Annual Report 2011/12

AHPRA

Chiropractic
Dental
Medical
Nursing and Midwifery
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

The Australian Health Practitioner Regulation Agency and the National Boards, reporting on the National Registration and Accreditation Scheme

The Australian Health Practitioner Regulation Agency (AHPRA) is the national organisation responsible for implementing the National Registration and Accreditation Scheme across Australia, in partnership with the National Boards.

Guided by a nationally-consistent law, AHPRA and the National Boards work to regulate the health professions in the public interest. This includes registering practitioners who are suitably trained and qualified to provide safe healthcare and investigating concerns about registered health practitioners.

This annual report is prepared and submitted in accordance with Clause 8 to Schedule 3 of the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory. All references in this report should be understood to refer to the National Law.

Copies of this annual report are publicly available at www.ahpra.gov.au and at no cost by contacting AHPRA by telephone on 1300 419 495, in writing to GPO Box 9958, Brisbane Qld 4001 or by email through the online enquiry form at the AHPRA website: www.ahpra.gov.au

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AHPRA in numbers 2011/12

- On 30 June 2012, there were more than 548,500 health practitioners from 10 professions registered in the National Registration and Accreditation Scheme, an increase of 3.47% on 30 June 2011.
- AHPRA renewed the registration of more than 557,000 health practitioners.
- AHPRA generated more than 1.5 million email registration renewal reminders.
- AHPRA responded to more than 517,000 phone calls to state and territory offices; more than 80% of which were answered within 90 seconds. The most common question was from practitioners asking about the status of their current application.
- AHPRA manages 15 websites, including one for each National Board. These hosted almost eight million visits and there were more than 45 million page views.
- There were almost 39,000 enquiries at the state and territory office counters.
- AHPRA issued close to 550,000 certificates of registration to health practitioners across Australia.
- The National Scheme received 7,594 notifications about health practitioners; 775 of them were mandatory reports.
- There were more than 1,500 meetings of National Boards, state and territory boards and their committees.
- There were more than 110,000 students studying to be health practitioners in Australia at the end of the year. A register of these currently enrolled students is maintained by AHPRA as part of the national register, with information collected from 145 education providers.
- 12 new registration standards were approved by Ministerial Council and published by the National Boards.
- AHPRA and the National Boards issued nearly 100 media releases, as well as responding to more than 1,300 media enquiries.
- AHPRA published six issues of *AHPRA Report*, a regular newsletter containing updates and news.
- The National Boards issued 20 newsletters and more than 100 communiqués.
- AHPRA requested more than 68,000 criminal history checks.
- AHPRA maintained a suite of around 300 forms to support a wide range of complex and technical interactions between practitioners and AHPRA/National Boards.
- AHPRA undertook the largest ever renewal in Australia when more than 333,000 nurses and midwives renewed their registration in May 2011. More than 92% renewed online.

Forewords

Foreword from the Agency Management Committee Chair

Looking back to the March 2008 decision of the Council of Australian Governments (COAG) to create a national registration and accreditation scheme for health professions, there can be no doubt that governments' initial aspirations have been delivered. Australia's health professionals can now register once and practise across state and territory boundaries; red tape has been reduced; and enhanced systems to protect the public from unsafe practitioners are in place.

The opportunities created by Australia's national scheme across the 14 now regulated professions frame the next stage of development; development that is likely to attract increasing international interest.

Two years after the National Registration and Accreditation Scheme (the National Scheme) assumed the responsibilities identified by COAG, we can reflect on the impact on health practitioners, employers and the Australian community.

As reported in last year's annual report, our first year was focused on setting the foundations, and developing the systems and procedures required to effectively deliver the National Scheme. Our second year has been about consolidation, strengthening key relationships and becoming more ambitious and innovative in what can be achieved by national regulation. In our business planning, we are working towards making sure all our efforts are focused on strengthening consistency, capability and service.

The Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards are responsible for implementing the National Scheme. We are also jointly responsible for ensuring all the potential opportunities for improvement are addressed. An overarching objective is to protect the public by ensuring that only suitably trained and qualified practitioners are registered. In our first year, we put systems and processes in place to ensure this objective was met. In our second, we built on these foundations, streamlined our systems and worked to ensure the registration processes for practitioners continued to improve.

A foundational objective of the National Scheme is to enable the development of a flexible, responsive and sustainable workforce; an outcome facilitated by COAG's decision to have a single scheme covering many health professions. In part, this requirement establishes distinct responsibilities for National Boards in their policy-setting and individual decision-making. More broadly, AHPRA is able to support this objective through the publication and distribution of much of the important information that we collect. Our data – across our operations – are vital resources in helping to analyse and understand trends in notifications which in turn help inform National Board policy development and other work to increase public

safety. Registration data, including types of registration and the distribution of practitioners between and within professions across Australia, are invaluable for workforce planning and development. During the year, significant progress has been made to ensure the data we hold, publish and provide to others are as complete, consistent and useful as possible. We are continuing to strengthen our reporting capability, to improve access to some of the information we hold and ensure reliable conclusions can be drawn from it.

