruption associated with moving to any new arrangements and their ongoing maintenance, including direct financial costs and the significant financial investment already made by the professions and governments in establishing the National Scheme, as well as the loss of momentum and continuity in dealing with current notifications.<sup>64</sup> Fee variations across jurisdictions are likely with increasing divergence in notifications management. Costs need to be transparent to the professions and what they pay for needs to be clear and consistent with the functions of the National Law. It is important to ensure registrant funds are not inadvertently used to fund complaints about health services or unregistered health practitioners.

National adoption of the Queensland model has the potential to incur significant costs associated with the transition to any new arrangements and in supporting its ongoing maintenance. National Boards are understandably concerned about the cost implications of wider adoption of the Queensland model.

The National Law in Queensland requires that the Minister for Health annually determine the amount of the complaints component of registration fees payable by Queensland health practitioners that

<sup>64</sup> There were four changes to medical regulation in seven years in Queensland to 2010.

reflects the reasonable cost of the Health Ombudsman performing functions relating to the health, conduct and performance of health practitioners that would otherwise be performed by National Boards and AHPRA.

The funding requirements of the new complaints management system in Queensland and the core operating overhead costs will need to be sourced through registrant fees. To the extent that the model is more expensive in Queensland, this would require an additional, differential registration fee for Queensland practitioners. This would be necessary to maintain the principle that registrants in other jurisdictions should not have to contribute to a different model established in Queensland.

This arrangement has not been in operation for a sufficient period of time to measure or identify potential duplication and it is too early to estimate costs incurred by each agency.

4. ***Unintended impacts on timeliness:*** The new co-regulatory system aims to improve the timeliness of the management of complaints. However, there is concern that the additional steps involved in the process may inadvertently add time to the management of notifications. Once received by National Boards, complaints must be managed efficiently, but do need to follow the legislative steps and operational processes required by the National Law. However, it is too early to rely on the very early statistics available about the management of complaints in the new Queensland co-regulatory system to establish a reliable trend.

More widely, there may be scope to make changes to the approach to the management of notifications according to the risk profile of professions within co-regulatory arrangements and to review the inclusion of professions based on their risk profile and volume of notifications. It is likely that for a number of professions with lower registrant numbers, co-regulatory arrangements may not be proportionate and financially sustainable. For example, in NSW the registration fee for two smaller professions is already higher.

#### **Question 11: Should there be a single entry point for complaints and notifications in each state and territory?**

National Boards and AHPRA recognise that the first contact with the notifier is the most important, the most influential and has the ability to set expectations and understanding on the part of the notifier. All notifiers need to have a clear pathway to raise concerns about the conduct, performance or health of a registered health practitioner.

After a notification is received, AHPRA works with the local HCE to agree which is the most appropriate organisation to manage the notification. This 'joint consideration' process is a requirement of the National Law and makes sure that notifications are managed in the best way to protect the public.

Where it operates, the existing joint consideration process works well. However, there is scope for continued improvement, in particular explaining to community notifiers how the joint consideration process works. More widely, there is also scope to strengthen joint work in areas such as sharing of investigation reports and possible splitting of matters that raise a number of issues. For example: a dental matter which may raise issues about practitioner performance and where the notifier is also seeking a refund or costs for further treatment.

The main focus should be on continuing to strengthen the joint consideration process. This is because regardless of where a concern about a registered health practitioner is raised, joint consideration means that there is a clear and timely process to decide which organisation is best placed to deal with the issue(s).

Minor legislative amendments related to section 146 of the National Law have been suggested at question 28. This will enable a notification, in certain circumstances, to be sent directly to the local HCE prior to an investigation by a board, therefore saving money; and providing a more timely response to, and reducing unnecessary stress for, both the notifier and practitioner. This is also likely to reduce the number of matters considered by a board that result in no further action.

National Boards and AHPRA are concerned that any proposed changes to the point of entry for notifications do not inadvertently add delay, cost, confusion or complexity to the system. Strengthening the MoU between HCEs and AHPRA will provide a tool to achieve this.

## Background

In the current arrangements in all jurisdictions except NSW and Queensland, notifications can be lodged either with AHPRA or the jurisdictional HCE. The National Law mandates a process whereby every notification lodged about a registered health practitioner is jointly considered by AHPRA and the relevant HCE to determine the appropriate body to deal with the matter. This means that it does not matter where a person lodges a notification, as there is a process to determine the most appropriate body to deal with their concerns.

The public consultation forums conducted as part of the review suggest that this joint consideration process works well in all jurisdictions, but there is scope for improvement. In particular, around ensuring there is clear communication with the notifier about the joint consideration process and the reasons why their concerns have been referred to the National Scheme.

The HIC report commissioned by AHPRA, identified the need to ensure that community notifiers are assisted in understanding the role of regulation in dealing with their concerns; are given clear sign-posts about the range of available options; and receive clear and straightforward communication throughout the notifications process. The 2014 Victorian Parliament *Inquiry into the performance of the Australian Health Practitioner Regulation Agency*<sup>65</sup> found, in summary, there was scope to improve the experience of the notifier in the current framework.

There are also opportunities for changes in the way that HCEs work. For example, the *Victorian Health Quality Commissioner Bill 2014* proposes changes to facilitate open communication between the Commissioner and the National Boards and refers to the National Law in relation to the Commissioner's duties if a complaint is made that may also be the subject of a notification under the National Law. Specifically, there will be the capacity to split or divide a complaint, for the Commissioner to follow up a matter which has been the subject of a decision by a National Board or delegate.

## Question 12: Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

National Boards and AHPRA support the introduction of uniform national performance measures and prescribed timelines.

The length of time it can take to complete a notification has been an area of concern for National Boards and AHPRA, as well as stakeholders. While some notifications are complex and require significant interagency liaison (for example with police and coroners), the general view is that the notifications process has been taking too long.

There are little systematic data on timeliness from previous state and territory arrangements on which to make comparisons.<sup>66</sup> Anecdotally, there appear to have been few formal performance measures, partly based on legislative requirements, profession-specific approaches and custom and practice.<sup>67</sup> The National Law is essentially silent on quantitative measures of timeliness, apart from the requirements for preliminary assessment to be completed in 60 days, outlined in section 149.

An important initiative of National Boards and AHPRA has been to develop KPIs measuring timeliness at all stages of the notifications process. These were implemented in July 2013 and apply to all notifications lodged with AHPRA since 1 July 2013, in jurisdictions other than NSW.

<sup>65</sup> Parliament of Victoria (2014) *'Inquiry into the performance of the Australian Health Practitioner Agency'*.

<sup>66</sup> See annual reports of former state and territory boards.

<sup>67</sup> In setting notifications management KPIs, AHPRA worked with National Boards to make sure any prior knowledge or expectations in place for previous boards were at least matched.



There are a number of important elements of timeliness:

- initial triage and risk assessment, especially if any form of immediate action may be required to ensure public safety
- ensuring that matters which do not meet the risk threshold for regulatory action under the National Law are dealt with as quickly as possible
- the timely progress of matters which may require further assessment and investigation to determine whether regulatory action is needed
- the response of tribunals in determining final regulatory action in the most serious matters.

The KPIs enable AHPRA to measure the timeliness of each stage of the notifications process. The KPIs establish both performance measurement and performance improvement targets. See Section 3 for details of our performance and a comparative desktop assessment between the National Scheme and some regulators in the United Kingdom when looking at timeliness as an indicator of performance.

Performance reporting is in the form of a traffic-light system reported to National Boards and the Agency Management Committee on a quarterly basis. National Boards and AHPRA review any matter that falls outside the KPIs to identify the issue and enable any corrective action to be taken. We have set these KPIs carefully, taking into account our current performance and reasonable expectations of what we should achieve. They will be reviewed annually.

In addition, the Agency Management Committee has established a [Performance Committee](#) to monitor, scrutinise and assure regulatory performance.

Adopting consistent performance measures and prescribed timeframes at all levels of the notifications management process has the potential to enhance the efficiency and effectiveness of the National Scheme as well as strengthen the performance evidence base upon which future operational improvement decisions would be made.

It is also important to note that timeliness is only one element of quality regulatory decision-making. Consideration must be given to the appropriateness of timeframes while ensuring that the National Scheme is delivered in line with the objectives and guiding principles of the National Law.

National Boards and AHPRA note that ministers could require a set of clear KPIs for regulatory performance, including notifications, through a policy direction or minor legislative amendment to their adopting legislation and require reporting to each parliament on performance.

**Question 13: Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?**

The guiding principles of the National Law state that the National Scheme is to operate in a transparent and accountable way, National Boards and AHPRA recognise that scope exists to improve the manner in which transparency is applied in communicating with notifiers.

The confidentiality provisions of the National Law restrict the information that can be disclosed to notifiers (section 192(4)). Under previous legislation, boards in most states were able to give notifiers more information about the status, progress, and outcome of their notification than the National Law currently permits.

While health ministers have agreed on amendments<sup>68</sup> to the National Law that will improve communication with notifiers and practitioners, further legislative change may be required to enable us to provide more complete, clear and direct information to notifiers; in particular, the release of additional

<sup>68</sup> Amendments relate to sections 167, 177 and 180 of the National Law.

information to notifiers with the consent of practitioners. We think this would help consumers understand and, in some cases we hope, more readily accept the outcome of their notification.

Improved transparency would:

1. improve the quality of the conversation with the notifier at initial contact, set expectations, identify what the notifier wants and offer options
2. require a smooth interface between the National Board and the HCE. The handover points between the HCE and AHPRA need to be visible to the notifier and the role of the notifier will need to be understood and accommodated and
3. require improvement of the perception/reality of how to get into the system to get notifications or complaints resolved – improve external communication so all participants know what the National Board is able to achieve.

Much of this can be achieved within the current legislative framework and forms part of the action plan in response to the HIC report.

**Question 14: Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?**

Given the two separate but interrelated roles, National Boards and AHPRA do not consider that it is the role of the regulator to also undertake alternative dispute resolution and have duplicate powers, which may lead to further confusion with the role of the HCEs in each jurisdiction. If conciliation is needed, referral to the HCE is the appropriate response. This may require amendment of HCE legislation to make sure it is clear that once a matter has been finalised by the Board, if required or appropriate, it can be referred back or referred to a HCE for alternative resolution.

The functions of HCEs are determined by the laws of the state or territory in which the HCE is established and generally include the resolution of health complaints, by conciliation or other forms of alternative dispute resolution<sup>69</sup>, with privilege attached to ensure confidentiality. While the National Scheme operates in partnership with HCEs, its function is to regulate health practitioners and relies on HCEs actively (and concurrently) participating in health complaint resolution where necessary.

The strength of this process is that the HCEs can focus on an individual's complaint and seek resolution. By contrast, as regulators, the National Boards must focus on action that might be needed to address the health, conduct or performance of individual practitioners to protect the public.

For example, a notifier may want to withdraw a serious complaint but the regulator must continue. While a notifier is an important participant, the notifier cannot determine the action that should be taken.

If conciliation is needed, referral to the HCE is the appropriate response. This may require amendment of HCE legislation to make sure it is clear that once a matter has been finalised, if required or appropriate, it can be referred back or referred to a HCE for alternative resolution. For example, the *Victorian Health Quality Commissioner Bill 2014* proposes changes in this regard.

**Question 15: At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?**

Currently, the National Law (s226) provides National Boards with the power to remove information relating to the reprimand of a registered, practising health practitioner from the National Register or Specialists Register, if it considers it is no longer necessary or appropriate for the information to be recorded on the Register.

<sup>69</sup> Memorandum of Understanding, AHPRA and HCEs 27 October 2010.

In order to remove a condition<sup>70</sup>, the Board must reasonably believe that the condition/s imposed on the registration of a registered health practitioner (or student) registered by the Board are no longer necessary.

While the National Law is silent on the removal of a condition by a National Board as a result of 'sufficient' time elapsing (while practising) from the time it was imposed, the current discretion provided to National Boards in relation to this may also allow National Boards to consider the removal of a condition that is triggered by a particular time period elapsing, so long as it also complies with section 226 of the National Law.

In relation to conditions being publically available on the National Register or the Specialists Register, consideration could also be given to modifying the National Law to enable the operation of a time-based automatic removal of information from the public register (such as conditions). Best practice examples could be sought from practitioner regulation in overseas jurisdictions.

There is still an important community debate to be had about whether further information about proven disciplinary history should be published or remain on the National Registers in the public interest.<sup>71</sup> For example, some National Boards are of the view that conditions and orders should stay on the record permanently unless the body<sup>72</sup> that ordered them, specified that once the condition or order had been satisfied, it could be approved for removal by the Board; or the practitioner makes an application to consider lifting the 'spent' conditions and orders. Some National Boards are of the view that reprimands should never be removed.

#### e) Public protection – protected practice, advertising, cosmetic procedures and a national code of conduct

##### Question 16: Are the legislative provisions on advertising working effectively or do they require change?

National Boards and AHPRA support option 3 to remove the ban on the use of testimonials about a health profession service or business.

National Boards and AHPRA have had substantial feedback from community and practitioners that the National Law ban on testimonials is not consistent with current community practice and expectations and should be removed as it does not provide specific or definable protection for the public.

AHPRA considers that advertising is primarily a consumer issue. The Australian Competition and Consumer Commission (ACCC), the Therapeutic Goods Administration (TGA), AHPRA and state and territory HCEs share roles in relation to the accuracy of claims in the health care sector. AHPRA works with the ACCC to ensure the work in relation to false and misleading advertising dovetails effectively in protecting the public with the approach of AHPRA and the National Boards. While good progress is being made on raising issues of concern with practitioners, the function might more appropriately be dealt with by HCEs or the Australian Competition and Consumer Commissioner.

Advertising issues often raise important detailed considerations in relation to what are essentially commercial issues and questions as to technical compliance with section 133 of the National Law. For example, in relation to section 133(1)(b), AHPRA is unclear whether it was the intention of legislators to allow regulated health practitioners to offer gifts, discounts and other inducement to attract a person to the service or business. Many professions would argue that the words 'unless the advertisement also states the terms and conditions of the offer' should be removed, to ensure that regulated health practitioners cannot offer gift, discounts and other inducements, particularly in online advertising, in relation to a regulated health service.

<sup>70</sup> As it relates to section 226(1) and (2).

<sup>71</sup> Moynihan, R (2012) 'A watchdog to bite the giants' *The Medical Journal of Australia*; 196 (1): 15.

<sup>72</sup> National Board, panel or tribunal.

In the event that the advertising offence provisions in Part 7 are retained, some clarification on testimonials would assist. A possible amendment is that section 133(1)(c) be removed and the use of false testimonials could be pursued under section 133(1)(a), in line with the Australian Competition and Consumer Commission's powers under the Australian Consumer Law which prohibits making a false or misleading representation that purports to be a testimonial by any person relating to goods or services or concerning a testimonial or a representation that purports to be a testimonial (any such representation will be taken to be misleading unless evidence is adduced to the contrary).

In relation to the offence provisions as a whole, the timeframes within which to lodge a complaint for a statutory offence vary from jurisdiction to jurisdiction – from six months to two years. National Boards and AHPRA think that consistency would be very helpful and we find the six-month timeframe to be very challenging from the perspective of preparing the complaint. For that reason, our preference would be a consistent limitation period of two years – for all states and territories.

#### **Question 17: How should the National Scheme respond to differences in the states and territories in protected practices?**

National boards and AHPRA advocate for consistency in approach to protected practices across Australia.

While the National Law does not define or restrict the scope of practice, there are three areas of restricted practices that restrict these acts to practitioners with particular training and skills to protect the public. The restricted practices are:

- restricted dental acts (restricted to medical and dental practitioners)
- prescription of optical appliances (restricted to optometrists and medical practitioners)
- manipulation of the cervical spine (restricted to medical practitioners, physiotherapists, chiropractors and osteopaths).

Further information on spinal manipulation is at Appendix 2.

Since the commencement of the National Scheme, SA has restricted birthing practices to medical practitioners or midwives (or students from these professions), and has defined *birthing practice*. The NT has introduced a reporting requirement for privately practising midwives to advise the Chief Health Officer (CHO) before practising private midwifery and then annually to provide the CHO with reports on private midwifery cases undertaken. While not advocating a specific position in relation to birthing practices, AHPRA and the Nursing and Midwifery Board of Australia support a nationally consistent position.

Some jurisdictions (SA and Tasmania) also continue to have legislative requirements/restrictions about the dispensing of optical appliances.

In order to recognise that different considerations might arise between jurisdictions, the Ministerial Council could agree that any state- or territory-based amendments be proposed and debated by parliaments in the jurisdictions. National Boards and AHPRA support consistency in approach across Australia.

#### **Question 18: In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?**

National Boards and AHPRA consider that progress on the introduction of a National Code of Conduct for unregistered health practitioners is positive. However, there appears to be a challenge in that any orders would be enforced at a state level by the relevant complaints body. This has proved to be a challenge in relation to practitioners who might seek to practice across a number of jurisdictions.

AHPRA suggests that consideration be given to amending the National Law to:

- expressly deem that a prohibition order made by a responsible tribunal under the National Law has effect in all participating jurisdictions, and

- provide for national enforceability of such orders by creating an offence provision for breaching a prohibition order<sup>73</sup>. At present enforceability of prohibition orders is only through state-based legislation establishing the respective tribunals, which also brings with it disparity between states in relation to maximum penalties.

## f) Mandatory notifications

**Question 19: Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australia and Queensland legislation covering health practitioners under active treatment?**

Mandatory reporting is an important public protection mechanism in the National Scheme. We support the goal of nationally consistent mandatory reporting provisions, whatever ministers decide about future exemptions for treating practitioners. Findings from early research indicate there are several feasible 'intermediate' options warranting examination. They may all be mechanisms to reduce the risk of practitioners not seeking treatment, while maintaining a requirement to report practitioners who pose a substantial risk to the public.

Mandatory reporting was an important policy initiative at the commencement of the National Scheme that extended the reporting requirements from some professions in some jurisdictions, to all practitioners registered in the Scheme, including for treating practitioners. At the time of commencement for all jurisdictions other than WA, there was a consistent approach established in legislation to ensure public protection, and continue the protections in place prior to the National Law in Victoria and NSW for medical practitioners, and also in Queensland just prior to 1 July 2010. Changes to the emerging national approach in the legislation were made through passage of the National Law in WA in 2010, subsequent to the passage of the National Law by other jurisdictions. Further change was implemented in Queensland from 2014 with the introduction of the Health Ombudsman and associated amendments to the National Law application in Queensland.

The consultation paper highlights the experience and incidence of mandatory reporting up to July 2013 and subsequent data is provided for the 2013-14 period in this submission at Table 13 and in the [Annual Report 2013/14](#). The inclusion of data from 2013-14 does not demonstrate any substantial changes in the trends described in the consultation paper for previous years. It is noted that the deeper research-based analysis of the subset of mandatory notifications by treating practitioners is under investigation by Senior Research Fellow Dr Marie Bismark and colleagues<sup>74</sup>, in partnership with AHPRA and National Boards.

There is no clear data or research on the effects of mandatory reporting on practitioners who avoid seeking help and treatment for fear of being reported. There is also an understanding that both the moral and ethical practice requirements for registered health practitioners and other existing legal requirements may require a doctor to report another health practitioner to regulatory authorities, including one they are treating, if there is a *real future risk of harm* to the practitioner or a patient, or indeed anyone else.

The early experience and analysis of outcomes to date, along with perceptions by stakeholders, may offer the following 'intermediary' options between the current situation and total exemption for treating practitioners:

1. **Reword the statutory requirement** to focus on future rather than past risk (may be consistent with the previous Victorian legislation)
2. **Establish a statutory discretion**, whereby a treating practitioner 'may' report certain forms of notifiable conduct with statutory protections for notifications made in good faith (consistent with the New Zealand provisions relating to performance concerns)

<sup>73</sup> Please note the proposed prohibition orders will be distinguished from the prohibition orders provided for in s149C(5) National Law (NSW).

<sup>74</sup> Dr Marie M Bismark MB ChB, LLB, MBHL et al (MJA 201 [7], 6 October 2014).

3. **Introduce a new ‘shielding clause’** whereby patient-practitioners who are actively engaged in treatment with an [approved] health program<sup>75</sup> and do not pose a substantial risk to the public are explicitly ‘shielded’ from being the subject of a mandatory report by a treating practitioner (as occurs between a number of regulators in the United States of America (USA) and the physicians’ health programs in their State).

The third option (option 3) may be seen as potentially relevant and suitable by a range of stakeholders in Australia and has some evidence of effectiveness in the USA. Should there become a national exemption for a treating practitioner to make a notification, we consider that it should be framed as follows:

*‘A treating practitioner is exempt (shielded) from the requirement to report a patient-practitioner in situations where the practitioner-patient is complying with the requirements of an appropriate treatment program [may need to be defined], including appropriate adjustments and/or restrictions on his or her practice. If the patient-practitioner chooses not to participate in or comply with the requirements of such a program, then this exemption lapses and reporting may be required to protect the public from a risk of substantial harm.’*

## g) Workforce reform and access

**Question 20: To what extent are National Boards and accrediting authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?**

Outlined below is the work National Boards and AHPRA have done and are undertaking to deliver on our statutory objectives and guiding principles of the National Law:

- a. The **public are protected with only suitably trained and qualified practitioners** being registered. Under the National Law, each board sets registration standards, approved by the Ministerial Council, which every registered health practitioner must meet. These standards are designed to ensure patient safety. Registration standards for each National Board are published on National Board websites and the AHPRA website. The [2014-15 Business Plan](#) outlines a number of initiatives by National Boards and AHPRA designed to develop or review and implement regulatory standards and policies, including medical radiation standards for supervised practice; midwife standards for practice; and new registration standards and a memorandum of understanding with pharmacy premises-registering authorities.

In 2013-14, of the 474 immediate actions taken – for the most serious risks – 75 per cent led to restrictions on registration; 228 panel and 116 tribunal decisions were made and 75 suspensions issued, all of which have provided for the protection of the public.

The quality of the assessment of overseas-qualified practitioners, accreditation standards and accreditation of programs of study determines whether practitioners who complete programs of study or are assessed as qualified for registration have the knowledge, skills and professional attributes to practise their professions and is critical to protecting the public.

- b. **Workforce mobility across Australia has been facilitated** with registered practitioners now able to pay a single registration or renewal fee to practise anywhere in Australia within the scope of their current registration. State and territory barriers no longer exist. There are now more than 619,500 registered health practitioners. For the first time under the National Scheme, we can be confident about the nature, scope and profile of Australia’s health workforce<sup>76</sup>. Trends are being constantly monitored and information appropriately shared with key agencies.

<sup>75</sup> Not all professions have an approved health program, for some it is generally sufficient that there is an appropriately supervised and articulated health management program approved by the Board.

<sup>76</sup> 96 per cent of practitioners completed the workforce survey, creating invaluable data for workforce planning and reform.



In addition, national accreditation functions support workforce mobility, and have established national accreditation standards and processes where in some cases they did not previously exist.

- c. **High-quality education and training of health practitioners** is being provided. A significant achievement was the uninterrupted delivery of accreditation through the transition to the National Scheme. The National Boards and AHPRA, in collaboration with the accreditation authorities for each of the first ten professions to be regulated under the National Law, supported a seamless transition from the diverse range of accreditation approaches pre-1 July 2010, to the delivery of accreditation by these independent external entities within a single statutory framework. In 2012 each of the National Boards for the 2010 professions reviewed accreditation arrangements, as required by the National Law.

High-quality education and training of health practitioners is assured through the assessment of education providers and their programs by accreditation authorities against accreditation standards as set out in Part 6 of the National Law. Accreditation standards and accreditation of programs of study against those standards are fundamental determinants of the quality of the education and training of health practitioners. AHPRA's [\*Procedures for the development of accreditation standards\*](#) (the procedures) are an important mechanism for articulating a common process for the development and approval of accreditation standards, and the interrelationships between the National Scheme entities on this function. Accreditation standards are developed by accreditation authorities but standards cannot be applied to accreditation assessments unless they have been approved and published by the National Board. There are approved accreditation standards for all 14 health professions.

Accreditation authorities must develop processes to assess overseas qualified practitioners and publish details of these processes. They undertake those processes, and therefore accreditation authorities control the responsiveness and rigorousness of those assessments on a day-to-day basis. In 2011, the external accreditation entities, National Boards and AHPRA developed the [\*Quality Framework for the Accreditation Function\*](#) (Quality Framework) to support quality assurance and continuous quality improvement of accreditation under the National Law. Each accreditation authority is required to submit reports against the Quality Framework to the respective National Board on a six-monthly basis. The Quality Framework, noted by ministers, is the principal reference document for National Boards and AHPRA to assess the work of accreditation authorities, including the responsiveness and rigorousness of their assessments.

More details about accreditation are in Appendix 4.

- d. **Facilitating the rigorous and responsive assessment of overseas-trained health practitioners**

The National Boards have specific accountabilities to assess applicants for registration who were qualified and trained overseas. AHPRA has worked with National Boards to develop robust processes to support this assessment. These are consistent with the National Law and are largely profession-specific.

The Boards have put a range of safeguards in place to make sure that international graduates, who are registered to practise in Australia, are safe to do so. The provision of and requirements for health practitioner education around the world vary. It would be impossible – and inappropriate – to accredit every individual course outside Australia.

National Boards have developed tailored approaches to assessing international qualifications in their discipline. In terms of qualifications for medicine, for example, courses listed on the current International Medical Education Directory (IMED) (online only) of the Foundation for Advancement of International Medical Education and Research are acceptable for the purposes of sitting the Australian Medical Council examination and for limited registration, provided all the other requirements in the National Law and the registration standards are met.

Assessing qualifications is only one of the steps towards registration in Australia. The education and training that are provided in a course are important considerations, but the experience, additional



training and skills of each health practitioner are absolutely crucial factors in determining whether they are competent and safe.

Every practitioner registered to practise in Australia must meet their Board's registration standards, published on each National Board's website, accessible through the AHPRA website. These standards also apply to international graduates to make sure they are competent and safe to practise. These go over and above the health practitioner course completed and aim to assess the competence of the practitioner, not just the course that they completed.

Other requirements for registration: in medicine the various pathways to registration for international medical graduates include extensive assessment of the practitioner's competence, skills and training. More detailed information about how the Medical Board of Australia has used the advent of the National Scheme to streamline, make consistent and generally improve the assessment of international medical graduates can be provided on request. This has been a significant achievement, reached in partnership with a number of stakeholders including the Australian Medical Council, the specialist colleges and the jurisdictions. Innovation in this area continues, enabled by the National Law. See [this link for the Medical Board of Australia consultation on changes to registration pathways to streamline assessment](#).

Information about how the Nursing and Midwifery Board of Australia and AHPRA manage applications from [internationally qualified nurses and midwives is published here](#). This National Board and AHPRA are actively working on initiatives that will streamline and improve the assessment of the qualifications and competence to practise of internationally qualified nurses and midwives.

Over the past four years, AHPRA has made steady progress on a range of work to support the National Boards to develop and implement rigorous and responsive assessment of overseas-trained practitioners, such as establishing an International Qualifications Assessment Working Group. This aims to develop a cross-profession approach to exploring further work on issues of potential cross-profession relevance to assessment of overseas-trained practitioners.

**e. Facilitate access to services provided by health practitioners in accordance with the public interest.**

For the past four years, there has been a growth in the registered health workforce in Australia. National Boards provide registration types tailored to meet workforce needs (including limited registration and area of need). Access to services is also facilitated by avoiding the inclusion of unnecessarily onerous or restrictive requirements in accreditation standards and in the processes for assessment of overseas-qualified practitioners. If accreditation standards are unnecessarily onerous, education providers may not be able to meet those standards and so may decide not to offer the program. If the processes for assessment of overseas-qualified practitioners are unnecessarily onerous or restrictive, they can affect the number of overseas-qualified practitioners who can qualify for registration to practise in Australia. Each of these outcomes reduces the number of registered health practitioners and so has a negative impact on access to services.

The National Boards, accreditation authorities and AHPRA strive to develop and implement standards, policies and procedures that achieve a balance between facilitating access to services and ensuring those services are only provided by suitably qualified, competent and ethical practitioners.

**f. National Boards and AHPRA are enablers of continuous development of a flexible, responsive and sustainable Australian health workforce.**

The National Scheme is not the main driver of workforce reform, but should be responsive to government priorities. We have established mechanisms to engage with governments on these issues across Boards and intend to work closely with the Australian Health Ministers' Advisory Council (AHMAC) and the Health Workforce Principal Committee (HWPC) to ensure we have a clear understanding of government priorities. This will help make sure our regulatory processes are appropriately responsive. We also make sure our registration standards meet the requirements set by the Office of Best Practice Regulation (OBPR).

There are fewer barriers to workforce reform in the Scheme than stakeholders may perceive, given that the National Law is not prescriptive legislation and does not define scope of practice. Registration types are also tailored to meet workforce needs (for example, limited registration and area of need).

There is a consistent focus by National Boards to make sure that regulatory measures (standards, codes, and guidelines) do not constrain workforce reform, except when needed to ensure public safety. Boards ensure that regulatory responses reflect emerging models of service delivery and practice (for example, endorsements as an enabler of reform).

The National Boards have also worked actively to support change that will remove current barriers created by variations in jurisdictional law (e.g. the need to harmonise drugs and poisons legislation).

The links between workforce reform and accreditation are also important. There is also a critical role for accreditation standards and processes to prepare the health workforce for future practice needs.

The National Scheme's workforce data are an important enabler of workforce reform. Current, effective partnerships are in place with Medicare, the Australian Institute of Health and Welfare and the Commonwealth Department of Health. There is scope for the National Scheme to apply and share data more strategically to support reform.

Accreditation is also an enabler of continuous development of a flexible, responsible and sustainable Australian health workforce. For example, the accreditation standards for each profession do not preclude the use of interdisciplinary supervision models for student clinical placements. The accreditation standards generally require clinical placement supervisors to have the skills, knowledge, authority, time and resources to provide supervision that is appropriate to the learning outcomes the student is to achieve during the placement. In some professions supervision by health practitioners from other professions is an established practice.

Another example of the avoidance of barriers to workforce development is that many of the approved accreditation standards encompass the use of simulated learning environments (SLE). The role of simulation as a learning method is recognised; its use should be supported by evidence that shows students achieve the relevant learning outcomes. Several accreditation authorities recognise that SLE could be used to enhance, support and even in certain circumstances replace some direct clinical involvement by students.

National Boards and AHPRA have identified as a priority the need for **innovation in the education of, and service delivery by, health practitioners**. The outcomes focus of many of the accreditation standards approved by National Boards over the past four years facilitates innovation in education. For example, outcomes-focused standards do not prescribe fixed staff/student ratios. Instead they require education providers to show the ratio enables students to achieve the relevant learning outcomes. More specifically, we have put the following three key issues on the agenda for accreditation authorities to examine and respond to in the next five years:

- opportunities to increase cross-profession collaboration and innovation and address the guiding principles of the National Law (e.g. that the scheme is to operate in a transparent, accountable, efficient, effective and fair way). This may involve each authority identifying opportunities for joint projects with other accreditation entities or the Health Professions Accreditation Councils' Forum.
- opportunities for each accreditation authority to facilitate and support inter-professional learning in its work and
- opportunities for each accreditation authority to encourage use of alternative learning environments, including simulation, where appropriate.

The Forum of National Board Chairs has also established a Workforce Reform Committee to provide oversight of the Scheme's contribution to the health workforce reform agenda. This committee includes jurisdictional representation to support a seamless approach to workforce reform priorities between jurisdictions and the Scheme.

Work on these areas is either in the early stages of planning or is underway. See also further detail on accreditation in Appendix 4.

### Performance in relation to guiding principles

There is always scope to improve the ways in which the operation of the National Scheme supports the **guiding principles of the National Law**. Critically, our regulatory principles (see section two: achievements) reflect the guiding principles of the National Law and provide the framework National Boards and AHPRA will apply to all decisions. Over time, these principles will shape all decisions made across the National Scheme by AHPRA, the National Boards and their delegates. More immediately, we have put in place many initiatives that support the guiding principles defined in the National Law:

1. **Transparent:** The introduction of an online and publicly available national register of practitioners, which provides accurate, reliable and up-to-date information about the registration status of all registered practitioners, regardless of where in Australia they practise. This includes publishing descriptions of any limitations and conditions on registration, other than for some health matters, when this detail is not published. An online register of cancelled health practitioners, linked to tribunal decisions, is also readily accessible to the community.

Details are published annually relating to regulatory outcomes, expenses, data access requests, administrative complaints and details on finalised freedom of information applications. As a new initiative in 2012, not possible before the Scheme, National Boards started publicly publishing quarterly data profiling Australia's workforce, including a number of statistical breakdowns about registrants. National Boards and AHPRA also share information with other entities, where permitted by law, in the interest of public protection and workforce mobility.<sup>77</sup> The National Boards and AHPRA publish annual Health Profession Agreements, detailing how Boards and AHPRA spend registrant fees. Each annual report provides detailed financial information. Communiqués from meetings of the [Professions Reference Group](#), [Community Reference Group](#), National Boards and the [Agency Management Committee](#) minutes are also made publicly available on the AHPRA website.

The National Boards, AHPRA and the accreditation authorities publish a range of information about accreditation. A list of accreditation authorities and the functions they exercise under the National Law is published on the AHPRA website (<http://www.ahpra.gov.au/Education/Accreditation-Authorities.aspx>). Each accreditation authority publishes information about its accreditation processes and procedures (see Attachment C of Appendix 4 for links). Each National Board publishes a link to the approved standards on their website.

The Quality Framework and information about the reviews of accreditation arrangements are also published on the AHPRA website. National Boards, accreditation authorities and AHPRA have also developed a reference document *Accreditation under the National Law*, which is published on the AHPRA website (<http://www.ahpra.gov.au/Publications/Accreditation-publications.aspx>). As further reference documents describing agreed good practice approaches are developed, they are progressively published to build more transparency over time.

2. **Accountable:** Since February 2011, at the request of ministers, AHPRA has provided regular updates on key operational activities and emerging issues to the Ministerial Council at the Standing Council on Health meetings. This has provided a timely opportunity for National Boards and AHPRA to have direct, regular contact with all ministers and their advisors. We look forward to this continuing. This contact complements the bilateral discussions that AHPRA has, as needed, with individual health ministers on matters of particular local interest. AHPRA and the National Boards are accountable to all nine health ministers. To improve accountability, we would encourage ministers to require National Boards and AHPRA to report on performance against agreed key performance indicators. This year, we will be providing each state and territory with tailored information about registered health practitioners specific to their jurisdiction, as part of our annual reporting process.

<sup>77</sup> All information sharing within the National Law framework.

More detail on processes established by the Agency Management Committee to support performance and good governance (e.g. audit committee, performance committee, internal audit function) is provided later in this submission. Suggestions on accountability in the National Scheme are outlined in section three.

- 3. Efficient:** For the first time in 2014-15, National Boards and AHPRA implemented a single aligned and collaborative approach to business planning that has resulted in well-articulated outcomes; a reduction in duplication, effort and cost; and contributes to making the scheme as efficient as possible. These outcomes are detailed in the [2014-15 Business Plan](#).

An organisational restructure of AHPRA that took effect from 1 July 2014 also seeks to improve all aspects of our work. The restructure introduced specific national accountability for performance in our core regulatory functions, while maintaining a responsive local framework. The restructure responds to the need of a more outward-focused approach to stakeholder engagement.

National Boards and AHPRA are actively harnessing the flexibility in the National Law and working towards differentiated models that ensure regulation is proportionate, sustainable, effective and targeted to risk. We are examining opportunities for new and more streamlined approaches by and for Boards to save costs and be proportionate to regulatory challenge.

Already Boards are exploring opportunities to regulate some professions more flexibly at lower cost. This has included taking multi-profession approaches, increased delegations and shared committee work. Some of this work is detailed in question 4 in section one of this submission.

Some National Boards and AHPRA would also welcome targeted changes to the National Law in relation to board member ratio requirements. The current requirement can create a barrier to succession planning and merit-based appointments. This is particularly so for professions that have a geographical concentration of registrants entrenched in one or two states, such as the Osteopathy Board of Australia, with over 80 per cent of osteopaths practicing and residing in NSW and Victoria, which is viewed to be a contributing factor to delays to appointments. This may also be achieved through policy guidance from ministers. It would also be consistent with recommendation 3 of the Senate inquiry, which recommended that the Scheme contain sufficient flexibility for the composition of Boards to properly reflect the characteristics and needs of individual professions.<sup>78</sup>

- 4. Effective:** One of the core roles of the National Scheme is to keep the public safe through proportionate and fair regulatory decision-making. The Boards set standards (approved by the Ministerial Council) that practitioners must meet to become registered and standards that dictate what they have to do to stay registered.

Agreed regulatory principles<sup>79</sup> underpin our decision-making and will increasingly shape the National Scheme into the future.

One of the important ways Boards manage risk to the public is by setting national standards, codes, and guidelines that all registered practitioners must meet.

Question nine in section one makes suggestions for change to improve the consumer experience of the interface between regulation and Australia's network of health complaints agencies. We are working on improving consumers' experience of our processes and have a number of initiatives in place to change how we work. We are revising our letters to notifiers and practitioners to make them more accessible, clear and direct. Refer to Attachment E for examples of recently modified template letters to notifiers.

<sup>78</sup> Recommendation 3 (paragraph 2.178) of [the Senate: Community Affairs Legislation Committee inquiry into the National registration and accreditation scheme for doctors and other health workers, Commonwealth of Australia, ISBN 978-1-74229-160-4](#).

<sup>79</sup> Refer section two: our achievements or <http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx>.

Opportunities for greater community involvement have been implemented and will be continued through consultations and input into National Board standards, codes and guidelines, and through the AHPRA and National Boards' community engagement program..

We are developing an *Accountability Framework* in the National Scheme that aims to support both National Boards and AHPRA to work together to deliver their respective functions consistent with the Scheme's guiding principles. It is based on similar frameworks developed by regulators in the United Kingdom.

The Professional Standards Authority (PSA) in the United Kingdom now assesses UK regulators against 24 standards, spanning five regulatory functions<sup>80</sup>, outlined in the *Standards for good regulation*. AHPRA has conducted a desk-top self-assessment against the standards established by the PSA, refining where appropriate for the Australian context<sup>81</sup>. The findings, that are reflective of the level of maturity of the organisation, have been reported against the standards as strengths, weaknesses, scheduled planned activity and opportunities for improvement. Work in this area will continue to evolve and be developed. A copy of the internal report is at Attachment D.

AHPRA has published a [Service Charter](#) that sets the standards of service that the community and practitioners can expect. This has recently been reviewed and has benefited from advice from our Community Reference Group.

We have established a complaint-handling policy and procedure to manage complaints about AHPRA, a board or committee, or the behaviour of an AHPRA staff member or a board or committee member. A [Performance Committee](#) tasked with strengthening a performance culture across the Scheme was established in late 2013. The [2014-15 Business Plan](#) contains a number of improvement initiatives that focus on improving and strengthening the scheme, including notifications improvements, strengthening the performance reporting framework, and implementing a national health impairment project for nurses and midwives.

5. **Fair:** When we take action to address complaints against practitioners we use the minimum regulatory force to manage the risk posed by their practice, to protect the public. Our actions are designed to protect the public and not to punish practitioners.

Nationally consistent registration standards and processes for registration and endorsement are in place. These enable the fair and transparent assessment of applications in all jurisdictions and nationally consistent processes for notifications. New processes to support the consistent assessment of notifications about practitioner performance, health or conduct have been implemented in all jurisdictions. National Boards recognise there are opportunities for improvement over time to ensure that desirable processing times are routinely achieved in all jurisdictions.

AHPRA worked collaboratively with National Boards to improve communication with notifiers within the requirements of the National Law, using plain English, and in a timely way. AHPRA also publishes readily accessible information about the notifications and registration process on the website.

6. **Fees under the National Scheme are reasonable**, and are agreed annually having regard to the efficient and effective operation of the Scheme. Four years in, with the costs of establishing the National Scheme behind us, fees have stabilised or reduced. In 2013-14, four professions decreased registration fees, two did not make any changes and all others increases were limited to the consumer price index (CPI). In 2014-15, six professions decreased their registration fees, two stabilised and the remaining six professions limited increases to the CPI.
7. **Restrictions on the profession are imposed only if it is necessary to ensure health services are provided safely and are of an appropriate quality.** The National Law is based on a title protection

<sup>80</sup> Standards and guidance; registration; fitness to practise (known in Australia as health, performance and conduct); education and learning; and governance and external relations.

<sup>81</sup> AHPRA liaised with the Professional Standards Authority in the United Kingdom for this part of the process.

model and imposes very few restrictions on the practice of registered health practitioners. Our regulatory principles require that when Boards take action about practitioners, they use the minimum regulatory force to manage the risk posed by their practice, to protect the public. Their actions are designed to protect the public and not to punish practitioners.

**Question 21: Should the proposed reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?**

Successful workforce reform at a national level is a collaborative effort between policy makers, regulators, educators, funders, consumers and health professionals. The Forum of National Board Chairs has created a Workforce Reform Committee to provide advice on the National Scheme's contribution to health workforce reform. The Workforce Reform Committee includes jurisdictional representation to support a seamless approach to workforce reform priorities between jurisdictions and the National Scheme.

The National Scheme recognises it has a role to play in supporting national health workforce reform priorities. The Forum of National Board Chairs has created a Workforce Reform Committee to provide advice on the National Scheme's contribution to health workforce reform. The Workforce Reform Committee includes jurisdictional representation to support a seamless approach to workforce reform priorities between jurisdictions and the National Scheme.

The National Scheme also believes that the sharing of advice and information regarding workforce reform should be a two-way communication process. Indeed, the National Scheme now has developed a significant amount of workforce data and information that can inform itself and other stakeholders of progress in addressing workforce and service priorities. In addition, there is a need for the National Scheme to be able to provide input to workforce reform policy and strategy, including the addressing of barriers and enablers that may be intrinsic or extrinsic to the National Scheme. The proposed reconstituted AHWAC could play an important vehicle for this purpose.