Looking ahead, further development of our relationships with accreditation authorities, consumers of health services, the tribunals determining action in response to allegations of serious misconduct, and health profession regulators across the world, hold increasing prospect that Australia's reform will more than deliver against COAG's 2008 aspirations.

None of this would have been achieved without AHPRA and the National Boards working closely together to achieve our joint targets. I thank each of the National Boards, including those joining the National Scheme on 1 July 2012, for their expertise, leadership and resilience.

Over the coming year, our top priority will be to make sure everything we do builds national consistency, service and capability. This is our challenge and commitment.

Progress to date has also depended on the wise counsel, shared purpose, and resilience of my colleagues on the Agency Management Committee, and the dedication and hard work of the AHPRA staff, expertly led by Martin Fletcher. All share my thanks for their contribution to the successful delivery of major national reform.

Peter Allen
Chair, AHPRA
Agency Management
Committee

Foreword from the Chief Executive Officer

The progress that AHPRA has made over the past two years in delivering the benefits of the National Scheme, and supporting the National Boards to regulate the professions, has been phenomenal.

Looking back to where we were two years ago when our journey began, I am immensely proud of our dedicated staff who have worked tirelessly to deliver all that has been achieved.

We have made the transition from 37 regulatory bodies into one national organisation supporting the regulated professions. But it is much more than that – we are implementing nationally-consistent work processes that benefit the public and health practitioners; we have established constructive relationships between all those involved in health system management and the delivery of health services in Australia; and we have continued to ensure that we focus on public safety as the core of what we do.

A key focus this year has been on greater transparency in the work that AHPRA and the National Boards do. This helps to increase public confidence in the National Scheme and strengthen links with the community. We are committed to ensuring there is transparency as far as possible in our processes and procedures, while meeting our regulatory responsibilities and operating lawfully. At its core, there is at times a fine balance between transparency and confidentiality in the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory, and we will work closely with National Boards to establish policy positions that manage these competing tensions in the public interest. Transparency is a theme that carries through this annual report.

Increasing the visibility of the work of both the Boards and AHPRA is an important way to communicate the scope of our responsibilities and efforts, and to continue to build understanding of the National Scheme. The publication of Health Profession Agreements between AHPRA and each National Board from mid-2012 is another example of our goal of transparency.

We have worked hard to inform the professions and the community about developments, and have a series of communication channels that we use on a regular basis. We have concentrated substantial effort into improving the accuracy and completeness of the information published on the national registers – so there are now consistent and robust published data on registered practitioners in Australia, which also provide a platform for workforce planning and policy development.

This year we have been preparing to welcome four new professions into the National Scheme – Aboriginal

and Torres Strait Islander health practitioners, Chinese medicine practitioners, medical radiation practitioners and occupational therapists. With them comes further opportunity to demonstrate the benefits that can be gained from having a multi-profession scheme, and how collaboration between professions can be mutually beneficial.

In all that we have done this year, we have constantly strived to implement processes and procedures that make full use of the 'national' aspect of our work, to consolidate the National Scheme and to increase effectiveness and value.

We had an ambitious improvement program at the start of 2011/12, and have seen giant steps taken towards our goals. These are detailed in these pages. A wide range of initiatives have been completed, are ongoing, or are planned in the coming years. All of these will continue to consolidate improvements to quality and productivity.

All of the work detailed in this annual report could not be possible without the dedication and hard work of our staff. Working together as a team, we have achieved so much more than many thought possible at the start of this journey. The determination to succeed that has been demonstrated through their work over the past year has also been shown in their enthusiasm to participate in the Global Corporate Challenge – an international health program aimed at improving staff health and wellbeing. Seventy-six per cent of staff at AHPRA have joined a team and have committed to taking the World Health Organization's 10,000 steps a day between May and September 2012. The enthusiasm for the challenge went well beyond expectations and I congratulate our staff for their teamwork and drive for success.

We have matured as an organisation in 2011/12. I am proud of the achievements we have made in meeting the obligations of the National Scheme, harnessing innovation and making sure we are the best we can be, now and into the future.

Martin Fletcher,
Chief Executive Officer,
AHPRA

Foreword from the National Board Chairs

The National Scheme provides the National Boards with a unique opportunity to lead the ongoing development of a national system of health practitioner regulation which benefits the community wherever they live in Australia. Each National Board is focused on making robust decisions that enable us to meet our regulatory responsibility to protect the public and facilitate access to health services.