**Question 22: To what extent are accrediting authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing needs?**

National Boards and AHPRA continue to work with accreditation authorities, particularly through the Accreditation Liaison Group, to make progress on work in these areas.

AHPRA is supporting work in a range of areas to explore and test collaborative and innovative cross-profession approaches by accreditation authorities. AHPRA is also engaged in cross-profession policy work to ensure the National Boards and accreditation authorities are aware of and are developing the potential of the National Scheme in relation to collaboration and innovation opportunities in accreditation.

More information about this work is in Appendix 4.

AHPRA provides support to the accreditation authorities that are committees established by the National Board. The accreditation standards developed by each of these accreditation authorities and approved by the relevant National Boards focus on demonstration of outcomes by education providers and their programs.

Historically, accreditation standards often prescribed inputs whereas an outcomes-focused approach:

- allows for greater flexibility and diversity in how education providers design and deliver programs
- promotes innovation and encourages education providers to 'showcase' how they meet the accreditation standards in the context of changing technology, new models of care and changing needs of entry-level practice
- minimises constraints to change in curriculum and models of delivery of programs



- is consistent with contemporary accreditation practice in Australia and overseas, and
- is aligned to the objectives of the National Scheme.

In keeping with the focus on outcomes, the approved accreditation standards developed by the three accreditation committees do not specify:

- the required length of programs, instead requiring education providers to demonstrate how the program meets the specifications, including volume of learning, of the relevant Australian Qualification Framework (AQF) level, or
- the required curriculum content, instead requiring education providers to demonstrate how the program learning outcomes and assessment ensure students attain the knowledge, skills and professional attributes to practise the profession.

**Question 23: What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?**

National Boards and AHPRA consider a relationship is required between accreditation authorities and educational institutions to ensure the minimum qualification for entry to professions remains available. Accreditation standards provide a potential mechanism to facilitate this outcome by ensuring these standards require graduates to competently and ethically practice the profession.

The role of National Boards in approval of accreditation standards enables the Boards to ensure that the accreditation standards reflect the minimum qualification for entry to the profession. The accreditation standards have no effect unless they have been approved and published by the National Board.

The National Boards do not require a direct relationship with educational institutions to ensure that minimum qualifications for entry to the profession remain available. National Boards can achieve this by ensuring that the accreditation standards they approve do not specify higher qualifications with potential negative impacts on the workforce.

Appendix 4 contains more details about work of the National Boards, AHPRA and the accreditation authorities in the development and approval of accreditation standards.

However, many National Boards engage in regular dialogue with education providers on a range of other important regulatory issues including limited registration for teaching/research (applicable for many professional staff working in education programs), student registration and student mandatory notifications. Other areas for dialogue include the design and scope of curricula above the minimum qualifications for entry to practice that may be creating unnecessary challenges to the National Law objective of facilitating access to health professionals, and whether the supply of graduates from programs of study appropriately match the workforce demand requirements on a national scale.

## h) Assessment of overseas-trained practitioners

**Question 24: How effective are the current processes with respect to assessment and supervision of overseas-trained practitioners?**

The assessment and supervision of overseas-qualified practitioners requires careful balance in meeting the objectives of the National Scheme. National Boards must ensure that assessment and supervision of overseas-qualified practitioners is rigorous enough so that practitioners who are safe to practise are registered, while allowing for the registration of practitioners necessary to fill positions to meet the healthcare needs of the community.

Currently, the National Boards have varying approaches to the recognition of international qualifications and examination/assessment of overseas-qualified practitioners. It should be noted that some National Boards are still subjected to transitional arrangements that existed prior to the National Scheme with respect to recognition of overseas education providers or qualifications. Across the 14 National Boards



there are 'standard' pathways for assessment of individuals as well as 'substantial equivalence pathways' and 'competent authority pathways' for recognition of international qualifications.

One of the key challenges in this area is the difference, across most of the 14 regulated health professions, in the assessment of qualifications and work experience for migration purposes (which requires an evaluation of some different elements of the individual's qualifications and work experience) compared to the assessment for registration purposes.

AHPRA and the National Boards are committed to further work in the underpinning processes of the assessment and supervision of overseas-qualified practitioners. The International Qualifications Assessment working group (the IQA working group) has been established to inform National Boards' policy approaches to the assessment of overseas-qualified practitioners, and to explore opportunities for greater clarity and consistency across professions. Some of the key areas of work are to:

- engage with the relevant federal government departments that intersect in the process of assessment and supervision of overseas-qualified practitioners, especially AEI-NOOSR, and
- develop consistent communications about the difference between assessment for registration purposes and assessment for migration purposes for inclusion in each National Board's information for overseas-qualified practitioners.

As the assessment and supervision processes of overseas-qualified medical, nursing and midwifery practitioners has been the subject of inquiry over the last years, the approach to these professions are addressed specifically.

### Medical practitioners

Assessment and supervision of international medical graduates (IMGs) demonstrates in practice the delicate balance necessary to meet the objectives of the National Scheme. It requires the Medical Board of Australia (MBA) to ensure that assessment of IMGs is rigorous enough so that practitioners who are safe to practise are registered, while allowing for the registration of practitioners necessary to fill positions to meet the medical needs of the community.

The MBA has a number of mechanisms in place to make it possible for it to register IMGs who otherwise may not be registered. By way of international comparison, there are many IMGs who are registered in Australia who would not be registered in Canada or the United States of America. These mechanisms have been included in the registration standards approved by the Ministerial Council.

Before being granted medical registration, all applicants (IMGs and non-IMGs) have to demonstrate that they are medical graduates and their qualifications are listed in the current International Medical Education Directory (IMED) (online only) of the Foundation for Advancement of International Medical Education and Research. However, the MBA understands that medical degrees around the world vary in quality. It would be impossible to accredit every individual course. While the education and training that are provided in the medical course are important considerations, the experience, additional training and skills of each medical practitioner are also important considerations when deciding whether a medical practitioner is competent and safe to practice medicine. The additional requirements set via the registration standards acknowledge that IMGs are individuals and should be assessed on a case-by-case basis.

The individual nature of IMG assessments, which aims to make the process flexible and tailored, also makes the process much more complicated. IMG assessment would be most streamlined if it was 'one size fits all' as it was before the work by COAG in 2006 on the pathways to registration. However, that would not take into consideration the characteristics of the individual applicant and the workforce needs of the community.

The mechanisms in place to allow the MBA to register IMGs include:

### The pathways to registration

Most IMGs are required to be in one of the following pathways

1. Competent authority pathway or
2. Specialist pathway or
3. Standard pathway.

Each pathway has its own assessment and qualification requirements. For example, practitioners in the competent authority pathway have completed certain qualifications or assessment and specified practice which is comparable to Australian training. Practitioners in the specialist pathway are internationally qualified specialists and have been assessed by the relevant specialist college. Practitioners in the standard pathway have passed the Australian Medical Council multiple-choice examination and have therefore had a test of their medical knowledge.

### **Requirement to have completed an intern year**

All applicants for limited registration must have completed an intern year equivalent overseas and therefore have previous clinical experience before being eligible for registration in Australia. The Board is proposing to provide an exemption to this requirement in the revised registration standards, but is proposing that applicants can only practise in Australia in an accredited intern position which is by definition closely supervised and provides training.

### **Supervision**

All international medical graduates with limited or provisional registration are required to practise under supervision for the duration of their limited or provisional registration. The level of supervision varies, depending on the assessed competence of the practitioner and the level of risk inherent to the position. The requirement for supervision is assessed case-by-case to allow flexibility.

Assurance of supervision enables the Board to grant registration to IMGs in circumstances where it otherwise would not.

### **Pre-employment structured clinical interviews**

Applicants for limited or provisional registration who wish to practise in high risk positions such as in general practice or senior non-specialist hospital positions are also required to have a pre-employment structured clinical interview in which trained panels assess whether or not a practitioner is suitable for a particular position.

### **Responses to *Lost in the Labyrinth***

The consultation paper refers to the inquiry by the House of Representatives Standing Committee on Health and Ageing in 2011. The final report *Lost in the Labyrinth – Report on the inquiry into registration processes and support for overseas-trained doctors* made recommendations to streamline assessment processes while ensuring public safety.

Since the report was published, the MBA and AHPRA have been working with stakeholders, including the Australian Medical Council and the specialist colleges, to streamline assessment processes for international medical graduates.

Changes made on 1 July 2014 include:

- Streamlining the competent authority pathway (CAP).

There has been no change to the eligibility for the CAP. However, IMGs now apply for provisional registration (rather than limited registration) and are not required to apply to the Australian Medical Council for an advanced standing certificate or the AMC certificate. Rather, after 12 months satisfactory supervised practice, they are eligible for general registration. This has resulted in

significantly less administrative red tape and substantially reduced costs for the IMG (the entire process from application through to general registration has been reduced from \$3,770 to \$2,056).

The changes to this pathway were possible because of the flexibility in the National Law.

- Streamlining the specialist pathway

We have worked with the AMC and the specialist colleges to make administrative changes to this pathway that result in streamlining and clearer accountabilities. IMGs deal directly with specialist colleges to apply for assessment in the specialist pathway. With the agreement of the AMC, we have removed the need for IMGs to interact with colleges through the AMC.

Other changes to the pathway include the use of a secure portal for AHPRA, colleges and AMC to communicate, reducing the need for multiple written communications, revised and consistent definitions of comparability and clearer documentation for colleges to communicate the result of their assessments.

- Changes to the standard pathway

The AMC, with the financial assistance of HWA and the Commonwealth has built a world-class assessment centre that has significantly reduced waiting times for IMGs to sit the clinical examination.

Other work done or in progress that will further streamline IMG assessment and that addresses concerns in the *Lost in the Labyrinth* report includes:

- The Medical Board has established a working group to develop guidelines for the specialist colleges on good practice in the specialist IMG assessment process in accordance with the objectives and guiding principles of the National Registration and Accreditation Scheme.

The working group will work with specialist colleges and it is expected that this process will further standardise and streamline the assessment of specialist IMGs.

- Supervision guidelines for IMGs

The supervision of IMGs is a difficult issue with stakeholders providing conflicting views and advice about the adequacy of current arrangements. Some stakeholders express a view that the supervision guidelines are too onerous while others believe that the guidelines are not sufficiently protective.

The Board is currently reviewing the supervision guidelines for IMGs, taking into consideration the experience over the past four years.

- Pre-employment structured clinical interviews (PESCI)

The Board and AHPRA have published additional information on the Medical Board website about PESCI – what they are and who needs to have a PESCI.

After receiving feedback from stakeholders, the AMC, at the request of the Board, has reviewed the guidelines for PESCI. The review included wide-ranging consultation and significant input from AHPRA and the Board. It is expected that the revised guidelines will be approved by the Board in October 2014. The revised guidelines provide additional information about the requirements of PESCI providers and about the reporting to the Board.

- Primary source verification (PSV)

The Educational Commissioner for Foreign Medical Graduates has established the Electronic Portfolio for International Credentials (EPIC) which allows IMGs to apply for PSV much earlier, rather than having to submit via the AMC. The Board is revising its registration standards to allow the use of EPIC, which should streamline PSV.

- English language proficiency

The English language registration standard has been reviewed by all Boards and will be submitted to the Ministerial Council shortly. The revised version is clearer and gives additional flexibility without reducing the standard expected.

A great deal of work has been done to streamline the assessment of IMGs without compromising standards. However, the flexibility of the system adds to its complexity. Further 'tinkering' will result in further complexity.

The assessment of IMGs is complex: for the practitioner, their livelihood is at stake; for the community, their health is at stake. The safeguards that the Board has in place balance the need to register practitioners while supporting safe practice.

### Nurses and midwives

Prior to the commencement of the National Scheme, there was no nationally consistent approach to the assessment of internationally qualified nurses and midwives (IQNMs) in Australia. The previous state and territory nursing and midwifery boards approached the process in accordance with the relevant legislation in the jurisdiction.

At the commencement of the National Scheme a framework approach was adopted by the Nursing and Midwifery Board of Australia (NMBA), which had been developed by the then Australian Nursing and Midwifery Council prior to the National Scheme.

On 10 February 2014, a new assessment model for IQNMs was implemented after:

- three years' experience with the National Scheme and applying the National Law
- continuing evidence-based research on international best practice in the assessment of the qualifications of internationally educated nurses and midwives, and
- reviewing decisions from Australian tribunals.

The changes made clearly define the steps required to assess substantial equivalence (to an approved qualification) under section 53(b) of the National Law. They create a robust and transparent decision-making model to support the nationally consistent assessment of international nursing and midwifery qualifications. The criteria that underpin the model are drawn from NMBA-approved accreditation standards for the enrolled nurse, registered nurse and midwife.

The assessment and comparison of international qualifications continues to evolve internationally and the NMBA will continue to benchmark its assessment model with international trends. The NMBA and AHPRA will apply this model to assess the qualifications of international applicants until a long-term approach is adopted, which is a key project for the NMBA in the next 12 months.

The NMBA is acutely aware of its obligations under the National Law to ensure that overseas-qualified persons who apply for general registration have the knowledge, clinical skills and professional attributes necessary to practise the profession in Australia, and to balance this ensuring there is a flexible, responsive and sustainable nursing and midwifery workforce.

## i) Governance of the National Scheme

### Question 25: Should the appointment of a Chair of a National Board be on the basis of merit?

National Boards and AHPRA support the principle that the person assessed as being the best person for the role of Chair should be appointed. Currently this process is in place for all national board members and chair appointments, however the National Law does not presently allow community members to be appointed as Chair.

Effective community membership of National Boards (and state, territory and regional boards) is a key element to protecting the public. Community members on National Boards have an active voice in the regulation of health professions and bring a range of perspectives to board discussions.

The National Law requires at least two members of a National Board to be community members and community membership must be no less than 1/3 of the total membership of the board. National Boards have either nine or 12 members (the size agreed by Ministerial Council). Under current arrangements, the Chair of a National Board must be a practitioner member. At least one member of a National Board must live in a regional or rural area. Most National Boards agree that the current balance of National Board membership is appropriate.

When current statutory composition requirements are applied to each board, the following applies:

**Table 3: How current statutory composition requirements are applied to each board**

<b>9-member boards</b>	Aboriginal and Torres Strait Islander Health Practice; Chiropractic; Chinese Medicine; Optometry; Osteopathy; Podiatry; Occupational Therapy	6 practitioner members – each large state has a practitioner member, with the 6th member being from either NT or ACT or Tasmania.  3 community members – for balance (and as appropriate) these members may come from the state/territories that do not have practitioner members.
<b>12-member boards</b>	Dental; Medical; Nursing and Midwifery; Medical Radiation Practice; Pharmacy; Physiotherapy; Psychology	8 practitioner members – every state and territory has a practitioner member.  4 community members – there will be some duplication of jurisdictions (e.g. there could be a practitioner member <u>and</u> a community member from the NT).

The National Law does not define what it means to bring a community perspective to the board. This encourages a diversity of views and backgrounds for community members. However, there is one important eligibility requirement to safeguard and support this diversity. To be eligible to be a community member on a National Board, a person must not now, or at any time have been, a registered health practitioner in the health profession for which the board is established. For example, a former registered nurse could not be appointed as a community member on the Nursing and Midwifery Board of Australia, even if that person was registered by a state board before 2010 or had not practised the profession of nursing for many years.

Public interest in being appointed to the National Boards as vacancies arise remains high. When Ministerial Council made appointments to 10 National Boards in July 2012, following the expiry of the inaugural terms of National Board members, 140 people expressed their interest for 33 vacancies. Ministers considered that this response reflected the considerable interest from the community in the work of the National Boards and the importance of the contributions that community members make to the Boards and the National Scheme.

National Boards and AHPRA are keen to acknowledge the important contribution of community members in the National Scheme.

The Victorian Minister for Health, the Hon. David Davis MLC, has called for a focus on the role of consumers and their contribution to regulation in the National Scheme. More widely, the Minister has questioned whether consumer views are represented adequately and strongly enough in the national registration arrangements.<sup>82</sup>

<sup>82</sup> Hansard. *Legal and Social Issues Legislation Committee, Tuesday 23 October 2012, page 4688*

The National Boards and AHPRA note the view that practitioner-member chairs are an important mechanism for providing credible leadership to support effective regulation for their profession, maintaining high professional standards and facilitating workforce reform within their profession. They also acknowledge the alternative views that the chair roles should not be strictly limited to practitioner members.

If the chair roles were to be open to community members to be appointed, then the same principle should continue to apply – that the best person for the role should be appointed by the Ministerial Council.

**Question 26: Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?**

The division of roles and functions between National Boards and accreditation authorities is effective and can meet the objectives of the National Law. The roles and functions of accreditation authorities are able to be undertaken in a range of ways to suit the specific requirements of the professions regulated by each National Board in order to meet their objectives under the National Law.

The continuous delivery of accreditation functions through the transition to the National Scheme is a significant achievement. The National Boards and AHPRA worked with accreditation authorities to support a seamless transition from the diverse range of accreditation approaches pre-1 July 2010, to the delivery of accreditation functions by independent accreditation authorities within a single statutory framework.

Over the past four years, the change flowing from applying the objectives and guiding principles of the National Law to accreditation is profound, and has important and far-reaching implications for the delivery of accreditation functions. Similar to other areas of the Scheme, perceptions of the extent of this change vary and may not always reflect the significant shift that has occurred.

The National Boards and AHPRA continue to work with accreditation authorities, particularly through the Accreditation Liaison Group, to deliver against the objectives of the National Law. More information about this work is in Appendix 4.

**Question 27: Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?**

Under the model of independent accreditation functions within the National Scheme, the review of accreditation decisions is primarily undertaken through an internal review mechanism. If the internal review does not address the concern raised then judicial review is open to an educational institution or individual.

National Boards and AHPRA would support clarification that the National Health Practitioner Ombudsman has jurisdiction to address complaints about accreditation decisions through a review of the administrative process applied and any deficiencies that may require remedy rather than solely relying on judicial review as the only external review mechanism.

Decisions made by accreditation authorities form the basis for the National Boards to make their own decisions on approval of programs of study for registration purposes. The National Boards and AHPRA have worked with accreditation authorities, particularly through the Accreditation Liaison Group, to develop a communication framework for accreditation decisions. More details about this framework are provided in Appendix 4.

## j) Cost and sustainability of the National Scheme

The National Boards and AHPRA note the collaborative work undertaken by the Professional Standards Authority (PSA) and the Centre for Health Services Economics and Organisation in the United Kingdom to review the cost-effectiveness and efficiency of the National Scheme in Australia.

National Boards and AHPRA acknowledge that the methodology applied for this review was originally developed in 2011 specifically for assessing the cost-effectiveness and efficiency of the professional

regulatory arrangements and it has been used in the past to assess the nine UK health and care regulators.

Given the different regulatory arrangements in the UK and Australia, National Boards would like to highlight some key differences that are likely to have some bearing on the cost of regulation in Australia, and, in particular, the registration and notifications functions.

- a) In the UK, the National Health Service (NHS) is the major provider for health. Any regulatory activities work with the health system and many of the regulatory activities are funded from within the structure and resources of the NHS (so effectively the NHS and regulator are linked by legislation).
- b) In Australia, we have many more registration types than exist in the UK.
- c) Anecdotally, National Boards and AHPRA receive and process many more overseas applications than the UK. Overseas applications take much longer to process than general applications. In the UK, mutual recognition is extended to include another 'relevant European State' (another country within the European Economic Area or Switzerland) and includes 31 countries. In Australia, mutual recognition only extends to New Zealand.
- d) In Australia, employees that work in our customer service team (approximately 50 FTE) are costed directly to the registration function. It is unclear if this is the case in the UK.
- e) The objectives of the National Scheme as outlined in the National Law provide for public protection **and** workforce reform, this brings with it additional activities<sup>83</sup> (and cost) that do not appear to be present in the UK.
- f) The consultation paper notes that the cost of notifications through the NSW co-regulatory arrangements was \$19.4 million in 2013-14. In 2013-14, National Boards provided \$26.36 million for the NSW co-regulatory arrangements. The operational surplus of more than \$6.8 million has been retained by the relevant Health Professional Councils in NSW.

The adopted equity target for National Boards essentially comprises three main components: risk of unexpected and uninsurable legal expenditure; forecast increase in net fixed assets from asset growth; and other large one-off expense items that align with the Board's strategic plan and beyond the capacity of annual operating budgets. Refer to Appendix 1 for further details on fee-setting principles and National Board equity.

## k) Proposed changes to the National Law

### Question 28: The Review seeks comment on the proposed amendments to the National law:

National Boards and AHPRA support the minor technical amendments to the National Law endorsed by the Australian Health Workforce Ministerial Council on 11 November 2011 (AHWMC Agenda Item No. 7) and outline some additional technical legislative amendments.

National Boards and AHPRA have outlined some additional minor technical amendments for consideration as part of the review (refer table four).

We note also that the Health Practitioner Regulation National Law (NSW) No. 86 will also be the subject of a review by the NSW Government. It would be desirable to integrate, where appropriate, any consideration of amendments in NSW, in the interests of maintaining or achieving consistency for the public, practitioners and notifiers.

#### Table 4: Proposed minor technical amendments for consideration

<sup>83</sup> For example, but not limited to, the collection and sharing of workforce data; relevant aspects of registrations standards, codes and guidelines; workforce reform and prescribing working groups; and interactions with the Health Workforce Principal Committee (HWPC).



Issue	Legislative amendment proposal
Appellable decision	<p>Amendment to s81(1) to enable the Board to propose to refuse to grant the type of registration applied for and to propose to grant a different type. This can be achieved by adopting the wording from s84(2) as follows:</p> <p><i>"If, after considering an application for registration, a National Board is proposing to register the applicant, or to register the applicant in a type of registration other than the registration applied for or subject to a condition, the Board must give the applicant written notice of the proposal."</i></p>
Title protection - Acupuncture <sup>84</sup>	<p>Consideration might be given to the amendment of s113(3) (Title Protections) Table to expressly include the word 'Acupuncture'.</p>
Review of conditions	<p>At present, review of conditions on the Board's initiative during a review period is dependent on the existence of a material change in circumstance.</p> <p>There are a number of instances when a change might be appropriate to update conditions s125(2)(a) – for example where the conditions were set in a legacy arrangement and are not formulated in accordance with preferred approaches for monitoring compliance, or do not import a review period.</p> <p>Allowing some flexibility to review conditions within the review period to both address any public safety/interest concerns (for example, a requirement for increased urine screening because of breaches) and to take into account situations where the conditions have been complied with in a shorter period of time and there is no public interest to continue to the end of the review period. To provide the Board with power to add or remove conditions other than as a consequence of a material change would assist.</p>
How a notification is made	<p>Amend s146 to allow for a matter to be excluded from being a notification where it is to an HCE and the HCE accepts the matter as better addressed by that body.</p>
Co-regulatory issue in section 148(2)(a). Allow possibility to refer back to the National Agency	<p>s148(2)(a) – Delete this sub-section to enable the Agency to deal with a notification if it is referred back from co-regulatory jurisdiction. This will provide clarification that, in the event that the co-regulatory jurisdiction does not wish to retain the issue, it can be referred back to the National Board.</p>
Procedure after investigation	<p>S167(a) to be amended to read:</p> <p><i>"to take no further action in relation to the matter: <b>and/or</b> to do either or both of the following: (i) take the action; (ii) refer the matter to another entity, including for example, a health</i></p>

<sup>84</sup> This amendment is proposed due to the poor understanding and hence interchangeable use of the term 'acupuncture' with the protected title 'acupuncturist' by health practitioners. Given that the primary objective for the National Scheme is public safety and it is primarily achieved through title protection, inclusion of acupuncture will provide better protection of public health and safety.

Issue	Legislative amendment proposal
	<i>complaints entity, for investigation or other action."</i>
Health and performance assessment	<p>For consistency, although it may be rarely required, s177 to be amended so it reads:</p> <p><i>"After considering the assessor's report and the discussions held with the registered health practitioner or student under section 176(3), the National Board may decide to <b>do one or more of the following</b>:</i></p> <p><i>(a) take the action; or</i></p> <p><i>(b) refer the matter to another entity, including, for example, a health complaints entity, for investigation or other action; or</i></p> <p><i>(c) take no further action in relation to the matter".</i></p>
Management of a health assessment where the practitioner refuses to meet with the Board	<p>s176 (3)(a) – Health Assessments – change to the requirement that the Board must give the practitioner an opportunity to meet with the Board to discuss the report to take account of the circumstance where the practitioner refuses to meet.</p> <p>s177 would then require consequential amends to change from <i>"the discussions"</i> to <i>"any discussion"</i>.</p>
Clear incorporation of performance in s178(1)(a)(i)	<p>Amendment to the wording in s178 (1) (a) (i) might be considered to include the words <i>"or the practitioner's professional conduct, is or may be unsatisfactory"</i>. At present, the National Law does not clearly incorporate performance and could be amended to read <i>"the practitioner's performance is unsatisfactory or conduct is unprofessional"</i>.</p>
Action in relation to Show Cause	<p>Technically the wording of s179 (2) (a) request amendment to the wording currently to <i>"... take no action in relation to the matter; or"</i></p> <p>to</p> <p><i>"take no action in relation to the matter; and/or"</i></p>
Matters to be referred to responsible tribunal	<p>Section 193 concerns the mandatory referral of matters to the tribunal. Although currently expressed as mandatory, a limited discretion in relation to exercising the power to refer, to allow the Board to take into account the public safety and public interest issues as a factor in the referral to the tribunal.</p> <p>Any amendment should cover the circumstances where it is not in the public interest to proceed to refer the matter to the tribunal – for example, where a practitioner has been previously dealt with by the tribunal and as a result there is no public interest in proceeding on the matter. This needs to be worded carefully as it must be exercised with caution.</p>
Delay between an adverse finding by a	<p>At present, a gap may arise between the decision of a tribunal that there is an adverse finding and the decision to take action.</p>

Issue	Legislative amendment proposal
tribunal and the decision to take action	<p>There may be a period within which the parties need to make submissions as to the nature of any action.</p> <p>AHPRA would proposed the following insertions:</p> <p>s206(1)(a)(iii) amend to insert <i>"has decided ... and/or has made an adverse finding"</i></p> <p>s206(1)(a)(iii) amend to insert <i>"has decided ... and/or has made an adverse finding."</i></p> <p>To cover a gap in between the finding of an adverse outcome and the decision to take action. To ensure protection of the public.</p>
Change of conditions – clarification of notice to the employer	<p>We think that there is also merit in giving notice to the employer when the existing conditions change. Not all conditions will appear on the register. The employer may also have changed and may need to pick up a range of business relationships to reflect the circumstances that practitioners in private practice are engaged in.</p>
Protection of panel members	<p>We think that it would be appropriate to consider extending the protection afforded by s236(3) (definition of protected person) to panel members exercising powers in good faith under the National Law.</p>

### Profession-specific input

The National Law currently recognises 'nursing and midwifery' as a single health profession with a separate Register for Midwives. The Nursing and Midwifery Board of Australia would like 'nursing' and 'midwifery' to be recognised as two separate health professions.

### Barriers in other legislation

National boards and AHPRA consider the review an important opportunity to consider the following:

- Progress on work being undertaken by states and territories on how they might address inconsistencies in drugs and poisons regulations that have an impact on health service delivery and health workforce reform potential.
- Whether or not there is or should be scope for the future consideration of a standardised national approach to the regulation of pharmacy premises to improve the efficient and effective regulation of pharmacists and pharmacy premises across Australia.
- Whether or not separate user licenses are still needed to manage risk to public for registered health practitioners, for example, medical radiation practitioners.

### Drugs and poisons

There are many similarities in the state and territory legislation that regulates the manufacture, sale, supply, possession and prescription of controlled substances. Despite these similarities, there are significant differences in the authority granted to registered health practitioners under drugs and poisons legislation across states and territories.

These lead to inefficiencies in practice, have public safety implications and limit the National Scheme's capacity to take full advantage of workforce mobility and reform across Australia. Examples of challenges linked to the variation of related key legislation include:

- a pharmacist must understand different approaches across the states' and territories' drugs and poisons legislation when dispensing a prescription written by a Nurse Practitioner
- Nurse Practitioners must understand their varied prescribing capacity across Australia
- the administration authorisations for registered nurses, enrolled nurses, dental hygienists and dental therapists are varied across Australia
- the variations in the authorities given to podiatry practitioners whose registration is endorsed for scheduled medicines and that
- there are nuances related to the authorisations given to medical practitioners and dentists across Australia in relation to authorisation, prescribing and handling of S8 drugs.

### **Regulation of pharmacy premises**

The Intergovernmental Agreement for the National Scheme did not include the licensing of pharmacy premises and pharmacy ownership restrictions. Governments' decision to not include the regulation of pharmacy premises at that time is acknowledged.

The separation between registration of pharmacists and ownership and premises controls is unique to the pharmacy profession in terms of practitioner regulation.

The Pharmacy Board of Australia (PBA) has adopted a national oversight and risk-based approach to notifications made in relation to pharmacy practitioners. There now appears to be evidence that the variation of approaches across states and territories in relation to the regulation of pharmacy premises, particularly the operational challenges of managing often-overlapping issues identified about a pharmacist and the pharmacy premises, is problematic.

Examples of this are:

- The pharmacy premises registering authorities conduct regular inspections of pharmacy premises. Issues may be identified in the inspection process that raise issues about the practice of the pharmacist. This currently requires referral to the PBA for management, which may lead to multiple investigations of related issues.
- Notifications made about a pharmacists' practice often include issues related to excessive dispensing workload and insufficient resources provided by management/owners of the premises. Outcomes of these processes would be managed more effectively if the individual practitioner and the pharmacy premises were able to be dealt with by one regulator.
- There are also challenges with the implementation of the referral processes between AHPRA (on behalf of the PBA) and the multi-jurisdictional pharmacy premises registering authorities, which may result in relevant matters not being raised or delays/inefficiencies in the management of matters.

### **Regulation of radiation equipment and use**

The *Australian Radiation Protection and Nuclear Safety Act 1998* (Cth) is administered by the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA). The National Directory for Radiation Protection, developed by the Radiation Health Committee of ARPANSA, sets out the uniform national framework for radiation protection. State and territory legislation regulates non-Commonwealth entities such as hospitals, universities and industry users of radioactive sources and applies the National Directory.

There is significant variation across Australia in radiation safety legislation and the issue of 'use licenses'. Most states and territories still require nationally registered health practitioners (e.g. medical radiation practitioners) using radiography and radiation sources to also have a 'use license' issued by that jurisdiction. The Review provides Governments with an opportunity to consult on whether or not this approach is still needed to manage risk to the public for registered health practitioners, noting that

national registrants need to adhere to national standards to become registered, and to renew their registration.

If separate licenses, in addition to national registration, were not needed, the regulatory burden placed on nationally registered practitioners could reduce. These inconsistencies can impede workforce mobility and increase compliance costs.

### Student registration

There continues to be some debate about whether the provisions in the National Law for student registration are correctly balanced. Some education providers and some National Boards would support a more comprehensive regulatory framework for students. This might include the capacity to take action in situations that may amount to professional misconduct.

Before the National Scheme, there was significant variation across states and territories in the regulatory status of students. Some jurisdictions had a legislative requirement for students of all professions to be registered. In some cases this applied to small number of professions (e.g. medicine and dental). In others there was no regulatory provision for students.

There was also significant variation in arrangements between jurisdictions that did register students. Some requirements included registration for clinical training; others linked registration to enrolment in a program. Boards' powers in relation to students also varied. In most cases jurisdiction spanned only impairment and offences. South Australia was the only jurisdiction in which students could be managed with a full suite of regulatory powers, that is, matters of unprofessional conduct or professional misconduct.

Legislative requirements for student registration are captured in Part 7 Division 7 of the National Law. For students there are reporting obligations linked to being charged with or convicted of a particular offence. Education providers have mandatory reporting obligations for students. National Boards are able to take action against students when there is a criminal charge or conviction of a serious nature; or when the student has, or may have, an impairment, either of which may affect public safety.

Education providers must also notify AHPRA if they reasonably believe that a student has an impairment that may place the public at risk of harm in the course of any clinical training and/or placements.

## Section 2: Key achievements of the National Scheme

The National Scheme is the product of one of the most ambitious reforms of health practitioner regulation undertaken anywhere in the world. It involved the transition from 97 separate health practitioner boards to 14 National Boards; a shift from more than 75 different pieces of legislation to one nationally consistent law enacted by each state and territory parliament; 38 regulatory organisations replaced by one organisation; and the integration of eight separate state and territory regulatory systems into one National Scheme.

	Pre-2009 regulatory landscape							
Nurses and midwives	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Medical practitioners	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Psychologists	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Physiotherapists	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Pharmacists	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Dental practitioners	NSW <sup>1</sup>	VIC	QLD <sup>1</sup>	WA <sup>1</sup>	SA	TAS <sup>1</sup>	ACT <sup>1</sup>	NT
	NSW <sup>1</sup>		QLD <sup>1</sup>	WA <sup>1</sup>		TAS <sup>1</sup>	ACT <sup>1</sup>	
Optometrists	NSW <sup>2</sup>	VIC	QLD <sup>2</sup>	WA <sup>2</sup>	SA	TAS <sup>2</sup>	ACT <sup>2</sup>	NT
	NSW <sup>2</sup>		QLD <sup>2</sup>	WA <sup>2</sup>		TAS <sup>2</sup>	ACT <sup>2</sup>	
Chiropractors	NSW	VIC	QLD	WA	SA	TAS <sup>3</sup>	ACT <sup>3</sup>	NT <sup>3</sup>
Osteopaths	NSW	VIC	QLD	WA		TAS <sup>3</sup>	ACT <sup>3</sup>	
Podiatrists	NSW	VIC	QLD	WA	SA	TAS	ACT	UR <sup>4</sup>
	Four new professions joined in 2012							
Aboriginal and TSI practitioners	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>	NT
Chinese medicine practitioners	UR <sup>4</sup>	VIC	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>	UR <sup>4</sup>
Medical radiation practitioners	UR <sup>4</sup>	VIC	QLD	UR <sup>4</sup>	UR <sup>4</sup>	TAS	UR <sup>4</sup>	UR <sup>4</sup>
Occupational therapists	UR <sup>4</sup>	UR <sup>4</sup>	QLD	WA	SA	UR <sup>4</sup>	UR <sup>4</sup>	NT

Under National Scheme								
National Nursing and Midwifery Board								
NSW	VIC	QLD	WA	SA	TAS	ACT	NT	
National Medical Board								
NSW	VIC	QLD	WA	SA	TAS	ACT	NT	
National Psychology Board								
NSW	QLD	VIC, TAS, ACT Regional Board				WA, SA, NT Regional Board		
National Physiotherapy Board								
VIC	All other state boards abolished							
National Pharmacy Board								
National Dental Board								
National Optometry Board								
National Chiropractic Board								
National Osteopathy Board								
National Podiatry Board								
Under National Scheme								
National Aboriginal and Torres Strait Islander Health Practice Board								
National Chinese Medicine Board								
National Medical Radiation Practice Board								
National Occupational Therapy Board								

<sup>1</sup> NSW, QLD, WA, TAS and ACT all maintained separate dental technicians and dental prosthetists boards and/or committees in addition to dental boards

<sup>2</sup> NSW, SA and WA maintained optical dispensing boards and/or committees in addition to optometry boards

<sup>3</sup> SA, TAS, ACT and NT maintained combined osteopathy and chiropractic boards

<sup>4</sup> UR = jurisdictions where the profession did not have a designated registration/licensing body

**Sources:** Productivity Commission: *Australia's Health Workforce – Productivity Commission Research Report* (2005) and *AHPRA Annual Report 2010*

**Note:** Two state/territory boards that existed pre-2009 are not shown above

**Figure 2: Evolution of previous state/territory-based bodies to National Scheme (created by KPMG).**

National standards and robust public protections are cornerstones of the National Scheme. Well-regulated practitioners are the foundation of a healthcare system that provides safe, high-quality healthcare. The legal framework set by governments when creating the National Law as in place in each state and territory is designed to protect patients and be fair to practitioners, while facilitating access to health services. This is a carefully managed balance.

The National Scheme is built on the strengths of previous regulatory arrangements. It was designed to promote:

- mobility – so practitioners can register once and practise across Australia within the full scope of their registration
- consistency – through uniform national standards for each profession
- efficiency – with less red tape associated with registrations and notifications, processes have been streamlined, there are economies of scale and increased online options
- collaboration – through sharing, learning and understanding of innovation and good regulatory practice across professions and



- transparency – with a national online register of the current registration status of all registered health practitioners.

The National Scheme has delivered benefits for public protection and improvements for practitioners. Improvements to public safety include:

- national online registers of more than 619,500 health practitioners and specialists<sup>85</sup>
- a national notifications (complaints) system for consumers, noting co-regulatory systems in place.
- mandatory identity checking
- mandatory criminal history checking
- mandatory reporting of 'notifiable conduct' by health practitioners
- mandatory professional indemnity insurance arrangements
- mandatory continuing professional development requirements, and
- student registration.

In this section we outline the key achievements of the National Scheme across eight major categories:

- a. Improved public protection through stronger professional standards
- b. Streamlined and better registration and renewal processes
- c. Reduced costs in the National Scheme
- d. Improving notification management
- e. Establishing effective partnerships
- f. Supporting effective regulation
- g. Bringing four new professions into the National Scheme.

## a) Improved public protection through stronger professional standards

### Consistent national standards

The National Scheme has prime responsibility for registering practitioners who are suitably trained and qualified to provide safe care, investigating concerns about health practitioners (known as notifications) and managing any resulting implications on the registration of health practitioners, as necessary.

### Consultation, engagement and transparency

The National Scheme has increased the transparency and involvement of stakeholders in the ways the professions are regulated. There are documented and consistent processes for developing registration and accreditation standards, supported by robust consultation processes.<sup>86</sup> The consultation requirements built into the National Law have led many National Boards to engage more widely with new stakeholders outside the professions. This enables input into Board standards about workforce and other issues that it would have been difficult to coordinate previously before the National Scheme.

### Standards, codes and guidelines

The mandatory national registration standards (English language skills, professional indemnity insurance, criminal history, recency of practice and continuing professional development) required under the National Law are the main way National Boards define the minimum *national* standards they expect of practitioners, regardless of where they practise in Australia.

The consistent and approved national standards provide assurance about practitioners' safety to practise, and align the practice of practitioners within professions, regardless of where they work. They also provide clear guidance to health practitioners, the community, governments, employers, professional associations and education providers about registration and renewal requirements.

<sup>85</sup> In the first 12 months following the start of the Scheme, 264,290 individual health practitioner records were cleansed and corrected.

<sup>86</sup> See Agency Management Committee approved and National Board endorsed [procedures for developing registration standards, accreditation standards and consultations](#).



The standards bring consistency across geographic borders; make the Boards' expectations clear to the professions and the community; and inform Board decision-making when concerns are raised about practitioners' conduct, health or performance.

When the Ministerial Council approved the initial registration standards, in most cases this was the first time that national standards were in place in each profession. In some professions it was the first time that there had been any standards on these issues.

Boards have published a range of codes, guidelines and policies that give more detailed guidance to practitioners on important issues and make clear to the community what the Boards expect and the law requires. The Boards hold practitioners to account against these.

Several Boards have developed, and the Ministerial Council has approved, additional standards beyond the five mandatory standards required by the National Law. Some examples include *Endorsement for conscious sedation for dentists*; *General registration for overseas-qualified dental practitioners*; and *Limited registration for teaching or research* for dental practitioners and *Nursing and Midwifery Endorsement nurse practitioners registration standard* and *Eligible midwife registration standard* for nursing and midwifery.

### **Common standards, informed by evidence**

The National Scheme has enabled common standards across professions when this is appropriate. All National Boards have adopted the same criminal history registration standard, which describes the factors a board will take into account when considering an applicant or registrant's criminal history. There is significant commonality across the English language skills registration standards for all National Boards except the Aboriginal and Torres Strait Islander Health Practice Board of Australia, which has unique considerations.

National Boards have developed common Guidelines for advertising regulated health services and Guidelines for mandatory notifications. Most National Boards have a similar Code of Conduct. This commonality facilitates the National Law guiding principles of efficiency, effectiveness and fairness. It also helps consumers to understand what they can expect from their health practitioners.

Through the Scheme, the National Boards can now build a stronger evidence base for standards and have the opportunity to draw on experience and knowledge in other professions when this is appropriate. The National Scheme has enabled research to be commissioned that is relevant to all professions, avoiding duplication and facilitating an evidence-based approach to regulation.

For example, the National Boards have adopted a coordinated approach to their current review of English language skills registration standards. To prepare, AHPRA commissioned research about English language skills in the regulatory context to inform the review.<sup>87</sup> The research was combined with National Boards' experience in administering their English language skills registration standards and supplemented with further information, including discussions with other regulators and language test providers. National Boards consulted stakeholders through a single consultation paper and cross-profession recommendations were developed taking into account stakeholder feedback and the other information collected during the review.

Similarly, the National Boards for the first 10 professions to be regulated under the National Scheme and the Medical Radiation Practice Board of Australia are currently reviewing their recency of practice, continuing professional development and professional indemnity insurance arrangements registration standards. The reviews have been coordinated across these professions. This has enabled multi-profession research to be commissioned to inform the reviews. It has also facilitated National Boards considering issues of consistency and examples of good practice across the professions in the National Scheme.

<sup>87</sup> 2013 Dental Board of Australia [public consultation: \*Review of criminal history registration standard and English language skills registration standard\*](#).

## Leading practice development, review, consultation and approval

Routine consultation processes adopted by National Boards and AHPRA provide an avenue for state- and territory-specific engagement and for local issues to be addressed in a national framework.

Consistent with COAG best practice regulation principles, the National Boards consult extensively on all proposed changes and additions to the standards, guidelines, codes, and policies. This specifically includes all relevant professional associations, education providers, state and territory health departments, the Ministerial Council, the Australian Health Ministers' Advisory Council's Health Workforce Principal Committee, and consumer organisations and individuals in all jurisdictions. Our [approach to consultation is published here](#). We publish all submissions to our consultations in the interests of transparency, unless specifically requested not to.

Processes to seek Ministerial Council approval of these revised standards have been developed and planning for implementation of approved revised standards is well underway.

We have a policy roadmap to identify the key cross-board policy projects over the next three to five years and the evidence base required to deliver the work.

We meet the standards set by the Office of Best Practice Regulation and develop regulatory impact statements where necessary, in line with these requirements.

Registration standards for each National Board are published on National Board websites.

### Establishing shared regulatory principles

National Boards and the Agency Management Committee have agreed on shared regulatory principles for decision-making that will anchor our work and guide how National Boards and AHPRA operate. These are currently being piloted (starting 1 July 2014), and will be amended over time as needed. The principles will support improvements to the National Scheme, as a more consistent regulatory philosophy guides all activity and decision-making across professions and AHPRA.

The principles are:

1. The Boards and AHPRA administer and comply with the Health Practitioner Regulation National Law, as in force in each state and territory. The scope of our work is defined by the National Law.
2. We protect the health and safety of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.
3. While we balance all the objectives of the National Registration and Accreditation Scheme, our primary consideration is to protect the public.
4. When we are considering an application for registration, or when we become aware of concerns about a health practitioner, we protect the public by taking timely and necessary action under the National Law.
5. In all areas of our work we:
  - a) identify the risks that we are obliged to respond to
  - b) assess the likelihood and possible consequences of the risks and
  - c) respond in ways that are proportionate and manage risks so we can adequately protect the public.

This does not only apply to the way in which we manage individual practitioners but in all of our regulatory decision-making, including in the development of standards, policies, codes and guidelines.

6. When we take action about practitioners, we use the minimum regulatory force to manage the risk posed by their practice, to protect the public. Our actions are designed to protect the public and not to

punish practitioners. While our actions are not intended to punish, we acknowledge that practitioners will sometimes feel that our actions are punitive.

7. Community confidence in health practitioner regulation is important. Our response to risk considers the need to uphold professional standards and maintain public confidence in the regulated health professions.
8. We work with our stakeholders, including the public and professional associations, to achieve good and protective outcomes. We do not represent the health professions or health practitioners. However, we will work with practitioners and their representatives to achieve outcomes that protect the public.

### Continuing to adopt risk-based regulation

We are adopting a risk-based approach to regulation and have worked closely with Professor Malcolm Sparrow<sup>88</sup> to identify and apply the principles to our work.<sup>89</sup>

In relation to notifications this means:

- ensuring that matters posing the most risk to the community are given the highest priority/and attention by National Boards and AHPRA
- the degree of risk associated with a notification determines investment and resource allocation. This aims to make sure appropriate resources are deployed when they are needed to keep the public safe and that the regulatory response by Boards (such as any limits on registration) is proportionate to the level of risk
- notifications data will be collected, organised, assessed, analysed and used to inform potential high-risk areas of harm for policy or other action by National Boards, and
- staff education and learning reflects risk-based regulation.

Already we have identified the following priorities for close examination and further work:

- medication safety – includes medication errors which can encompass prescribing, dispensing and administration across a range of professions<sup>90</sup>
- boundary violations in the professional conduct of practitioners<sup>91</sup>, and
- diagnostic error and the resulting harm to patients.

### Continuous improvements in accreditation

Accreditation is a key quality-assurance and risk-management mechanism for the National Scheme. It is the most important way to ensure that graduates of approved programs of study have the qualifications, skills and professional attributes to competently and ethically practise their professions in Australia.

Appendix 4 details the extensive work and progressive achievements in accreditation.

### Better guidance to support delegations and decision-making

#### Delegations

The National Law confers a number of functions and powers on AHPRA and the National Boards. For the efficient and effective application of the National Law, it is necessary for AHPRA and the Boards to delegate these functions and powers to other entities, such as committees and AHPRA staff.<sup>92</sup> Strong

<sup>88</sup> Professor of the Practice of Public Management at Harvard's John F. Kennedy School of Government

<sup>89</sup> Sparrow, MK (2008) *The Character of Harms – Operational Challenges in Control* ISBN 9780 5218 72102. Professor Sparrow has worked with AHPRA and National Boards facilitating a range of strategic planning sessions.

<sup>90</sup> See existing [Pharmacy Board of Australia guidelines on dispensing](#).

<sup>91</sup> National Boards have already issued guidance on this issue in Codes of Conduct and for the Medical Board of Australia, specific guidance. See National Board websites and [MBA website](#).

<sup>92</sup> The Board's power to delegate, see s.37; for delegation of AHPRA's powers see Schedule 3, cl 2(2).

management of delegations by committees of Boards, including state or territory boards and AHPRA, is crucial to the operation of the National Scheme.

The National Law imposes a number of rules about delegations. Many of these rules reflect the requirements of the general law and are consistent with how other legislation regulates delegations. We have published a [legal practice note about delegations to make this clear](#).

The delegations are reviewed annually and National Boards and AHPRA continue to work together to identify efficiencies and align the delegations between professions. Delegated powers authorise general directions only, leaving the delegate to decide each case on its merits. Across the National Scheme, there are more than 2,100 functions delegated by the National Boards.

Since late 2013, [Board delegations have been published on the AHPRA website](#) and made accessible through each Board website. This assists the community and practitioners to understand how decisions are made within the National Scheme.

### **Improved resources to support decision-makers**

AHPRA has developed a range of resources to support decision-makers in the National Scheme and to promote consistency in decision-making.

#### ***Legal Practice Notes***

Since 2010, to promote consistency of decision-making, AHPRA has developed a Legal Knowledge Management resource including Legal Practice Notes designed to support the consistent interpretation of the National Law.<sup>93</sup> Table five lists the Legal Practice Notes that have been prepared:

**Table 5: Legal Practice Notes**

Title	
LPN 1 – Conditions and Notations under the National Law	LPN 2 – Power to Amend, Repeal or Overturn a Decision
LPN 3 – Cautions and Reprimands	LPN 4 – The National Boards’ Power to take Immediate Action
LPN 5 – Students with an Impairment	LPN 6 – Circumstances in which a Board can amend conditions imposed by a Tribunal
LPN 7 – What Is Meant By a Fit and Proper Person	LPN 8 – Consideration of Similar Fact Evidence
LPN 9 – Mediation and Other Forms of Alternative Dispute Resolution in Tribunals	LPN 10 – Extraterritorial Operation of the National Law
LPN 11 – Reasonable Belief	LPN 12 – Practitioners and Students with an Impairment
LPN 13 – Public Interest	LPN 14 – Conflict of Interest
LPN 15 – Requests for Release of Investigator Reports	LPN 16 – A Guide to Responding to Subpoenas to Produce Documents

<sup>93</sup> See [legal practice notes on](#) [www.ahpra.gov.au](http://www.ahpra.gov.au).

LPN 17 – Procedural Fairness/Natural Justice	LPN 18 – Client Legal Privilege
LPN 19 – 21 tips for a successful performance in the witness box	LPN 20 – Obtaining expert opinions; Releasing expert opinions to the practitioner
LPN 21 – Court or Tribunal Power to Stay a Board Decision	LPN 22 – Delegations under the National Law
LPN 23 – Self-executing Decisions or Decisions Following a show cause	LPN 24 – Use of Investigator and Inspector powers under the National Law

### ***Guides to decision-making***

To support delegates to make decisions about notifications from each jurisdiction, AHPRA has produced the following Guides to Decision-making to encourage consistency of decision-making about notifications across professions:

- Guide to Decision-making – Decision to take no further action at preliminary assessment
- Guide to Decision-making – Preliminary assessment – relate to grounds
- Guide to Decision-making – Immediate action with scenarios
- Guide to Decision-making – Options for managing a notification
- Guide to Decision-making – Taking action Part 8 – Division 10, 11 or 12
- Guide to Decision-making – Dealing with a breach of a condition or an undertaking
- Guide to Decision-making – Dealing with declarations, false declarations, disclosures and non-disclosures
- Guide to Decision-making – Responding to requests for information about a notification

### ***Health Practitioner Court and Tribunal Case Notes***

AHPRA is improving knowledge sharing and information about matters listed and decisions made at tribunals; and is developing systems and processes for publishing tribunal and panel information.

In the interests of transparency, AHPRA now publishes a direct link from the [cancelled practitioners register](#) to the relevant court or tribunal decision.

We also provide a link to the Australasian Legal information Institute (AUSLII) for tribunal decisions about more serious matters <http://www.ahpra.gov.au/Notifications/Hearing-Decisions.aspx> and case summaries of some matters.

### ***Panels***

Panels are an important tool used by Boards to protect the public under the National Law. More detailed information about panel hearings is published on our website.

To support the work of panels we established a Panel Working Group, comprising AHPRA staff, and a Panel Reference Group, comprising National Board nominees. Achievements to strengthen the way panels operate in the National Scheme include:

- Updating the *Guide to the Conduct of Panel Hearings 2011* (3rd edition published in June 2014)
- Conducting an extensive recruitment campaign to appoint panel members for each health profession (section 183). There are currently 762 panel members appointed in the National Scheme. National lists of panel members help support independent and fair decision-making across jurisdictions and has significant advantages for small professions, small jurisdictions and areas of speciality within professions

- Establishing a training program for panel members to be delivered nationally by 30 June 2015 via e-learning and face-to-face training on topics such as decision-making, writing reasons and accountability
- Aligning panel processes in each jurisdiction nationally (as much as possible given that panels may establish their own procedures under section 185).

AHPRA also publishes a [record of panel hearing decisions made since July 2010](#). Summaries are provided when there is educational and clinical value. The summaries are accessible from hyperlinks within the table published on the website. Practitioners' names and other identifying features are not published, consistent with the requirements of the National Law. The table does not include summaries of panel decisions made under previous legislation, even if these were held after July 2010.

## b) Streamlined and better registration and renewal processes

			Total Registrants at 30 June 2014									
>25,000	5,000 – 25,000	<5,000	TOTAL	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	
TOTAL			619,509*	181,025	160,286	117,622	64,015	51,352	13,572	10,723	6,650	
Nurses & Midwives			362,450	100,440	95,807	69,129	36,800	32,690	8,577	5,784	4,240	
Medical Practitioners			99,379	31,269	24,137	19,032	9,889	7,554	2,155	1,960	1,084	
Psychologists			31,717	10,575	8,603	5,626	3,340	1,573	527	832	230	
Pharmacist			28,282	8,769	6,985	5,536	3,046	2,033	679	469	212	
Physiotherapists			26,123	7,578	6,412	4,823	3,207	2,175	426	489	173	
Dental Practitioners			20,707	6,361	4,768	4,056	2,422	1,708	349	386	147	
Occupational Therapists			16,223	4,592	3,976	3,174	2,397	1,298	263	261	137	
Medical Radiation Practitioners			14,387	4,812	3,592	2,832	1,246	1,107	284	251	116	
Optometrists			4,788	1,632	1,224	950	386	246	86	74	29	
Chiropractors			4,845	1,619	1,283	753	564	364	53	65	24	
Chinese Medicine Practitioners			4,271	1,737	1,194	810	214	164	34	64	14	
Podiatrists			4,129	1,076	1,318	698	427	394	98	52	17	
Osteopaths			1,865	529	979	166	56	34	40	34	1	
Aboriginal and TSI Practitioners			343	36	8	37	21	12	1	2	226	

\* 14,264 health practitioners are registered with AHPRA but do not have a principal place of practice in Australia. Sources: AHPRA Annual Report 2013-14

Figure 3: Registration numbers as at 30 June 2014 (table designed by KPMG)

### Registration

Registration standards define the requirements that practitioners need to meet to be registered, in addition to entry requirements for qualifications. We have established robust processes and systems that allow National Boards to consider every application carefully and assess it against the requirements for registration. The processes and other guiding material support Boards to make informed and transparent decisions and AHPRA to make sure these decisions are reflected on the national registers.

We are finalising a full range of procedure manuals, work instructions, templates and other information to support nationally consistent outcomes and improve the quality of our registration data. This is important for the introduction of the new key performance indicators and the publication of information about our performance against these KPIs from October 2014.

AHPRA continues to build expertise and improve understanding of specialised areas of practice to ensure there is sufficient rigour in assessing more complex applications. We have centralised assessment for some professions and application types, such as podiatry endorsements for scheduled medicines and internationally qualified dental specialists, to support this.

## Renewals

Online renewals have increased progressively since 2010 across all professions, dramatically in some professions. Online renewal in nursing and midwifery, for example, has increased from 55 per cent to 97 per cent in four years. AHPRA's systems are efficient and trusted by the profession. Online registration also provides early assurance to employers that their nurses and midwives are registered. More in section three: our performance.

## Registering new graduates

Since 2010, AHPRA has progressively improved online services to support the registration of new graduates. We have worked with education providers to streamline and improve our services. This makes the process easier for graduates to navigate and more timely for employers keen to recruit new graduates to meet workforce demand. More information about graduate online services is [published here](#).

## Workforce mobility and access to services

The National Law requires the National Scheme to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to practise in more than one participating jurisdiction.

National Boards and AHPRA have met this objective. Since 1 July 2010, registered practitioners have been able to register once and practise anywhere in Australia within the full scope of their registration. Additionally the title protection (rather than practice-based restriction) model in the National Law has effectively removed the previously constraining legislative barriers and restrictions to enable registered health practitioners to practice to the full scope available and consistent with their education and competence.

Before 2010, there were more than 637,000 active health profession registrations in Australia. With the National Scheme, this reduced to around 536,000 and currently more than 619,500 through growth in the health practitioner workforce. We estimate that about 15 per cent of practitioners nationally had previously paid more than one registration fee.

## Audit

AHPRA has worked with National Boards to develop and implement an auditing framework to assure compliance with the registration standards through a practitioner audit project. The standards that may be audited are as follows:

- Continuing professional development
- Recency of practice
- Professional indemnity insurance arrangements and
- Criminal history.

Each time a practitioner applies to renew their registration they must make a declaration that they have met the registration standards for their profession. Practitioner audits are an important part of the way that National Boards and AHPRA can better protect the public by regularly checking these declarations by a random sample of practitioners. They help to make sure that practitioners are meeting the standards they are required to meet and provide important assurance to the community and the National Boards.

AHPRA and the National Boards conducted pilot audits with a number of professions in 2012 and 2013 that helped determine the size, frequency and type of audits required. The pilots enabled the establishment of the ongoing audit methodology for all professions, including determining suitable sample sizes for each profession and ensuring the sample is representative of all practitioners registered within a profession across Australia in terms of age, sex, and location of practice.

The pilot audits were conducted with statistically significant sample sizes. The results revealed compliance rates of between 84 and 93 per cent for the professions that participated in the pilot audits. Further, the statistical analysis undertaken on the pilot data supported the hypothesis that the audit



samples were representative of the wider practitioner population for the professions. As such, compliance rates identified in the pilots is expected to be representative of 'whole' professions.

The results of the pilot audits, detailing the methodology, parameters and findings, have been published. For the pilot audits, the key statistical results are as follows:

- Pharmacy – estimated 92.2 per cent of all pharmacists currently registered would be compliant with the four registration standards
- Chiropractic – estimated 87.3 per cent of all chiropractors currently registered would be compliant with the four registration standards
- Optometry – estimated 90.5 per cent of all optometrists currently registered would be compliant with the four registration standards
- Nursing and midwifery – estimated 84.5 per cent of all nurses and midwives currently registered would meet both the recency of practice and continuing professional development registration standards.

All professions have commenced audits of practitioners' compliance with the registration standards, with some professions now into their second cycle of audits as annual audits are established according to an agreed schedule. AHPRA develops tailored, National Board-approved policies to guide AHPRA staff involved in auditing practitioners. Information to guide practitioners is published on the AHPRA and National Board websites and in direct correspondence with audited practitioners.

### Forms management

AHPRA manages a suite of more than 370 forms, with the majority of these designed to assist health practitioners apply for registration and apply to renew their registration. It also includes workforce survey and other business-support forms. In the first year of operation forms management was moved in-house; reducing forms maintenance costs by 75 per cent, increasing efficiency in the forms development process and creating the ability to provide in-house design services for publications, creating further cost savings. A current initiative sees our forms-management software platform being migrated to an enterprise forms solution, which will provide many benefits, some of which include:

- increasing the effectiveness and consistency of our forms
- allowing for on-demand rendering of accessible forms and other PDF documents
- the potential for our forms to be used from a greater range of devices (desktop, smartphone or tablet).

### c) Reduced costs in the National Scheme

With transition costs behind us, registration fees in the National Scheme are stabilising or reducing.

The approval by National Boards of the fees for 2014-15 saw six of the 14 boards reduce their fees, two boards with stabilised fees at the 2013-14 levels and six boards that limited increases to within the consumer price index (CPI). The self-funded scheme meets the full costs of regulation (noting co-regulatory arrangements), with no cross-subsidisation across professions.

Fee reductions are a significant achievement, and are being achieved despite an overall increase in notifications over the past year. The number and complexity of these cases is not entirely predictable. Managing notifications is a major cost for National Boards, which will continue to keep fee levels under close review to ensure careful financial management and maintain appropriate reserves.

Since the start of the Scheme, National Boards have generally applied only CPI fee increases to the national fees. The Nursing and Midwifery Board of Australia is the exception; fees were not increased at the start of the Scheme, but the Board did apply an above-CPI fee increase in 2012. National Boards have maintained their commitment to limiting fee increases to CPI if no unforeseen circumstances arise. There is an agreed process in place with the Ministerial Council, involving a detailed business case, if National

Boards propose to increase fees above CPI. Table six below lists fees by profession and financial year, including the proposed fees for 2014-15.

**Table 6: Fee by profession and financial year**

Profession	Fee 2010-11	Fee 2012-13	Fee 2013-14	Fee 2014-15	Change
Aboriginal and Torres Strait Islander Health Practice		\$100	\$100	\$100	0.0%
Chinese Medicine		\$550	\$563	\$579	2.8%
Chiropractic	\$495	\$518	\$530	\$545	2.8%
Dental	\$545	\$572	\$586	\$603	2.9%
Medical	\$650	\$680	\$695	\$715	2.9%
Medical Radiation Practice		\$325	\$295	\$250	-15.3%
Nursing and Midwifery	\$115	\$160	\$160	\$150	-6.3%
Occupational Therapy		\$280	\$230	\$160	-30.5%
Optometry	\$395	\$415	\$395	\$365	-7.6%
Osteopathy	\$480	\$504	\$516	\$416	-19.4%
Pharmacy	\$295	\$310	\$317	\$317	0.0%
Physiotherapy	\$190	\$199	\$179	\$159	-11.2%
Podiatry	\$350	\$368	\$377	\$388	2.9%
Psychology	\$390	\$409	\$419	\$431	2.9%

### International comparisons

The National Scheme includes all Australia's regulated health professions – including medicine (most complex), nursing and midwifery (largest), dental, pharmacy and psychology. The risk profiles range from low to high, and the size of the professions from small to large. The National Scheme model is structurally distinct from any other model internationally.

While there are some similarities with the United Kingdom Health Care Professions Council (HCPC), there are also significant differences. The National Scheme regulates over 619,500 health practitioners across 14 National Boards.

In comparison, the HCPC regulates 16 professions with over 322,000 registrants in the United Kingdom.<sup>94</sup> There are only five professions common to both the HCPC and the National Scheme in Australia.

Importantly, the HCPC does not regulate medicine, nursing and midwifery, pharmacy, dental practitioners, chiropractors, osteopaths and optometrists. Each of these professions has a separate profession-specific council in the United Kingdom.

<sup>94</sup> Professions regulated by the HCPC are arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, social workers in England and speech and language therapists.

As an indication of a greater level of risk and complexity, about 95 per cent of notifications (complaints) received relate to five professions (medicine, nursing and midwifery, psychology, pharmacy and dental), four of which are not regulated by the HCPC. Managing notifications is a significant driver of costs in health practitioner regulation.

It is worth noting in the international comparison of costs outlined in table 15 of the consultation paper, four of the six professions that are regulated by a separate National Board in Australia and a separate council in the United Kingdom are cheaper to regulate in Australia. In fact in the case of chiropractic and osteopathy, regulation costs in Australia are half of the United Kingdom costs.

However two of the five professions regulated by separate National Boards in Australia and a single council in the United Kingdom, the Health Care Professions Council, are more expensive. It is not clear, however, what the risk profiles are of the other 11 professions regulated by the HCPC. These professions are not currently regulated through the National Scheme in Australia and therefore do not attract any regulation costs.

Further, as a core principle, there is no cross-subsidisation between professions in the National Scheme. Each profession must meet the full costs of regulating itself in the National Scheme. In contrast, cross-subsidisation is a feature of the HCPC.

## d) Improving notifications management

National Boards and AHPRA have done much to improve the timeliness of our management of notifications. Significant additional resources have been added for assessment and investigation of notifications. We have robust processes in place to swiftly identify and manage serious risk to the public. We have built consistent national systems and introduced a range of performance measures so we can better manage, improve and report on our work. We have adopted a set of regulatory principles to guide our work and the decision-making across the National Scheme, to make sure that regulation is proportionate and effective.

### Responding to Queensland

In April 2013, National Boards and AHPRA acknowledged a number of significant issues associated with the management of notifications about regulated health practitioners in Queensland, including those received since the introduction of the National Scheme. Those issues included backlogs inherited at transition to the National Scheme and delays in finalising matters lodged since the beginning of the National Scheme. These issues were identified by the findings of the *Forrester Report April 2013 (QLD): Final Report Chesterman Report Recommendation 2 Review Panel*. This independent review of cases over the past five years relating to medical practitioners had been initiated by the Queensland Minister for Health and funded by the Medical Board of Australia.

AHPRA worked with National Boards to implement a range of measures to improve performance on notifications in Queensland and across Australia and to build on work already done to embed national systems and processes. The aim was to improve the timeliness and consistency of notifications management and processes.

During 2012-13, with the support of National Boards, AHPRA increased resourcing to its Qld office with close to \$1 million for additional staffing to improve assessment processes. These additional resources have led to a reduction in the number of matters in assessment from 764 in March 2013 to 334 at the end of June 2014 (a 56 per cent reduction). During this period, the average age of matters in assessment has reduced from 5.4 months to 1.4 months.

The number of notifications received in Queensland continued to increase during the 2013-14 financial year with 2,375 notifications received about practitioners in Queensland. This compares to a total of 2,042 notifications received about practitioners for the whole of the 2012-13 financial year and indicates an increase of approximately 16 per cent increase on the last financial year.

Against this sustained increase in notifications our improvement work in Queensland has led to a 21 per cent reduction in the number of open notifications in Queensland since March 2013.

### Making wider improvements

As a result of the serious issues identified in Queensland, AHPRA worked with National Boards to review notifications performance across Australia and to establish whether the shortcomings in Queensland were evident in other jurisdictions. This review has been complemented by case audits in relation to matters being managed for specific professions, including dental and psychology.

This national review did not identify systemic problems in other jurisdictions at the same scale as Queensland. There were a set of issues which appeared largely unique to Queensland and the specific transitional arrangements there. Table 7 illustrates this in relation to the comparison between Victoria and Queensland.

**Table 7: Issues unique to Queensland, in comparison to Victoria**

Queensland	Victoria
Around 30% more open matters than most other jurisdictions on 1 July 2010	Around 30% fewer open matters on 1 July 2010
20% of staff joined AHPRA (medicine)	100% of eligible staff joined AHPRA
Four changes to medical regulation in seven years	One change to medical regulation in seven years
National Law very different to former Queensland legislation	National Law built on former Victorian legislation
Blurred lines and overlapping roles with HQCC and others	Clear roles and no overlap with HSC
Concern about light-touch regulation	No evidence of light-touch regulation

However, our review identified areas in which our performance needed to improve, particularly as this related to the timeliness of management of matters. As a result, system improvements in notifications management have been made in five main areas:

1. **Resources:** Increased resourcing of notifications in each state and territory. In 2013-14, a further \$4.8 million was invested in conjunction with the five bigger National Boards. These resources have resulted in an additional 48 full-time positions in assessment, investigation and legal services. The main focus is on reducing timeframes for assessment and investigation. In an organisational restructure that took effect from 1 July 2014, an Executive Director, Regulatory Operations now provides a single point of accountability for the regulatory operations of the National Scheme. There are now national directors of registration, notifications, compliance and legal services reporting to this executive director.
2. **Reporting:** KPIs have been implemented to measure each stage of the notifications process. The KPIs apply to all notifications lodged with AHPRA since 1 July 2013, in jurisdictions other than NSW. Performance reporting is in the form of a traffic-light system, which is reported on a quarterly basis. AHPRA reviews any matter that falls outside the KPIs to identify the issue and enable any corrective action to be taken. We have set these KPIs carefully, taking into account our current performance and reasonable expectations of what we should achieve. They will be reviewed on an annual basis. It is our intention to move to greater public reporting of performance.

3. **Procedures:** Strengthened operational procedures have been implemented in the form of an Operational Directive to AHPRA notifications staff. The first directive focused on the lodgement and preliminary assessment phases. Further directives setting requirements for investigation and immediate action have since been issued. In addition, there has been training associated with these directives, including a national investigator training program.
4. **Oversight:** Board and Agency Management Committee oversight has been improved through performance reporting to Boards. We have also established a Notifications Taskforce made up of the national chairs of the Medical Board of Australia, the Nursing and Midwifery Board of Australia, the Pharmacy Board of Australia, the Dental Board of Australia, the Psychology Board of Australia and the Chiropractic Board of Australia. The Medical Board of Australia also established a taskforce to examine notifications management nationally and to identify areas for improvement, specifically in relation to managing the volume of notifications about medical practitioners.
5. **Scrutiny:** The Agency Management Committee has established a [Performance Committee](#) to monitor, scrutinise and assure AHPRA's regulatory performance. This Committee scrutinises and provides commentary on performance reporting to National Boards.
6. **Information:** AHPRA has worked with National Boards to improve the content (in particular, ease of understanding through use of plain English) and timeliness of communication with notifiers within the requirements of the National Law. This is an ongoing challenge that AHPRA has adopted a range of strategies to meet; work is continuing.

Two plain English guides have been published for the community and registered health practitioners: The guide for community members, [Guide for notifiers](#) explains to notifiers what we can do about complaints about a registered health practitioner (e.g. manage the risk to the public) and what we can't do (order a practitioner to pay compensation or make an apology). A hard copy of this guide is sent to everyone who writes to AHPRA with a concern about a health practitioner. This guide has recently been reviewed by the National Scheme Community Reference Group. [A guide for practitioners: Notifications in the National Scheme](#) includes an information sheet outlining what happens when a notification is made about a health practitioner.

AHPRA also publishes readily accessible information about the notifications process on our website: [www.ahpra.gov.au/Notifications/The-notifications-process.aspx](http://www.ahpra.gov.au/Notifications/The-notifications-process.aspx). Fact sheets are also published there to provide information for practitioners or students who are the subject of a notification.

## Other initiatives to improve our work managing notifications

### Improving the experience of notifiers

In March this year, AHPRA commissioned the Health Issues Centre Victoria (HIC) to investigate and make suggestions to improve the consumer experience of the notifications process. AHPRA published the report – [Setting things right: Improving the consumer experience of AHPRA including the joint notification process between AHPRA and the Office of the Health Services Commissioner](#) (OHSC), along with [AHPRA's action plan](#) that outlines work that AHPRA has undertaken to date, and what will be done next to address the report's recommendations.<sup>95</sup>

The publication of the report and AHPRA's action plan is part of the commitment to transparency and improving how people interact with us in the National Scheme.

The HIC Chief Executive Officer Ms Mary Draper led the research and has publicly said *"it is pleasing to see how open AHPRA has been to this feedback and the steps that are being taken. This is important because the National Scheme relies on members of the public who have concerns about a health*

<sup>95</sup> This project predated the findings of the *Victorian Parliamentary Inquiry into the performance of the Australian Health Practitioner Regulation Agency*.

*practitioner to bring these to the attention of the regulator. The public must have an understanding and confidence in the scheme for it to do its job of protecting the public.”<sup>96</sup>*

## **Strengthening monitoring and compliance**

When the National Scheme started in 2010, AHPRA received records from the previous 97 health regulation boards. The data about health practitioners with conditions and/or undertakings on their registration reflected the many different processes in place to monitor practitioners’ compliance with the restrictions on their registration. In some cases, however, no records about health practitioners with conditions and/or undertakings on their registration were transferred to AHPRA.

We conducted a detailed review of practitioners with conditions and/or undertakings in place on 1 July 2010 and established case files for each person. In many cases, this involved recalling hard-copy records held in offsite secondary storage facilities and an extensive review of legacy databases. Each state and territory office developed procedures to monitor practitioners with conditions and/or undertakings on their registration for the first 12 months of the Scheme.

In September 2011, we started work to establish a nationally agreed and consistent process for monitoring all practitioners whose registration was restricted in some way. This included practitioners with conditions and/or undertakings, as well those with provisional or limited registration whose category of registration imposes limitations on practice.

From August 2013, AHPRA introduced a nationally consistent procedure to monitor practitioner compliance with restrictions on registration. The procedure was supported by system support and staff training. We then implemented an exhaustive ‘data cleansing’ process to make sure the data in the system were accurate and reliable, to enable analysis and reporting by profession and state.

Since the appointment of a new National Director Compliance from 1 July 2014, a detailed work plan has been developed and started. The objectives of that work plan are to:

- establish a National Compliance Forum
- develop an overarching strategy (including structure and caseloads) and a comprehensive policy framework for the compliance function
- review, re-develop and implement the Urine Drug Screening Protocol
- evaluate the process of annual registration renewal of those with restrictions and the process for monitoring practitioners who move between jurisdictions
- establish a National Restrictions Bank
- establish KPIs for compliance and a reporting framework (including escalation triggers)
- contribute to the development of the Regulatory Compliance Solution
- negotiate and implement data provision by Medicare to support effective monitoring and investigations.

## **e) Establishing effective partnerships**

In partnership, National Boards and AHPRA bring together a combination of expertise that supports leading practice regulation.

National Boards have extensive professional experience and relevant content expertise, with members recognised as leaders in their professions and/or the broader community.

<sup>96</sup> <http://www.ahpra.gov.au/News/2014-09-23-media-release.aspx>

AHPRA staff bring experience and expertise in regulatory policy, operations and sector administration (including financial management and business system support). The success of this partnership model, based on mutual respect, brings out the best of the National Scheme.

AHPRA's role is to support 14 National Boards; 60 national board committees; 18 state and territory boards and two regional boards; and a number of state, territory and regional committees to implement the Scheme across eight states and territories.

### Stakeholder engagement

In the National Scheme, AHPRA and the National Boards engage daily with a large number and variety of stakeholders across the professions, community, government and statutory agencies, education providers and employers. The needs and interests of these groups sometimes overlap and sometimes are profession- or jurisdiction-specific.

National Boards and AHPRA continue to work closely with all our many stakeholders and have a stakeholder engagement plan to guide our interactions locally, nationally and internationally. Following the recent AHPRA organisational restructure, AHPRA's engagement with local stakeholders in the states and territories is being increased with adjustments to the responsibilities of state and territory managers.

In this context, making the National Scheme work relies on effective partnerships; National Boards and AHPRA are serious about our commitment to stakeholder engagement. We also recognise there are opportunities to strengthen and increase the scope of this work.

### Advisory groups

We have established two important standing committees to support our work with the community and the health professions.

AHPRA established a [Community Reference Group](#) (CRG), which had its first meeting in June 2013, to work across the National Scheme. This is the first time a national group of this kind, with a focus on health practitioner regulation, has been established in Australia.

The group has a number of roles, including advising AHPRA and National Boards on ways in which community understanding and involvement in our work can be strengthened. This includes strategies for promoting greater community response to consultations, ways in which the national registers can be more accessible and better understood and strategies to build greater community understanding of how practitioner regulation works.

While the group is a conduit between communities and AHPRA/National Boards, it is not representative of particular communities. Rather, members of the group represent only themselves and share their opinions as individuals. The group is chaired by a community member appointed to one of the 14 National Boards. The group does not discuss individual registration or notifications matters and has no decision-making powers.

Communiqués from meetings of the CRG are published on the [AHPRA website](#).

Our work with the CRG is complemented by our communication with our 'online community of interest'. These are individuals who have attended our community briefing sessions or otherwise expressed interest in the National Scheme and the work of health practitioner regulation.

Feedback from the CRG to issues raised in the consultation paper is included in Appendix 3.

In recent years, AHPRA had a partnership with the Consumer Health Forum of Australia (CHF) to engage with health consumers and the broader community across Australia. The partnership aimed to:

- raise community awareness of health practitioner regulation
- increase community access to information about health practitioner regulation



- facilitate community input into the development of standards, codes of practice, guidelines and policies for health practitioners, and
- increase transparency, particularly in relation to the processes in place for managing notifications about registered health practitioners.

We have also worked with the Health Issues Centre on a project to improve the experience of notifiers in the National Scheme.

AHPRA's [Professions Reference Group](#) was established to provide feedback, information and advice on strategies for building better knowledge from within the professions about health practitioner regulation, and advising AHPRA on issues affecting the professions. The group includes the key national professional associations and does not discuss individual registration or notifications matters and has no decision-making powers.

## f) Supporting effective regulation

AHPRA and the National Boards have a range of initiatives that support the effective regulation of the professions and the efficient operation of the National Scheme, in the public interest.

### Board governance and succession planning

A program of ongoing evaluations has started, including peer assessment across the National Boards and Agency Management Committee. Themes from the outcomes of these reviews are used to inform changes to how we work and have supported the development of a scheme-specific Board member governance program based on the Australian Institute of Company Directors program but modified for our context.

Succession-planning principles and statutory appointment processes have been developed<sup>97</sup> to ensure National Boards are well structured in terms of skills and experience, and were applied to support the recruitment for appointments to the four 2012 National Boards. A strategy to help streamline and improve the recruitment and appointment processes has been endorsed by the Australian Health Ministers' Advisory Council.<sup>98</sup> Further work on this continues, including a board member training and development program.

### Customer service

AHPRA supports web and telephone enquiries from the community and health practitioners through a National Customer Service Team (CST). On a typical day the CST manages approximately 1,400 calls, increasing to approximately 4,000 at the end of a renewal cycle, and approximately 220 web enquiries.<sup>99</sup> The CST resolves approximately 94 per cent of all these enquiries on a first-contact resolution basis; this is an improvement of approximately 6 per cent compared to 2012-13.

The most common questions asked by callers to our customer service teams are about:

- applications for registration
- registration renewal campaigns
- registration standards
- online services
- contact information, and
- notifications
- other reasons for calls include feedback, employer online service, practitioner information exchange and [requests for copies of the/access to the?] register of practitioners.

<sup>97</sup> Endorsed by the Australian Health Ministers' Advisory Council at its meeting on 29 September 2011; noted by the Australian Health Workforce Ministerial Council out-of-session on 15 November 2011 (paper 15); and implemented by AHPRA on 1 January 2012.

<sup>98</sup> Meeting on 20 September 2013, agenda item 2.5.

<sup>99</sup> For the period 1 July 2013 – 30 June 2014, the CST has responded to more than 50,000 web enquiries.

When the Scheme started, there was a single CST located in each of the eight state and territory offices. In October 2013, AHPRA centralised the management of the CST to improve service, efficiency and consistency in this important service. The service now operates from four sites using a single 1300 number.

Each working day we can receive up to 1,700 phone calls and 225 web enquiries. Our busiest times are between March and May, during the nursing and midwifery renewal period, when calls peak at 4,000 per day and average 2,100 calls daily.

AHPRA's target is to answer 70 per cent of phone calls within 90 seconds. In 2013-14 we exceeded this, reaching 79 per cent, while receiving 2 per cent more calls and using fewer staff. We improved this performance with better management, training and coaching of our staff.

During the 2013-14 financial year, we asked 165,000 callers to rate their level of satisfaction with the way we handled their enquiries – 95 per cent of people who responded rated the interaction with us as satisfied/very satisfied; an increase of 8 per cent on the previous year.

### Technology management

National Boards and AHPRA rely on information technology for systems and information management. For example, more than 96 per cent of annual health practitioner renewals – including the renewal, fee collection and health workforce survey – are completed online.

Information technology has been developed in three broad phases to support the work of National Boards and AHPRA:

- Initial implementation – before July 2010, a base information technology environment was established. Basic initial information technology infrastructure included basic corporate systems such as general ledger, payroll, office applications and critical business applications such as the online Public Register (web-based), registration system and practitioner database. Registrant data from some 38 separate organisations was merged into single registration system and practitioner database.
- Stabilisation – the stabilisation of information technology infrastructure phase provided an opportunity to focus on improving core functionality to reflect developing business processes including information security, processes (largely based on ITIL<sup>100</sup> practices), governance, project management and portfolio management, quality assurance and information management outcomes such as data quality and data governance.
- Operational enablement – enabling AHPRA's business operations. This has involved a strategic, platform-based approach to information technology to better support workflow management, enterprise-wide data reporting<sup>101</sup>, improved human resource systems and information exchange services. Focus continues on AHPRA's enterprise information management including data quality, data accessibility and data management so this can be useful widely, outside AHPRA.

### Getting the value from our data

For the first time under the National Scheme, accurate and complete workforce data are being produced, shared and analysed. More information about our data partnerships (for example with the Department of Human Services [Medicare] and the Australian Institute of Health and Welfare) is outlined below.

The workforce data, gained through high take-up of workforce surveys linked to registration renewal, are a significant data source. We believe the data gathered in the National Scheme provides significant value and will enable further strategic reform.

<sup>100</sup> Information Technology Information Library (ITIL) is the most widely accepted approach to IT service management in the world. ITIL provides a cohesive set of best practice, drawn from the public and private sectors internationally.

<sup>101</sup> There are over 3.7 billion pieces of data managed by AHPRA in the Pivotal database alone.

Data from registration and notifications are also being used increasingly to inform Board policy and decision-making. This makes regulation and standard setting proactive and tailored to emerging issues.

Almost all the work in the National Scheme facilitates access to services provided by health practitioners in the public interest. Detailed profession specific registration data, including broad trends in registration, showing increasing numbers of health practitioners and students, are published quarterly on each National Board website.

### **Data exchange services**

AHPRA's information exchange platform regularly passes de-identified practitioner data to a number of legislated and other subscribers. In terms of e-Health, AHPRA acts as the trusted source of practitioner information and actively shares data with commonwealth entities in support of their operations, within appropriate legal limits.

These organisations include:

- The Department of Human Services (Medicare) for the Practitioner Directory Service
- the Health Identifier Service, who in turn provide this data to the personally controlled electronic health record (PCeHR) service
- the National e-Health Transition Authority provides technical oversight and funding for the information technology development to secure a joined up e-Health network to benefit all Australians.

The data exchange platform uses a web service, providing a secure and robust data exchange method. This method means that information exchange is quick and automated, the infrastructure is reliable, supported by a data quality plan and reporting metrics, and publishes auditable data records.

Using existing web service platforms, the Practitioner Information Exchange service (PIE) provides improved access to information from the public register for approved users. These are typically employers of health workforces such as public hospitals. PIE has been released to several important customers (e.g. Epworth, Queensland Health and the Department of Justice [Births, Deaths and Marriages Victoria]) and interest continues to be strong. Significant benefits for subscribing organisations include lower administration costs to ensure that their practitioners remain registered to practice, better risk mitigation and an improved ability to meet audit requirements.

### **Other data sharing and research activity**

AHPRA has been providing regulatory data to health workforce agencies under a MOU since early 2012. AHPRA is currently in discussions with the Australian Institute of Health and Welfare and the Commonwealth Department of Health on a revised MOU. This enables workforce planning and forecasting to support the future of all Australians in a climate of supporting an aging population with an aging workforce.

National Boards and AHPRA are receiving an increasing number of requests for data to be used by a range of organisations. A policy that includes a comprehensive guide for individuals, agencies, institutions and researchers on the type of requests that may be considered is available on the [AHPRA website](#). These requests are subject to a strict public interest test. The requests during 2013-14 are summarised in appendix 5 of the *Annual Report 2013/14*. It is an encouraging sign that so many organisations are interested in securing this data and AHPRA recognises its value to a range of organisations, in the public interest.

AHPRA is currently working collaboratively with leading researchers to help reduce harm to the public and facilitate safe workforce reform by increasing the use of data and research to inform policy and regulatory decision-making. Some notable examples are:

- an Australian Research Council Linkage Project in partnership with the University of Sydney on a comparative study of the complaints and notification system under the national system and in NSW, since September 2011

- a three-year partnership with the University of Melbourne to harness the potential of health practitioner notifications to inform understanding and improve the quality of healthcare services, and
- a collaborative project with the University of Melbourne to undertake a 'hot-spotting' analysis by studying complaints against medical practitioners over a 10-year period, then determining the general risk factors for complaints.

A number of National Boards and AHPRA are investing in data- and research-based initiatives to inform policy and regulatory decision-making. As outlined in the [2014-15 Business Plan](#), the Medical Radiation Practice Board of Australia has committed to research to gain a better understanding of the impact of Board's current regulatory efforts, with a particular focus on risk data that relates to regulating medical radiation practice and the development of a risk profile that will inform evidence-based decision-making.

## g) Bringing four new professions into the National Scheme

During 2011-12, AHPRA worked in partnership with the four new National Boards for the four professions (appointed by the Ministerial Council in July 2011), as well as the existing 12 state and territory registration boards for these professions, to bring more than 29,000 health practitioners into the National Scheme for the first time. The four new professions were: Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy.

The *Annual Report 2011/12* (pages 19-22) provides information on the work carried out by AHPRA and the four new National Boards to manage this transition and prepare the professions for national regulation.

A report summarising the NRAS 2012 project and evaluating what could be improved to support the entry of any new professions to the National Scheme was prepared in September 2012. The report provides detailed information about the costs, logistics and implications of new professions entering the national scheme. A copy of this report has already been provided to the NRAS review team in confidence.