There is no doubt that the introduction of national regulation brought with it major change, and significant challenges. Our second year has seen great improvements in the operational processes and systems that support the work of the National Boards. More detail about this is published in this report.

National Boards have worked hard to address the specific requirements of regulating each of our professions in the public interest. More detail about the work of each National Board is published from page 15 of this report.

National Boards represent a wide range of professions, each with unique characteristics. Four new Boards were transitioned and welcomed into the National Scheme in the past year. Our breadth and diversity brings both opportunities and challenges.

Some of these challenges are common. It takes time for change of this magnitude to settle; for practitioners and our stakeholders to understand new responsibilities and relationships, and for National Boards to deepen their understanding and application of the National Law.

Each National Board, collectively and individually, aims to bring greater consistency to our work across Australia, wherever needed. An important part of this equation involves our partnership with AHPRA, whose work in developing and implementing consistent operational processes is the foundation of much of what we do.

National consistency also involves the decision-making of National Boards, particularly in terms of individual health practitioners in the context of Board standards and guidance. Our focus is on working with our colleagues in state, territory, regional and national committees on this issue.

We want to build on the best of the past, while building a new regulatory approach guided by the powers and principles of the National Law.

While much has been achieved, there is still much to do. Collectively we want to strike the right balance between the at times competing principles of transparency and

privacy in the National Law. We are also mindful about making sure we bring out the best of national regulation for the community and the professions, in a financially responsible way.

It takes significant effort, respect and goodwill to make any partnership work. This is particularly true of the partnerships at the heart of the National Scheme – those among National Boards, between National Boards and AHPRA, with accreditation authorities, the AHPRA Agency Management Committee, governments and others.

Everyone involved in these complex and new relationships has invested heavily in making them work, with much having been achieved over the past year. This will be an ongoing priority for all who are part of the National Scheme over the coming year.

The National Board Chairs


Mr Peter Pangquee, Chair, Aboriginal and Torres Strait Islander Health Practice Board of Australia


Professor Charlie Xue, Chair, Chinese Medicine Board of Australia


Dr Phillip Donato OAM, Chair, Chiropractic Board of Australia


Dr John Lockwood AM, Chair, Dental Board of Australia


Dr Joanna Flynn AM, Chair, Medical Board of Australia


Mr Neil Hicks, Chair, Medical Radiation Practice Board of Australia


Ms Anne Copeland, Chair, Nursing and Midwifery Board of Australia


Dr Mary Russell, Chair, Occupational Therapy Board of Australia


Mr Colin Waldron, Chair, Optometry Board of Australia


Dr Robert Fendall, Chair, Osteopathy Board of Australia


Adjunct Associate Professor Stephen Marty, Chair, Pharmacy Board of Australia


Mr Glenn Ruscoe, Chair, Physiotherapy Board of Australia


Mr Jason Warnock, Chair, Podiatry Board of Australia


Professor Brin Grenyer, Chair, Psychology Board of Australia

Delivering the National Registration and Accreditation Scheme

Introduction

Two years ago, Australia became the first country in the world to introduce a single national regulatory system for 10 health professions. A single, nationally-consistent law (the Health Practitioner Regulation National Law, as in force in each state and territory), introduced in all state and territory parliaments, aimed to protect the public and facilitate access to health services across Australia.

The Australian Health Practitioner Regulation Agency (AHPRA) works with 10 National Boards (and the Boards for the four professions to be regulated from July 2012) to implement the National Registration and Accreditation Scheme (National Scheme) to ensure that Australians have access to safe, high-quality health practitioners. Four new professions will join the National Scheme in July 2012.

Professions in the National Scheme July 2011–June 2012

- Chiropractic
- Dental
- Medicine
- Nursing and midwifery
- Optometry
- Osteopathy
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology

Since the introduction of the National Scheme, AHPRA has managed around 79,000 applications for registration each year and twice renewed the registration of more than half a million practitioners. We have more than 110,000 students registered and we have increased the uptake of online renewals to more than 90%.

We have managed around 7,500 notifications per year on behalf of National Boards. Our 15 websites receive an average of 664,000 visits per month and we respond to more than 2,500 phone calls and enquiries each day.

AHPRA operates nationally through offices in every capital city of Australia, with around 570 employees (full-time equivalent) who work together to deliver the regulatory functions of AHPRA. Before 2010, health practitioner regulation was state and territory based.

AHPRA and the National Boards work with accreditation authorities to make sure the education and training of registered health practitioners is robust and enables graduates to meet the requirements for registration in Australia.

Overview of the National Scheme

The Health Practitioner Regulation National Law (the National Law), as in force in each state and territory, established a national system of regulation for health practitioners in 10 professions. It came into effect in most of Australia on 1 July 2010 and in Western Australia on 18 October 2010. NSW is a co-regulatory jurisdiction. This means it is part of the National Scheme but manages notifications about practitioners' health, performance and conduct differently. See page 85 for details.