The transition of the 2012 professions was inherently complex, because of the need to establish grandparenting provisions. While the number of practitioners to be regulated was smaller, their professions were previously only partially regulated (with practitioners being registered in one or more jurisdictions) across Australia. This resulted in a mix of already registered practitioners who automatically converted from their state or territory-based systems, alongside practitioners who needed to apply for registration for the first time. Many of these first-time national registrants had practised their profession for many years but had not been required to be registered to do so in their state or territory, and many were not aware that national registration would apply from 1 July 2012.

A comprehensive multi-lingual communication strategy was implemented to help make sure that these practitioners were aware of the national requirements and lodged their applications in time for national registration to be granted on 1 July. This aimed to minimise any risk of disruption to public health services, or to a practitioner's private-sector practice.

## Section 3: Our performance

We report in this section on our performance across four core areas:

- a. Public protection and professional standards
- b. Registration
- c. Notifications
- d. Monitoring and reporting

### a) Public protection and professional standards

#### Performance against objectives and guiding principles

Refer to question 20 in section one.

### b) Registration and renewal performance

#### Headlines

- 619,509 health practitioners from 14 professions registered in the National Scheme on 30 June 2014 – an increase of 4.37 per cent from 30 June 2013.
- AHPRA had renewed the registration of 566,430 health practitioners on behalf of National Boards.
- In 2013-14, AHPRA sent more than two million email registration renewal reminders and online renewal rates now average above 96 per cent.<sup>102</sup>
- 58,789 applications for registration across professions were assessed in 2013-14.
- Applications for general registration account for 69 per cent of applications and on average take around 12 days<sup>103</sup> to complete across all professions.
- In 2012-13, AHPRA implemented improved systems to track and manage the timeframes for assessing and processing applications for registration.
- Online renewal of a health practitioners' registration is a significant national capability now offered by AHPRA to all professions, irrespective of size, which makes it easier for registrants to renew and means increased efficiencies and cost-effectiveness.
- Current rates of online renewal set international best practice, on available international comparators.
- Current health workforce survey completion rates are approximately 90 per cent; up from 53 per cent completion rates before the commencement of the National Scheme.
- In 2013-14, AHPRA issued close to 680,000 certificates for new registrations, renewed registrations and requests for certificate reprints across Australia.
- Most recently, AHPRA renewed the registration of more than 360,000 nurses and midwives in May 2014. Online renewal rates topped 96.7 per cent – up from 54.71 per cent in 2010-11. Registration renewal is efficient, robust and routine for all professions in the scheme. In September 2014, 96.6 per cent of medical practitioners renewed their registration online – an increase of 1 per cent on last year.
- Between 1 July 2013 and 30 June 2014, National Boards and AHPRA had requested more than 61,000 criminal history checks of which 3,597 (6 per cent) had disclosable court outcomes. These resulted in 79 actions to limit registration.
- Initial establishment costs have been absorbed and six Boards have reduced registration fees.
- More than 120,000 students are studying to be health practitioners in Australia.

#### Applications for registration

One of the main ways in which National Boards meet the objectives of the National Law is by making sure that only those practitioners who are suitably trained and qualified to practise in a competent and ethical

<sup>102</sup> 97 per cent of nurses and midwives now renew their annual registration online.

<sup>103</sup> Average time taken to finalise complete applications in calendar days: 12 days for general registration; 27 days for limited registration (these are the most complex applications); 7 days for non-practising registration; 12 days for provisional registration; and 11 days for specialist registration.

manner are registered. AHPRA works with each National Board to carefully consider every application for registration and assess it against the requirements set out in registration standards and the National Law. Determining the outcome of applications for registration is not just an administrative process. Establishing and being satisfied about an applicant's fitness, suitability and qualification for registration is a cornerstone of good regulatory practice.

Under the National Law, there are consistent types of registration between professions across states and territories:

- **General registration** means a practitioner is either Australian-qualified, or has met the requirements of the relevant accreditation authority for training to be recognised as equivalent to accredited training in Australia; practitioners with general registration usually do not need to be supervised.
- **Specialist registration** means a practitioner has undergone additional training in a particular field of practice and has met the requirements of the relevant board and/or specialist college to be recognised as specialising in that particular field; specialist registration applies to the medical, dental and podiatry professions.
- **Provisional registration** is granted to new practitioners of a profession, such as medical interns; provisional registrants are supervised and must meet number of requirements, including regular reports on their progress from their supervisors, before progressing to general registration. For some professions, provisional registration is also granted in circumstances where overseas-qualified registrants are being assessed under supervision, or for practitioners returning to the profession after a break in practice.
- **Student registration** was launched nationally for the first time in Australia in April 2011. There are currently more than 120,000 students studying to be health practitioners in Australia<sup>104</sup>. A register of these currently enrolled students is maintained by AHPRA as part of the national register, with details collected from education providers. This register is not publicly available.
- **Limited registration** covers a number of sub-types of registration, including practising in an area of need, teaching and research, and in the public interest. It applies requirements to registration, such as allowing a practitioner to practise only at a specific location and/or in a particular field of a profession. Practitioners with limited registration must be supervised by practitioners with general registration. Many overseas-trained practitioners apply for limited registration so they may practise while undergoing further training to achieve full registration in Australia. There are specific registration application processes that apply to overseas-qualified health practitioners.
- **Non-practising registration** covers practitioners who have retired from practice, are not practising temporarily (for example, if they are on parental leave), or who are not practising in Australia but are practising overseas.

National Boards and AHPRA publish extensive information about the requirements for registration and processes for renewing registration. This includes detail about the registration and renewal process; the multiple registration categories and endorsements (when these apply); fees; and application and assessment processes for practitioners with overseas qualifications who wish to apply for registration.

Common application and profession-specific forms have been developed and are published on the AHPRA and Board websites. In the first year of operation, forms management was moved in-house reducing costs by 75 per cent. AHPRA manages 289 regulatory forms.<sup>105</sup> These forms are used by practitioners and other external stakeholders to support health practitioner registration and renewal, as well as supervised

<sup>104</sup> 128,343 active students appear on the student register with an expected completion data indicating that study is still occurring. Of those, 120,459 are in an approved program of study and 7,884 are clinical training students. Refer to Table R3 in the *Annual Report 2013/14* for more details.

<sup>105</sup> Other forms maintained by AHPRA include business support forms (for example, human resource; finance and legal forms) and 16 workforce survey forms (one for each profession and a combined survey form for nurses/midwives with multiple profession registration).

practice, the notifications process and other requests for services (such as Certificate of Registration Status).

### Our performance in managing applications for registration

The time it takes to assess and process applications for registration varies according to the type of registration requested and the requirements of the application. Routine applications take less time to manage and assess than more complex registration applications.

In 2012-13, AHPRA implemented improved systems to track and manage the timeframes for assessing and processing applications for registration. More than 58,000 applications for registration were assessed in 2013-14.<sup>106</sup> AHPRA has developed KPIs for registration applications which will be reported against from 1 July 2014.

The average time it takes to complete an assessment of a general application, once a complete application is received, is 11.83 days. The majority of applications are for general registration (69 per cent).<sup>107</sup> On average in 2013-14, it took around 12.2 days to complete the assessment of these applications across all professions.

### Student registration

Student registration was introduced nationally for the first time in Australia in April 2011. Almost 100,000 students were registered in 2011 through direct partnership between AHPRA and Australian universities and training providers. As at 30 June 2014, there were 128,343 students registered. There are no fees for student registration. As decided by the Ministerial Council, the register of students is not publicly available.

### Renewals

Health practitioners in Australia must renew their registration annually. Each time they renew, they must make declarations to confirm that they meet the registration standards of their National Board. AHPRA has renewed the registration of approximately 600,000 health practitioners each year (about 1.8m over three years).<sup>108</sup>

To maximise efficiency, the annual registration renewal of the majority of practitioners is coordinated across three key dates:

- nursing and midwifery renew by 31 May each year
- most of the medical profession renew by 30 September each year, and
- all other professions renew by 30 November each year.

All health practitioners, except those with limited or provisional registration for whom additional data are required, can renew their registration online. Online renewal of a health practitioner's registration is a significant national capability now offered by AHPRA to all professions, irrespective of size. It makes it easier for practitioners to renew, has reduced late renewals by 85 per cent, and increased efficiencies and cost-effectiveness.

AHPRA has also embraced digital communication to remind health practitioners when their renewal is due. A sophisticated software program enables us to monitor and manage renewal emails so reminders to practitioners are timely and targeted. Our method and strategy for renewal reminders is effective and applies across professions and has reduced print and postage costs. Increased online renewal is better for practitioners and means less manual handling from records-management staff and fewer records to be kept in secondary storage facilities.

<sup>106</sup> The total applications processed in 2013-14 across the 14 professions was 58,789 and includes all registration types such as general, general and specialist, non-practising, limited, provisional, and specialist, for example.

<sup>107</sup> 1 July 2013 – 30 June 2014.

<sup>108</sup> AHPRA has renewed the registration of 566,430 practitioners between 1 July 2013 and 30 June 2014.



Increased online renewal rates have also reduced the number of hard-copy applications that need to be printed from approximately 150,000 in 2010 to approximately 12,000 in 2014.

The 2014 nursing and midwifery renewal campaign was launched in March 2014 with renewals due by 31 May 2014. Almost 340,000 nurses and midwives renewed their registration on time and the online renewal rate remains at about 97 per cent. This rate sets international benchmarks.

**Table 8: Online Renewal Rates**

Authority	Online renewals
AHPRA and NMBA	<b>97%</b>
Texas Board of Nursing	87%
HCPC (UK)	86.2%
California Board of Nursing	68%

## Workforce

### Surveys

At each registration renewal, health practitioners are offered the opportunity to complete a voluntary survey that informs the National Health Workforce Dataset. This form was developed in consultation with Health Workforce Australia, and maintained by AHPRA and is delivered via AHPRA's LiveCycle infrastructure.

There are 16 surveys (one for each profession and a combined survey form for nurses/midwives with multiple profession registration).

The rate of return on the Health Workforce Surveys is a significant improvement based on previous paper-based collections, with return rates of approximately 96 per cent with each renewal. This contrasts with return rates of 53 per cent before the commencement of the National Scheme and the subsequent increase in online uptake. The data from surveys completed online can now be reported to the Australian Institute of Health and Welfare (AIHW) in a timely manner. The high completion rate and timely supply is important because this means more accurate and complete workforce data can be provided for statistical and health workforce policy development.

AHPRA continues to work collaboratively with AIHW and the Commonwealth Department of Health (following the closure of Health Workforce Australia on 6 August 2014) to ensure the valuable workforce data collected from registrants continues to be used to inform workforce reform priorities that sees Australia maintain a high-quality health system that is sustainable and affordable into the future.

## c) Notifications management

### Headlines

- 10,047 notifications received in 2013-14 – up from 8,648 in 2012-13. Nursing and midwifery experienced an increase of 26 per cent in notifications. 56 per cent of notifications were about medical practitioners, who make up 16 per cent of total practitioners.
- 9 per cent increase in mandatory notifications; with variations across states, territories and professions, including some decreases.
- 35 per cent of notifications were about conduct, 8 per cent about health, and 55 per cent about performance.
- 75 per cent of 'immediate actions' – for the most serious risks – resulted in registration restriction.

- Of the 139 appeals that were finalised during the year, 80 per cent resulted in no change to the Board decision.
- Of the matters decided by tribunals in the year, 88 per cent resulted in disciplinary action.

Our performance in notifications spans a range of areas and in this section we report on:

- The number of notifications we are managing
- Who makes and who is subject to notifications
- How we measure our performance in managing notifications
- How often National Boards take immediate action
- How many mandatory notifications are received
- How we manage practitioners with impairment
- How we manage prior law matters
- Tribunal action
- How we manage statutory offences, and
- Local decision-making in a national framework.

### Number of notifications

The rate of notifications received is growing year on year. In 2012-13, AHPRA had received 5,607 notifications (excluding NSW). In 2013-14, 6,811 notifications were received. Table 9 sets out the number of notifications received by profession and jurisdiction.

There was a 14 per cent increase in notifications from 2011-12 to 2012-13 and 16 per cent increase from 2012-13 to 2013-14. Based on this data trend, National Boards and AHPRA can expect notifications to increase annually by approximately 15 per cent.

The increase in notifications has been uneven across states and territories and professions. It is not clear why this is so.

**Table 9: Notifications received in 2013-14 by profession and state and territory**

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	2014 Subtotal <sup>3,4</sup>	NSW	2014 Total	2013 Total <sup>5</sup>	2012 Total
Aboriginal and Torres Strait Islander Health Practitioner <sup>5</sup>		6						6		6	4	
Chinese Medicine Practitioner <sup>5</sup>	3		10	1		3	1	18	8	26	30	
Chiropractor	1	1	8	18	3	34	14	79	32	111	72	115
Dental Practitioner	24	14	207	45	23	218	51	582	369	951	1,052	992
Medical Practitioner	166	109	1,361	421	173	1,125	457	3,812	1,773	5,585	4,709	4,001
Medical Radiation Practitioner <sup>5</sup>	1		5	1	1	6	1	15	13	28	26	
Midwife	8	2	68	15	1	8	5	107	3	110	69	51
Nurse	35	55	438	201	67	377	134	1,307	593	1,900	1,528	1,401
Nurse and Midwife											1	
Occupational Therapist <sup>5</sup>	2	2	12	5		11	2	34	9	43	50	
Optometrist	1	1	15	6		15	3	41	25	66	42	54
Osteopath				1		4		5	6	11	8	17
Pharmacist	4	10	87	26	14	142	39	322	192	514	429	387
Physiotherapist	1	10	39	14	2	28	8	102	32	134	83	88

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	2014 Subtotal <sup>3,4</sup>	NSW	2014 Total	2013 Total <sup>5</sup>	2012 Total
Podiatrist			12	7	3	12	7	41	13	54	44	43
Psychologist	21	5	112	29	11	114	27	319	168	487	471	367
Not identified <sup>2</sup>		1	1	3		15	1	21		21	30	78
2014 Total	267	216	2,375	793	298	2,112	750	6,811	3,236	10,047		
2013 Total <sup>4</sup>	201	137	2,042	616	200	1,844	567	5,607	3,041		8,648	
2012 Total <sup>6</sup>	176	86	1,548	497	219	1,571	519	4,616	2,987			7,594

**Notes:**

<sup>1</sup> Based on state and territory where the notification is handled for registrants who do not reside in Australia.

<sup>2</sup> Profession of registrant is not always identifiable in the early stages of a notification.

<sup>3</sup> Data include some cases where early enquiries were received in 2012/13 but information to support a formal notification was only received in 2013/14.

<sup>4</sup> The process for recording of notifications received from HCEs and jointly considered with AHPRA has been modified this reporting year to ensure consistency of reporting across all jurisdictions.

<sup>5</sup> Regulation of four new professions, Aboriginal and Torres Strait Islander health, Chinese medicine practitioners, medical radiation and occupational therapy practitioners, started on 1 July 2012.

<sup>6</sup> NSW data revised since initial publication.

### Which practitioners are subject to notifications?

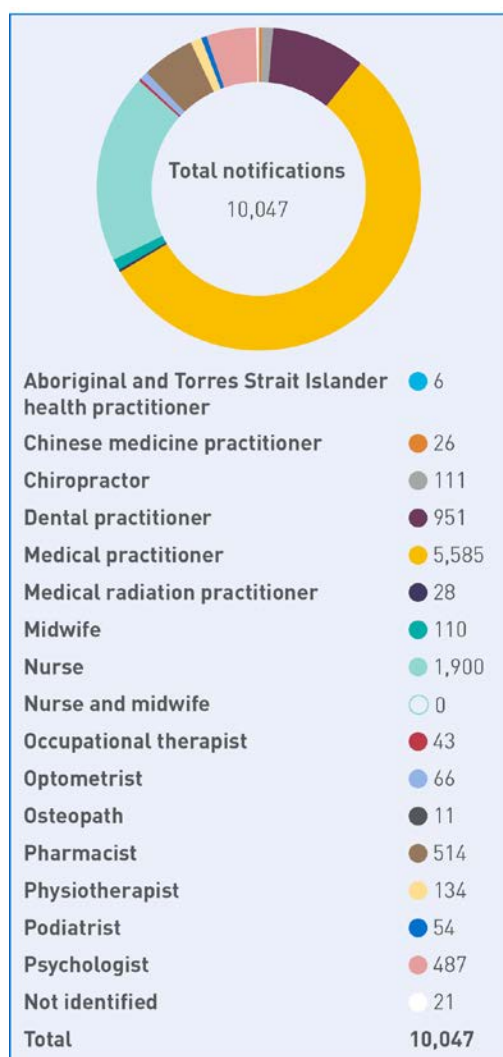
Five National Boards account for approximately 95 per cent of all notifications<sup>109</sup>: medicine (3,812 is the number of notifications received for this profession during 2013-14), nursing and midwifery (1,414), dental (582), pharmacy (322) and psychology (319). Medicine alone represents approximately 56 per cent of all notifications received. Nine professions account for 5 per cent of the total notification volume.

The medical profession has the highest average number of notifications per practitioner<sup>110</sup>, with medical radiation practitioners having the lowest average.<sup>111</sup>

<sup>109</sup> 6,171 of the 6,811 notifications received for 2013-14 were for these five professions. Earlier data can be found in annual reports.

<sup>110</sup> 4.9 per cent of registrant base with notifications received. This is consistent with NSW which recorded 4.8 per cent.

<sup>111</sup> 0.1 per cent of registrant base with notifications received. NSW recorded 0.3 per cent.



**Figure 4 – Which professions were notifications made about (including NSW)**

### Who makes notifications?

Typically, notifications are made by patients or their families, other health practitioners, employers and health complaints entities in each state and territory.<sup>112</sup>

AHPRA and the National Boards have developed a classification system for notifications that reflects in greater detail the issues of concern about health practitioners that are notified to the boards. More detailed information about how we categorise notifications and patterns of reporting is published in the performance reporting section of the *Annual Report 2013/14*.

### How is performance measured?

We are committed to transparency and accountability through better performance reporting. During the year, key performance indicators (KPIs) were developed jointly by National Boards and AHPRA and implemented to better measure and therefore manage notifications.

<sup>112</sup>Prepared *AHPRA and National Boards Annual Report 2013/14* shows: there were 2,329 notifications (34 per cent) directly from the community, patients (1,529), relatives (492) or the public (308). In 766 notifications (11 per cent), the source of the notification was another practitioner (679) or the treating practitioner (87) and 653 notifications (10 per cent) came from an employer (639) or hospital (14). 1,995 matters were received from an HCE (29 per cent).

KPIs have been implemented to measure each stage of the notifications process. The KPIs apply to all notifications lodged with AHPRA since 1 July 2013, in jurisdictions other than NSW. Performance reporting is in the form of a traffic-light system, which is reported to National Boards on a quarterly basis.

AHPRA reviews any matter that falls outside the KPIs to identify the issue and enable any corrective action to be taken. We have set these KPIs carefully, taking into account our current performance and reasonable expectations of what we should achieve. They will be reviewed annually.

Key features include:

- **Risk evaluation:** All matters undergo a risk evaluation within three days of receipt by AHPRA. When there is a question of risk to public safety, immediate action can be initiated within hours and must be initiated within five days of receiving the notification. Immediate action can also be initiated at any stage of the notifications process, if there are concerns about immediate risks to public safety.
- **Board decision to take no further action:** National Boards take no further action on more than 80 per cent of notifications received, because the risk threshold for action under the National Law has not been met. The KPI sets out a timeframe of 90 days for a Board decision in these matters including an assessment process.
- **Board action on registration:** After an assessment, National Boards can take action to limit a practitioner's registration. This can include imposing conditions to restrict registration or accepting an undertaking to achieve the same effect. The KPI requires that 60 per cent of these matters are decided within 60 days and the remaining 40 per cent within 110 days. This allows for the appropriate provisions of the National Law to be followed, in particular the requirement to allow the practitioner to 'show cause' why the Board should not take the proposed action.
- **Investigation:** When further investigation is required after assessment, the KPI requires that 80 per cent of these will be completed within six months. A Board can initiate immediate action at any time during an investigation if there is a concern about public safety.

This level of performance reporting is significantly more comprehensive than existed under previous state and territory arrangements, when there was wide variation in performance reporting across jurisdictions and professions. Reporting was largely limited to notifications volumes and outcomes with almost no reporting on measures of notifications handling.

The initial focus of the KPIs is on indicators of timeliness, as these are the basic building blocks of performance. Future development will consider measures to assess other dimensions of quality and effectiveness and will tackle the question of costs associated with performance.

The KPIs enable AHPRA to measure the timeliness of each stage of the notifications process. The KPIs establish both performance-measurement and performance-improvement targets.

Performance against KPIs for matters lodged in 2013/14 indicates:

- Initial risk evaluation: *Target 100% within three (calendar) days.* Result to date 90 per cent, with the median age of initial risk evaluation taking less than one day.
- Assessment to completion: *Target 100% within 60 days.* Result to date 87 per cent, with the median age of an assessment taking 45 days.
- Investigation to completion: *Target 80% within six months.* Result to date 59 per cent, with a 20 per cent cut in the number of investigations open more than 12 months.
- Establishment of panel hearing: *Target 100% within five months.* Result to date 65 per cent, with a 34 per cent drop in the number waiting more than five months.
- Panel hearing completion: *Target 100% within six months.* Result to date 73 per cent with a reduction in median age of panel matters from 30 to 24 weeks.

Quarterly reports on KPIs are reviewed by National Boards. We use the results to analyse and address underlying issues and identify what action we need to take, working with Boards, to improve performance. We know from this work that we have an issue with the time investigations take and will be continuing to address this as a priority in 2014-15.

We will be publishing more detailed performance data during 2014-15.

**Table 10: Notifications closed in 2013-14 by profession and state and territory (including NSW)**

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	2014 Subtotal	NSW	2014 Total	2013 Total <sup>1</sup>	2012 Total
Aboriginal and Torres Strait Islander Health Practitioner <sup>1</sup>		5						5		5	3	
Chinese Medicine Practitioner <sup>1</sup>			9	1		3	2	15	13	28	14	
Chiropractor			9	10	2	27	10	58	31	89	71	88
Dental Practitioner	12	13	243	55	23	250	40	636	379	1,015	1,075	865
Medical Practitioner	145	63	1,342	339	180	1,111	500	3,680	1,835	5,515	4,323	3,379
Medical Radiation Practitioner <sup>1</sup>	2		6	2		5	2	17	11	28	12	
Midwife	2	5	66	8	1	9	10	101	2	103	59	38
Nurse	21	49	393	176	56	379	146	1,220	554	1,774	1,425	1,013
Occupational Therapist <sup>1</sup>	2	1	8	7	1	11	2	32	9	41	35	
Optometrist	1	1	13	7		19	2	43	23	66	44	50
Osteopath			1			7		8	6	14	8	10
Pharmacist	6	5	90	16	15	118	36	286	178	464	396	287
Physiotherapist	1		28	15		22	7	73	31	104	80	79
Podiatrist			11	6	2	14	12	45	13	58	40	36
Psychologist	33	4	107	31	12	106	29	322	162	484	407	303
Not Stated <sup>2</sup>		2	1	3		9		15		15	21	61
<b>2014 Total</b>	<b>225</b>	<b>148</b>	<b>2,327</b>	<b>676</b>	<b>292</b>	<b>2,090</b>	<b>798</b>	<b>6,556</b>	<b>3,247</b>	<b>9,803</b>		
<b>2013 Total<sup>1</sup></b>	<b>185</b>	<b>124</b>	<b>1,957</b>	<b>549</b>	<b>187</b>	<b>1,552</b>	<b>487</b>	<b>5,041</b>	<b>2,972</b>		<b>8,014</b>	
<b>2012 Total</b>	<b>166</b>	<b>89</b>	<b>1,148</b>	<b>471</b>	<b>180</b>	<b>1,191</b>	<b>330</b>	<b>3,575</b>	<b>2,634</b>			<b>6,209</b>

**Notes:**

<sup>1</sup> Regulation of four new professions, Aboriginal and Torres Strait Islander health, Chinese medicine practitioners, medical radiation and occupational therapy practitioners, started on 1 July 2012.

<sup>2</sup> Practitioner profession may not have been identified in notifications closed at an early stage.

**Table 11: National Law notifications closed in 2013-14 by profession and stage at closure (including NSW)**

Profession	Assessment		Investigation		Health or performance assessment		Panel hearing		Tribunal hearing		Subtotal 2014		Total 2014
	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	
Aboriginal and Torres Strait Islander Health Practitioner <sup>1</sup>	3		1		1						5		5
Chinese Medicine Practitioner <sup>1</sup>	12	10	2		1	1		2			15	13	28
Chiropractor	31	23	19	5		3	7		1		58	31	89
Dental Practitioner	419	322	158	8	28	13	23	34	8	2	636	379	1,015
Medical Practitioner	2,653	1,197	771	149	91	361	122	110	43	18	3,680	1,835	5,515
Medical Radiation Practitioner <sup>1</sup>	11	8	5		1	1		2			17	11	28
Midwife	65		22		8	2	3		3		101	2	103
Nurse	681	203	298	30	182	189	20	117	39	15	1,220	554	1,774
Occupational Therapist <sup>1</sup>	22	8	8		1	1			1		32	9	41
Optometrist	30	21	11		2	2					43	23	66
Osteopath	3	4	2		3	1		1			8	6	14
Pharmacist	157	133	90	5	13	23	14	11	12	6	286	178	464
Physiotherapist	49	20	16	6	5	4	2	1	1		73	31	104
Podiatrist	25	9	12		6	4	1		1		45	13	58
Psychologist	211	138	54	2	14	11	36	9	7	2	322	162	484
Not Identified	15										15		15
<b>Total 2014</b>	<b>4,387</b>	<b>2,096</b>	<b>1,469</b>	<b>205</b>	<b>356</b>	<b>616</b>	<b>228</b>	<b>287</b>	<b>116</b>	<b>43</b>	<b>6,556</b>	<b>3,247</b>	<b>9,803</b>
<b>Total 2013<sup>1</sup></b>	<b>3,720</b>	<b>2,258</b>	<b>903</b>	<b>113</b>	<b>197</b>	<b>431</b>	<b>166</b>	<b>132</b>	<b>55</b>	<b>39</b>	<b>5,041</b>	<b>2,973</b>	<b>8,014</b>
<b>Total 2012</b>	<b>2,389</b>	<b>1,978</b>	<b>922</b>	<b>147</b>	<b>150</b>	<b>345</b>	<b>92</b>	<b>137</b>	<b>22</b>	<b>27</b>	<b>3,575</b>	<b>2,634</b>	<b>6,209</b>

**Notes:**

<sup>1</sup> A matter may result in more than one outcome. Only the most serious outcome from each closed notification has been noted.

<sup>2</sup> Regulation of four new professions, Aboriginal and Torres Strait Islander health, Chinese medicine practitioners, medical radiation and occupational therapy practitioners, commenced on 1 July 2012.

<sup>3</sup> Since the 2012 annual report, system and process changes have enabled better recording of these cases which were previously recorded as No further action, Refer all or part of the notification to another body, or, in some states, were not previously recorded.



Table 12: National Law notifications closed in 2013-14 by outcome (including NSW)

Profession	No further action	Refer all or part of the notification to another body	HCE to retain <sup>3</sup>	Accept undertaking	Caution or reprimand	Fine registrant	Impose conditions	Accept surrender of registration	Suspend registration	Cancel registration	Prohibited from undertaking services relating to midwifery	Not permitted to reapply for registration for 12 months	Total 2014
Aboriginal and Torres Strait Islander Health Practitioner <sup>2</sup>	3						2						5
Chinese Medicine Practitioner <sup>2</sup>	10		3	1			1						15
Chiropractor	39		2		3		12		1			1	58
Dental Practitioner	292	3	180	39	79		42	1					636
Medical Practitioner	2,132	13	982	56	361	4	121	2	6	3			3,680
Medical Radiation Practitioner <sup>2</sup>	12		2		2		1						17
Midwife	68		11	6	9		5			1	1		101
Nurse	706	4	94	88	183	2	126	4	6	7			1,220
Occupational Therapist <sup>2</sup>	26		4		1		1						32
Optometrist	22		15	2	3		1						43
Osteopath	2		2				4						8
Pharmacist	136		6	9	110		19	2	3	1			286
Physiotherapist	47		9	6	8		3						73
Podiatrist	23		8	3	8		3						45
Psychologist	222	1	14	8	31	1	41	2	2				322
Not Identified	4		10										15
<b>2014 Total</b>	<b>3,744</b>	<b>22</b>	<b>1,342</b>	<b>218</b>	<b>798</b>	<b>7</b>	<b>382</b>	<b>11</b>	<b>18</b>	<b>12</b>	<b>1</b>	<b>1</b>	<b>6,556</b>
<b>2013 Total<sup>2</sup></b>	<b>3,026</b>	<b>43</b>	<b>1,019</b>	<b>174</b>	<b>522</b>	<b>7</b>	<b>228</b>	<b>14</b>	<b>5</b>	<b>3</b>			<b>5,041</b>
<b>2012 Total</b>	<b>2,868</b>	<b>159</b>		<b>124</b>	<b>245</b>		<b>159</b>	<b>6</b>	<b>11</b>	<b>3</b>			<b>3,575</b>

**Notes:**

<sup>1</sup> A matter may result in more than one outcome. Only the most serious outcome from each closed notification has been noted.

<sup>2</sup> Regulation of four new professions, Aboriginal and Torres Strait Islander health, Chinese medicine practitioners, medical radiation and occupational therapy practitioners, commenced on 1 July 2012.

<sup>3</sup> Since the 2012 annual report, system and process changes have enabled better recording of these cases which were previously recorded as No further action, Refer all or part of the notification to another body, or, in some states, were not previously recorded.

A comparative preliminary desktop assessment between the National Scheme and some regulators in the United Kingdom, looking at timeliness of notifications activity as an indicator of performance, has been conducted. The timeliness measures are those used by the Professional Standards Authority in their performance assessment of UK regulators.

The preliminary results of the desktop assessment (refer to Attachment F) indicate that the National Scheme appears to be performing well. In Australia, we have a shorter median timeframe to process an initial complaint from receipt through to decision at assessment or investigation stage (9 weeks) and a shorter median timeframe to process high-risk matters from initial receipt of notification and information

through to a decision by an immediate action committee, reflecting timely public protection. Differences in the two models (including language used) may also have an impact on the analysis.

We are keen to pursue future opportunities for benchmarking with regulators in overseas jurisdictions.

### Immediate action

A Board has the power to take immediate action at any time. This is a serious step and a board can only take this action if it believes that it is necessary to protect the public. As outlined in Table 13, as at 30 June 2014, 474 matters had been considered for immediate action during the year, of which 358 resulted in some form of restriction on registration<sup>113</sup>. The number of immediate actions initiated in 2013-14 is almost double the number received in 2011. This is due to a stronger focus on early risk assessment and the strengthened operational procedures implemented in the form of an Operational Directive to AHPRA notifications staff. The number of high-risk matters requiring a National Board to take immediate action is relatively low for nine professions.

<sup>113</sup> 75 resulted in suspended registration; 3 accepted surrender of registration; 187 resulted in imposed conditions; and 93 accepted an undertaking.

Table 13: Immediate action cases (including NSW)

	No action taken		Action taken										Total 2014		Total 2013 2		Total 2012	
			Suspend registration		Accept surrender of registration		Impose conditions		Accept undertaking		Decision pending <sup>3</sup>							
Profession	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW <sup>4</sup>	AHPRA	NSW
Aboriginal and Torres Strait Islander Health Practitioner <sup>2</sup>																		
Chinese Medicine Practitioner <sup>2</sup>			1				1	1					2	1				
Chiropractor	2						1		3				6		2	2	1	1
Dental Practitioner	4	2	1	6			7	4	6				18	12	14	10	14	3
Medical Practitioner	61	5	25	17	1		77	26	33		1		198	48	103	44	78	46
Medical Radiation Practitioner <sup>2</sup>	1												1		1			
Midwife			3				13	1	2				18	1	4	2	6	1
Nurse	37	9	42	7	1		83	71	31		4		198	87	108	58	120	49
Occupational Therapist <sup>2</sup>							1	1	1				2	1				
Optometrist																		
Osteopath	1												1					
Pharmacist	2	13	1	1				14	16			2	19	30	18	16	15	8
Physiotherapist		1	1	2			1	2			1		3	5	1		5	
Podiatrist							3						3		1		2	1
Psychologist	2		1	2	1			2	1				5	4	14	8	10	2
Total 2014	110	30	75	35	3		187	122	93		6	2	474	189				
Total 2013	38	23	72	29	2	4	96	84	58						266	140		
Total 2012	50	12	52	15	2	9	62	75	80		5						251	111

**Notes:**

<sup>1</sup> Cases where immediate action has been initiated under Part 8, Division 7 of the National Law.

<sup>2</sup> Regulation of four new professions, Aboriginal and Torres Strait Islander health, Chinese medicine practitioners, medical radiation and occupational therapy practitioners, started on 1 July 2012.

<sup>3</sup> In these cases where immediate action was initiated towards the close of the reporting year, an outcome decision has not been finalised.

<sup>4</sup> Initial actions only; excludes reviews of immediate action decisions.

## Mandatory notifications

There were 1,145 mandatory notifications (of the total 10,047 notifications received) in 2013-14, including in NSW. In addition, 27 mandatory notifications were received about registered students. Outside NSW, AHPRA received 903 mandatory notifications. The number of mandatory notifications received by AHPRA increased by about 15 per cent compared with 2013-14, when 782 notifications were received. This increase is not consistent across states and territories or professions. Nationally, including NSW, more than half of mandatory notifications were about nurses or midwives (54 per cent); a further 31 per cent were about medical practitioners. Notifications about pharmacists represent 5 per cent of the notifications received with a further 4 per cent relating to psychologists. The other mandatory notifications were

spread across seven professions that each accounted for fewer than 2 per cent of notifications. No mandatory notifications were received in 2013-14 about Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, or osteopaths.

Compared with last year, there was a decrease in the number of mandatory reports received in all states other than Queensland and Tasmania. With 376 mandatory notifications, Queensland saw an increase of 63 per cent and in 2013-14 accounted for 42 per cent of the mandatory notifications received under the National Law. This strong trend varies from the directions in most other states and territories. It suggests that there are factors specific to Queensland that has affected the rate of mandatory reporting in that state in this reporting year.

Tasmania has the highest rate of mandatory notifications per 10,000 practitioners, with a rate of 33.9; Tasmania has overtaken South Australia,<sup>114</sup> which consistently has had the highest rate in past years. The ACT has the lowest rate at 9.3 per 10,000 practitioners, followed closely by Victoria with a rate of 10.2 per 10,000 practitioners (see Table 14).

**Table 14 – Mandatory notifications received by professions and jurisdiction (including NSW)**

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	Subtotal	NSW	Total 2014	Total 2013 <sup>1</sup>	Total 2012
Chinese Medicine Practitioner <sup>1</sup>											2	
Chiropractor				1		1	3	5	2	7	3	4
Dental Practitioner		1	10	3	3	4	2	23	3	26	20	11
Medical Practitioner	5	2	134	51	17	39	27	275	76	351	299	221
Medical Radiation Practitioner <sup>1</sup>			2			2		4	4	8	7	
Midwife	1	1	19	8		1	3	33	1	34	29	21
Nurse	4	4	157	98	24	122	44	453	137	590	540	421
Occupational Therapist <sup>1</sup>			3	2		1		6	3	9	4	
Optometrist			1	1				2		2		2
Osteopath											1	2
Pharmacist	1		20	8	5	8	6	48	7	55	38	31
Physiotherapist			6	2	1	2		11	3	14	7	14
Podiatrist			2		1	1		4		4		4
Psychologist			22	6		8	3	39	6	45	63	44
<b>Total 2014</b>	<b>11</b>	<b>8</b>	<b>376</b>	<b>180</b>	<b>51</b>	<b>189</b>	<b>88</b>	<b>903</b>	<b>242</b>	<b>1145</b>		
<b>Total 2013<sup>1</sup></b>	<b>20</b>	<b>10</b>	<b>230</b>	<b>185</b>	<b>42</b>	<b>200</b>	<b>95</b>	<b>782</b>	<b>231</b>		<b>1013</b>	
<b>Total 2012</b>	<b>24</b>	<b>13</b>	<b>245</b>	<b>122</b>	<b>18</b>	<b>111</b>	<b>56</b>	<b>589</b>	<b>186</b>			<b>775</b>

**Notes:**

<sup>1</sup> Regulation of four new professions, Aboriginal and Torres Strait Islander health, Chinese medicine practitioners, medical radiation and occupational therapy practitioners, started on 1 July 2012.

## Managing practitioners with a health impairment

One of the important functions of the National Boards is to manage practitioners with an impairment that may pose a risk to the health and safety of the public. During 2013-14, 566 notifications (or just over 8.3 per cent of all notifications received) were about the health of registered practitioners.

<sup>114</sup> 28.8 notifications received per 10,000 practitioners in 2013-14. In 2012-13 it was 36.1; and in 2011-12 it was 24.8.

Practitioners with a health impairment present significant, individual challenges to a National Board in terms of public safety. To obtain evidence-based knowledge of contemporary biological monitoring of practitioners who misuse or abuse drugs or alcohol, AHPRA established an Impaired Practitioner Steering Group and commissioned a report on *Testing Impairing Substances in Health Care Professionals March 2014* from the Victorian Institute of Forensic Medicine (VIFM). AHPRA has implemented an interim protocol *Urine Drug Screening (UDS) – Information and requirements for health practitioners and students*. Work is continuing to implement the remaining recommendations from the VIFM report.

National Boards' responsibilities for managing impairment under the National Law are distinct from the service to practitioners that may be provided by external health programs.

On 10 April 2014, the MBA announced it would fund health programs to deliver a nationally consistent set of services to medical practitioners and students in all states and territories, to be run at arm's length from the Board. Work is continuing to implement this.

The NMBA is funding a project to undertake a comprehensive review of the role of national and international regulators in relation to referral, treatment and rehabilitation programs for health professionals with a health impairment.

### Managing prior law matters

A decreasing number of legacy (prior law) matters are still being managed through the notifications process. Prior law matters are notifications that were open when the National Scheme started on 1 July 2010 and have been managed consistent with the relevant state or territory law in place when the conduct occurred (except in South Australia where these are managed under the National Law). The number of prior law matters being managed has dropped from 1,157 in 2011 to 80 as at 30 June 2014.<sup>115</sup> Many of these remaining prior law matters are involved in panel or tribunal processes, or there are other reasons for the timeline that are outside the control of a National Board or AHPRA.

### Serious matters in tribunals

National Boards refer allegations of the most serious unprofessional conduct (or misconduct) to independent tribunals for hearing. These hearings are one of the most important and visible ways the National Boards protect the public.

In 2013-14, 116 matters were closed after a tribunal hearing, more than doubling the number of tribunal hearings closed in 2012-13 when 55 cases were closed by tribunals and in 2011-12, when 22 cases were closed by tribunals.

This reflects that it takes longer to investigate the more complex matters that are referred to tribunals. It also signals a maturing of the National Scheme, as the complex matters received early in the scheme are now being heard and decided by tribunals.

<sup>115</sup> Excludes NSW data. NSW currently has 11 prior law matters open.

**Table 15: Outcomes of cases under the National Law closed at tribunals by profession (excluding NSW)**

Profession	No further action	Caution	Reprimand	Fine registrant	Accept undertaking	Impose conditions	Practitioner to surrender registration	Suspend registration	Not permitted to re-apply for registration for 12 months	Cancel registration	Permanently prohibited from undertaking services relating to midwifery	Total
Chiropractor									1			1
Dental Practitioner		1	3		3	1						8
Medical Practitioner	7		10	4		14		5		3		43
Midwife						1				1	1	3
Nurse	5		18	2		3	1	3		7		39
Occupational Therapist						1						1
Pharmacist	1		2		3	3		2		1		12
Physiotherapist			1									1
Podiatrist			1									1
Psychologist	1			1		2	1	2				7
<b>Total</b>	<b>14</b>	<b>1</b>	<b>35</b>	<b>7</b>	<b>6</b>	<b>25</b>	<b>2</b>	<b>12</b>	<b>1</b>	<b>12</b>	<b>1</b>	<b>116</b>

**Notes:**

<sup>1</sup> A matter may result in more than one outcome. Only the most serious outcome from each closed tribunal matter has been noted.

Tribunal decisions and the outcome of appeals to tribunals are an important measure of the 'regulatory touch' in the National Scheme. For 2013-14, 111 decisions made under the National law were appealed. Of those, 57 appeals related to decisions on registration applications<sup>116</sup>; 45 appeals related to decisions about conditions placed on registration<sup>117</sup>; 8 appeals related to decisions to suspend a person's registration and one appeal related to a reprimand of a practitioner by a National Board.

The majority of these appeals related to medical practitioners (47) or nursing and midwifery practitioners (38). More than half of these appeals were lodged in the jurisdictions of Queensland (34) and NSW (30).

Of the 139 appeals that were finalised during 2013-14, 81 per cent resulted in no change to the original decision<sup>118</sup>. These data show that, generally, tribunal outcomes uphold National Board decisions to prosecute matters; and there are very few appeals against tribunal decisions or National Board decisions.

AHPRA is also working collaboratively with tribunals nationally on a range of measure to improve the transfer of matters between AHPRA and tribunals that support timeliness and efficiency.

### Managing statutory offences to keep the public safe

The National Law legislates for a number of offences, including those relating to advertising of regulated health services (section 133) and title protections (sections 113-119). These include holding-out and practice protections for restricted dental acts, prescription optical appliances and spinal manipulation

<sup>116</sup> decisions to refuse to register a person (47); decision to refuse to renew a registration (3); or decisions to refuse to endorse a person's registration (7)

<sup>117</sup> Including a decision to impose or change a condition on a person's registration or endorsement (40) or a decision to refuse to change or remove a condition placed on a person's registration or endorsement (5).

<sup>118</sup> 95 matters were finalised because the application was withdrawn. The remaining 44 matters resulted in confirmation of the original decision (17 matters), substitution of the original decision for a new decision (15 matters) and amendment of the original decision (12 matters).

(sections 121-123) and, in South Australia, dispensing optical applicants (Part 5, *Health Practitioner Regulation National Law (South Australia) Act 2010*).