The National Scheme vision:

"A competent and flexible health workforce that meets the current and future needs of the Australian community"

Through the National Law, the National Scheme was established. Its key objective is to protect the public by ensuring that only suitably trained and qualified practitioners are registered. It also facilitates: workforce mobility across Australia; the provision of high-quality education and training of health practitioners; and rigorous assessment of overseas-trained practitioners.

The National Scheme supports the development of a flexible and sustainable health workforce by enabling mobility of practitioners across the country, and collection of accurate national data about regulated practitioners in each of the professions.

The National Scheme brings with it efficiency: processes and procedures can be streamlined and there can be economies of scale. AHPRA is continuing to focus on identifying and realising these. Collaboration between the professions engendered by the National Scheme allows for sharing, learning and understanding of innovation and good regulatory practice.

Guiding principles of the National Scheme, as set out in the National Law:

- transparent, accountable, efficient, effective and fair operation of the National Scheme
- the fees required to be paid under the National Scheme are to be reasonable, having regard to the efficient and effective operation of the National Scheme, and
- restrictions on the practice of a health professional are to be imposed only to the extent necessary to ensure health services are provided safely and are of an appropriate quality.

In March 2011, the Agency Management Committee and the National Boards endorsed a strategy for the National Scheme for 2011–2014. This set out the key strategic priorities on which the work during 2011/12 was based, which were to:

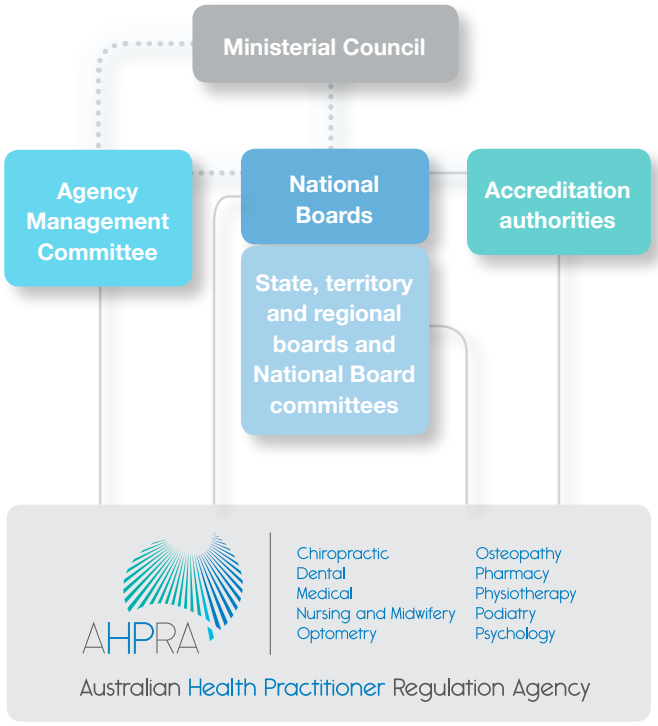
1. ensure the integrity of the national registers
2. drive national consistency of standards, processes and decision-making
3. respond effectively to notifications about the performance of health practitioners
4. adopt contemporary business and service delivery models
5. engender confidence and respect of health practitioners
6. foster community and stakeholder awareness of, and engagement with, health practitioner regulation
7. use data to monitor and improve policy advice and decision-making, and
8. become a recognised leader in professional regulation.

Roles and responsibilities

The functions of AHPRA and the National Boards are set out in the National Law. A Health Profession Agreement between each Board and AHPRA outlines the services that AHPRA will provide each year to enable the Boards to meet their regulatory responsibilities. In the interests of transparency and accountability, from 2012/13 National Boards will publish their Health Profession Agreements.

Partnership and collaboration are key to the effective implementation of the National Scheme. AHPRA's partnership with the National Boards must be strong, respectful and flexible. The regulatory framework provided to support and implement the decisions of the National Boards must support national consistency, quality service, and build capability in AHPRA people, processes and systems.

Structure of the National Scheme



National Boards

The National Law establishes a National Board for each of the health professions within the National Scheme, responsible for health practitioner regulatory policy-setting and decision-making.

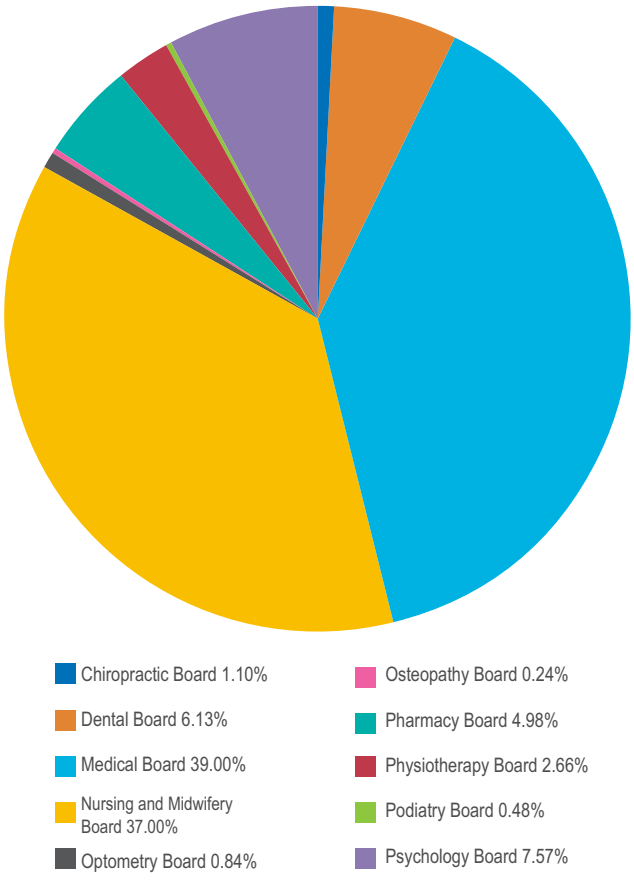
The functions of the National Boards include:

- responsibility for registering health practitioners who meet the requirements of the approved registration standards
- investigation and management of notifications about performance, conduct or health of practitioners
- development of standards, codes and guidelines, and
- setting national fees.

Some of the National Boards have established and delegated specific powers to state, territory and regional boards. See page 15 for more detail about the National Boards.

As a principle, there is no cross-subsidisation between professions in the National Scheme. The percentage allocation of AHPRA costs between National Boards in 2011/12 is shown in *Figure 1*. This allocation will be reviewed during 2012/13. Detailed financial statements are published from page 107.

Figure 1: Board % of AHPRA costs 2011/12



Agency Management Committee

AHPRA is governed by the Agency Management Committee, which has responsibility for overseeing AHPRA policy and ensuring AHPRA functions properly, effectively and efficiently in working with the National Boards. Membership comprises:

- a Chair who is not a registered health practitioner and has not been a health practitioner in the last five years
- at least two people with expertise in health and/or education and training, and
- at least two people with business or administrative expertise who are not current or previously registered health practitioners.

Members were appointed for a three year term by the Australian Health Workforce Ministerial Council (Ministerial Council).

The Agency Management Committee has established two committees:

- The Remuneration Committee, chaired by Mr Peter Allen (Chair, Agency Management Committee) is established to determine the remuneration policy and performance management framework for AHPRA senior managers.
- The Audit and Risk Committee is responsible for ensuring an effective audit and risk assessment function for AHPRA. The committee also oversees the AHPRA Investment Policy. The committee is independently chaired by Mr Geoff Linton.

The members of the Agency Management Committee are:

Peter Allen, Chair

Peter Allen is Chair of the Agency Management Committee, and has been since March 2009.

Mr Allen is Deputy Dean of the Australia and New Zealand School of Government (ANZSOG), and Victoria's Public Sector Standards Commissioner. He joined ANZSOG after more than 20 years in the Victorian Public Service, during which time he held several positions including Under Secretary in the Department of Human Services; Victoria's Chief Drug Strategy Officer; Secretary of the Department

of Tourism, Sport and the Commonwealth Games; Secretary of the Department of Education; Director of Schools; and Deputy Secretary, Community Services.

Between 2001 and 2003, Mr Allen was a Vice-Chancellor's Fellow at the University of Melbourne, and prior to joining the public service, he was Director of Social Policy and Research at The Brotherhood of St Laurence.

Mr Allen holds a Bachelor of Arts and a Diploma in Journalism and was awarded a Centenary Medal in 2001.

Professor Constantine (Con) Michael AO

Con Michael was appointed to the Agency Management Committee in March 2009 as a member with expertise in health, education and training.

Professor Michael is the Principal Adviser of Medical Workforce for the Western Australia Health Department, Consultant Medical Adviser for St John of God Health Care Inc. and Emeritus Professor of Obstetrics and Gynaecology at the University of Western Australia (UWA).

Professor Michael is the current Chair of the Western Australian Board of the Medical Board of Australia, Director of the Australian Medical Council, a member of various state and national medical committees and Chair of the St John of God National Ethics Committee and Chair of the Reproductive Technology Council of Western Australia. He is a Director and Governor of the University of Notre Dame Australia and Chair of its Advisory Board of the School of Medicine Fremantle.