National Boards have recently published updated common guidelines for advertising regulated health services to help practitioners and others understand their responsibilities under the National Law when advertising a regulated health service.

AHPRA has established a Statutory Offences Unit to advise on potential breaches of the offence provisions of the National Law and to oversee the prosecution of all statutory offence matters, including those about advertising.

During 2013-14, AHPRA received 846 complaints/notifications alleging breaches of the National Law. Of the 489 cases closed during the year, 472 (96 per cent) were resolved when the individual or organisation complied with AHPRA's demand to comply with the National Law, and required no further action. This has been a cost-effective strategy to manage offences, meet our responsibilities under the National law and protect the public.

There has also been a successful prosecution under the holding-out provisions of the National Law<sup>119</sup> and AHPRA is currently running five prosecutions across a number of professions, including dental, psychology, chiropractic, osteopathy and nursing and midwifery.

The introduction of the updated *Guidelines for advertising regulated health services* triggered significant debate, particularly in online communities, about whether the restriction on the use of testimonials in the National Law aligned with the reality of social media in the 21st century.

### Local decision-making – national framework

National Boards have adopted a range of models to ensure state- and territory-specific issues are effectively addressed. For detailed Board and committee structures, see appendix 1 of the *Annual Report 2013/14*. In different ways, this ensures profession-specific expertise is accessible and informs the handling of all notifications and complex registration applications.

In general, medicine, nursing and midwifery, and dental have state and territory boards or committees that make all decisions about individual registered practitioners, locally. Psychology has regional boards in place to achieve this. Having recently reviewed its committee structures, the Psychology Board of Australia is likely to maintain current arrangements as the most cost-effective and viable model for that profession to deal with individual registration and notification decisions about registered psychologists. Physiotherapy this year moved to a national committee structure, except in Victoria where a local committee has been retained pending a current review of its efficiency and effectiveness.

More broadly, all National Boards must have one member from large participating jurisdictions (NSW, Queensland, SA, Victoria and WA), to provide insight into local issues that are brought to the attention of a National Board.

Through these and other mechanisms (including local delegations), supported by local AHPRA offices in every state and territory, regulation in the National Scheme is delivered locally, supported by a national policy, standards and process framework.

There is a local registration team dealing with local registration matters for all National Boards. Notifications about practitioners are managed in the states and territories with a team of assessment, investigation and compliance staff which supports the state boards and committees in their decision-making. A national customer service team means that questions from the community and practitioners are answered consistently and, in most instances, locally.

<sup>119</sup> The first prosecution of a National Law offence resulted in a guilty verdict and the accused person ordered to pay fines totaling \$20,000. See [media release here](#).



There are strong and active links between AHPRA state and territory offices, to support AHPRA's commitment to consistency, capability and service. Economies of scale enable all AHPRA's state and territory offices to coordinate their efforts, better manage workflow across offices and meet peak demands.

The [2014-15 Business Plan](#) outlines one of our core focus areas for the coming financial year, holding ourselves accountable for what we do.

## d) Monitoring and reporting

Assessing regulatory effectiveness and whether regulation in the National Scheme is currently 'right touch' involves comparisons with like regulators overseas and in NSW; assessing internal consistency (of both process and outcome); reviewing appeals decisions and the decisions of tribunals; and assessing our performance against KPIs.

Having analysed these data, we believe that the regulatory approach of National Boards is proportionate and increasingly 'right touch'. Ministers also have a stake, by approving standards set by Boards which practitioners must meet to become registered, as well as the standards that dictate what they have to do to stay registered.

### Reporting

AHPRA recognises the importance of reporting on regulatory performance. It has critical value in supporting transparency about our performance; and provides data that enable us to better understand and manage our operations.

The Agency Management Committee has established a [Performance Committee](#) with specific responsibilities to strengthen the performance culture across the National Scheme; has oversight and scrutiny of operational performance measures and data and provides assurance that any organisational performance-related issues, including the consistency of data and statistics, are being well managed. Two National Board Chairs are members of the Committee.

AHPRA and the National Boards introduced an *Enterprise Risk Management Policy and Framework*, informed by AS/NZS ISO3100:2009.<sup>120</sup> This is designed to provide a common platform for all risk-management activity undertaken in the National Scheme, from individual functional, process or project-based assessments to whole-of-organisation assessments. This aims to enable us to compare, analyse and prioritise risks and manage them effectively.

AHPRA's internal audit program, conducted by Grant Thornton, is phased over three years and includes a rolling review of issues, prioritised according to risk. The Annual Internal Audit Program is also informed by the priorities identified in the Corporate Risk Profile. The program for 2013-14 included a review of the system of internal controls supporting current business processes in relation to notifications handling.

A Critical Incident Management Plan has been developed and implemented. The plan integrates incident response activities; ICT and facilities disaster recovery; business continuity activities; and the timely and systematic identification, analysis and response to identified trends in serious incidents or emerging risks through the implementation of a serious incident reporting system.

A strengthened Fraud and Corruption Control Policy and Framework has been developed, which incorporates conflict of interest procedures for all AHPRA staff. This framework will be implemented during the first quarter of the new financial year.

<sup>120</sup> Standards Australia and Standards New Zealand, AS/NZS ISO 3100:2009 *Risk Management—Principles and Guidelines*, Standards Australia and Standards New Zealand, 2009.

## Section 4: Appendices and further information

### Appendix 1: Fee-setting principles and National Board equity

Under the National Law, National Boards do not have the power to acquire, hold, dispose of and deal with real property. These powers are delegated to AHPRA, which manages resources on the National Boards' behalf.

On entering the National Scheme, the newly formed National Boards contributed equity that had been built up by the health professions under the previous state-based regulatory arrangements.

The Australian Health Ministers Advisory Council (AHMAC) established the financial principles for the transfer of assets and liabilities for previous state and territory boards. The Council agreed that boards were required to transfer funds to cover:

- prepaid fees on commencement
- funds to cover transferring liabilities, and
- reserve funds equivalent to one year's operating, or if not available, all reserve funds.

In addition, the Commonwealth and state and territory governments contributed initial funds towards the National Scheme's implementation.

Under the National Law, there is to be no cross-subsidisation between health professions. Hence, equity is now held by AHPRA (in the Australian Health Practitioner Regulation Agency Fund [Agency Fund]) under a separate account for each National Board.

The National Scheme is intended to be self-funded through practitioners' registration fees. Registration fees and the National Board's annual budget are determined via Health Profession Agreements between AHPRA and each National Board. Within the first two years of the National Scheme, in many cases, professions experienced an increase in registration fees. This occurred, in part, to ensure that National Boards possessed enough equity to meet their legislative responsibilities under the National Scheme.

Consistent with the Intergovernmental Agreement (IGA), the National Scheme is funded by practitioners' registration fees. Each National Board must set a fee that enables it to meet its regulatory responsibilities under the National Scheme while striving to be an effective and efficient regulator.

The National Law requires that National Boards and AHPRA reach agreement on fees that are payable by health practitioners. These fee schedules form part of the published Health Profession Agreements. These agreements set out the services AHPRA will provide in supporting the Boards to regulate their profession. If a National Board and AHPRA are unable to reach agreement, the matter is referred to the Ministerial Council for direction.

Since the start of the Scheme, there has been a standing agreement that, if a National Board and AHPRA propose to raise fees above the national consumer price index, a business case is brought to the Ministerial Council so ministers can consider the case and provide advice.

#### National Board equity

The *Annual Report 2013/14* (from page 183) includes detailed reporting of National Board financial results and a more detailed breakdown of each board's equity position since the start of the Scheme. In the interests of transparency, National Boards have also published their Health Profession Agreements with AHPRA on their websites, accessible through [www.ahpra.gov.au](http://www.ahpra.gov.au).

Early in the Scheme, concerns were raised about the increase in registration fees under the National Scheme compared to previous state- and territory-based registration fees. The main factors leading to increased fees in the National Scheme were advised to the Ministerial Council at the time, and included:

- that the Scheme needs to be self-funding, with each National Board assuming that there will be no additional government funding in the future
- there is no cross-subsidisation between professions – each profession needs to pay its own way
- fewer assets than expected were transferred to National Boards from existing state and territory boards
- the cost of implementation, including investment in new IT systems and customer service infrastructure and processes, was greater than anticipated and more than the funding allocated by governments, and
- National Boards need to fund important new services as part of the National Scheme (including the new national complaints model to operate across all jurisdictions and the co-regulatory arrangements in NSW; student registration which is at no cost to the student; and costs associated with mandatory identity and criminal history checks and mandatory reporting).

The National Law specifies that AHPRA must ensure that its procedures, including internal control procedures, afford adequate safeguards with respect to:

- the correctness, regularity and propriety of payments made from the Agency Fund
- receiving and accounting for payments made to the Agency Fund, and
- prevention of fraud or mistake.

As part of its role to afford adequate safeguards, AHPRA must continue to work with each National Board to ensure it possesses, or is taking measures to obtain, an appropriate level of equity to meet all prudential requirements under the National Scheme.

In October 2013, Deloitte delivered report on the equity reserves for National Boards. To develop the report, Deloitte applied a tailored qualitative framework to assess the appropriate level of equity that each National Board should target in the context of litigation risk and capital expenditure requirements of AHPRA. The adopted equity target essentially consists of three main components: risk of unexpected and uninsurable legal expenditure; forecast increase in net fixed assets from asset growth; and other large one-off expense items that align with the Board's strategic plan and are beyond the capacity of annual operating budgets. It should be noted that not all National Boards accepted the proposed equity reserves recommended by Deloitte.

Consideration of the appropriate equity levels for each Board was governed by a common set of principles including:

- Prudence – conservative judgement should be applied when determining an appropriate equity level. Future liabilities and their likelihood should not be underestimated and revenue-raising ability should not be overestimated.
- Appropriateness – funds should not be set aside for purposes that don't have broad support from relevant stakeholders; or where both the risk consequence and likelihood is extremely low.
- Evidence-based – the equity level assessment should be informed by the most up-to-date, robust and auditable information.
- Efficiency – risks should be effectively addressed and mitigated at the lowest possible cost.
- Transparency – clear and transparent information outlining the rationale, assumptions and methodology associated with the equity target should be publicly available.
- Regular review – equity balances and reserve policies should be regularly reviewed to take into account the latest available data and changes in circumstances.

National Boards approve fees, taking the equity levels into consideration.

## Appendix 2: Restricted practices

### Spinal manipulation

The current practice restrictions with respect to spinal manipulation under section 123 of the National Law are that a person must not perform manipulation of the cervical spine unless the person is registered in an appropriate health profession (chiropractic, osteopathy, medical and physiotherapy). Students enrolled in an approved program of study undertaking clinical trainings are also permitted to perform manipulation of the cervical spine.

There is also the capacity to allow further classes of people to perform manipulation of the cervical spine, prescribed under regulation, however no such regulations have been developed. A breach of this section of the National Law can result in a maximum penalty of \$30,000. AHPRA and the National Boards have not, to date, prosecuted a person under this section.

In late 2008, the issue of spinal manipulation was the subject of a separate consultation paper in the lead-up to the drafting of the National Law. The paper clearly summarised the variation across state and territory legislation at that time; the limited evidence to support a practice restriction; and the clear link between the potential for catastrophic risk being associated with cervical spine manipulation. The Regulatory Impact Statement for the National Law provided a summary of the consultation undertaken and also clearly summarised the position and balanced the regulatory impact of a restriction with public protection (see pages 66-68).

There continues to be some further evidence available for a broader practice restriction in relation to spinal manipulation. Some insurance providers have reported that more members of the public make claims about lumbar spinal manipulation than vertebrobasilar accidents (leading to stroke). These claims are made against registered health practitioners. The experience of the Chiropractic Board of Australia<sup>121</sup> is that the receipt of notifications involving lumbar disc injuries either induced or exacerbated by manipulation is higher than those for vertebrobasilar incidents. Although lumbar disc injuries do not attract catastrophic consequences, they appear more common and are associated with potentially high levels of morbidity. Again, if these claims are being made about registered health practitioners, then it is possible that unregistered practitioners are having similar outcomes associated with lumbar spinal manipulation (which is not restricted). This issue is raised for further consideration.

Manipulation of the cervical spine is defined in the National Law as '**manipulation of the cervical spine** means moving the joints of the cervical spine beyond a person's usual physiological range of motion using a high-velocity, low-amplitude thrust.' The risks associated with manipulation of the cervical spine do not solely reside in movement beyond the normal physiological range. Vertebrobasilar accidents, for example, are well known to occur with movement within the normal range. In contested matters it may become incumbent on the prosecution to determine whether or not a thrust delivered to a person went beyond the normal range – this is very difficult to do due to the nature of low-amplitude thrusting. It is the view of the Chiropractic Board of Australia that the definition be modified as follows: '**manipulation of the cervical spine** means **moving or intending to move** the joints of the cervical spine beyond a person's usual physiological range of motion using a high-velocity, low-amplitude thrust'. This amendment not only better addresses the risks associated with the activity, but provides more clarity for decision-makers on this issue.

<sup>121</sup> Note there is no evidence in the notifications received by the Physiotherapy Board of Australia to suggest the same problems exist.

### Appendix 3: Community Reference Group response to the consultation paper

The Community Reference Group (CRG) provides the following feedback to AHPRA in relation to the NRAS review of the National Scheme.

#### Community Reference Group principles in response to the NRAS Review

The CRG put forward some overarching principles that they would like considered in the review. The Community Reference Group supports:

- increased access to information (for notifiers)
- transparency of process and outcome
- more effective communication with notifiers and greater recognition of their right to information
- increased resources to improve the experience of notifiers through better management and better access to information and ensuring a single point of contact
- allowing the notifier to be heard and provided with natural justice
- seamless notifier/notification movement across complaints organisations so the notification/complaint is dealt with by the right agency in a simple and straightforward way. In effect, this would be a 'no wrong door' policy. There would also be consistent case management (this does not necessarily imply co-regulation was a solution). The group noted it was premature to assess the impact of the co-regulatory model in Queensland
- increased accountability to complainants and the public as well as to government and practitioners.

The CRG provides the following responses to issues raised in the NRAS consultation paper.

#### Mandatory notifications

- The CRG does not support amending the National Law to reflect exemptions in place in QLD and WA. There was some support for models such as in place in parts of the United States, in which treating practitioners (and all other potential mandatory notifiers) have the option to refer a potentially impaired practitioner to an approved health program for evaluation and treatment. The CRG supports national consistency in mandatory reporting requirements across states and territories.

#### Appointment of Chairs for National Boards

- The CRG expressed support for removal of the aspect of the Law restricting the appointment of Chairs of National Boards to registered practitioners of the relevant profession.

#### Information made available on the public register

- Clarification on how long conditions/reprimands/undertakings should and do remain on the register, including when they relate to impairment, should be provided. The possibility for relapse after the mandatory testing period has ended, in relation to substance abuse/dependence, was a concern.
- The CRG supported the following for consideration in the NRAS review:
  - a) Publication of surrender of registration when surrender occurs by common agreement during a disciplinary process or when a board or tribunal makes a finding in the case of a practitioner who is no longer registered.
  - b) Publication of cautions issued for a period of 12 months
  - c) Publication of the history of disciplinary sanctions via a separate tab linked to the practitioner's entry on the register, starting with the publication of the history of:

- i. cancellation of registration
  - ii. reprimands issued
  - iii. cautions issued
  - iv. Suspensions (except in cases where the final outcome of the notification indicated that there was no case to answer)
- d) Publication of the history of conditions and undertakings relating to the disciplinary history of the practitioner, (except when a condition or undertaking relates to health, when the details of the condition or undertaking would not be published, consistent with current practice).
- The CRG supported a requirement for practitioners to nominate and the register to also publish practitioners' working names, to enable more complete searches.

### **Notifier status**

- The CRG noted that the consultation paper described notifiers as witnesses and suggested that this description could be used more widely by AHPRA in its information to notifiers and consumers. The opportunity to present a victim impact statement could be aligned with this approach, and be useful in assisting Boards and HCEs to assess the seriousness of a matter.
- The CRG supported any improvements to a notifier's access to information about their complaint, and increasing opportunities for notifiers to respond to new information (for example, a health practitioner's response to their complaint).

### **Notifications**

- The CRG supported a seamless notifier/notification movement across complaints organisations so their notification/complaint is dealt with by the right agency in a simple and straightforward way. In effect, this would be a 'no wrong door' policy. The CRG also supported as the introduction of a notifier/complainant having a single case manager who could help them navigate the process and be a single point of contact, when they were part of the AHPRA/ National Boards notification process.
- The CRG supported giving notifiers the option to request that their matter be referred to an HCE after it has been dealt with by a National Board. This would apply regardless of the nature of the Board's decision, along with exchange of the notification history and documentation. This would be facilitated by a memorandum of understanding between AHPRA and the health complaints entities so that changes of leadership personnel did not change established cooperative practice.
- The CRG noted that it was important for notifiers to know the processes and reasons behind receiving a 'no further action' response to their complaint. To convey to the notifiers that 'no further action' does not mean no action was taken.

### **Advertising guidelines**

- The CRG supported the option 2, "amend the National Law provision preventing the use of testimonials to clarify when comment is permissible".

### **National Code of Conduct for unregistered health practitioners**

- The CRG supported a national code of conduct for unregistered health practitioners (in line with the UK model as proposed in the consultation paper)

### **Data collection**

- The CRG was concerned that further fragmentation of the National Scheme – including in relation to notifications management because of the potential for differences in data management – might

reduce the value of data currently held in the National Scheme, about registrations and complaints. This, in turn, might lead to a loss of transparency, cost-effectiveness and accountability.

- The CRG supported any opportunity for the review of the Scheme to strengthen data collection methods across the states and territories and to guard against any unintended consequences of data fragmentation.

#### **Alternative dispute resolution (ADR)**

- The CRG advised that the option for alternative dispute resolution could be included in the memorandum of understanding between AHPRA and the health complaints entities in each state and territory.

#### **Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions?**

- The CRG noted that if this became the preferred model as a result of the review, that community members with experience across Boards – and therefore experience in greater volumes of notification and registration decision-making – might be in a position to add considerable value to Board and committee membership.

#### **Independent reporting on the operation of the National Scheme**

- The CRG supported the reinstatement of the Australian Health Workforce Advisory Council to report on the operation of the National Scheme.

#### **Consumer education**

- The CRG noted that public awareness of the National Scheme is relatively low and that consumers did not have a high awareness of opportunities to raise concerns about health practitioners or health systems. The report following the review of the scheme may provide a valuable opportunity for education to promote consumer awareness, however members believed that AHPRA should further develop and resource its strategy for increased community awareness and engagement.



# **Accreditation within the National Registration and Accreditation Scheme (NRAS) – a paper developed by the Accreditation Liaison Group**

The Accreditation Liaison Group (ALG) is an advisory group comprised of representatives of the National Boards, Accreditation Authorities and the Australian Health Practitioner Regulation Agency (AHPRA).

The ALG initially developed this paper in July 2014 and submitted it as a background paper to the NRAS review team to inform its public consultation processes. The ALG approved this version of the background paper for submission by the Health Professions Accreditation Councils' Forum, the National Boards and AHPRA as an appendix to their responses to the NRAS public consultation in October 2014.

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## Introduction

The National Registration and Accreditation Scheme has established a common statutory framework for accreditation bodies that had previously operated within a diversity of profession-specific models. Since the Scheme commenced, the accreditation functions have been exercised within the statutory context of the National Law and the approach to independent accreditation functions within the National Scheme agreed by Ministers. Within the parameters of this model, much has been achieved by the Accreditation Authorities, National Boards and AHPRA.

The objectives and guiding principles of the National Law are broad and extend from matters specific to education and training, workforce sustainability and access to services. The objectives and guiding principles all apply to any body exercising functions under the National Law, including Accreditation Authorities, National Boards and AHPRA, and provide a shared context for the accreditation functions and work on accreditation issues. The Accreditation Authorities, National Boards and AHPRA collectively have worked to develop a common understanding of the National Scheme and its accreditation function, and to effectively implement the accreditation functions of the Scheme.

AHPRA, the National Boards and Accreditation Authorities have increasingly worked collaboratively to identify opportunities for improvement, aspects of accreditation that need some consistency of approach, such as the *Quality Framework for the Accreditation Function* and reporting and areas within accreditation that lend themselves to cross-professional approaches. Steady progress continues and there is work that is either in the early stages of implementation or that is planned, with the aim of further demonstrating good practice in health profession accreditation.

## Governance

### Model of accreditation

Judgements about the effectiveness of accreditation need to be made in the context of the model Ministers deliberately established.

The model of accreditation in the National Scheme changed as the National Scheme evolved from the 2008 *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the health professions* (the IGA). This is evident from consultation documents on key aspects of the Scheme, Ministerial announcements and the National Law, which embodies the final Scheme agreed by Health Ministers. In particular, the model of independent accreditation functions established by the National Law has important differences from both the recommendations on accreditation in the 2005 Productivity Commission *Report on the health workforce* and the IGA.

In addition to independence, which is discussed separately below, there are other important aspects of the model of accreditation that evolved as the Scheme developed. For example, as the IGA acknowledges, the Productivity Commission recommended that there should be a single national registration board for health professionals, as well as a single national accreditation board for health professional education and training. However, the IGA specifies that there will be boards for each of the professions covered by the scheme and that the boards will be responsible for both the registration and accreditation functions. The IGA goes on to state that "...as a transitional measure, the Ministerial Council ... will assign accreditation functions to existing accreditation bodies, with the requirement that within the first 12 months of the new scheme they meet standards and criteria set by the national agency for the establishment, governance and operation of external accreditation bodies."

Similarly, there was a change from the IGA to the National Law in relation to the ongoing decisions about the bodies to perform accreditation functions. Initially the IGA proposed that following a review of accreditation arrangements, ongoing decisions about whether external bodies should continue to perform accreditation functions would be taken by the Ministerial Council following consultation with the National Boards. However, as announced by Ministers in a communiqué on 27 August 2009 (see <http://www.ahwo.gov.au/natreg.asp>) and reflected in the National Law, ongoing decisions about the bodies to perform accreditation functions are solely a matter for the National Boards.

## Independence

The concept of independent accreditation functions is critical to the model of accreditation in the National Scheme and evolved as the Scheme developed. The IGA explains the concept of independent accreditation as:

“Governance arrangements that provide for community input and promote input from education providers and the professions but provide independence in decision-making”

By the time a consultation paper about accreditation arrangements was issued by the National Registration and Accreditation Implementation Project in late 2008<sup>1</sup> (the accreditation consultation paper), the concept of independence explicitly included independence from government (see statement of principles on p. 6 of the accreditation consultation paper). The accreditation consultation paper referred to the *World Health Organisation/World Federation of Medical Education Guidelines for Accreditation of Basic Medical Education (2005)* statement that “The legal framework must secure the autonomy of the accreditation system and ensure the independence of its quality assessment from government, the medical schools and the profession”.

Ultimately, Health Ministers further modified the model of independent accreditation to remove their role in approving accreditation standards, as reflected in their 8 May 2009 communiqué (see Attachment A). Under the National Law, Ministers do not approve accreditation standards and only have the power to issue a direction to a National Board about a proposed accreditation standard or proposed amendment of an accreditation standard if (a) in the Council's opinion, the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners and (b) the Council has first given consideration to the potential impact of the Council's direction on the quality and safety of health care.

Consistent with this concept of independence, the accreditation consultation paper proposed that accreditation decisions would be reviewable through a process of internal review by the accreditation body followed by an external appeal. Elsewhere the consultation paper implies that the reference to external appeals implies continuation of the appeal arrangements before the National Scheme, in which education providers ultimately had recourse to review through the courts. The Quality Framework has built on this approach, by requiring accreditation authorities to have complaints, review and appeals processes which are rigorous, fair and responsive, and to report to their National Board on the complaints made.

Ministers have clearly expressed the intention that accreditation functions be independent of all stakeholders including government through the IGA, accreditation consultation paper and the National Law. National Boards, Accreditation Authorities and AHPRA have worked to implement the model of independent accreditation functions consistent with Ministers' intentions.

## Accreditation Authorities

There are currently 11 external Accreditation Authorities and three accreditation committees exercising accreditation functions in the Scheme (see [www.ahpra.gov.au/Education/Accreditation-Authorities.aspx](http://www.ahpra.gov.au/Education/Accreditation-Authorities.aspx)). All Accreditation Authorities, whether external authorities or committees, are independent in making accreditation decisions.

Ministers assigned accreditation functions to external Accreditation Authorities for the first ten professions to be regulated under the Scheme, for the first three years of the Scheme. In December 2008, the Ministerial Council appointed Accreditation Authorities for chiropractic, dental care, medicine, optometry, osteopathy, pharmacy, physiotherapy and psychology. In March 2009 an Accreditation Authority was appointed for podiatry and then for nursing and midwifery in 2010.

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<sup>1</sup> see

[www.ahwo.gov.au/documents/National%20Registration%20and%20Accreditation/Consultation%20paper%20on%20Accreditation%20v1.0.pdf](http://www.ahwo.gov.au/documents/National%20Registration%20and%20Accreditation/Consultation%20paper%20on%20Accreditation%20v1.0.pdf)

In contrast, Ministers provided for the National Boards for the 2012 professions to decide whether their accreditation function is to be exercised by an external accreditation entity or a committee established by the National Board. The 2012 professions are relatively small and were not regulated in all jurisdictions before the Scheme commenced (two professions were only regulated in one state or territory prior to the National Law). For two 2012 professions there was not an obvious or well-established body to take on accreditation functions.

The National Law also provided for the review of the accreditation arrangements for the first ten professions after three years.

### **Review of accreditation arrangements**

In 2012, there was a review of the accreditation arrangements for each of the first ten professions to be regulated under the National Law. The process for these reviews was considered jointly by the National Boards, AHPRA and the Accreditation Authorities (initially through the Accreditation Liaison Group) and the agreed process provided for a submission from the Accreditation Authority and wide-ranging consultation by the National Board. In this review process, each Accreditation Authority prepared a detailed submission explaining their roles and functions, and providing evidence of their performance against the domains of the *Quality Framework for the Accreditation Function*. These submissions were available publicly and National Boards consulted widely in making a decision about the review of the accreditation arrangements for their profession.

There was significant additional work undertaken by the Accreditation Authorities to prepare for this assessment at short notice, and the very substantial submissions developed had resource implications for the authorities. The submissions continue to be available publicly and are a useful reference on the work of the authorities.

As a result of these reviews, each National Board determined that its Accreditation Authority was meeting the domains of the Quality Framework for the accreditation function and would continue to exercise accreditation functions, most commonly for a five year period. In some cases, individual National Boards have required the relevant Accreditation Authorities to make changes to better meet the Quality Framework and model of independent accreditation decision-making.

The review processes highlighted how much has been achieved in implementing the accreditation component of the National Registration and Accreditation Scheme and demonstrated that the business of accreditation had transitioned well into the new framework. Prior to 2010, health profession accreditation operated outside a national regulatory framework, and although there was a regulatory framework for several professions there was considerable diversity in their operation. The reviews document how Accreditation Authorities have reviewed their governance structures to strengthen their operations as independent entities consistent with the accreditation model established by the Scheme.

Issues raised in the review by stakeholders such as Health Workforce Australia were identified as areas for further consideration by Accreditation Authorities and National Boards (and articulated in the renewed Agreements), such as:

- opportunities to increase cross-profession collaboration and innovation and address the guiding principle of the National Law that the Scheme is to operate in a transparent, accountable, efficient, effective and fair way, for example, opportunities involving joint projects with other accreditation entities or the Health Professions Accreditation Councils' Forum (the Forum)
- opportunities for each Accreditation Authority to facilitate and support inter-professional learning in its work
- opportunities for each Accreditation Authority to encourage use of alternative learning environments, including simulation, where appropriate.

Individual Accreditation Authorities are reporting separately to their National Boards on their response to these issues.

More information is available in the attached report of the review of accreditation arrangements (see Attachment B) which was submitted to Ministerial Council, through the Australian Health Ministers' Advisory Council and its Health Workforce Principal Committee.

### **Accreditation and the objectives and guiding principles of the National Law**

Accreditation Authorities have worked within the framework, structure and provisions of the National Law to deliver accreditation functions that meet the objectives and guiding principles of the National Law assisted by collaborative work with National Boards and AHPRA.

The objectives and guiding principles in section 3 of the National Law apply equally to all those exercising functions under the National Law i.e. National Boards, Accreditation Authorities and AHPRA. In exercising their functions each must have regard to the objectives and guiding principles.

#### *Objectives directly related to accreditation functions*

Section 42 defines accreditation functions quite broadly. The objectives relating to facilitating the provision of high quality education and training of health practitioners (s3(2)(c)) and facilitating the rigorous and responsive assessment of overseas qualified practitioners (s3(2)(d)) relate directly to accreditation functions. Accreditation standards and accreditation of programs of study against those standards are fundamental determinants of the quality of the education and training of health practitioners. Accreditation Authorities develop processes to assess overseas qualified practitioners and undertake those processes, and therefore control the responsiveness and rigorousness of those assessments.

#### *Other objectives*

Parts of section 3 dealing with protection of the public, workforce mobility, public access to services, the development of the workforce and innovation in the education of, and service delivery by, health practitioners are also relevant to accreditation functions, as described below.

#### *Protection of the public*

The quality of the assessment of overseas qualified practitioners, accreditation standards and accreditation of programs of study determines whether practitioners who complete programs of study or are assessed as qualified for registration have the knowledge, skills and professional attributes to practise their professions and is critical to protecting the public.

#### *Facilitate workforce mobility*

The establishment of the National Scheme has facilitated workforce mobility, including by establishing national accreditation standards and processes where in some cases they did not previously exist.

#### *Facilitate access to services in the public interest*

If the registration standards, codes and guidelines developed by national boards are unnecessarily onerous or restrictive, this could impact on access to services. Similarly, if the assessment process for overseas practitioners is unnecessarily onerous or unduly restrictive, it could impact on the number of overseas qualified practitioners from professions in shortage who are able to enter Australia to provide services. If accreditation standards are unnecessarily onerous, institutions may decide not to offer courses, impacting on the supply of practitioners and ultimately on access to services.

#### *Continuous development of a flexible, responsive and sustainable workforce*

Registration standards, codes and guidelines as well as accreditation standards, the quality of accreditation of programs of study and assessment of overseas qualified practitioners may all influence the attainment of this objective.

## Other bodies involved in accreditation

### *The Health Professions Accreditation Councils' Forum*

The Health Professions Accreditation Councils' Forum (the Forum) is the coalition of the accreditation councils of the external Accreditation Authorities for the professions regulated under the National Law. The Forum has been meeting regularly since 2007, prior to the commencement of the Scheme, to consider matters of common interest, principally matters concerning the accreditation of education and training programs in the health professions and advocating for good accreditation practices. The Forum has worked to ensure that the requirements of best practice in accreditation and the independence of the accreditation bodies is reflected in the National Law and in the implementation of the Law, and engages with AHPRA and the National Boards in relation to the operation of the Scheme, particularly in the area of accreditation, education and training.

### *Forum of National Board Chairs*

The Forum of National Board Chairs (the Chairs Forum) supports the national boards and AHPRA to achieve good regulatory performance and decision-making by bringing cross-professional leadership and focus to the administration and strategic development of the National Scheme. The Chairs Forum comprises all National Board Chairs, the Chair of AHPRA's Agency Management Committee and AHPRA's National Executive. It has a number of committees, including the Accreditation Liaison Group.

### *Chairs of Accreditation Committees*

The Chairs of Accreditation Committees also meet regularly to share their experience and learnings from exercising accreditation functions through Committees and to facilitate collaboration.

### *Accreditation Liaison Group*

The National Boards, Accreditation Authorities and AHPRA have established an Accreditation Liaison Group (ALG) to facilitate effective delivery of accreditation within the National Scheme. The ALG is a committee of the Forum of National Board Chairs and provides an important mechanism to consider shared issues in accreditation across National Boards, Accreditation Authorities (nominated through the Forum) and AHPRA. It is an advisory group which has developed a number of reference documents to promote consistency and good practice in accreditation while taking into account the variation across entities. These documents have been approved by National Boards and Accreditation Authorities. Examples include the *Quality Framework for the Accreditation Function*.

## Accountability

Under the model of accreditation functions established by the National Law, National Boards are ultimately accountable for overseeing accreditation functions through their decisions about the body which will perform accreditation functions. In turn, National Boards are accountable to the Australian Health Workforce Ministerial Council. Accreditation Authorities are accountable for the performance of accreditation functions and their decisions may be subject to appeal through the courts. AHPRA has a role in relation to the agreements with external bodies for accreditation functions, content in the Health Professions Agreements in relation to accreditation committees and the establishment of procedures, such as the *Procedures for the development of accreditation standards*.

## Functions and infrastructure

### Overview of accreditation functions under the National Law

Accreditation is the second of the two branches of the National Registration and Accreditation Scheme. The National Law defines accreditation functions as:

- develop accreditation standards and recommend them to the relevant National Board for approval
- accredit and monitor education providers and programs of study to ensure that graduates are provided with the knowledge, skills and professional attributes to safely practise the profession in Australia.



- provide advice to National Boards about issues relating to their accreditation functions
- assess overseas qualified practitioners
- assess overseas accrediting authorities.

Attachment C sets out the accreditation functions exercised by each Accreditation Authority.

Accreditation is an important quality assurance and quality improvement mechanism for health practitioner education and training. It is also the key quality assurance mechanism to ensure that graduates completing approved programs of study have the knowledge, skills and professional attributes to practise the relevant profession in Australia. Accreditation standards and accreditation of programs of study against those standards are fundamental determinants of the quality of the education and training of health practitioners; and by international benchmarking Accreditation Authorities ensure best practice in accreditation standards. Accreditation Authorities develop and undertake processes to assess overseas qualified practitioners, and therefore are responsible for the responsiveness and rigorosity of those assessments.

Accreditation Authorities and National Boards have separate, but complementary, functions under the National Law. For example, as discussed below, the National Law provides that:

- the Accreditation Authority develops the accreditation standards which are then approved by the National Board
- the Accreditation Authority accredits a program of study and the relevant National Board approves the accredited program of study for the purposes of registration.

#### *Development of accreditation standards*

Accreditation standards are used to assess whether a program of study, and the education provider that provides the program of study, provides graduates of the program with the knowledge, skills and professional attributes to practise the profession. Each Accreditation Authority publishes on its website the approved accreditation standards for the profession and information about any reviews of the standards and opportunities for stakeholder input to those reviews.

Accreditation Authorities are required to develop accreditation standards for the education and training for the profession through a wide-ranging consultation process and taking into account the requirements of the *Procedures for the Development of Accreditation Standards* (the Procedures) (see [www.ahpra.gov.au/Publications/Procedures.aspx](http://www.ahpra.gov.au/Publications/Procedures.aspx)). The Procedures also apply to amendments to an accreditation standard. The Procedures are currently being updated to include engaging with the Office of Best Practice Regulation about regulatory impacts, and this step is occurring in anticipation of the revised Procedures. Proposed accreditation standards are submitted by the Accreditation Authority to the National Board for approval.

The National Board must decide whether or not it approves the proposed accreditation standards submitted by the Accreditation Authority.

#### *Assessment and accreditation of education programs and providers*

The Accreditation Authority:

1. assesses education and training programs of study, and the education providers that provide the programs of study, against the approved accreditation standards to determine whether the programs meet the approved accreditation standards, and
2. advises the National Board of its accreditation decision – i.e. whether program of study, and the education provider that provides the program of study, meet an approved accreditation standard for the profession; or the program of study and provider substantially meet an approved accreditation standard for the profession and the imposition of conditions on the approval will ensure the program meets the standard within a reasonable time.

### *Approval of the accredited programs of study for registration purposes*

When a program of study has been accredited, the relevant National Board considers whether it will approve, or refuse to approve, the accredited program of study for the purposes of registration. Only graduates of approved programs are qualified for registration under s. 53(a) of the National Law. A searchable list of approved programs of study is available on this website.

### *Monitoring of accredited programs and education providers*

The National Law requires Accreditation Authorities to monitor accredited programs and education providers to ensure that the authority continues to be satisfied that the program and provider meet an approved accreditation standard for the profession. Although Accreditation Authorities already had monitoring processes in place before the National Scheme commenced, the introduction of statutory requirements for monitoring strengthen consistency and improve its effectiveness as a quality assurance mechanism to ensure that graduates of approved programs of study have the knowledge, skills and professional attributes to practise the relevant profession.

Effective approaches to monitoring involve substantial work for Accreditation Authorities and education providers. Regulation of monitoring is changing the dynamic of accreditation and has brought much more of a focus on ongoing review against the standards. Accreditation Authorities are now providing more thorough reporting on their monitoring work.

### *Assessment of overseas qualified practitioners*

Ten Accreditation Authorities (see Attachment C) assess overseas qualified practitioners, with varying approaches and requirements which typically include a desktop qualifications assessment and clinical examination, but also often involve a written examination, and may involve a portfolio assessment or requirement for orientation to Australian practice.

### *Assessment of overseas assessing authorities*

Nine Accreditation Authorities (see Attachment C) assess overseas assessing authorities, and have established competent authority pathways, which provide streamlined assessment processes for certain cohorts of overseas qualified practitioners. The competent authority pathways are necessarily specific to the particular characteristics of the relevant professions and assessing authorities.

## **Funding accreditation**

Each of the Accreditation Authorities that existed prior to the Scheme had a different model of funding their accreditation activities although there were some common features. These models included contributions from the relevant state and territory registration boards on whose behalf the authorities carried out accreditation activities – albeit generally without a statutory basis. It is clear from the IGA and consultation documents from the development of the Scheme that the Scheme would be self-funding from registration and accreditation fees. The IGA states (at para 12.6): *Where appropriate, registration fees will continue to contribute to the accreditation function and transitional arrangements will apply as necessary.*

The guiding principles of the National Law require the Scheme to operate in a transparent, accountable, efficient, effective and fair way, and fees paid under the Scheme (including Accreditation Authorities' fees to education providers) must be reasonable having regard to the efficient and effective operation of the Scheme. The *Quality Framework for the Accreditation Function* requires that, in setting its fee structures, each Accreditation Authority balances the requirements of the principles of the National Law and efficient business processes.

Proportionally, accreditation is a modest cost to the National Scheme. For most National Boards a small percentage of their income is distributed to Accreditation Authorities to carry out their required functions under the National Law.

Under current arrangements, each Accreditation Authority derives all or part of its revenue from:

- fees paid by education providers for program assessment and accreditation, and
- a contribution from the relevant National Board.

Some Accreditation Authorities also receive fees for service activities in relation to assessing overseas qualified practitioners.

Each Accreditation Authority sets the fees paid by education providers in accordance with their respective business model and in consultation with the provider. The fees contribute towards (but do not cover) the cost of accreditation being: initial and re-accreditation of a program; monitoring to ensure continued compliance with Standards; and, other activities arising from the accreditation function such as advice to the provider.

The Accreditation Authorities submit their requests for a contribution by the relevant National Board as part of the Boards' annual budgeting processes. AHPRA, as agreed with the relevant National Board, may approve an adjusted funding amount each year having regard to the activity to be undertaken by the Accreditation Authority, and in consultation with the Accreditation Authority and agreement wherever possible. Where the accreditation function is exercised by an external entity, this amount is included as part of the profession's *Agreement for the Accreditation Function* between AHPRA and the Accreditation Authority. Where the accreditation function is exercised by a committee established by the Board, the amount is reflected in the Board's budget as a net cost of accreditation.

The costs of accreditation vary between professions and reflect the variable complexity of professions, education providers and programs of study across the 14 professions within the Scheme. For example, the length of programs varies, the number of divisions of the National Boards' registers vary, the providers themselves range from small private registered training organisations to large public and private universities, and the education and training pathways differ in terms of their complexity and any relevant international benchmarks.

### **Mechanisms to support accreditation functions**

A number of mechanisms have been established to support the statutory framework and facilitate accreditation functions meeting the objectives and guiding principles of the National Law. These include:

- agreements for the accreditation functions between AHPRA, in consultation with the relevant National Board, and each external Accreditation Authority
- *AHPRA Procedures for the development of accreditation standards*
- the work of the Accreditation Liaison Group on key shared accreditation issues
- annual meetings between representatives of all National Boards, Accreditation Authorities and AHPRA to discuss common accreditation issues
- terms of reference for each Accreditation Committee.

### **Agreements for the accreditation functions**

The agreements for the accreditation functions between AHPRA, on behalf of the relevant National Board, and each external Accreditation Authority is the formal document which describes the details of the accreditation functions, reporting, funding and work program for the Accreditation Authority. The agreement and/or work program is a mechanism to highlight priority issues for Accreditation Authorities to consider in their work.

### **Terms of reference for accreditation committees**

The terms of reference for each accreditation committee set out the functions, reporting, process to identify annual funding and work program for the Accreditation Authority. While the National Board establishes an accreditation committee and sets its terms of reference, the committee's statutory decision-making functions are conferred directly by the National Law and are not delegated by the National Board.

The terms of reference for each accreditation committee are published on the relevant National Board's website.

### **AHPRA Procedures for the development of accreditation standards**

AHPRA's *Procedures for the development of accreditation standards* (the procedures) are an important mechanism for articulating a common process for the development and approval of accreditation standards, and the interrelationships between the National Registration and Accreditation Scheme entities on this function. The procedures were developed with input from the Australian Health Professions Councils' Forum and others. They inform National Boards, Accreditation Authorities and AHPRA about the matters:

- that an Accreditation Authority should take into account in developing accreditation standards or changing accreditation standards
- which an Accreditation Authority should explicitly address when submitting accreditation standards to a National Board for approval
- that a National Board should consider when deciding whether to approve accreditation standards developed by the Accreditation Authority, and
- which National Boards should raise with Ministerial Council as they may trigger a Ministerial Council policy direction and the timing for this to occur.