Professor Michael holds a Bachelor of Medicine and Bachelor of Surgery (UWA), Doctor of Medicine (UWA) and Diploma of Diagnostic Ultrasound. He is a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (a past President) and Fellow of the Royal College of Obstetricians and Gynaecologists, London (a previous Sims Black Professor).

Among his numerous awards, Professor Michael was named an Officer of the Order of Australia (AO) in 2001 for service to medicine, particularly in the field of obstetrics and gynaecology, as a contributor to the administration of the profession nationally and internationally, and medical education.

Professor Genevieve Gray

Genevieve Gray was appointed to the Agency Management Committee in March 2009 as a member with expertise in health, education and training.

Professor Gray is Professor of Nursing at the Queensland University of Technology (QUT) and Professor Emeritus University of Alberta. In recent years she has been a Nurse Scholar for the World Health Organization (WHO), Geneva, and worked in Canada as a Professor of Nursing, Dean and Director, WHO Collaborating Centre in Nursing and Mental Health for the University of Alberta and WHO. She is currently Director of QUT's Vietnam Nursing Capacity Building Program.

Professor Gray was previously Inaugural Chair of the International Academic Nursing Alliance, a member of the Multidisciplinary Board of the International Council of Women's Health Issues and member of the Deans Council, General Faculties Committee and Health Sciences Council of the University of Alberta.

Professor Gray has a General Nursing Certificate, Midwifery Certificate, diplomas in Nursing Education and Advanced Nursing Studies, a Master of Science (Nursing) and a Distinguished Life Fellowship from the Royal College of Nursing Australia, and Honorary Professorship from Hanoi Medical University, Vietnam.

Mr Michael Gorton AM

Michael Gorton was appointed to the Agency Management Committee in March 2009 as a member with business and administrative expertise.

Mr Gorton is a commercial lawyer with considerable experience providing legal advice on medical registration, training, education and administrative practice. As a principal of Russell Kennedy Solicitors, he has significant experience in business management and administration. He is a Board member of Melbourne Health (Royal Melbourne Hospital). He is a former Chair of the Victorian Equal Opportunity and Human Rights Commission and former Chair of the Code of Conduct Committee of Medicines Australia.

Mr Gorton is the Chair of the Patient Review Panel (Victoria) and chairs the Minister's Expert Panel to review health complaints legislation in Victoria. He has extensive experience in governance for a wide range of organisations including health and ethics committees.

Mr Gorton holds a Bachelor of Laws and Bachelor of Commerce.

In 2004, Mr Gorton received the Member of the Order of Australia (AM) for community service.

Professor Merrilyn Walton

Professor Walton was appointed to the Agency Management Committee in March 2009 as a member with business and administrative expertise.

Professor Walton is Professor of Medical Education (Patient Safety), Sydney School of Public Health and Associate Dean International, Faculty of Medicine, University of Sydney. She is a leading patient safety academic who works nationally and internationally in the field. For the last four years she has been a lead writer and editor for the WHO patient safety curricula guides for multi professionals and medical schools.

Professor Walton is currently assisting universities in Vietnam, Timor Leste and China to build capacity in patient safety and curriculum development. She is the author of two books and co-authored her latest, *Safety and Ethics in Health Care*, with Professors Runciman and Merry.

Professor Walton was a member of the Australian Health Ethics Committee of the National Health and Medical Research Council (2009–2012). She is a visiting professor and affiliate of The Buehler Center on Aging, Health and Society at Northwestern University in the USA. Prior to her academic role, Professor Walton was the first Health Care Complaints Commissioner in NSW (1993–2000).

National Executive

AHPRA is led by Martin Fletcher, the Chief Executive Officer (CEO). The National Executive supports the CEO in setting the strategic direction and delivery of AHPRA's services. Membership comprises the CEO (Chair), Director of National Board Services, Director of Finance and Corporate Operations, Director of Business Improvement and Innovation, General Counsel, and Chair of the State and Territory Managers Committee.

Key accountabilities include approving the annual business plan and budget (ahead of approval by the Agency Management Committee), monitoring AHPRA performance against targets and opportunities for improvement, and approving enterprise-wide organisational strategies and plans.

The members of the National Executive are:

Martin Fletcher, Chief Executive Officer, began with AHPRA in December 2009. With more than 10 years' experience in patient safety in Australia, the United Kingdom and internationally, he brings strong expertise to the work of establishing and leading AHPRA. Before joining AHPRA, Mr Fletcher was Chief Executive of the National Patient Safety Agency, the leading National Health Service body for patient safety in England and Wales. He holds a Master of Management degree in public sector management, an Honours degree in behavioural sciences and an undergraduate degree in social studies.

Chris Robertson, Director of National Board Services, has more than 10 years' expertise in health policy and legislation, workforce planning and innovation. He was appointed to his current role at AHPRA in January 2010. Previously, Mr Robertson served as the National Director Policy and Legislation, National Registration and Accreditation Implementation Project. He holds a Graduate Certificate of Health Management from the Queensland University of Technology and a Bachelor of Commerce from Griffith University. He was previously a registered nurse working in critical care and holds a Diploma of Applied Science Nursing from Monash University.

John Ilott, Director of Finance and Corporate Operations, came to AHPRA with more than 30 years' experience as a senior executive in both the public and private health sectors. Before his current role at AHPRA he was General Manager, Victoria for St John of God Pathology and Chief Executive Officer of the Victorian Branch of the Pharmaceutical Society of Australia. Mr Ilott holds a Master of Arts by research from the Faculty of Law and Management, La Trobe University. He also holds an undergraduate degree in business. He is a Member of the Australian Institute of Company Directors and a Fellow of the Australian Society of Certified Practising Accountants.

Jim O'Dempsey, Director of Business Improvement and Innovation, has more than 20 years' experience in clinical practice, health management and health practitioner regulation. He established and was CEO of Queensland Nursing from 1993 to 2002, before leading the Office of Health Practitioner Registration Boards in Queensland from 2002 to 2010. Appointed to his current role in February 2011, Mr O'Dempsey joined AHPRA as State Manager, Queensland on 1 February 2010. He holds a Psychiatric Nursing Certificate (Baillie Henderson Hospital, Toowoomba) and a General Nursing Certificate (Repatriation General Hospital, Greenslopes).

Dominique Saunders, General Counsel, has more than 20 years' experience in the community, public and private sectors. Before joining AHPRA, Ms Saunders was Corporate Counsel, Executive Director at Western Health. Dominique holds a Bachelor of Social Work and a Bachelor of Laws. She is admitted to the High Court of Australia and the Supreme Court of Victoria.

Kym Ayscough, Chair of the State and Territory Managers Committee, is State Manager of AHPRA New South Wales. She came to AHPRA in March 2010 after seven years as Chief Executive Officer and Registrar of the Pharmacy Board of New South Wales. She holds a Bachelor of Law and Masters of Law and Management degrees.

Accreditation authorities

Ministerial Council appointed external accreditation authorities for all health professions in the National Scheme.

AHPRA and the National Boards work with these authorities to make sure the education and training of registered health practitioners is robust and enables graduates to meet the requirements for registration in Australia.

Accreditation authorities for each National Scheme profession

- Council on Chiropractic Education Australasia Inc.
- Australian Dental Council
- Australian Medical Council
- Australian Nursing and Midwifery Accreditation Council
- Optometry Council of Australia and New Zealand
- Australian and New Zealand Osteopathic Council
- Australian Pharmacy Council
- Australian Physiotherapy Council
- Australian and New Zealand Podiatry Accreditation Council
- Australian Psychology Accreditation Council

The National Boards

AHPRA works with the National Boards to implement the National Scheme to ensure that Australians have access to safe, high-quality health practitioners.

Partnership and collaboration between the National Boards and AHPRA is key to the effective implementation of the National Scheme. National Boards set regulatory policy and professional standards that registered practitioners must meet, and AHPRA works with the Boards to provide the support – through people, processes and systems – to regulate the professions.

The structure of the National Boards and their committees is below.

Reports from each of the National Boards follow from page 23.

Structure of the National Boards and their committees

National Board	National committees	Regional boards	State and territory boards	State and territory / regional committees
Chiropractic Board of Australia	Accreditation and Assessment Committee Communications and Relationships Committee Continuing Professional Development Committee Governance, Finance and Administration Committee Immediate Action Committee International Matters Committee Joint Professional Development Committee Post Graduate Advisory Steering Committee Registration, Notification and Compliance Committee Standards, Policies, Codes and Guidelines Committee	None	None	None
Dental Board of Australia	Accreditation Committee Administration and Finance Committee Registration and Notification Committee	None	None	Immediate Action Committee (excluding New South Wales) Registration Committee (New South Wales only) Registration and Notification Committee (excluding New South Wales)