## **Change and achievements**

Before 1 July 2010, health profession accreditation functions were largely conducted outside a statutory framework. Accreditation Authorities reflected considerable diversity, which has continued under the Scheme, however all the Accreditation Authorities are now operating within the framework of the National Law. Many Accreditation Authorities have been undertaking accreditation of programs and assessment of overseas qualified practitioners for many years. While many of the established accreditation policies and procedures continue, Accreditation Authorities have evolved and adapted to the requirements of the Scheme. Achievements include: stronger governance and operating structures including the contribution of a wide range of stakeholders; reporting directly against the accreditation standards; and the ongoing monitoring of education providers.

Differences between the Accreditation Authorities include the following:

- some Accreditation Authorities have been operating as independent national bodies for many years while some operated on a state and territory basis and became national bodies only after the Scheme commenced, others have been in place for only around 18 months
- some Accreditation Authorities accredit large numbers of programs (over 400) while others accredit very small numbers (eg less than ten)
- some Accreditation Authorities operate in Australia only while others are joint Australia/New Zealand bodies and some operate in other countries, for example, where an Australian education provider delivers part or all of an approved program of study in another country,
- eleven Accreditation Authorities are independent external organisations while three are committees established by National Boards
- some authorities exercise functions for professions with complex structures, including multiple divisions of the register, specialties, endorsements, examinations systems and compulsory vocational pathways, while others exercise functions for professions with less complex regulation
- ten Accreditation Authorities assess overseas qualified practitioners, with varying approaches and requirements
- nine Accreditation Authorities assess overseas assessing authorities

### **Change since the National Scheme**

Accreditation Authorities (and the relevant National Boards) have made very significant organisational and operational adjustments to effectively deliver accreditation functions within the new statutory framework. The relationships between Accreditation Authorities, and the National Boards and AHPRA have developed and matured since 1 July 2010. Each of the National Boards and their Accreditation Authorities have agreed to the process for reporting of accreditation decisions and have further enhanced this communication by developing their own arrangements for engagement within the framework of the National Law and the shared understanding built between National Boards, Accreditation Authorities and AHPRA. These relationships have also been supported by the Forum, which now includes discussions

with all the Accreditation Authorities as well as discussions amongst the external authorities only, the Accreditation Liaison Group and meetings of the Chairs of the three accreditation committees.

### **Achievements against the objectives and guiding principles of the National Law**

The uninterrupted delivery of accreditation functions through the transition to the National Scheme is a significant achievement. The Accreditation Authorities in particular, with National Boards and AHPRA, worked to support a seamless transition from the diverse range of accreditation approaches pre-1 July 2010, to the delivery of accreditation functions by independent Accreditation Authorities within a single statutory framework.

The importance of including accreditation as a fundamental part of the Scheme cannot be underestimated. The change flowing from applying the objectives and guiding principles of the National Law to accreditation is profound, and has important and far-reaching implications for the delivery of accreditation functions. Similar to other areas of the Scheme, perceptions of the extent of this change vary and may not always reflect the significant shift that has occurred.

#### *Comments on specific objectives*

The effective delivery of accreditation functions directly achieves objective (c) facilitating the high quality education and training of health practitioners and (d) the rigorous and responsive assessment of overseas-trained health practitioners. Individual Accreditation Authorities will provide examples of their achievements in these areas. However, since the Scheme commenced, accreditation has made an important contribution to objective (f) enabling the continuous development of a flexible, responsible and sustainable Australian health workforce and innovation in the education of, and service delivery by, practitioners.

For example, the accreditation standards for all professions contribute to the objectives and guiding principles particularly objective (f), by:

- not precluding the use of interdisciplinary supervision models for student clinical placements. The focus of standards is more that the supervisor has the required competencies, skills, knowledge, authority, time and resources to provide the supervision appropriate to the learning outcomes the student is to achieve. In some professions supervision by health professionals from alternative disciplines is an established practice.
- allowing the use of simulated learning (SLE). The role of simulation as a learning method is recognised; its use should be supported by evidence for achieving the learning outcomes the student is to achieve. For several Accreditation Authorities it is particularly recognised that SLE could be used to enhance, support and in certain circumstances replace some direct clinical involvement.

The outcomes focus of accreditation standards generally facilitates innovation by education providers.

Including accreditation in the National Scheme made a significant contribution to the objective of facilitating workforce mobility. The availability of national accreditation standards, and nationally accredited and approved programs of study are fundamental elements to support workforce mobility across Australia which were not always in place before the National Scheme commenced.

#### *Other key achievements*

Other key achievements include:

- developing a Quality Framework as the primary measure of quality accreditation functions under the National Law
- documenting an agreed understanding of the shared responsibilities in the accreditation function under the *National Law*, promoting efficiency and effectiveness
- developing a *Framework for Accreditation Authorities and National Boards on Communicating Accreditation and Program Approval Decisions and Requests for Changes to Accreditation Standards* and other reference documents which reflect the objectives and guiding principles of

the National Law and promote a consistent framework for the performance of accreditation functions

- developing an agreed process for the consultation and review of the assignment of the accreditation functions
- work to develop a *Guideline on the management of complaints relating to accreditation functions under the National Law*
- availability of additional data – including significant work to provide information for inclusion in the searchable register of approved programs of study on each National Board and AHPRA's website, promoting transparency.

Other matters that have been the subject of joint work include:

- the agreements between AHPRA, for the National Boards, and the external Accreditation Authorities
- the issues related to accreditation of new programs of study
- AHPRA's *Policy for approved programs of study*
- the Forum regularly discusses good practice in accreditation and has shared approaches such as procedural guides contributing to commonality across authorities. Some Forum members have also provided assistance to the accreditation committees and their support unit
- the Forum has delivered multi-profession workshops for accreditation assessors, and the Forum Chair contributed to assessor training for accreditation committees
- some Accreditation Authorities have undertaken joint work on the development of accreditation standards
- jointly considering the principles for the development of accreditation standards and processes for prescribing
- the three accreditation committees have largely common processes.

Key achievements are discussed in more detail below.

### **The Quality Framework for the Accreditation Function**

The Accreditation Authorities, National Boards and AHPRA have agreed to a *Quality Framework for the Accreditation Function* to support quality assurance and continuous quality improvement of accreditation under the National Law.

The framework identifies eight domains of good practice:

1. Governance
2. Independence
3. Operational management
4. Accreditation standards
5. Processes for accreditation of programs and providers
6. Assessing authorities in other countries
7. Assessing overseas qualified practitioners
8. Stakeholder collaboration.

The Quality Framework is the principal reference document for National Boards and AHPRA to assess the work of Accreditation Authorities. Accreditation Authorities provide six-monthly reports to their National Boards on developments relevant to the domains of the Quality Framework. The Quality Framework was also used in 2012, when the performance of the Accreditation Authorities of the first ten professions to be regulated under the National Law was assessed during the review of accreditation arrangements.



The Quality Framework is an important document in promoting consideration of the objectives and guiding principles of the National Law. It emphasises that the National Law requires those exercising functions under the National Law to do so having regard to the objectives and guiding principles. In addition, the Quality Framework itself promotes effectiveness and efficiency in accreditation functions.

The Quality Framework will be reviewed at least every three years. The Accreditation Liaison Group has begun work on its first review, and is planning consultation with key stakeholders such as government.

### **Routine reporting on accreditation functions against the Quality Framework**

The agreement between AHPRA, in consultation with the relevant National Board, and external Accreditation Authority for the accreditation functions specifies the reporting requirements for the authority. The reporting requirements for accreditation committees mirror these requirements with minor modifications to take into account that an accreditation committee is not a separate legal entity (eg its financial accounting is part of the National Board/AHPRA's accounts).

Accreditation Authorities report against the domains of the Quality Framework for the Accreditation Function. The Accreditation Liaison Group has developed a *Sample guide for a report by an Accreditation Authority* with input from National Boards and Accreditation Authorities. The Sample guide indicates that an Accreditation Authority will provide two reports per year:

1. a retrospective report, which includes:
  - a copy of the annual report prepared on behalf of the authority's governing body for the previous period including the publicly available financial statements
  - a detailed financial report on revenue and expenditure relevant to the accreditation function and any other projects or work funded by the relevant National Board through AHPRA
  - a report, as outlined in the sample guide, against domains in the Quality Framework
  - a half yearly update on activity against the work program; and
2. a prospective report, with a draft work plan and budget for the next financial year.

Since the Scheme commenced, the quality, consistency and comprehensiveness of reporting has continued to develop. Accreditation Authorities also report to National Boards each time they make an accreditation decision and when they review, or develop new, accreditation standards.

Reporting against the Quality Framework is an important accountability mechanism and contributes to the guiding principles of efficiency and effectiveness.

### **Processes streamlined**

#### *Communication framework for accreditation decisions*

The Accreditation Liaison Group has developed a *Framework for Accreditation Authorities and National Boards on Communicating Accreditation and Program Approval Decisions and Requests for Changes to Accreditation Standards* (the Framework).

The National Law requires communication between the Accreditation Authorities and the National Board when certain decisions are made or required. The Framework provides guidance on what Accreditation Authorities should report to National Boards to enable the Boards to discharge their separate roles and how National Boards and Accreditation Authorities can work collaboratively to facilitate good decision-making.

The Framework provides a set of guiding principles for Accreditation Authorities and National Boards on (i) matters to address in reporting an accreditation decision; and (ii) reporting on new or revised accreditation standards. It facilitates consistent approaches that promote good decision making and the objectives and guiding principles of the National Law. It is expected to be published on the AHPRA and Health Professions Accreditation Councils' Forum websites shortly.



The Framework contributes to the effectiveness and efficiency of accreditation functions and the respective decision-making roles of National Boards and Accreditation Authorities.

### *Complaints*

The Accreditation Liaison Group is developing a template complaints protocol, as a resource for all Accreditation Authorities and National Boards. The template protocol aims to clarify the respective roles, responsibilities and processes of Accreditation Authorities, National Boards and AHPRA in the management of complaints about matters relevant to accreditation functions. It aims also to describe good practice in managing complaints relating to accredited programs and providers of those programs. The guidance document is expected to be completed shortly and will be published as a reference document. It will contribute to the guiding principle of fairness, and as with all resource documents will promote efficiency and effectiveness and avoid duplication.

### **Publicly available information**

A feature of the National Law is the requirement for published information about accreditation functions. The establishment of the Quality Framework has also facilitated the development of consistent reporting requirements. In addition, there are now published reference documents which document and expand upon some of the obligations of all Accreditation Authorities within the statutory framework of the Scheme such as the Quality Framework and wide-ranging public consultation on the accreditation standards. This contributes to the guiding principle of transparency.

The AHPRA website publishes a list of Accreditation Authorities and which functions they exercise under the National Law (<http://www.ahpra.gov.au/Education/Accreditation-Authorities.aspx> ).

The National Law provides that each Accreditation Authority must publish how it exercises the accreditation function. Each Accreditation Authority publishes information online about its functions (see Attachment C for links).

National Boards must publish the accreditation standards they approve. National Boards do this by publishing the standards on their websites or publishing via a link to where the approved standards are published by the relevant Accreditation Authority.

National Boards, Accreditation Authorities and AHPRA have also developed a reference document *Accreditation under the National Law*, which is published on the AHPRA website (<http://www.ahpra.gov.au/Publications/Accreditation-publications.aspx>). The Quality Framework and information about the reviews of accreditation arrangements are also published on the AHPRA website. As further reference documents describing agreed good practice approaches are developed, they are progressively published to build more transparency over time.

### **Joint meetings**

Joint meetings are held annually between representatives of all National Boards, Accreditation Authorities and AHPRA on an annual basis. These meetings provide a formal mechanism to discuss common accreditation issues. They aim to facilitate shared understandings of accreditation under the National Law to address the objectives and guiding principles of the National Scheme. For example, previous joint meetings have focussed on routine reporting requirements, reporting on accredited programs of study and the potential for cross-profession approaches in accreditation. This work has contributed to the efficiency and effectiveness of accreditation arrangements.

## **Future opportunities**

### **Collaboration and multi-profession approaches**

Opportunities for collaboration in accreditation continue to be actively explored by the Health Professions Accreditation Councils Forum, individual Accreditation Authorities and Committees and the Accreditation Liaison Group.

For example, the ALG workplan for 2014 includes:

- Support for interprofessional education, and consideration of the scope for a cross -profession workshop on interprofessional education
- 2014 Joint Meeting, to consider facilitation and achievements in relation to simulation, interprofessional education and collaboration that can be presented to the NRAS review
- Review of Quality Framework and Sample Reporting Guide

There is scope to continue to build collaboration between Accreditation Authorities within the framework of the National Law. Accreditation functions are currently delivered through separate profession-specific structures. External Accreditation Authorities are separate organisations, although in two cases their Secretariat and administrative services are delivered by the same service company. Accreditation Committees are also profession-specific and are supported by AHPRA. However, these arrangements are not the only possibilities within the existing framework of the National Law, which allows for greater collaboration and shared administrative arrangements if appropriate. For example, the National Law is not an impediment to two or more Accreditation Authorities agreeing to combine their administrative functions. However, the criteria when this would be appropriate would need to be articulated and sustainability, efficiency and effectiveness would be important considerations.

The implications of these opportunities, identifying exemplars of good practice, whether there is potential to build greater collaboration or consistency or whether diverse approaches are more appropriate are issues for further consideration by the Accreditation Authorities, and other bodies in the National Scheme.

## **Conclusion**

Accreditation Authorities in particular, with National Boards and AHPRA, have worked hard to develop a shared understanding of the model for accreditation established by the National Law and to effectively deliver the accreditation functions under the Law. Accreditation Authorities, National boards and AHPRA have proactively established liaison mechanisms to facilitate joint understanding, share good practice and build common resources where appropriate. This work continues to progress steadily and contributes to the critical work of individual Accreditation Authorities to ensure that graduates of accredited and approved programs of study have the knowledge, skills and professional attributes to practise their profession and overseas qualified practitioners are subject to rigorous and responsive assessment.

Attachment A: Australian Health Workforce Ministerial Council 8 May 2009 communiqué

Attachment B: Report to the Ministerial Council on review of accreditation arrangements

Attachment C: Overview of accreditation functions by profession

Attachment D: Desktop self-assessment against the Professional Standards Authority Evidence Framework: Standards of Good Regulation

Attachment E: Examples of recently modified template letters to notifiers

Attachment F: Australia and United Kingdom performance comparator (timeliness)

Attachment G: Osteopathy Board of Australia submission to the review of the National Registration and Accreditation Scheme (October 2014)

Attachment H: Accountability Framework



## Australian Health Workforce Ministerial Council

### **Communiqué**

**8 May 2009**

#### **DESIGN OF NEW NATIONAL REGISTRATION AND ACCREDITATION SCHEME**

The Ministerial Council has today reached a national consensus on how the new National Registration and Accreditation Scheme for the Health Professions will work. This will deliver improvements to the safety and quality of Australia's health services through a modernised national regulatory system for health practitioners.

The Ministerial Council acknowledged and welcomed the very high level of participation by consumers, practitioners and regulatory bodies in the consultation process to date. Over 1,000 people have attended forums around the country and over 650 written submissions have been received in response to the consultation papers issued in 2008 and 2009.

As a result of the consultation process and the feedback received, the Ministerial Council has determined that a number of changes should be made to the original proposals put forward, in particular in the areas of accreditation, the role of state bodies and complaints handling. The following sections outline the main matters on which Ministers have made decisions today.

#### **Independent accreditation functions**

The Ministerial Council agreed today that the accreditation function will be independent of governments. Accreditation standards will be developed by the independent accrediting body or the accreditation committee of the board where an external body has not been assigned the function.

The accrediting body or committee will recommend to the board, in a transparent manner, the courses and training programs it has accredited and that it considers to have met the requirements for registration. The final decision on whether the accreditation standards, courses and training programs are approved for the purposes of registration is the responsibility of the national board. The accrediting body will have the ability to make its recommendations publicly available in the circumstance that agreement between the accrediting body and the national board cannot be achieved.

The Ministerial Council will have powers to act, for instance, where it believes that changes to an accreditation standard, including changes to clinical placement hours or workplace and work practice, would have a significantly negative effect.

National accreditation standards which exist prior to the commencement of the new scheme are to continue until they are replaced by new standards.

Existing external accrediting bodies such as the Australian Medical Council and the Australian Pharmacy Council are expected to continue. The specific governance arrangements for these bodies will be a matter for them, although they will be expected to meet modern governance standards.

### **Changes to registers**

Ministers today agreed there will be both general and specialist registers available for the professions, including medicine and dentistry, where ministers agree that there is to be specialist registration. Practitioners can be on one or both of these registers, depending on whether their specialist qualification has been recognised under the national scheme. Ministers agreed specialist registers will not cover practitioners registered to practice in an area of need.

Ministers have also decided that there will now be separate registers for nurses and for midwives.

### **Support for continuing professional development**

The Ministerial Council has agreed that there will be a requirement that, for annual renewal of registration, a registrant must demonstrate that they have participated in a continuing professional development program as approved by their national board.

Each profession's requirements will be set by the relevant board. A board may use its accrediting body to set standards for such programs and approve providers of such programs (including, in the case of medicine, specialist medical colleges) where that is the best arrangement for that profession.

### **Extension of scheme to other professions**

The Ministerial Council also decided that, from 1 July 2012, Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners and medical radiation practitioners will be regulated under the scheme. These are in addition to the ten professions already agreed for inclusion in the national scheme from 1 July 2010 (chiropractors; dental (including dentists, dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists and psychologists).

### **Other improvements to quality and safety of health services**

The Ministerial Council also agreed a number of other changes to registration arrangements in order to improve the quality and safety of health services being delivered to the public. These are set out below.

#### **Mandatory reporting of registrants**

The Ministerial Council agreed on 5 March 2009 that there will be a requirement that practitioners and employers (such as hospitals) report a registrant who is placing the public at risk of harm.

Ministers agreed that reportable conduct will include conduct that places the public at substantial risk of harm either through a physical or mental impairment affecting practice or a departure from accepted professional standards. Practitioners who are practising while under the influence of drugs or alcohol, or have engaged in sexual misconduct during practice must also be reported.

This requirement will deliver a greater level of protection to the Australian public.

#### *Criminal history and identity checks*

National agreement was reached on 5 March 2009 on criminal history and identity checks to apply to registered health professionals.

Mandatory criminal history and identity checks will apply to all health professionals registering for the first time in Australia. All other registrants will be required to make an annual declaration on criminal history matters when they renew their registration and these declarations will be audited on a random basis by an independent source.

Ministers also agreed that national boards will have the power to conduct ad hoc criminal history and identity checks on registrants.

#### *Simplified complaints arrangements for the public*

Assistance will be provided to members of the public who need help to make a complaint. Ministers agreed that this new arrangement will not affect the services provided by health complaints commissions across the country. However it will help make the complaints process simpler for members of the public.

#### *Student registration*

The Ministerial Council agreed that national boards will be required to register students in the health professions. Boards will decide at what point during their programs of study students will be registered, depending on the level of risk to the public.

Ministers agreed the national scheme will enable national boards to act on student impairment matters or where there is a conviction of a serious nature which may impact on public safety. This requirement will come into effect at the beginning of 2011.

Students will be registered by a deeming process based on lists of students supplied to boards by education providers

#### *Handling of complaints*

Given the diversity of arrangements in Australia at this time, Ministers have agreed to a flexible model for the administrative arrangements for handling complaints.

The National Law and/or State or Territory law, depending on each jurisdiction's choice, will provide the legislative framework for investigations and prosecutions and the definitions of offences and contraventions and outcomes will be recorded as part of a single national framework.

Where the national legislative framework is adopted, it will also be up to each State and Territory to decide whether the prosecution and investigation functions remain with the national boards or be undertaken by an existing State or Territory health complaints arrangement.

The Ministerial Council also agreed a number of other elements related to the effective functioning of the new scheme.

### **Appointments to national boards**

Ministers confirmed the arrangements set out in the *Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008* (the Act), that boards will be appointed by the Ministerial Council with vacancies to be advertised. At least half, but not more than two thirds, of the members must be practitioners and at least two must be persons appointed as community members.

Adding to the Act, Ministers have also agreed that the National Law will require all national boards to contain at least one practitioner member from each of the larger jurisdictions (Queensland, New South Wales, Victoria, South Australia and Western Australia) and at least one other practitioner member drawn from the three smaller States and Territories (Tasmania, the Australian Capital Territory or the Northern Territory). Members of existing boards and State and Territory boards under the national scheme (see below) will be eligible for appointment to national boards. Members of the Agency Management Committee may not hold an appointment to a national board.

Ministers have also agreed that each national board will have at least one member from a rural or regional area.

### **State and Territory boards (previously “State and Territory committees”)**

Ministers agreed that the main committee of a national board in each State or Territory where a committee is appointed will be known as a State or Territory board, for example the South Australian Board of the Pharmacy Board of Australia. Each national board will need to determine where State or Territory boards will be appointed, taking into account the need to provide efficient processes in each profession.

The role of these State and Territory boards will be to oversee registration and complaints processes in that State or Territory where these functions are delegated to them by the national board. State and Territory boards will perform these functions under the national legislation for the scheme. Appointments to State boards will be made by State Ministers following an open and transparent process.

Ministers also agreed that from 1 July 2010 (and subject to the decision of a national board that there will be a State or Territory board of that national board located in a jurisdiction), members of the existing board in that jurisdiction will comprise that State or Territory board for the balance of the terms of their appointment.

### **New national regulation of cosmetic lenses**

To protect the public from injuries arising from the misuse of cosmetic contact lenses, the Ministerial Council has agreed that the prescribing of cosmetic lenses will be restricted to optometrists and medical practitioners. These are the same restrictions that will apply to the supply of other contact lenses under the new scheme.



## **Area of need arrangements**

The Ministerial Council agreed that national boards will be required to consider applications for registration from practitioners seeking to work in a location or position that has been declared by the relevant State or Territory Minister as an area of need. Boards will determine whether the practitioner is eligible for registration and, if registration is granted, what conditions will apply.

## **Privacy protections for practitioners and consumers**

Ministers agreed to build on the Commonwealth's leadership and adopt under the national scheme the Commonwealth National Privacy Principles and privacy regime (or its successor). This will provide practitioners and consumers with the protection needed in relation to information collected by the national boards and the national agency.

## **Location of national office**

Ministers agreed that the national office of the new Australian Health Practitioner Regulation Agency will be located in Melbourne.

## **Next steps**

Ministers agreed that these decisions should be included in the exposure draft of the *Health Practitioner Regulation National Law Bill 2009*, which will provide the legal framework for the national scheme. The exposure draft of the legislation will be released by the Ministerial Council later in 2009 for a further round of public consultations.

When comments have been received on the exposure draft, the Ministerial Council will determine the final form the legislation should take.

Melbourne  
8 May 2009



Aboriginal and Torres Strait Islander Health Practice	Occupational Therapy
Chinese Medicine	Optometry
Chiropractic	Osteopathy
Dental	Pharmacy
Medical	Physiotherapy
Medical Radiation Practice	Podiatry
Nursing and Midwifery	Psychology

Australian Health Practitioner Regulation Agency

## Reviews of accreditation arrangements

### 1. Introduction

This report describes and evaluates the reviews of accreditation arrangements for the first ten professions to be regulated under the Health Practitioner Regulation National Law Act as in force in each state and territory (the National Law).

#### Context

Section 253 of the National Law requires National Boards to review the arrangements for the exercise of the accreditation functions no later than 30 June 2013. These arrangements were generally established before the commencement of the National Law and involve the appointment of an external Accreditation Authority for each of the first ten professions to join the National Registration and Accreditation Scheme (the Scheme). When Health Ministers appointed the first of the Accreditation Authorities, they indicated that the assignment of accreditation functions would be 'subject to the requirement to meet standards and criteria set by the national agency for the establishment, governance and operation of external accreditation bodies'.

Boards and Authorities collectively have worked to develop a common understanding of the Scheme and how it operates. The relationships between boards, authorities and AHPRA have evolved and matured during the period of assignment. Each of the profession-specific Boards and Authorities have developed their own arrangements for communication, including meetings, reporting etc. Within the common framework and shared understanding agreed by all Boards and Authorities, they have also each developed specific reporting and operating processes that reflect the complexity, volume and nature of the particular accreditation business.

#### Accreditation functions after the reviews

Although Ministers initially appointed the Accreditation Authorities, the National Law provides that Boards must make subsequent decisions about how accreditation functions are to be exercised:

- the National Board..... must decide whether an accreditation function for the health profession for which the Board is established is to be exercised by (a) an external accreditation entity; or (b) a committee established by the Board (s43), and
- the National Board must ensure the process for the review includes wide-ranging consultation about the arrangements for the exercise of the accreditation functions (S253 (5)).

Accordingly, the reviews considered both how the accreditation arrangements had been operating and what arrangements should continue from 1 July 2013.

### 2. How the review process was developed

The review process was developed by the Accreditation Liaison Group (ALG) in consultation with National Boards and Accreditation Authorities. The ALG is a joint body of the National Boards, the Health Professions Accreditation Councils' Forum (the Forum) and AHPRA, with members from each group. The ALG provides an opportunity for collaborative work on matters related to the accreditation functions under the National Law.

When the ALG started to develop a proposed review process, it carefully considered the wording of s. 253. The ALG's interpretation was that s. 253 conveys a focus on the existing arrangements and whether they should continue, rather than starting from a "blank page".

Accordingly, given the arrangements already in place, the ALG considered that the review process should begin with an assessment of the way in which the Accreditation Authority appointed for each profession had performed the accreditation functions. The ALG was aware that the process would also need to take account of the differences in size of the health professions, the volume of accreditation activity and the range of accreditation functions undertaken by the accreditation entities.

The proposed review process developed by the ALG was agreed by National Boards and Accreditation Authorities.

### 3. Overview of the review process

The scope of the review was defined by the objectives of the National Law, in particular those objectives most relevant to the accreditation functions, as well as the elements of the Quality Framework, which is essentially an agreed list of aspirational principles for the accreditation work of the Accreditation Authorities, previously developed and agreed by the National Boards and the Accreditation Authorities.

#### Principles

The key principles of the review process included:

- an agreed and transparent process for the review
- an appropriate focus on the current accreditation arrangements
- an agreed cross-profession framework with the capacity to take differences between the professions into account
- weighing of relative risks, benefits and costs
- evaluation of the suitability of the process for future reviews required under the National Law.

The principles which informed the development of the *Quality Framework for the Accreditation Function* (the Quality Framework) also applied.

The review process drew on the information already accumulated about how the accreditation arrangements are working for each profession and provided the Accreditation Authority and the National Board an opportunity for open dialogue as part of the review.

#### Key questions for the review

The review considered the following key questions:

1. What accreditation functions has the Accreditation Authority undertaken under the National Law?
2. How well has the Accreditation Authority undertaken each of these functions under the eight domains of the Quality Framework since it was appointed?
3. Taking in to account the context for the profession and the complexity of registration and accreditation arrangements for the profession, how has the Accreditation Authority addressed its responsibilities under the National Law (or - aligned its delivery of accreditation functions with the National Law)?
4. Has the Accreditation Authority demonstrated that it is effectively undertaking the accreditation functions and that it is likely to continue to do so? Are the current arrangements satisfactory?
5. Considering the costs, risks and benefits, on balance, is continuing with the current arrangements for exercising the accreditation functions or changing the arrangements appropriate?
6. Is there a clear justification for any proposed changes to the current arrangements for exercising the accreditation functions?

## **Outline of the review process**

Key steps in the review process were:

1. accreditation authority made a submission to the Board, if it wished to continue exercising the accreditation functions
2. Board assessed the submission and made a decision about its proposed direction
3. wide-ranging consultation
4. Board made final decision

A full description of the steps in the review process is in [Attachment One](#).

### **Submission from accreditation authority**

The reviews started with the Board writing to its accreditation authority, inviting it to make a submission if it wished to continue exercising accreditation functions. The submission was intended to build on existing information where appropriate and to take into account the way the Authority had discharged the accreditation functions since its first period of assignment commenced. Each accreditation authority prepared a detailed submission explaining their roles and functions. The submission also specifically addressed the Quality Framework and the progress made by the Authority in moving toward alignment with the Framework.

After the Accreditation Authority made its submission to the National Board, representatives of the Board and Accreditation Authority met to discuss the submission and any other issues relevant to the review.

### **Assessment of submission and decision about proposed direction**

The National Board then considered the submission and discussions with the Accreditation Authority against the key questions for the review to make a preliminary decision about whether the current arrangements for the exercise of the accreditation functions were satisfactory and therefore should be continued. The National Board's proposed direction (eg to continue the current arrangements) formed the basis of consultation, but allowed stakeholders to express their views about the direction including any alternative options for exercising the accreditation functions.

### **Wide ranging consultation**

The Boards included "wide-ranging consultation about the arrangements for the exercise of the accreditation functions" (s. 253 (5)) as part of this review process. (See the next section for more information about the consultation process).

### **National Board makes final decision**

The National Board provided the Accreditation Authority with an opportunity to discuss any issues from the stakeholder feedback. The National Board reviewed the feedback from the consultation process and any further information provided by the Accreditation Authority against the key review questions to make its final decision about the review outcome. The National Board communicated the review outcome and reasons for its decision to its Accreditation Authority. It then publicly announced the decision.

### **Review timing**

While the review did not need to be completed until 30 June 2013, the aim was to complete the review earlier to allow certainty for National Boards and for Accreditation Authorities wishing to continue exercising these functions. It would also allow a transition to any new arrangements, should they be necessary. For this reason, the review process started in August 2012, with the aim of completing the reviews by the end of 2012, while recognising that some reviews may be more complex and take longer to complete.

#### 4. Consultation process and submissions

Each board conducted preliminary and public consultation, using a profession-specific consultation paper which drew on a template consultation paper and the submission made by the Accreditation Authority.

The consultation paper:

1. explained the history of the assignment and the requirement for the review of the accreditation arrangements
2. explained the options open to the National Board, its preliminary conclusion about whether the current arrangements are satisfactory and the proposed direction based on a preliminary review of the current arrangements, including an analysis of the risks, benefits and costs
3. attached the public part of the submission from the Accreditation Authority
4. linked the Reference Document - *Accreditation Under the Health Practitioner National Law Act* and included a diagram of the respective roles of the National Board, Accreditation Authority and AHPRA
5. invited comments on the accreditation functions and the domains of the Quality Framework and provided an opportunity for any other comments.

Boards consulted according to the published National Boards Consultation Process (<http://www.ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx>). Each Board published its public consultation paper on its website inviting feedback. It also alerted its key stakeholders to the consultation process. The Boards also invited the Accreditation Authorities to suggest any additional stakeholders to be directly approached by the Boards to participate in the review. In some cases the Accreditation Authority also encouraged its stakeholders to participate in the consultation process.

#### Submissions

Boards received 92 submissions during the public consultation process across all ten professions. A breakdown of the submissions is at [Attachment 2](#).

Each Board has published the submissions from the public consultation process on its website, except where stakeholders requested non-publication. The submissions are accessible from links on the AHPRA or each Board website eg <http://www.medicalboard.gov.au/News/Past-Consultations/2012/Consultation-September-2012.aspx>. All submissions were made available to the accreditation authority.

Health Workforce Australia and the Health Workforce Principal Committee also made confidential submissions to the reviews.

#### 5. Review outcomes

All Boards have decided that their accreditation authority will continue to exercise accreditation functions, with some variations in the continuation period:

- seven boards decided on a five year period
- one board decided on a three year period with a possible two year extension
- one board decided on a three year period
- one board decided on a one year period but is prepared to consider a longer period subject to some governance issues being addressed

#### 6. Implementing the review outcomes

The review outcomes were implemented through:

1. the National Board advising the accreditation authority of its decision
2. the National Board announcing its decision
3. extending the existing agreements for the exercise of accreditation functions to cover the new period from 1 July 2013, recognising the context of health reform issues and opportunities for collaboration
4. each National Board establishing a workplan with its Accreditation Authority which includes issues from the review process and a timeframe for future work.

80% of the reviews were completed within the target timeframe (by the end of 2012). The extension of nine of the ten existing agreements was completed by late June 2013.

As was previously the case, the accreditation arrangements are subject to the reporting requirements in:

1. the agreement between AHPRA on behalf of the National Board and the Accreditation Authority
2. the sample guide report, which provides guidance about the content for regular reports under the agreement, and
3. the annual workplan and funding arrangements.

## 7. Assessing the review against the objectives

The following table analyses the review against the key principles:

Principle	Evaluation of review
An agreed and transparent process for the review	<p>The ALG developed a proposed review process which was clearly documented. National boards and accreditation authorities agreed on the proposed review process.</p> <p>The preliminary and public consultation papers included a description of the review process. The submissions to public consultation were published and each Board publicly communicated the outcome of the review process.</p>
An appropriate focus on the current accreditation arrangements	<p>The review focused on the current accreditation arrangements, but enabled any recommendations for changes to the existing arrangements to be raised, including proposals from any organisation who wished to be considered as an alternative to the accreditation authorities appointed by Ministers (none were received).</p>
An agreed cross-profession framework as outlined in this paper with the capacity to take differences between the professions into account	<p>The review process and template consultation paper provided an agreed cross-profession framework with the capacity to take differences between professions into account. There was also enough flexibility in the process to enable adjustment for profession-specific issues. This resulted in two boards completing their review to a longer timeframe than the other eight boards.</p>
Weighing of relative risks, benefits and costs	<p>Boards made their decisions according to the key questions for the review, which required a weighing of relative risks, benefits and costs</p>
Evaluation of the suitability of the process for future reviews required under the National Law.	<p>This report specifically considers the suitability of the review process for future reviews required under the National Law.</p>

## 8. Suitability of the process for future reviews required under the National Law

Many aspects of the review process would be suitable for future multi-profession reviews required under the National Law, including:

- collaborative planning and implementation
- an agreed process between the National Boards and Accreditation Authorities
- coordinating processes and timeframes across professions to assist stakeholders of multiple professions.

## 9. Opportunities for improvement/ lessons learnt

Key learnings from the review include:

1. Detailed planning and coordination of the review process was important. The review aimed to coordinate the review process for stakeholders of multiple National Boards such as governments. This included providing a multi-profession submission template for these stakeholders to use.
2. The ALG's design, oversight and leadership role was an important element in achieving agreement about the review process and 80% of the reviews being completed within the target timeframe.
3. It was important for National Boards, Accreditation Authorities and AHPRA to have a shared understanding about the process and timeframes. An agreed, clearly documented review process helped participants and stakeholders all understand the process, and enabled effective coordination.
4. The submissions from the Accreditation Authorities were very large documents, up to 20 mb. This presented challenges in the preliminary consultation phase, as the documents could not be emailed. Drop-box style web access was used but some stakeholders had difficulties using the site and were provided with the submissions on a usb stick. There is an opportunity to make this process more user-friendly and simpler in future.

## 10. Conclusion

The reviews of accreditation arrangements were completed by 30 June 2013 as required by the National Law, although implementation of the reviews is continuing into 2013. The review processes highlighted how much has been achieved in implementing the accreditation component of the National Registration and Accreditation Scheme. The review also provided useful opportunities for National Boards and Accreditation Authorities to consider key issues that will be important factors for the future of accreditation within the National Registration and Accreditation Scheme.



1. Boards/AHPRA wrote to Accreditation Authority asking whether Accreditation Authority wishes to continue undertaking the accreditation functions and if so, to send a submission to Board
2. The Accreditation Authority provided a submission to the Board advising that it wished to continue exercising the accreditation functions
3. Representatives of the Board and Accreditation Authority met to discuss any key issues arising from the submission
4. National Board formed preliminary view about whether the current arrangement is satisfactory and approves consultation paper for preliminary consultation
5. National Board advised Accreditation Authority of its preliminary view
6. Preliminary consultation with key stakeholders
7. National Board considered outcome of preliminary consultation and advised accreditation authority of any change in approach from preliminary consultation
8. National Board approved consultation paper for public consultation
9. Public consultation on the preliminary view on whether or not the arrangements appeared to be satisfactory
10. National Board provided the Accreditation Authority with an opportunity to discuss any issues from the stakeholder feedback
11. National Board made final decision, communicated the decision and its reasons to the Accreditation Authority and then announced the decision
12. Implementation

## **Attachment two Submissions received in public consultation**

Attachment two has been removed from this public consultation version of the paper because it lists submissions that organisations and individuals identified as confidential. Submissions received in public consultation that were not identified as confidential are published on the National Boards' websites that can be accessed via [www.ahpra.gov.au](http://www.ahpra.gov.au)

## Attachment C: Overview of accreditation functions by profession

The Accreditation Authority for each health profession is listed in the table below with information about the accreditation functions they perform. Information about the accreditation process is also available on the website of each external authority and Accreditation Committee.

### Accreditation Authorities

This table lists the Accreditation Authorities that exercise accreditation functions under the National Law and work with the National Boards.

National Board	Accreditation Authority	Functions undertaken under the National Law
Aboriginal and Torres Strait Islander Health Practice Board of Australia	<a href="#">Aboriginal and Torres Strait Islander Health Practice Accreditation Committee</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Providing advice to National Board on accreditation functions
Chinese Medicine Board of Australia	<a href="#">Chinese Medicine Accreditation Committee</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Providing advice to National Board on accreditation functions
Chiropractic Board of Australia	Council on Chiropractic Education Australasia Inc.  <a href="http://www.ccea.com.au/">http://www.ccea.com.au/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions

National Board	Accreditation Authority	Functions undertaken under the National Law
Dental Board of Australia	Australian Dental Council  <a href="http://www.adc.org.au/">http://www.adc.org.au/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions
Medical Board of Australia	Australian Medical Council Limited  <a href="http://www.amc.org.au/">http://www.amc.org.au/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions
Medical Radiation Practice Board of Australia	<a href="#">Medical Radiation Practice Accreditation Committee</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Providing advice to National Board on accreditation functions
Nursing and Midwifery Board of Australia	Australian Nursing & Midwifery Accreditation Council  <a href="http://www.anmc.org.au/">http://www.anmc.org.au/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners (National Board is also undertaking this function)  Providing advice to National Board on accreditation functions

National Board	Accreditation Authority	Functions undertaken under the National Law
Occupational Therapy Board of Australia	Occupational Therapy Council (Australia & New Zealand) Ltd  <a href="http://otcouncil.com.au/">http://otcouncil.com.au/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions
Optometry Board of Australia	Optometry Council of Australia and New Zealand  <a href="http://www.ocanz.org/">http://www.ocanz.org/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions
Osteopathy Board of Australia	Australian and New Zealand Osteopathic Council  <a href="http://www.anzoc.org.au/">http://www.anzoc.org.au/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions

National Board	Accreditation Authority	Functions undertaken under the National Law
Pharmacy Board of Australia	Australian Pharmacy Council Ltd  <a href="http://pharmacycouncil.org.au">http://pharmacycouncil.org.au</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions
Physiotherapy Board of Australia	Australian Physiotherapy Council  <a href="http://www.physiocouncil.com.au/">http://www.physiocouncil.com.au/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions
Podiatry Board of Australia	Australian and New Zealand Podiatry Accreditation Council  <a href="http://www.anzpac.org.au/">http://www.anzpac.org.au/</a>	Development and review of accreditation standards  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Assessing overseas assessing authorities  Assessing overseas qualified practitioners  Providing advice to National Board on accreditation functions

National Board	Accreditation Authority	Functions undertaken under the National Law
Psychology Board of Australia	Australian Psychology Accreditation Council Limited <a href="http://www.psychologycouncil.org.au/">http://www.psychologycouncil.org.au/</a>	Development and review of accreditation standards  Assessing overseas assessing authorities  Assessing programs of study and education providers against the standards, including monitoring accredited programs and providers  Providing advice to National Board on accreditation functions

### More information about accreditation under the National Law

A reference document [Accreditation under the National Law](#) has been developed by Accreditation Authorities, National Boards and the Australian Health Practitioner Regulation Agency (AHPRA) to provide information about accreditation under the *Health Practitioner Regulation National Law Act* as in force in each state and territory (the National Law).





## Desktop self assessment against the Professional Standards Authority Evidence Framework: Standards for Good Regulation

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15 August 2014

### Summary report

#### Executive Summary

In July and August 2014 AHPRA conducted an initial desk top self-assessment against the United Kingdom (UK) Professional Standards Authority (PSA) *Evidence Framework*. Over 30 AHPRA staff were consulted including staff from Registration, Notifications, Legal Services, Compliance, Policy and Accreditation, Business Systems and Improvement directorates.

The PSA Standards of Good Regulation (PSA standards) include four core regulatory functions: Standards and Guidance, Accreditation, Registration and Notifications. There are a total of 24 standards, each standard is accompanied by two or more listed items that indicate 'evidence to be presented to PSA' to support standards compliance.

The outcomes of this desktop self-assessment are contained in this report and will be used to inform the continued development of AHPRA's National Quality (Business) Assurance program. Information was gathered through interviews conducted either by face to face, videoconference, or teleconference during July/August 2014.

Findings have been reported against the PSA standards as strengths, weaknesses, scheduled planned activity or improvement and opportunities for improvement. This desktop self-assessment is an initial self reflective exercise that provides a snapshot of how AHPRA and National Boards comply with the PSA standards of good regulation. The National Regulation Accreditation Scheme (NRAS) has only been established for four years and the findings reflect the maturity of the organisation.

Other considerations have been discussed including co-regulatory models for notification management, external reviews, other matters and considerations moving forward.

#### Background

As part of a program to benchmark AHPRA's work, the CEO, Martin Fletcher commissioned a desktop self-assessment using the UK PSA *Evidence Framework*. The outcome of the initial desktop self-assessment report will be used to inform the continued development of AHPRA's National Quality (Business) Assurance program.

The PSA is responsible for overseeing the UK's nine health and care professional regulatory bodies. They review the performance of the regulators on an annual basis. In addition they conduct special reviews outside the UK, examples of which include the Royal College of Dental Surgeons of Ontario, and both the Medical and Nursing Councils of New Zealand.

## PSA Standards of Good Regulation

The PSA Standards of Good Regulation (PSA standards) describe what the PSA considers should be the outcomes of good regulation for each of four core regulatory functions:

- Guidance and standards
- Education and training
- Registration
- Fitness to practise

There are a total of 24 standards and each standard is accompanied by two or more listed items that indicate 'evidence to be presented to PSA' to support standards compliance.

## Methodology

The initial desktop self-assessment was conducted by gathering information from more than 30 personnel from AHPRA's executive, management and senior staff across the organisation (refer to Appendix 1 for further details). Interviews were conducted either by face to face, videoconference, or teleconference over a three week period during July/August 2014. Documented evidence and the location of evidence e.g. website links were provided to support information that had been obtained. This information was then collated and analysed against the PSA standards to identify strengths, weaknesses, planned activities or improvement and opportunities to improve.

## Standards

In order to ensure the PSA standards were relevant to the National Law and applied to the Australian context of health practitioner regulation some of the 'standards' and the 'evidence to be presented to PSA' in all four core functions were adjusted (refer to Appendix 2) following consultation with National Directors in Registration, Notifications, Legal Services, Compliance, Policy and Accreditation, and Business Systems and Improvement directorates.

Informal discussions with a visiting member of the PSA from the UK confirmed adjustment of standards is required (in agreement with the Regulator) and is the usual process when international reviews are conducted by the PSA.

## Information collection

During the interviews with AHPRA staff, staff were asked to address the following questions in relation to their area of work and relevant standards:

- What and how does AHPRA do its business of regulation?
- Does AHPRA have evidence to support this?
- If so where is it located and/or can this be provided?
- Are you aware of any plans for improvement?
- Can you identify any opportunities for improvement?

## Collation of information

Following the interviews the information was collated and any suggested evidence was reviewed. During analysis:

- Strengths and weaknesses against standards were identified,
- Plans already in place which may address aspects of the standards were referred to and reviewed, and
- Opportunities for improvement were identified and listed.

It should be noted corporate documents such as the AHPRA Business Plan Draft 2013/2014 Achievements and the AHPRA Business Plan 2014/2015 were also reviewed to incorporate achievements from previous year and planned initiatives for business in the current financial year.

## Findings

The major findings of the initial desktop self-assessment against the PSA standards in each of the four core regulatory functions have been listed as strengths, weaknesses, scheduled planned activity or improvement and opportunities to improve.

### Section 1: Guidance and Standards

#### Strengths

- Professional standards, codes and guidelines reflect up to date practice and legislation through procedures that map the development and review of registration and accreditation standards which include consultation, statements of assessment and cross professional review of regulatory policy.
- Currently there are a number of professional standards, codes and guidelines under review across various professions.
- External stakeholder engagement framework and plan currently being implemented which includes stakeholders' views, experiences, external events and learning's from other areas.
- Procedures for the development and review of registration standards, codes and guidelines are in the final stages of being revised and strengthened.
- Consultations are being publicised more broadly, including through social media.

#### Weaknesses

- There is a lack of documented information about how the effectiveness of standards and guidance will be evaluated.
- There is potential to communicate more effectively with the public, service users and carers about the standards, including by publishing material specifically for this audience.
- The standards information published is not available in any language other than English.
- The standards information published is not always in 'plain' English, particularly documents produced early in the Scheme that have not yet been reviewed.

#### Scheduled planned activity or improvement

- To introduce a more comprehensive and systematic approach to implementing outcomes from reviews of policy, standards, codes and guidelines.
- Actions currently being implemented to conform to the 'Web Content Accessibility Guidelines (WCAG) 2.0' (completion due date December 2014), ensuring standards and guidelines are published in accessible formats.
- Consultation guide is being revised and updated
- Policy manual is being revised to provide improved guidance for policy development, evaluation and review

#### Opportunities for improvement

1. Progressively strengthen the evidence base for standards, codes and guidelines, through improved operational input, research, international benchmarking and data analysis such as trends from audit and notifications.
2. All website information could be presented in 'plain' English and interpreter services could be offered. The demand for multiple language options could also be explored.
3. When reviewing standards, codes and guidelines consider ways to strengthen input from patient and service users and be clearer about how proposed changes will support patient and service user centred care.

## Section 2: Accreditation

### Strengths

- There is a published *Quality Framework for the Accreditation Function* (Quality Framework) that is used by National Boards and AHPRA to assess the work of accreditation authorities. Accreditation authorities submit six-monthly reports against the Quality Framework to their respective National Boards and AHPRA.
- AHPRA has developed and published *Procedures for the development of accreditation standards* (the Procedures). The National Law requires accreditation authorities to develop accreditation standards through a wide-ranging consultation process and take into account the requirements of the Procedures.
- The Quality Framework and the Procedures ensure that accreditation standards and processes meet the requirements of National Law, and that relevant Australian and international benchmarks and stakeholder views are taken into account in accreditation.
- Information on all approved programs of study is available on AHPRA and the National Boards' websites.
- Accreditation authorities generally provide guidance to education providers to help them understand the accreditation standards and processes.
- Accreditation authorities require education providers to notify the authority if there is a major change to an accredited program. The authorities' processes have the flexibility to review programs for study that have had a major change in the course components.
- Accreditation committees for three of the professions that joined the National Scheme in 2012 have, with support from AHPRA, commenced site visits in line with the accreditation processes.
- AHPRA has supported the accreditation committees to recruit and train more than 50 accreditation assessment assessors. AHPRA applied a cross-profession approach to the training with attention to profession-specific considerations for standards related to professional capabilities.
- Accreditation standards generally require education providers to take into account the views of patients, service users and students in consultation about their education program.

### Weaknesses

- There is potential to analyse trends in notifications about new graduates from accredited programs and use this information in the development and revision of accreditation standards and guidance material.

### Scheduled planned activity or improvement

- Improvement initiatives planned, including an updated accreditation roadmap, support National Boards and AHPRA to deliver on the potential of accreditation within the National Registration and Accreditation Scheme. Areas of work most relevant to the initial self-assessment are:
  - Adoption and implementation of a framework to ensure best practice and consistency in how concerns about education programs are reported and addressed by National Boards, AHPRA and the accreditation authorities
  - Work is underway to strengthen the *Procedures for the Development of Accreditation Standards* and include liaison with the Office of Best Practice Regulation, and this step is occurring in anticipation of the revised Procedures
  - A planned three-year review of the Quality Framework (developed in 2011) is being led by the Accreditation Liaison Group during 2014. This includes a review of the format of the six-monthly reports by accreditation authorities to the National Boards and AHPRA.

### Opportunities for improvement

- 1 Use the outcomes of the review of the Quality Framework and reporting format to further improve these important resources.

- 2 Develop a cross-profession overview of reporting by accreditation authorities against the Quality Framework to support consistent approaches to assessment of the work of the accreditation authorities and facilitate risk-based approaches to performance reviews that inform quality improvement strategies.
- 3 Improve operational input and data analysis such as trends from notifications about new graduates to inform the development and revision of accreditation standards and guidance materials for education providers.
- 4 There is potential to more clearly map how the accreditation standards link to registration standards, codes and guidelines
- 5 There is potential to communicate more effectively with the public about the accreditation standards and processes, including by publishing more material specifically for this audience

## Section 3: Registration

### Strengths

- The Regulation Principles, Registration Standards, Policies, Protocols and Systems Guides are in place to ensure only those who meet the requirements are registered.
- The Public Register of Practitioners is easily accessible, current and reflects restrictions in place.
- Annual Practitioner Audits (all professions) are conducted on any of the four Registration Standards; Continuing Professional Development, Recency of Practice, Professional Indemnity Insurance arrangements and Criminal History Checks.
- A Graduate Online Application (GOA) Audit provided qualitative information of the assessment of the registration process to evaluate if it was fair, efficient and transparent; and to ensure that only those who met the requirements were registered.
- The Practitioner Information Exchange and Multiple Registration Checks assist employers to check registration status of employees.
- Broad internal consultation was conducted to identify necessary improvements for the registration compliance system.

### Weaknesses

- Limited analysis and qualitative reporting.
- Ambiguity of accountability for actioning data reports.

### Scheduled planned activity or improvement

- Plan to implement findings from the GOA audit via the National Director of Registration.
- Plan to strengthen performance reporting framework. Reporting for core regulatory functions enhanced by the AHPRA reporting services platform to report on performance. This will be in place by December 2014.
- Coordinate data and research for risk-based regulation to ensure increased statistical and research capability.
- Medical Board of Australia plan to investigate models of revalidation for medical practitioners.
- Plan to identify the national management of 'holding out' matters where a practitioner has practised whilst not registered.
- Planned re-audit of GOA – English Language Skills Standard and part of registration application processing.
- Develop workforce innovation and reform framework by investigating workforce issues and the Board's role in enabling workforce reform.

### Other opportunities for improvement

1. Develop reports identifying trends in number of refusals of registrations and reasons for refusal and present to National Boards and relevant AHPRA staff for review and action as required.
2. From the Practitioner Audit data identify if any trends for non compliance with registration standards and determine if any action is required.

## Section 4: Notifications

### Strengths

- Anyone can make a notification about a health practitioner; the notification process and possible outcomes are published on the website, with links available to access the notification process for the two co-regulatory authorities.
- The notifications process is transparent, fair and focused on public protection.
- Decision outcomes where a restriction is placed on a health practitioner are published on an up to date Register of Practitioners and there are website links to published decisions made by co-regulatory bodies.
- The regulators take forward own motion investigations on matters, determines necessary actions where relevant and ensures that lapsed registrants are identified within the internal systems in order to address outstanding issues should the practitioner apply for registration.
- Exchange of information between bodies in relation to notification cases occurs in accordance with legislation.
- External stakeholder engagement framework and plan currently being implemented to build relationships with other bodies and to facilitate information sharing.
- The regulators determine if there is a case to answer in accordance with the legislation and education and training is in place for AHPRA staff to assess notifications for national board review.
- Board, committee and panel members are provided education, have a range of information available to them to guide them in decision-making and have access to legal advice as required.
- AHPRA and the National Boards and the co-regulatory authorities conduct risk assessments and prioritise serious notification matters for immediate action; take relevant immediate action and monitor the actions for compliance.
- A Quality (Business) Assurance audit has been completed to evaluate notifications management processes and the publishing of relevant outcomes (in accordance with legislation) following decisions made by national boards, committees, panels and tribunals.
- AHPRA and the regulators ensure compliance with all information security policies, follow the National Law which imposes a duty of confidentiality on people who obtain information when exercising functions under that Law, and have the Code of Conduct and the Confidentiality Policy in place.
- Information about notifications matters is securely retained and any breaches are reported quarterly to the National Executive.

### Weaknesses

- The notifications information published is not available in any other language than English.
- Limited analysis and qualitative reporting.
- Limited integrated procedure manual for cross functional areas of regulatory business conducted by AHPRA.
- Evaluation of effectiveness of notifications education and training has not commenced.

### Scheduled planned activity or improvement

- Coordinate data and research for risk-based regulation to ensure increased statistical and research capability.
- Plan in place to improve online notification process to enable completion and submission of a notification electronically.
- Plan to develop governance arrangements for third-party organisations performing National Scheme functions to ensure clear accountabilities.
- Currently an external health program (funded by the Medical Board of Australia) is being developed for the referral of medical practitioners with impairment.
- A national Quality (Business) Assurance audit is in progress to evaluate processes and the publication of the outcome of decisions made to impose a restriction or action that impacts on the registration status of a health practitioner.



- Current exploratory study being conducted to identify trends in decisions made across professions for similar matters to provide learnings from the notifications process and decision-making on notification matters.
- Plan for external party to measure a decision-makers' ability to use available evidence based regulatory principles, support and guidance for decision making; the aim of this research is to identify barriers and learning needs of the decision-makers.
- Plan in place to review notifications data collected and to provide qualitative analysis and reporting on performance which will evidence continuous improvement cycles.
- Plan in place to provide better information on the AHPRA and National Board websites, improve initial contact with notifiers and improve accessibility for public on forms that are in plain English language.
- Plan to commission a regulatory compliance system that is fit for purpose and will provide extensive reporting facility to assist with more analytical and qualitative reporting on performance of notifications process and management.

### Opportunities for improvement

- 1 Qualitative reporting on compliance.
- 2 The website information could offer interpreter services and multiple languages options may also be considered.
- 3 Analysis of trends in outcomes of appeals about decisions made.
- 4 Analyse trends in feedback during complaints processes which relate to AHPRA and the notifications process; utilise learnings from feedback where relevant.
- 5 Consider implementing a learning and development framework to update and expand induction programs to include foundation training required for new board, committee and panel members; and establish a support system with e-resources.

### Other Considerations

There are a number of factors that should be considered in conjunction with this initial PSA self-assessment which include for example, the co-regulatory model in notification management, previous and current reviews of AHPRA and maturity of the organisation.

### Co-regulatory model for notification management

Unlike in other parts of Australia a co-regulatory framework operates for the management of conduct, health and performance matters in New South Wales (this has been in place since the 1 July 2010) and in Queensland which commenced more recently on 1 July 2014.

### External reviews

Since the commencement of the NRAS in 2010, there have been a number of reviews conducted by external parties, these include:

- Parliament of Australia, Senate Finance and Public Administration Reference Committee: The Administration of health practitioner registration by Australian Health Practitioner Regulation Agency (AHPRA) June 2011.
- Forrester, Davies and Houston 2013, Final Report: Chesterman Report Recommendation 2, Review Panel.
- Victorian Parliamentary Inquiry into Performance of the Australian Health Practitioner Regulation Agency March 2014.
- National Registration and Accreditation Scheme 2014, the three year review.
- Grant Thornton Internal Audit Project - current.

These reviews are other examples of assessment of the performance of health practitioner regulation in Australia; findings and action plans should be read in conjunction with this report.

## **Other matters**

The NRAS has a risk based policy which is implemented through regulatory principles. More recently an approach used to reduce risk to the public and facilitate safe workforce reform includes initiatives to increase the use of collating data and research to inform policy and regulatory decision-making. As the NRAS has only been established for four years, the findings of this self-assessment reflect the maturity of the organisation.

This desktop self-assessment is an initial self reflective exercise that provides a snapshot of how AHPRA and National Boards perform against the PSA Standards of Good Regulation. A more comprehensive self-assessment would include:

- Standards
  - application to the Australian legislation.
  - review of terminology is required to address the context of Australian health practitioner regulation.
  - broad consultation required to adjust PSA titles for core regulatory functions and standards to reflect Australian health practitioner regulation.
  - develop standards that incorporate monitoring and compliance of health practitioners with restrictions on their registration.
- Conduct self-assessment by:
- Broader consultation within AHPRA and within National Boards, committees and panels.
- Obtaining evidence to support compliance to standard/s.

## **Considerations moving forward**

So where to from here? For AHPRA and the National Boards to continue to progress forward towards "Good Standards in Regulation" the following strategies should be considered:

- Continue to develop relationships and seek opportunities for benchmarking with other international regulators, as recommended by the Australian National Audit Office (2014).
- Link internal audit strategy and schedule with the National Quality (Business) Assurance Program.
- Integrate the opportunities identified in this report to further develop the National Quality (Business) Assurance Plan.
- Plan for the possibility of PSA conducting a performance review of AHPRA and the National Boards within the next five years.

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## Document Control

	Name	Position	Date
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	Jo Place	Contracted Consultant	21 Jul to 6 Aug 2014
Report written by	Kay Hyde	Manager, National Quality (Business) Assurance	7 to 15 Aug 2014
	Jo Place	Contracted Consultant	7 to 15 Aug 2014
Sponsored by	Kym Ayscough	Executive Director of Regulatory Operations	18 Aug 2014

## Appendix 1: AHPRA Staff included in the consultation

Name	Title
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Kate Hawke	Senior Planning Coordinator
<b>Other than AHPRA staff</b>	
Dr Joanna Flynn	Chair, Medical Board of Australia
Douglas Bilton	Professional Standards Authority (UK)

## Appendix 2: Performance Review - Evidence Framework

<p>This framework sets out the evidence that we consider the regulators could present to show how they have met the <i>Standards of Good Regulation</i>. <i>This framework does not cover the overview questions contained on page 5 of the Standards of Good Regulation</i>.</p> <p>Please note that <del>strike through text</del> indicates PSA standards that do not reflect the Australian health regulatory approach. If wording has been inserted it is in italics and/or bracketed. This relates to the PSA 'Standard' and the 'Evidence that could be presented to PSA' columns.</p>			
Standard			Evidence that could be presented to PSA
1	Guidance and standards		
1.1	<del>Standards of competence and conduct reflect up to date practice and legislation. They prioritise patient and service user safety and patient and service user centred care.</del> <i>Professional standards, codes and guidelines reflect up to date practice and legislation (the objectives and guiding principles of the National Law) and capabilities or competency standards where the Board has developed or adopted these.</i>	1.1.1	<del>A breakdown/mapping of how the standards reflect up to date practice prioritise patient and service user safety and patient and service user centred care</del> <i>A breakdown/mapping of how the standards, codes and guidelines (and capabilities or equivalent where relevant) reflect up to date practice.</i>
		1.1.2	Information on how the regulator assures itself that the standards are up to date, <del>practice prioritise patient and service user safety and patient and service user centred care</del>
		1.1.3	How feedback from registrants and other relevant parties about the standards is gathered and how this feedback has been taken into account
		1.1.4	Evaluation of the effectiveness of the standards
1.2	Additional guidance helps registrants to apply the regulators' standards of competence and conduct to specialist or specific issues including addressing diverse needs arising from patient and service user centred care.	1.2.1	<del>A breakdown/mapping of the guidance produced and how it helps registrants to apply the regulators' standards to particular issues</del>
	-	1.2.2	Information on how the regulator assures itself that the guidance is <del>achieving its aim.</del>
	-	1.2.3	<del>How feedback from registrants and other relevant parties about the guidance is gathered and how this feedback has been taken into account</del>
	-	1.2.4	<del>Evaluation of the effectiveness of the guidance</del>

Standard			Evidence that could be presented to PSA
1.3	In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, <del>developments in the four countries</del> European and international regulation and learning from other areas of its work.	1.3.1	Information on which stakeholders were approached, how information was gathered from stakeholders and how their views and experiences impacted on the work
		1.3.2	Information on how the guidance/standards has been influenced by external events, <del>developments in the UK, Europe</del> and internationally and learning from other areas of its work
		1.3.3	Evaluation of the effectiveness of the regulators' approach to gathering and using information when developing and revising standards and guidance
1.4	The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, <del>patients, service users</del> and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed.	1.4.1	Information on the published formats, including language options, of the standards and guidance
		1.4.2	Information on whether the documents are <del>crystal marked or</del> have plain English certification
		1.4.3	<del>Details of the distribution plan for the standards and guidance e.g. circulation in GP practices or sent to all registrants</del>
		1.4.4	Evaluation of the accessibility and use of documents for registrants, potential registrants, employers, <del>patients, service users</del> and members of the public.

Standard			Evidence that could be presented to PSA
2	Education and training (Accreditation)		
2.1	Standards for <del>education and training</del> (accreditation) are linked to standards for registrants. They ( <i>embed or reference standards that</i> ) prioritise patient and service user safety and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the <del>quality assurance</del> (accreditation) process.	2.1.1	A breakdown/mapping of how the standards for education <del>and training</del> providers, <del>students and trainees</del> link to standards for registrants
		2.1.2	Guidance available to <del>students and trainees</del> /education <del>and training</del> providers to help them understand and meet the regulator's standards
		2.1.3	Guidance given to students with disabilities ( <i>by the education provider</i> ) to ensure that they do not face unnecessary barriers to successful careers in health
		2.1.4	A breakdown of how the standards relating to <del>students/trainees and</del> education <del>and training</del> providers prioritise patient and service user safety and patient and service user centred care
		2.1.5	Information on what stakeholders were approached during the development or revision of standards, how information was gathered and received from stakeholders and how their views and experiences impacted on the work.
	-	2.1.6	Information on how the development or revision of standards has been influenced by external events and learning from the quality assurance process
	-	2.1.7	Where appropriate, details of the number of student fitness to practise hearings, the nature of the allegations and how learning from student fitness to practise cases is used e.g. in the development or revision of standards and guidance, as evidence in the quality assurance process•
	-	2.1.8	Evaluation of the effectiveness of the regulators' approach to gathering and using information when developing and revising standards and guidance.
2.2	Through the regulator's continuing professional development/ <del>revalidation</del> systems, registrants maintain the standards required to stay fit to practise ( <del>registered</del> )	2.2.1	<del>Details of the regulator's revalidation plans and how these are focused on ensuring that registrants are maintaining the standards required to stay fit to practise</del>



Standard			Evidence that could be presented to PSA
		2.2.2	Details of CPD process and how it is targeted towards registrants developing their skills and knowledge in their areas of practice and public protection
		2.2.3	Details of number of audits that were carried out, the percentage of those that passed and failed to meet the regulator's standards, what issues were identified with individual professionals and how these were addressed, how wider learning was identified and used by the regulator to improve its performance e.g. revision of standards or CPD process
		2.2.4	Registrant feedback on whether the CPD and revalidation process helps them to maintain standards required to stay fit to practise ( <i>registered</i> )
		2.2.5	Evidence of consideration of F&P (Notification/Registration) outcomes to inform possible areas for CPD.
2.3	The process for <del>quality assuring</del> ( <i>accrediting</i> ) education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration	2.3.1	Details of the <del>quality assurance</del> ( <i>accreditation</i> ) process and how it meets the principles of good regulation including proportionality
		2.3.2	Feedback from education <del>and training</del> providers on the <del>quality assurance</del> ( <i>accreditation</i> ) process
		2.3.3	<del>Breakdown of how the quality assurance process is focused on ensuring providers produce students and trainees that meet the regulator's standards</del>
		2.3.4	Details of how the views of patients, service users, students, trainees are obtained
		2.3.5	Details of (2.3.4 have influenced the outcomes of the accreditation process) how their views have influenced the outcomes of the <del>quality assurance of education and training (accreditation) providers</del>
		2.3.6	Feedback from education and training providers on the <del>quality assurance</del> ( <i>accreditation</i> ) process
		2.3.7	Any learning identified about the education function, through the <del>quality assurance</del> ( <i>accreditation</i> ) process or development/revision of standards and how this is used to improve standards or ( <i>accreditation</i> ) of providers.
2.4	Action is taken if the <del>quality assurance</del> ( <i>accreditation</i> ) process identifies concerns about education and training establishments	2.4.1	Information on how many assessments undertaken and how many assessments identified concerns requiring action

Standard			Evidence that could be presented to PSA
		2.4.2	Examples of how concerns identified through the <del>quality assurance</del> ( <i>accreditation</i> ) process have been addressed by the <del>regulator</del> . Accreditation authority
2.5	Information on approved programmes and the approval process is publicly available.	2.5.1	Location of publicly available approval process and information on final assessments e.g. links to relevant webpages, Freedom of Information Publication Scheme.

Standard			Evidence that could be presented to PSA
3	Registration		
3.1	Only those who meet the regulator's requirements are registered	3.1.1	Details of the activities undertaken to ensure only those that meet the regulator's standards are registered (UK, EEA and international)-including maintaining professional skills and knowledge checks and being of good character
		3.1.2	% of <del>rejected</del> (refused) registration applications and the reasons for this
		3.1.3	The number of registration appeals, the number heard and the outcomes
		3.1.4	Details of how learning from this work is fed back into other areas of the regulator's work.
3.2	The registration process, including the management of appeals, is fair, based on the regulators' standards, efficient, transparent, secure, and continuously improving	3.2.1	Registration application processing service standards/key performance indicators and the regulator's performance against them
		3.2.2	Details of the data collection methods (and other processes) that ensure that the registration application process is fair, objective and free from bias or discrimination
		3.2.3	Location of publicly available information about the registration application process e.g. link to webpages, issued to students and trainees on graduation
		3.2.4	Details of how the regulator ensures compliance with its information security policies
		3.2.5	Details on how many data losses/breach incidents there have been and the action taken to address them
3.3	Through the regulators' registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice	3.3.1	A breakdown of what information is available on the register, including the registrant's personal details and any current or historical fitness to practise data and the reasons for any information not included on the register
		3.3.2	Details of how feedback is collated on the accessibility and content of the register and how this is used to make improvements.
3.4	Employers are aware of the importance of checking a health professional's <del>or social worker's</del> registration. <del>Patients, service users and members of the public can find and check a health professional's or social worker's registration</del>	3.4.1	Location of register e.g. link to a webpage, prominent advert on homepage, how to access register at regulator's office <del>or the information via the telephone</del>
		3.4.2	Activities undertaken to communicate the importance of checking that a professional is registered
		3.4.3	Evaluation of the effectiveness of these activities

Standard			Evidence that could be presented to PSA
3.5	Risk of harm to the public and of damage to public confidence in the profession related to nonregistrants using a protected title or undertaking a protected act is managed in a proportionate and risk based manner.	3.5.1	Activities undertaken to prevent non-registrants using a protected title or undertaking a protected act such as increasing public awareness of the importance of a health professional and social work regulation and registration; sending cease and desist letters, fostering relationships with organisations that share an interest in preventing title misuse, taking legal action.
		3.5.2	Number of prosecutions and their outcomes
		3.5.3	Evaluation of the effectiveness of these activities

Standard			Evidence that could be presented to PSA
4	Fitness to Practise (Notifications)		
4.1	Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant	4.1.1	Activities undertaken to publicise fitness to practise (notifications) process e.g. leaflets for the public, patients, service users, and employers, liaison with complaint leads in health organisations, CABS etc, meeting with employers, publicising outcomes of fitness to practise (notifications), information available via a helpline
		4.1.2	Examples of where a regulator has taken forward a fitness to practise concern notification (an own motion investigation) itself -the number taken forward and the reasons for this e.g. following press reports of poor standards at a particular hospital
		4.1.3	There are clear links between the registration and FtP (notification) functions to ensure that FtP (notifications) concerns are revisited if a lapsed registrant applies to be readmitted or reinstated. (registered)
4.2	Information about fitness to practise (notification) concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks (as required by law or as appropriate)	4.2.1	Analysis of fitness to practise concerns, analysis of the demographics of registrants going through the process is collected and shared with other bodies with similar interests
		4.2.2	Exchange of information between bodies in relation to fitness to practise (notification) cases
		4.2.3	Activities undertaken to build relationships with other bodies to facilitate information sharing
		4.2.4	MoUs
		4.2.5	Detail of work undertaken with commissioners and contractors
4.3	Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation	4.3.1	Guidance available on 'a case to answer'/realistic prospect test
		4.3.2	Training undertaken by case examiners (case managers and investigators) and panelists (board, committee and panel members) on determining a case to answer
		4.3.3	Evidence of individuals being referred to other organisations and liaison with other organisations to aid this referral
		4.3.4	Monitoring of use and effectiveness of the processes, training and guidance
		4.3.5	Details of how learning is used to improve this part of the process.

Standard			Evidence that could be presented to PSA
4.4	All <del>fitness to practise</del> complaints ( <i>notifications</i> ) are reviewed on receipt and serious cases are prioritised and where appropriate referred to an <del>interim orders panel</del> ( <i>an immediate action committee</i> )	4.4.1	Risk assessment process
		4.4.2	Prioritisation process
		4.4.3	Monitoring of use and effectiveness of these processes
		4.4.4	Number of <del>interim orders</del> ( <i>immediate actions</i> ) made compared to the number of <del>applications</del> ( <i>notifications</i> )
		4.4.5	<del>Number of cases which have not been substantively considered before the expiry of an interim order (or where relevant, an interim order that has been extended by the High Court)</del>
		4.4.6	Details of how learning is used to improve this part of the process.
4.5	The <del>fitness to practise</del> ( <i>notifications</i> ) process is transparent, fair, proportionate and focused on public protection	4.5.1	Details of how data is collected on <del>fitness to practise</del> ( <i>notifications</i> ) cases to ensure that the process is free from bias or discrimination
		4.5.2	Location of publicly available <del>fitness to practise</del> ( <i>notifications</i> ) process information e.g. link to webpages, published leaflets for those involved in the process or standard letter text
		4.5.3	An explanation of how the regulator excludes allegations that do not impact upon a registrant's <del>fitness to practise</del> from the <del>fitness to practise</del> ( <i>notification</i> ) process
		4.5.4	A breakdown or examples of how the process is focused on public protection e.g. within guidance for ( <i>board, committee and panel members</i> ) <del>panelists</del> and staff
		4.5.5	Details of how learning from the <del>fitness to practise</del> ( <i>notifications</i> ) process is used to improve all aspects of the work of the <del>fitness to practise</del> ( <i>notifications</i> ) function and the regulator's other functions.
		4.5.6	<del>Fitness to Practise</del> ( <i>Notifications chapter</i> ) Annual Report
		4.5.7	<del>Details of any proposed or impending section 60 orders that impact on F&amp;P notification processes</del>

Standard			Evidence that could be presented to PSA
4.6	<del>Fitness to practise (Notification)</del> cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of <del>interim orders (immediate action)</del>	4.6.1	The regulator's performance against its service standards
		4.6.2	The median time taken for cases to progress: <del>o From receipt of complaint to IC decision o From receipt of complaint to IO decision o From IC decision to final committee decision</del>
		4.6.3	The processes that the regulator has in place to ensure cases are progressed without undue delay
		4.6.4	Where there are delays in the process, details of how the regulator is working to identify and remedy the causes
4.7	<del>All parties (Parties associated with) to a fitness to practise (notification) case</del> are kept updated on the progress (as far as possible) of their case and supported to participate effectively in the process	4.7.1	Policy in place to maintain regular contact with those involved with a <del>fitness to practise (notification)</del> case
		4.7.2	Number of legitimate complaints about not being updated on progress and lack of support during the <del>FtP (notification)</del> process
		4.7.3	Analysis of feedback forms used as part of the <del>FtP (notification)</del> process
		4.7.4	Witness support arrangements including specific provision for vulnerable witnesses
4.8	<del>All fitness to practise (notification)</del> decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession	4.8.1	Outcomes of the regulator's internal quality assurance process
		4.8.2	Number of appeals and their outcomes
		4.8.3	Number of upheld complaints about the quality of the recorded decision
		4.8.4	Number of learning points about recorded decisions
		4.8.5	Details about the competencies required and the appointment process for ( <i>board, committee and panel members and expert advisors</i> ) <del>panellists and advisors to fitness to practise (notification) cases</del>
		4.8.6	Details about the appraisal process for ( <i>board, committee and panel members and expert advisors</i> ) <del>panellists and advisors to fitness to practise (notification) cases</del>



Standard			Evidence that could be presented to PSA
		4.8.7	Examples of training given to staff, ( <i>board, committee, panel members</i> ) <del>panelists and legal advisers</del> on undertaking their individual roles and any evaluation of the impact of this training
		4.8.8	Details of the process for regularly reviewing the guidance available. <del>to panelists</del>
		4.8.9	Details about how "learning points" or appeal outcomes are feedback to <del>panelists</del> ( <i>delegates</i> ) and staff
		4.8.10	Details of how the learning from these activities is used to identify and mitigate risks and otherwise improve decision making
4.9	All final <del>fitness to practise</del> ( <i>notification</i> ) decisions, <del>apart from matters relating to the health of a professional</del> , are published and communicated to relevant stakeholders ( <i>in accordance with national law</i> )	4.9.1	Disclosure policy including the regulator's process for publication <del>of allegations before a hearing, and about publication post hearing of decisions and/or transcripts</del>
		4.9.2	Links to webpages detailing the <del>fitness to practise</del> ( <i>notification</i> ) determinations
4.10	Information about <del>fitness to practise</del> ( <i>notification</i> ) cases is securely retained	4.10.1	Details of how the regulator ensures compliance with its information security policies
		4.10.2	The number of data breaches/incidents
		4.10.3	The action taken to address the breaches and incidents

## Private and Confidential

[letter date]

[notifier title] [notifier first name] [notifier last name]

[notifier address line]

[notifier suburb] [notifier state] [notifier postcode]

[notifier country, if not Australia]

Dear [notifier title] [notifier last name]

**Assessment of notification about [practitioner / student title] [practitioner / student first name] [practitioner / student last name]**

Thank you for taking the time to inform us of your concerns. We appreciate the effort this takes, and would like to assure you that we take all issues raised with us seriously.

The Australian Health Practitioner Regulation Agency (AHPRA) is a national body whose main aim is to protect the health and safety of the public. We work closely with the [Board Name] (the Board) to ensure that only health practitioners who are trained and qualified to practise in a competent and ethical manner are registered.

In assessing the concern you raised, we will now ask the following questions.

1. Is this concern about a registered health practitioner or student?
2. Are we the right agency to consider this concern?
3. Is there a risk that the health practitioner could harm the public?
4. Do we have good evidence of this?
5. Is the risk to the public so serious that the Board needs to restrict this practitioner's practice to make the public safe?

### What we will do now

The concern you raised is now being assessed. We will let you know what we have decided to do next. We will let you know if anything changes, or when we have made a decision. For your information, I have enclosed the principles that guide our decision-making and our Guide for notifiers.

### What we can do and what we cannot do

Once we look at the matter more closely, the Board can:

- caution the practitioner
- make sure the practitioner can practise only with certain restrictions
- refer the matter to another body (such as a tribunal or a panel) for action or mediation
- decide to take no action.

But neither the Board nor AHPRA can:

- make a health practitioner provide the treatment you want
- review any treatment provided by a health practitioner

- pay you compensation, or order a health practitioner to give you a refund or pay you compensation
- make a health practitioner apologise to you
- make a health practitioner give you access to your records
- deal with health service providers such as hospitals or community health centres
- take any part in any legal action you may be involved in.

When the Board and AHPRA take action about practitioners, we take action as required to keep the public safe. It is not our role to punish practitioners, nor to act for any individual.

### How long it will take

It takes time to consider notifications. We realise this can be frustrating, but we need to give everybody concerned time to answer our questions. Sometimes, we will tell you how we have addressed your concerns fairly quickly. When we need to investigate further, this can take much longer. The average time we take to address notifications is about six months, but it can take up to two years if the issues are very complicated. We ask you to be patient.

### Your role

We take all issues raised with us seriously, and we need your help to assess your concern.

### INCLUDE FOLLOWING PARAGRAPH IF CONSENT IS NEEDED

It may help us to be able to look at other information, such as those parts of your health record that are relevant to this issue. We would appreciate it if you could sign and return the enclosed consent form to us.

Please note that from here on, we will call the information you provide a 'notification'. And we will call you a 'notifier', because you have notified us about your concerns.

### What we will tell you

We are often limited in what we can tell you along the way, and even about the reasons for the Board's decision. At the very least, we will write to you to keep you informed of progress. We understand how important this matter is to you, however there may be a range of issues that relate to a decision and we may be unable to give full details.

Please contact us if you have any new information about this matter. We are available to speak with you more about the notifications process if that would help you. Your notifications liaison officer is [assigned to employee first name] [assigned to employee last name] and can be contacted on [assigned to employee phone number] or by email to [assigned to employee email address]

Yours sincerely,

[ADD ELECTRONIC SIGNATURE GRAPHIC HERE]

OR

[ADD MANUAL SIGNATURE HERE]

[Manager first name] [Manager last name]

[Manager, job title]

**Reference Number:** [notification number]

Encl: Guide for notifiers; regulatory principles

INCLUDE IF CONSENT IS NEEDED

Encl: consent form

PRA05

# Do you have a concern about a health practitioner?

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June 2013

A guide for people raising a concern (making a notification of complaint)

Notifications in the National Scheme

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## What is this document for?

Raising a concern about a health practitioner can be stressful. This brochure explains what happens after you have raised a concern about a registered health practitioner and tells you about:

- what we do: the role of the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA)
- what a notification is
- what we can do
- what we can't do
- what you can expect as a notifier (the person who raises the concern)
- the role of health complaints entities
- what you can expect from the notifications process
- what Boards can decide after assessing your notification, and
- answers to some common questions.

## What we do: the role of National Boards and AHPRA

The National Boards for 14 health professions and the Australian Health Practitioner Regulation Agency (AHPRA) work together to implement Australia's National Registration and Accreditation Scheme (the National Scheme). The National Boards regulate the health professions by setting the requirements for registration and the standards that practitioners must meet.

Information about the 14 professions in the National Scheme and our work is published on our website at [www.ahpra.gov.au](http://www.ahpra.gov.au). More information about how we do what we do is published in our Service charter at [www.ahpra.gov.au/About-AHPRA/Service-Charter](http://www.ahpra.gov.au/About-AHPRA/Service-Charter).

## What is a notification?

'Notifications' are concerns or complaints about registered health practitioners. Anyone can raise a concern about a registered health practitioner by contacting AHPRA, which has an office in each capital city.

**There are different arrangements in NSW where the Health Care Complaints Commission (HCCC) is the body which receives complaints. If you want to make a complaint about something that happened in NSW go to [www.hccc.nsw.gov.au](http://www.hccc.nsw.gov.au) for more information.**

Keeping the public safe is the goal that guides the way we deal with each notification we receive. When we look at notifications, we consider:

- whether the practitioner has failed to meet the standards set by the Board, and
- what needs to happen to make sure that the practitioner is aware of what has gone wrong and learns from this, so the same problem doesn't happen again.

The Boards also consider if they need to limit the practitioner's registration in some way to keep the public safe.

The powers of the National Boards and AHPRA are set down in the Health Practitioner Regulation National Law (the National Law). Responding to notifications about the health, performance or conduct of health practitioners is one of the most important parts of our role.

We also work with the independent health complaints entities (HCEs) in each state and territory to make sure the most appropriate organisation is dealing with the concern that has been raised. A list of the HCEs is available on our website at [www.ahpra.gov.au/Notifications/About-notifications/Working-with-health-complaints-entities/Health-complaints-entities](http://www.ahpra.gov.au/Notifications/About-notifications/Working-with-health-complaints-entities/Health-complaints-entities).

## The role of the National Boards

National Boards are made up of community and practitioner members. Board members are appointed by governments.

When dealing with notifications, the Boards and their committees make all the decisions about registered health practitioners. AHPRA staff work on behalf of the Boards to manage the notifications process.

Each notification is carefully considered to assess whether there is evidence that the practitioner poses a risk to patient and public safety. We will take action to manage any risks and to keep the public safe. If the Boards need more information before deciding what to do, we will investigate.

The Boards make every decision on the facts of each individual case. The focus is on:

- the health, performance or conduct (behaviour) of the practitioner
- understanding what has happened, and
- deciding what action, if any, the Board needs to take to make sure the public is safe and that the same thing won't happen again.

The actions the Boards can take are set down in the National Law.

To stop or limit a health practitioner's right to practise, a Board needs evidence, for example, that they:

- have not kept their clinical knowledge and skills up to date and are not competent
- have taken advantage of their role or have done something wrong, or
- are too ill, or have not adequately managed a personal health problem, to work safely.

In a small number of cases the Board may take immediate action to manage any risk to public safety while more information is gathered. This could include restricting what the practitioner can do at work, requiring extra supervision of their practice or in the most serious cases, suspending their registration.

### **AHPRA's role**

AHPRA staff receive concerns/complaints and manage the notifications process on behalf of the Boards.

Any correspondence you receive from AHPRA and the Board will be from AHPRA, on behalf of the National Board. Your contact person throughout the notification process will be an AHPRA staff member.

AHPRA does not make decisions about how to deal with notifications. These decisions are made by Boards.

### **What we can do**

We are responsible for making sure that registered health practitioners meet the standards of good practice set for them by each of the National Boards. If we identify serious concerns about a health practitioner we can:

- manage the risk to the public
- make sure the practitioner understands what went wrong, so the same thing doesn't happen again
- limit the practitioner's registration in some way, to change the way they practise, and
- share the lessons from what happened with other practitioners to help keep the public safe.

### **What we can't do**

There are some things that National Boards and AHPRA can't do.

We can't:

- order a health practitioner to provide the treatment you want
- pay you compensation or order a health practitioner to pay you compensation or repay you
- order a health practitioner to give you access to your records
- make a health practitioner apologise to you
- conciliate between you and the health practitioner
- resolve complaints about health systems
- advocate for you or the practitioner, or



- investigate concerns about health service providers such as hospitals or community health centres.

### What you can expect as a notifier

When you raise a concern about a registered health practitioner you are called the notifier. As a notifier, your role is to inform the Board and AHPRA of your concerns about the practitioner and to provide us with all the information you can about what has happened. We will ask you for information that is relevant to the concerns you have raised, and any supporting documentation you might have.

The Board can only make a decision based on the information it has. For this reason it is important that you provide all the information you can about what happened, so the Board can make an informed decision about what to do next. If you need help to provide this information, or need help understanding what we do, we can help you. Please contact us on 1300 419 495 if you need further assistance.

We must provide a copy of your notification to the practitioner you are concerned about, unless there is a risk to your safety if we do that.

Under the National Law, the National Boards and AHPRA are not advocates for you or for the practitioner. Our job is to:

- find out what happened
- decide whether the practitioner has failed to meet the required standards
- take any action needed to keep the public safe, and
- stop the same thing happening again.

More information about AHPRA and the notification process is published at [www.ahpra.gov.au/Notifications/The-notifications-process](http://www.ahpra.gov.au/Notifications/The-notifications-process).

### The role of health complaints entities

AHPRA and the National Boards work closely with the health complaints entities (HCEs), or commissioners, in each state and territory. We work closely with each of the HCEs to make sure that the right organisation deals with your concerns. There are different arrangements in NSW for dealing with notifications.

The role of the National Boards and AHPRA is to **protect the public**, including by managing notifications about health practitioners and when necessary, restricting their registration and their practice in some way.

The role of health complaints entities is to **resolve complaints or concerns**, including through conciliation or mediation.

AHPRA and the National Boards have no power to resolve complaints. Our focus is on managing any risk to the public.

HCEs deal with concerns about	National Boards and AHPRA deal with concerns about
Health systems	Health practitioners' conduct, health or performance
Health service providers (like hospitals or community health centres)	
Fees and charges	

Sometimes a person raises a concern with one agency and it ends up being managed by the other. This is because the HCEs and AHPRA work together and agree on which organisation should take responsibility for dealing with the concerns you have raised.

Each organisation has a role set down in the law and a different set of responsibilities. If you raised a concern with a health complaints entity and it is referred to AHPRA for the National Boards to deal with, this is because the issues you have raised relate to the conduct, health or performance of an individual registered health practitioner.

More information about HCEs and how they work with the National Boards and AHPRA is published in a fact sheet on the AHPRA website [www.ahpra.gov.au/Notifications/Fact-sheets/Health-complaints-entities](http://www.ahpra.gov.au/Notifications/Fact-sheets/Health-complaints-entities).

## What you can expect from the notifications process

### Getting started

You can raise a concern about a registered health practitioner with AHPRA by telephone, in writing in a notifications form (sent by email or in hard copy), or in person at an AHPRA office. The notifications form is available at: [www.ahpra.gov.au/Notifications](http://www.ahpra.gov.au/Notifications). Please contact us on 1300 419 495 if you need further assistance.

We can only do something about your concerns if they meet the legal grounds to be called a notification. This means your concerns must be about a registered health practitioner who:

- did not provide safe care because their standard of professional conduct was too low, and/or
- does not have reasonable knowledge, skill or judgement or exercise enough care, and/or
- is not a suitable person to hold registration, and/or
- is or may be ill and pose a risk to the public, and/or
- has or may have broken the National Law, and/or
- has or may have breached a condition on their registration or an undertaking, and/or
- obtained their registration improperly.

The exact legal grounds for a notification under the National Law are detailed on the website at [www.ahpra.gov.au/Notifications/What-is-a-notification/What-can-notifications-be-about](http://www.ahpra.gov.au/Notifications/What-is-a-notification/What-can-notifications-be-about).

If at first you do not provide us with enough information for your concerns to be considered a notification, we will contact you to find out more. We can help you to work out if your concerns meet the legal grounds for a notification. If **within 30 days** we cannot establish that your concerns are grounds for a notification, we will write to you and tell you we can't take any further action.

If your concerns do meet the grounds for a notification it is assessed by a National Board (see next section).

### Assessment

We conduct an assessment to see if the concerns raised in your notification can be quickly and easily addressed and if not, to make sure they are dealt with in the most effective way possible.

As part of the assessment process, we will send your notification to the health practitioner and ask them to respond, unless we believe your safety is at risk.

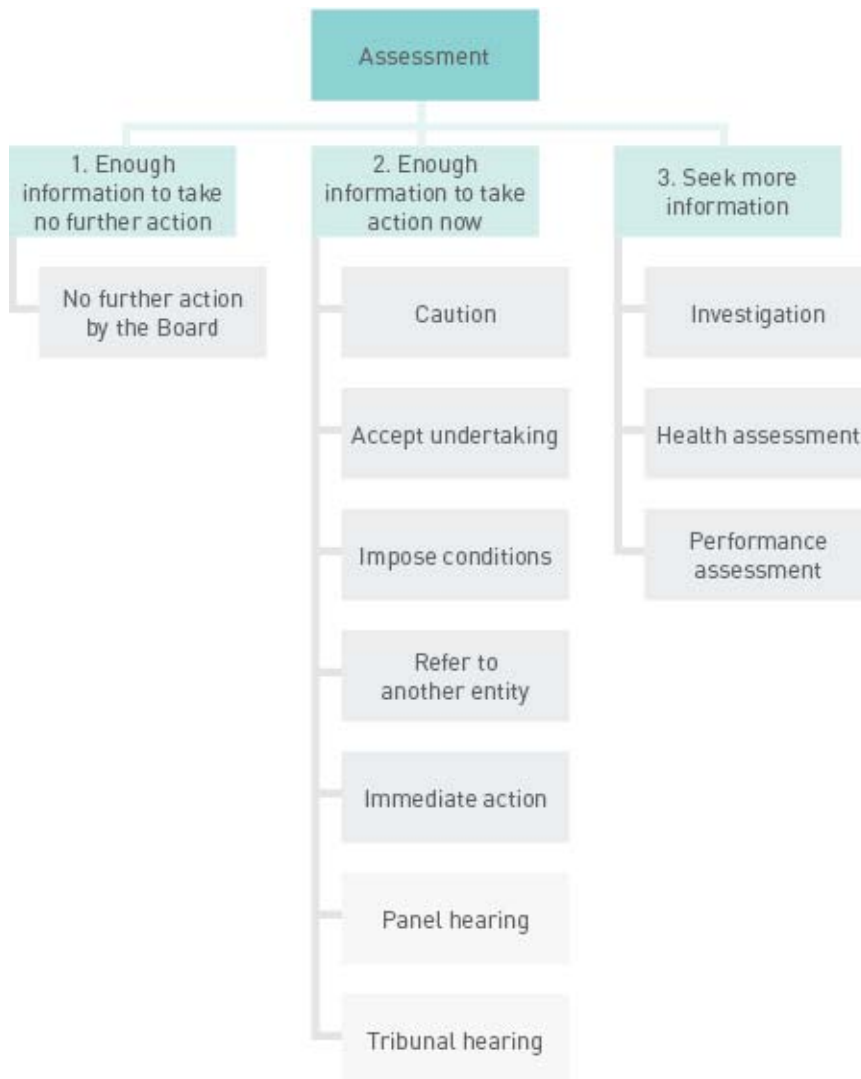
At this stage, the National Board has to decide if the notification raises issues of unprofessional conduct, unsatisfactory professional performance or impairment (illness) of a registered practitioner.

The decisions the Board can make after assessing the notification fall into three broad categories.

1. There is enough information to decide no further action is necessary to protect the public.
2. There is enough information to decide to take action now to protect the public.
3. There is not enough information, we need to seek more.

We will write to you after the assessment to let you know what the Board has decided to do about the notification you have lodged. We aim to conduct the assessment and let you know what has happened **within 60 days** of establishing that the concerns you raise meet the legal definition of a notification.

## What Boards can decide after assessing your notification



### 1. There is enough information to decide no further action is necessary to protect the public.

When there is enough information available at this stage, a National Board may decide there is no risk to the public that it needs to manage. In these cases the Board can decide to take no further action.

When a Board decides to take no further action after an assessment, it means it has decided that:

- there is no risk to the public that needs to be managed
- the issue does not require the practitioner's registration to be restricted in some way, or
- progressing the matter would not lead to any action being taken on the practitioner's registration.

If a Board decides to take no further action, it does not mean that the issue you raised was not important or that it was not worth making a notification. It means that the Board has decided there is not a risk to the public that it needs to address, or that managing the issue does not require the practitioner's registration to be restricted in some way. The information you provided stays on the practitioner's file, and can be considered again at a later time.

### 2. There is enough information to decide to take action now to protect the public.

In some cases a National Board believes it has enough information from the notifier, and perhaps the practitioner, to decide what action it needs to take to keep the public safe. In these cases, it can take any one or more of the following six courses of action:

1. caution the practitioner
2. accept an undertaking from the practitioner (to do or to not do something in relation to their practice)
3. impose conditions on the registration of the practitioner), for example that the practitioner:
  - undertakes further education or training and/or
  - has their practice supervised and/or
  - does, or does not do, something in relation to their practice and/or
  - manages their practice in a certain way and/or
  - reports to a specified person at set times about their practice and/or
  - does not employ someone or a type of person
4. refer the concerns to a health complaints entity because it relates to a wider health system issue, or refer the concerns to another organisation outside the National Scheme, for example, Medicare Australia or health insurance companies
5. take immediate action to protect the public by limiting the practitioner's registration in some way. This is an interim step and always involves another course of action as well, such as referral to an investigation
6. refer the practitioner to a panel hearing, or
7. refer the practitioner to a tribunal hearing.

When a National Board decides to **take immediate action, caution or impose conditions** on a practitioner's registration, it is legally required to seek submissions from the practitioner about what the Board proposes to do. These submissions can be made face-to-face or in writing and will inform the final decision made by the National Board.

More information about immediate action is published in this fact sheet available at [www.ahpra.gov.au/Notifications/Fact-sheets/Immediate-action](http://www.ahpra.gov.au/Notifications/Fact-sheets/Immediate-action).

If the Board decides to **limit a practitioner's registration** in some way, any restrictions are published on the register of practitioners at [www.ahpra.gov.au/Registration/Registers-of-Practitioners](http://www.ahpra.gov.au/Registration/Registers-of-Practitioners). This online public register provides information about the current registration status of every registered health practitioner in Australia. The only exception is in relation to private health information, which is not published.

It is not common for a Board to refer a matter directly to a panel or a tribunal without investigation, but this is possible under the National Law.

### **3. Not enough information is available, seek more information.**

Sometimes the Board decides it needs more information before it can make an informed decision about what, if any, action might be necessary to keep the public safe. In these cases, the Board can:

- refer the matter to investigation, and/or
- refer the practitioner for a health or performance assessment.

If the Board decides to investigate a matter, the investigation will usually be undertaken by AHPRA staff. During an investigation, we may seek more information from you or other people or organisations (such as hospitals, other practitioners or witnesses), including records, reports or expert opinions. This information forms the basis for a decision by the Board at the end of the investigation.

Practitioners can continue to practise while an investigation is underway, consistent with any limits on their registration a Board has put in place to keep the public safe in the meantime.

We will write to you every three months to inform you about the progress of the investigation and we will write to you at the end of the investigation to tell you what action the Board decided to take. After an investigation a National Board can decide to:

- take no further action
- refer the practitioner for a health or performance assessment
- refer the matter to a health or performance and professional standards panel
- impose conditions on/accept an undertaking from the practitioner

- caution the practitioner
- refer the matter to a tribunal, or
- refer the matter to another entity.

Information about performance assessments, health assessments and the role of panels and tribunals is available at [www.ahpra.gov.au/Notifications/The-notifications-process](http://www.ahpra.gov.au/Notifications/The-notifications-process).

## Answers to some common questions

### Can I seek compensation through a Board and AHPRA?

No, the Board cannot deal with issues of compensation.

Sometimes notifiers do seek compensation for what has occurred. The health complaints entity in your state or territory can advise you about compensation, even if your concerns are being handled by AHPRA and the National Boards.

### Can I seek advice about health treatment from a Board and AHPRA?

No, the Board cannot provide any advice about the health treatment you should seek or recommend which practitioners you should or could seek treatment from.

### Can I appeal a Board's decision if I am not happy with it?

Under the National Law this is not possible. The role of the Board is to assess the concerns you have raised about the practitioner and take action to protect the public. The Board conducts this assessment and decides what to do as a result.

If you are not happy with our processes or you think our systems were not fair and robust, you can make a complaint to AHPRA. If you are not satisfied with our response, you can also make a complaint to the National Health Practitioner Ombudsman and Privacy Commissioner at [www.nhpopc.gov.au](http://www.nhpopc.gov.au). The Ombudsman cannot overturn a decision of the Board but can review the process for managing the notification.

### How long does an investigation take?

Each investigation is guided by the facts of the individual case. How long an investigation takes is influenced by a number of issues including:

- how much evidence is available
- whether we need to get other expert opinions, and
- whether we are relying on information being provided by other people or organisations.

Most straightforward investigations are completed within nine to 12 months.

More common questions and answers are published on our website at [www.ahpra.gov.au/Notifications/Fact-sheets](http://www.ahpra.gov.au/Notifications/Fact-sheets).

## Private and Confidential

[letter date]

[notifier title] [notifier first name] [notifier last name]  
[notifier address line]  
[notifier suburb] [notifier state] [notifier postcode]  
[notifier country, if not Australia]

Dear [notifier title] [notifier last name]

### Request for more information

You notified us of concerns about [practitioner / student title] [practitioner / student first name] [practitioner / student last name] on [received date].

We need more information before we can take the matter any further. Could you please provide us with

Insert questions/information required. Use sentences attached to above paragraph if one or two items. Use a bulleted list for three or more items.

You can send this by mail, or by email to [assigned to employee email address], or by ringing us on [assigned to employee phone number].

Please note that to be fair to everybody concerned, we need this information by [date]. If we do not receive the information we need within that time, we will consider the matter closed.

### What AHPRA is

As we mentioned in an earlier letter, the Australian Health Practitioner Regulation Agency (AHPRA) is a national body whose main aim is to protect the health and safety of the public. We work closely with the [Board Name] (the Board) to ensure that only health practitioners who are trained and qualified to practise in a competent and ethical manner are registered.

In assessing the concern you raised, we will now ask the following questions.

1. Is this concern about a registered health practitioner or student?
2. Are we the right agency to consider this concern?
3. Is there a risk that the health practitioner could harm the public?
4. Do we have good evidence of this?
5. Is the risk to the public so serious that the Board needs to restrict this practitioner's practice to make the public safe?

### What we can do and what we cannot do

Once we look at the matter more closely, the Board can:

- caution the practitioner
- make sure the practitioner can practise only with certain restrictions
- refer the matter to another body (such as a tribunal or a panel) for action or mediation
- decide to take no action.

But neither the Board nor AHPRA can:

- make a health practitioner provide the treatment you want
- review any treatment provided by a health practitioner
- pay you compensation, or order a health practitioner to give you a refund or pay you compensation
- make a health practitioner apologise to you
- make a health practitioner give you access to your records
- deal with health service providers such as hospitals or community health centres
- take any part in any legal action you may be involved in.

When the Board and AHPRA take action about practitioners, we take action as required to keep the public safe. It is not our role to punish practitioners, nor to act for any individual.

### How long it will take

It takes time to consider notifications. We realise this can be frustrating, but we need to give everybody concerned time to answer our questions. Sometimes, we will tell you how we have addressed your concerns fairly quickly. When we need to investigate further, this can take much longer. The average time we take to address notifications is about six months, but it can take up to two years if the issues are very complicated. We ask you to be patient.

### What we will tell you

We are often limited in what we can tell you along the way, and even about the reasons for the Board's decision. At the very least, we will write to you to keep you informed of progress. We understand how important this matter is to you, however there may be a range of issues that relate to a decision and we may be unable to give full details.

Please contact us if you have any new information about this matter. We are available to speak with you more about the notifications process if that would help you. Your notifications liaison officer is [assigned to employee first name] [assigned to employee last name] and can be contacted on [assigned to employee phone number] or by email to [assigned to employee email address]

Yours sincerely

[ADD ELECTRONIC SIGNATURE GRAPHIC HERE]

OR

[ADD MANUAL SIGNATURE HERE]

[author employee first name] [author employee last name]  
[author employee job title]

**Reference Number:** [notification number]

PRA04



## Timeliness performance comparator<sup>i</sup>

		AHPRA (14) <sup>ii</sup>	MBA	UK - GMC	DBA	UK - GDC	AHPRA HCPC (4) <sup>iii</sup>	AHPRA HCPC (9) <sup>iv</sup>	UK – HCPC (16)
	<b>Registration Activity</b>								
1	Number of registrants	619,509	99,379	259,826	20,707	103,765	60,862	76,974	322,037
2	Number of applications received	58,789	15,425	13,246	1,907	10,210	6,616	8,240	19,857
3	Annual registration fee <sup>v</sup>		\$715	\$706	\$603	\$1,043	≈ \$239	≈ \$329	\$145
	<b>Notifications Activity<sup>vi</sup></b>								
4	Number of notifications (cases) received	6,811	3,812	9,895	582	2,990	192	341	2,069
5	Percentage of <u>unique</u> registrants subject to notification (fitness to practise case) <sup>vii viii</sup>	1.4%	4.9%		3.6%		0.5%	0.9%	0.6%
6	Percentage of registrants subject to notification (fitness to practise case) <sup>ix</sup>	1.1%	3.8%	3.8%	2.8%	2.9%	0.3%	0.4%	0.6%
7	Number of notifications (cases) <u>concluded</u> by a National Board / Delegate at assessment or investigation (investigative committee)	5,856	3,424	2,119	577	545	148	262	682
8	Number of notifications (cases) <u>concluded</u> by a panel or tribunal (final fitness to practise panel)	344	165	241	31	84	6	14	267
	<b>Notifications Performance</b>								
	<i>Time taken from receipt of initial complaint to the final Board / Delegate (investigating committee) decision at assessment or investigation: (weeks)<sup>x</sup></i>								
9	Median time taken to conclude	9	9	29	10	46	9	10	27
10	Longest case to conclude	222	222	388	174	187	132	180	162
11	Shortest case to conclude	-	-	1	-	5	-	-	4
	<i>Time taken from receipt of initial complaint to final panel or tribunal (final fitness to practise) hearing: (weeks)</i>								
12	Median time taken to conclude	99	102	97	82	100	82	92	68
13	Longest case to conclude	202	202	381	189	320	113	157	231
14	Shortest case to conclude	18	18	17	57	38	38	38	23
	<i>Median time taken from final Board / Delegate (investigating committee) decision to panel or tribunal (final fitness to practise) hearing decision: (weeks)<sup>xi</sup></i>								
15	Median – Investigating committee decision to hearing decision (Panel)	28	33	34	32	46	17	25	37

		AHPRA (14) <sup>ii</sup>	MBA	UK - GMC	DBA	UK - GDC	AHPRA HCPC (4) <sup>iii</sup>	AHPRA HCPC (9) <sup>iv</sup>	UK – HCPC (16)
	<i>Median time taken from initial receipt of complaint to immediate action (interim order) decision, and from receipt of information indicating the need for an immediate action (interim order) to an immediate action (interim order) decision: (weeks)</i>								
16	Receipt of complaint	0.7	0.9	8.4	0.6	45.0	1.1	1.1	15.0
17	Receipt of information	0.3	0.1	2.7	0.4	3.0	0.9	0.5	2.6
	<i>Number of open notifications (cases) older than:</i>								
18	52 weeks	1,185	600	919	96	364	12	48	298
19	104 weeks	410	183	330	34	99	8	28	42
20	156 weeks	87	44	76	11	44	3	10	2
21	Number of registrant appeals against notification (final fitness to practise) decisions:	54	33	36	1	3	2	7	8

<sup>i</sup> Datasets used:

- The AHPRA annual report 2013/2014 data was used for AHPRA rows: 1, 2, 3, 4, 5, 18, 19, 20, 21.
- The AHPRA Performance Reporting (KPI) data was used for AHPRA rows: 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17.
- The Professional Standards Authority Performance Review 2013/2014 data was used for GMC, DBA, and HCPC rows: 1, 2, 3, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21.
- The HCPC Fitness to Practise Annual Report 2013-14 data was used for HCPC rows: 4, 5, 6.
- The GMC Annual Report 2013 data was used for GMC row: 4.
- The GDC Annual Report 2013 data was used for GDC row: 4.

<sup>ii</sup> Includes all 14 professions currently regulated under the National Scheme.

<sup>iii</sup> Professions which qualify for the AHPRA HCPC (4) are: medical radiation practitioner, occupational therapist, physiotherapist, podiatrist. These professions are currently regulated by the HCPC in the UK.

<sup>iv</sup> Professions proposed for inclusion in a single Health Professions Australia Board (9) are: Aboriginal & Torres Strait Islander health practitioner, Chinese medical practitioner, chiropractor, medical radiation practitioner, occupational therapist, optometrist, osteopath, physiotherapist, podiatrist.

<sup>v</sup> For annual UK registration fees, an exchange rate of \$1.81 per £1 was applied, as per the consultation paper.

<sup>vi</sup> Notification activity data excludes NSW.

<sup>vii</sup> AHPRA modelling of HCPC data is the average percentage for the qualified professions.

<sup>viii</sup> This percentage is concerned only with the number of unique registrants who are subject to a notification. A registrant who has multiple notifications will be only counted once.

<sup>ix</sup> This percentage is a calculation of the number of notifications received divided by the number of registrants for the profession.

<sup>x</sup> An investigative committee determines whether there is a 'case to answer'. The NRAS equivalent is a National Board or Delegate decision at either the assessment or investigative stages.

<sup>xi</sup> A fitness to practise panel meets to determine whether the evidence exists to apply sanctions on a practitioner registration. There is no exact NRAS equivalent, as we refer 'professional misconduct' straight to a Tribunal Hearing. For comparative purposes, a combination of both the panel and tribunal stages has been used (noting the likely performance drop in tribunal as a result of the inherent delays of the judicial system).



# **SUBMISSION TO THE REVIEW OF THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME**

**OCTOBER 2014**



## Introduction

The Osteopathy Board of Australia (the OsteoBA) is one of 14 National Boards in the National Registration and Accreditation Scheme (NRAS). The OsteoBA has participated in the development of the joint submission to the Review from the National Boards and AHPRA; and the Chair of the OsteoBA fully supports the joint submission and is a co-signatory.

There are some features of the regulation experience which the OsteoBA thought may be more appropriate to highlight in a brief separate submission as the comments are able to be provided within the context of the OsteoBA and may be better placed in a stand-alone document.

Osteopathy has been regulated in Australia since the 1970s. Prior to the National Registration and Accreditation Scheme, there were boards and relevant legislation to regulate osteopathy in all jurisdictions. The osteopathy workforce is one of the fastest growing and has the largest proportion of younger practitioners.

## Submission

Overall, the regulation of osteopathy has gained many advantages under the NRAS, which are shared by other National Boards, and were outlined in the original combined National Boards' preliminary submission in the profession-specific attachment (1 July 2014). There are a couple of specific issues that have arisen during the five years of NRAS that the OsteoBA would like to outline briefly, by taking the opportunity of presenting this submission with more detail as a supplement to the combined National Board and AHPRA submission.

The geographical concentration of osteopaths continues to be entrenched with over 80% in the two largest states: Victoria (52.49%) and NSW (28.36%); as shown in Chart 1 as an appendix. This is a legacy of the location of longstanding osteopathy courses in Melbourne and is expected to continue with the addition of an accredited course in NSW since the commencement of NRAS.

Chart 2 shows that over 80% of the profession are below the age of 50, which are likely to be the years of establishing practices and family responsibilities. The number of students in accredited courses has more than doubled in the past three years (1,249 at 31 May 2014) but this trend will entrench growth of registered practitioner numbers in those of a young age group and in Victoria and NSW.

When overlaid, the geographical distribution combined with age has, on occasions, resulted in delays in appointments to the OsteoBA due to low number of potential applicants from some of the smaller jurisdictions. The OsteoBA stresses that, for the vast majority of the past five years, and currently, it operates under full capacity of membership; and further, it appreciates the fact that ministers have made these appointments out of sessions at times to allow full capacity to be achieved without further delay.

Should this situation arise in future, the OsteoBA would like to see pre-emptive targeted changes to the National Law in relation to **board member ratio requirements**, as the current requirement could create a barrier to succession planning and merit based appointments at another time. This could also be achieved through policy guidance from ministers. It would also be consistent with recommendation 3 of the Senate inquiry which recommended that the Scheme contain sufficient flexibility for the composition of Boards to properly reflect the characteristics and needs of individual professions.<sup>1</sup>

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<sup>1</sup> Recommendation 3 (paragraph 2.178) of [the Senate: Community Affairs Legislation Committee inquiry into the National registration and accreditation scheme for doctors and other health workers, Commonwealth of Australia, ISBN 978-1-74229-160-4](#).

From this flows a second position, that the OsteoBA supports legislative change to enable the **interim appointment of non-practitioner chair** of National Boards, in the event that suitable practitioner-member chair applicants are unavailable and on the basis of merit. Although it is acknowledged that not all Boards or stakeholders would support this approach, the OsteoBA see this Review as the opportunity to make a pre-emptive change to legislation should the need arise or as an interim measure; whilst recognising, supporting and benefitting from the leadership provided to date of practitioner chairs.<sup>2</sup>

The OsteoBA would like to alert the Review that a recent joint initiative with the Australasian Osteopathic Accreditation Council (the accreditation authority for the osteopathy and former known as ANZOC) has seen a majority of **osteopaths trained outside of Australia and New Zealand** taking up positions in practices outside of Victoria in the past year; and this a way of addressing previously difficult employment vacancies in geographical locations outside Victoria and NSW. There are now two pathways: the **competent authority pathway** and the **standard pathway**.

As provided for in section 42(c), at the request of the OsteoBA, the AOAC, considered whether osteopaths registered by the General Osteopathic Council in the UK (GOsC) have the knowledge, skills and professional attributes necessary to practise the profession in Australia.

In undertaking its assessment, AOAC developed a policy that specifies processes and criteria for the assessment and recognition of authorities under the National Law. The development of a competent authority pathway under this part of the National Law was the first by a Board, although there are other competent authority models used by other Boards.<sup>3</sup>

Finally, turning to the options in the Review<sup>4</sup>, the OsteoBA does not support the Option 1 of a Health Professions Australia Board.

The former OsteoBA Chair was instrumental in establishing (and Chairing) the multi-professions working group to allow professions with smaller regulatory workload to develop mechanisms within NRAS to become more efficient and cost effective, identifying the needs differential between the five larger and nine smaller regulatory volume professions. This work is ongoing and has identified some key areas of operational reform capable under the current arrangements, many of these being actively considered at present. So whilst the OsteoBA is fully supportive of Option 2 (dependent upon specific details) it is also comfortable with Option 3, knowing that the OsteoBA's involvement with the multi-profession's working group is proactively identifying, developing and implementing with the full support and assistance of AHPRA, many cost efficiencies, time efficiencies and facilitating greater consistency within the current regulatory framework.

Apart from, and ahead of this collaborative work with other Boards, the OsteoBA has been able to reduce registration fees in 2014/15 and will continue to identify further ways of reducing registrant fees in future.

Dr Nikole Grbin (Osteopath)

Chair

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<sup>2</sup> Question 25

<sup>3</sup> Question 24

<sup>4</sup> Questions 3 to 5

Chart 1:

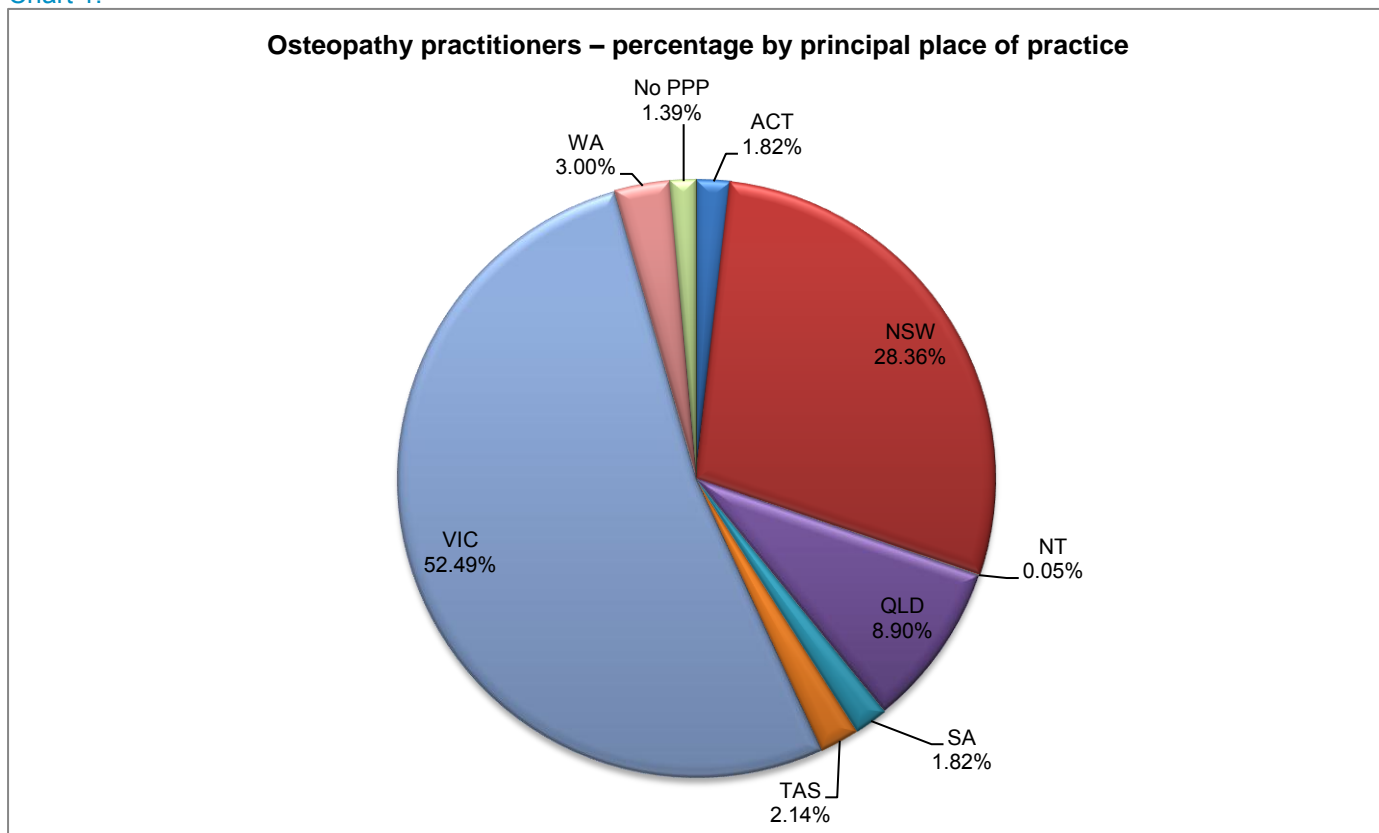


Chart 1: Osteopathy practitioners – percentage by principal place of practice, June 2014

Chart 2:

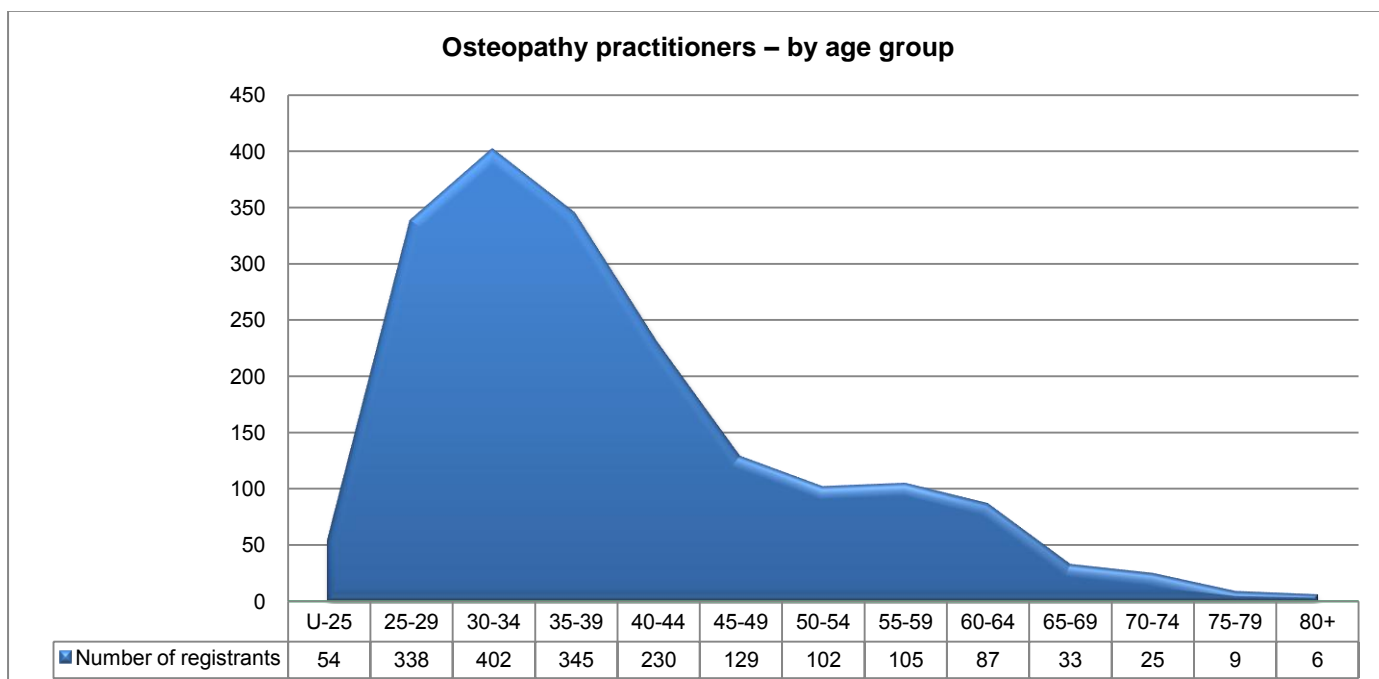


Chart 2: Osteopathy practitioners – by age group, June 2014



## **National Registration and Accreditation Scheme Accountability Framework**

All entities in the National Registration and Accreditation Scheme are ultimately accountable to the Australian public through the Ministerial Council. One of the recognised challenges of the scheme is the complex governance structure with no single point of accountability for the performance of the National Scheme. The effective delivery of professional regulation therefore relies on strong partnerships between entities based on clear and agreed roles and functions.

Accordingly, this framework is designed to articulate a shared understanding between the parties regarding who is accountable for what within the Scheme. The framework documents the principles that govern the exercise of powers and functions and aims to provide clarity about the distinct roles of the different entities, and their respective duties and obligations.

Accountability is defined as public and statutory accountability. Accountability cannot be delegated; however, responsibility can be assigned and powers and functions delegated by the accountable person or entity. To be accountable, a person must have genuine authority relating to the functions for which they are accountable.

The framework is designed to support the exercise of delegations in the Scheme, under section 37, and schedule 7 section 29 of the National Law. As a general principle, decision-making within AHPRA is delegated to the lowest reasonable level, having regard to the knowledge, experience and authority required to exercise the judgement. Delegators must specify any conditions or limitations placed on the exercise of delegated powers and functions. For example, if a health profession board requires assurance that a particular type of decision will only be made with appropriate clinical input, this can be specified. AHPRA is then accountable for compliance with that instrument of delegation.

External agencies, contractors or consultants cannot be held directly accountable for delivering the functions of an entity under the National Law. The mechanism for accountability for such functions is the contract or agreement that governs the provision of services. Accountability rests with the delegate approving the contractual arrangements.

### The Australian Health Workforce Ministerial Council is ultimately accountable for the Scheme

Ultimate accountability to the public for the performance of the Scheme resides with the parliaments of participating jurisdictions, through the Australian Health Workforce Ministerial Council (the Ministerial Council). The Ministerial Council may provide policy directions to the Agency and National Boards, approves registration standards, makes regulations and approves certain other recommendations from National Boards in respect of specialist registration, areas of practice and endorsement. The Ministerial Council appoints the Agency Management Committee and National Boards, and formally holds these bodies to account. The annual report provided to the Ministerial Council is a key component of the Scheme's accountability.

This framework clarifies the ways in which the following parties are accountable to the Ministerial Council under the National Law.

### Agency Management Committee is accountable for AHPRA's performance

The Agency Management Committee directs and controls the affairs of AHPRA, and sets its policy directions. The Agency Management Committee is accountable for the performance of AHPRA's functions, which include the establishment of regulatory procedures, and administration of the Scheme. To enable it to perform the executive functions within the Scheme, AHPRA has powers to employ staff and enter into contracts.

By whom	For what	How they are held to account	Complementary aspects
<p>All Australian parliaments.</p> <p>Ministerial Council</p> <p>Courts, administrative and regulatory bodies.</p>	<p>For all acts and things done by the National Agency (AHPRA).</p> <p>Corporate governance:</p> <p>Setting the strategic directions and performance expectations for the Agency.</p>	<p>Statutorily under National Law, section 30 (2).</p> <p>Through the inter-governmental agreement.</p> <p>As a board of directors under Corporations Act 2001 to the extent that specific obligations are not covered in the National Law, for example a duty to avoid insolvent trading.</p>	<p>While the Agency Management Committee is formally accountable for the performance of the Agency and the administration of the Scheme, the National Boards are dependent on the Agency to perform functions on their behalf. The Health Profession Agreements are the formal mechanism by which the boards hold the Agency to account (see below).</p> <p>In addition, the Agency has an obligation to consult with National Boards in relation to specific functions.</p>

	<p>Delivering functions required by the National Law.</p> <p>Compliance with obligations set by other regulators at the national, state and territory levels, including for the adequacy of regulatory procedures through the Commonwealth's Office of Best Practice Regulation.</p>	<p>Schedule 3, sections 8 and 9 require the submission of the Agency's <u>annual report</u>, incorporating information about the performance of National Law functions by the Agency and National Boards; and the provision of audited financial statements.</p>	<p>National Boards must, if asked, provide information to enable the Agency to compile its report.</p>
	<p>Financial management in relation to the administration of the Agency Fund.</p>	<p>Section 212 in respect of efficient operations and lawful expenditure including financial statements, compliance with Australian Accounting Standards and audit provisions.</p>	<p>A National Board must ensure that it operates efficiently and economically and that it takes action to ensure that the Agency is able to comply with its obligations.</p>
	<p>Appointment of CEO, conferral of powers and delegations to CEO.</p>	<p>Schedule 3, sections 1 – 4.</p>	<p>The CEO has functions conferred by their instrument of appointment and specific delegations.</p>
National Boards.	<p>Services provided by AHPRA to enable the board to carry out its functions.</p>	<p>National Law section 26 requires the Agency to enter into a Health Profession Agreement. These agreements outline the services to be delivered, including key performance indicators, and the budget. Contracts entered into on behalf of National Boards must be in accordance with the Health Profession Agreements.</p>	<p>In performing functions delegated by National Boards, or providing services to boards under the HPA, the Agency has an obligation to ensure that it is complying with all relevant legislative requirements.</p>

	Maintenance of a separate account for each board.	The Health Profession Agreement will specify the board's budget and work-plan, including provision for expenditure.	Financial delegations are held and exercised by AHPRA on behalf of boards, within the context of approved budgets under the Health Profession Agreements.  Payments from accounts are made in accordance with a HPA budget, or with approval of the board.
<b>Chief Executive Officer</b>			
<b>To whom</b>	<b>For what</b>	<b>How they are held to account</b>	<b>Complementary aspects</b>
The Agency Management Committee.	Implementing the AManC strategic directions and the Annual Business Plan.  Delivery of Agency functions.  Delivery of services to National Boards.  Exercise of delegated functions by AHPRA.  Procurement of services.	Employment contract.	<ul style="list-style-type: none"> <li>• Administration of internal controls and accountability mechanisms</li> <li>• Performance against expectations as reported in the Annual Report</li> <li>• Administration of Health Profession Agreements</li> <li>• Administration of contracts and Agreements, including with Accreditation Authorities</li> </ul>
National Boards.	Timeliness, cost and quality of regulatory procedures and services to boards.	Health Profession Agreements.	The quality of National Board decision-making is directly impacted by the quality of information and advice provided by AHPRA, and its implementation of regulatory procedures and operations. While the CEO's direct accountability is to the Agency Management Committee through the employment contract, the CEO has important obligations to deliver against the Health Profession Agreements.

### National Boards

National Boards are the principal regulatory decision-makers in the Scheme, with delegated functions undertaken by AHPRA and by their committees including where relevant State and Territory or Regional Boards. National Boards are accountable to the community through the mechanism of the Ministerial Council and parliamentary reporting for the quality of their regulatory decisions, and through the court system and relevant administrative review bodies for the legality of their regulatory decisions. While National Boards can propose regulatory procedures, they do not establish or administer them. National Boards have specific 'oversight' roles in relation to the assessment of overseas qualifications, monitoring of practitioners and the receipt, assessment and investigation of notifications. Without the power to employ staff or enter into contracts, National Boards must rely on the services provided, or contracted, by the Agency. The mechanism for National Boards to hold AHPRA to account is the Health Profession Agreements (HPAs). The HPAs include performance indicators to support the performance of National Boards' oversight functions.

To whom	For what	How they are held to account	Complementary aspects
Through the court system.	The legality of regulatory decisions, including by delegates.	Every decision can be tested by the courts, at the instigation of any person who has <i>locus standi</i> to bring an action in the court system. This may theoretically extend to scrutiny of the adequacy of standards, codes, guidelines, delegations, probity of decision-making processes and 'due diligence' around quality assurance of delivery of functions under HPA.	In terms of Registration Standards, and certain other decisions around endorsements and specialties, ultimate public accountability rests with the Ministerial Council which must approve them.  Under schedule 7, section 29, a function properly exercised by a delegate is taken to have been exercised by the delegator. The delegator must ensure the delegation is properly exercised.
Ministerial Council	Proper exercise of functions under National Law.	National Board members are appointed by the Ministerial Council, and can be removed by the Chairperson of the Ministerial Council in specific circumstances.	Schedule 4.

The Agency Management Committee.	Reciprocal obligations in respect of the Health Profession Agreement, and provision of information to enable the Agency to perform its financial management functions.	Section 26 regarding Health Profession Agreements. Section 212 (2) in respect of financial management.	The submission of the Agency's annual report to all parliaments ensures that the Agency Management Committee is held publicly accountable for the use of registrant funds for the purposes of administering the Scheme. The National Law specifies the responsibilities of National Boards in enabling the Agency to comply with its obligations.
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### Accreditation Authorities

An accreditation authority may be an external entity or a committee of the board. The National Law creates a 'separation of powers' between National Boards and accreditation authorities by clearly specifying distinct decision-making roles in accreditation functions. The National Law provides for AHPRA to enter into a contract with an accreditation authority, in accordance with its HPA with the relevant board. AHPRA has facilitated the development of a cross-profession Quality Framework for Accreditation Functions which provides an overarching set of expectations for the delivery of accreditation functions, including domains such as governance, stakeholder collaboration and accreditation standards and processes. The Quality Framework is the principal reference document for National Boards and AHPRA to assess the work of accreditation authorities.

To whom	For what	How they are held to account	Complementary aspects
National Boards.	The performance of assigned accreditation functions.	Under section 43, a National Board decides whether an accreditation function is to be exercised by an external entity or a committee of the board. Under Schedule 7 section 23, the National Board has the power to decide to repeal or amend that decision. If it is not satisfied that the authority is adequately performing these functions, it may decide that one or more accreditation functions could be performed by a different entity or a committee of the board.	A National Board also decides whether to approve an accreditation standard, and whether to approve an accredited program of study as a qualification for entry into the profession.
AHPRA.	Delivery of funded accreditation activities.	Through an accreditation agreement, entered into with AHPRA on behalf of the National Board.	Under section 32 (2) (a) National Boards do not have the power to enter into contracts. Consequently any contractual relationship with an accreditation authority is between AHPRA and the relevant authority. AHPRA may only enter into a contract if the terms and conditions of the contract are in accordance with the Health Profession Agreement.