National Board	National committees	Regional boards	State and territory boards	State and territory / regional committees
Medical Board of Australia	Finance Committee	None	All states and territories	Health Committee (excluding New South Wales) Notifications Assessment Committee (excluding New South Wales) Performance and Professional Standards Committee (excluding New South Wales) Registration Committee Immediate Action Committee (excluding New South Wales)
Nursing and Midwifery Board of Australia	Accreditation Committee Finance and Governance Committee Policy Committee	None	All states and territories	Immediate Action Committee (excluding New South Wales) Notification Committee (excluding New South Wales) Registration Committee State and Territory Chairs' Committee
Optometry Board of Australia	Continuing Professional Development Accreditation Committee Finance and Risk Committee Immediate Action Committee Policies, Standards and Guidelines Advisory Committee Registration and Notifications Committee Scheduled Medicines Advisory Committee Workforce Advisory Committee	None	None	None
Osteopathy Board of Australia	Finance Committee Registration and Notification Committee	None	None	None
Pharmacy Board of Australia	Compounding Working Party Finance and Governance Committee Immediate Action Committee Notifications Committee Policies, Codes and Guidelines Committee Registration and Examinations Committee	None	None	None
Physiotherapy Board of Australia	Continuous Improvement Committee	None	All states and territories	None
Podiatry Board of Australia	Endorsement for Scheduled Medicines Working Party Finance Working Party Immediate Action Committee Policy and Planning Working Party Registration and Notifications Committee	None	None	None
Psychology Board of Australia	Financial Management Committee Internship Review Working Party National Examination Committee Supervisor Training Working Party	Australian Capital Territory, Tasmania, Victoria, South Australia, Northern Territory and Western Australia	New South Wales, Queensland	Immediate Action Committee Registration and Conduct Committee (excluding New South Wales)

Forum of National Board Chairs – facilitating inter-board collaboration

The Forum of National Board Chairs facilitates collaboration between the Boards; providing a medium for the Chairs of each National Board to consider matters of common interest in relation to the operation of the National Scheme. The Forum, which has established five sub-committees, considers issues and makes recommendations to Boards.

It is also a forum for members of the AHPRA Agency Management Committee and National Executive to raise matters of interest to all Boards; for the AHPRA CEO to provide regular updates to Chairs; and for AHPRA to seek advice from the Chairs of the National Boards.

The Forum has provided mentoring to new Chairs and members of the Boards of the new professions introduced into the National Scheme from 1 July 2012, and has welcomed stakeholders who have spoken at Forum meetings, including Health Workforce Australia, the National Prescribing Service and the Australian Commission for Safety and Quality in Healthcare.

The Forum meets monthly by teleconference, with three face-to-face meetings each year. In 2012, the Forum was chaired by Pharmacy Board of Australia Chair, Adjunct Associate Professor Stephen Marty.

Release of quarterly registration data

Providing data that accurately reflect the number of registered practitioners is one of the important benefits of the National Scheme. It has enormous value for workforce planning and in helping to improve access to health services.

Each National Board released the first of their quarterly updates on registration data in May 2012, reporting on the March 2012 quarter. Registration data are published quarterly, after the end of each quarter.

The data are reported separately for each National Board and include information about types of registration held, principal place of practice, endorsements, registrant age and gender. The data are published on the relevant Board's website.

Consultations

The National Boards undertake wide-ranging consultation on proposals that affect the professions. From time to time, they release consultation papers, asking stakeholders to provide input that will help shape registration standards, codes and guidelines, and policies.

Consultations completed by the National Boards in 2011/12

Board	Consultations completed July 2011 – June 2012
Chiropractic Board	• Standards for limited registration • Definition of practice
Dental Board	• Guidelines on conscious sedation area of practice endorsement • Definition of practice • Guidelines on limited registration • Guidelines on supervision
Medical Board	• Guidelines on technology based patient consultations • Registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training. • Definition of practice • Funding external doctors' health programs • Registration standard for endorsement for acupuncture • Supplementary guidelines on cosmetic medical and surgical procedures for *Good Medical Practice: A code of conduct for doctors in Australia*
Nursing and Midwifery Board	• Policy on re-entry to practice for nurses and midwives
Optometry Board	• Registration standards for general registration and limited registration • Guidelines for supervision of optometrists • Definition of practice • Amendment to continuing professional development registration standard and guidelines on continuing professional development for endorsed and non-endorsed optometrists
Osteopathy Board	• Continuing professional development • Limited registration in the public interest • Limited registration for postgraduate training and supervised practice • Guidelines for supervised practice • Guidelines for infection control • Definition of practice • Guidelines for clinical records
Pharmacy Board	• Code of conduct
Physiotherapy Board	• Registration standard and guidelines on limited registration • Supervision guidelines • Definition of practice
Podiatry Board	• Definition of practice • Specialist registration standard • Limited registration standards • Guidelines for supervision of podiatrists
Psychology Board	• Amendment to the provisional registration standard for the 5+1 internship • Revised standard and guidelines on professional indemnity insurance for psychologists • Guideline for supervisors and supervisor training providers • National psychology examination curriculum

Registration standards

A number of registration standards for the currently regulated professions were approved by Ministerial Council during 2011/12. These were:

Dental Board

- General registration for overseas-qualified dental practitioners registration standard
- Limited registration for postgraduate training or supervised practice (section 66) registration standard
- Limited registration for teaching or research (section 69) registration standard

Nursing and Midwifery Board

- Amendments to the English language skills registration standard
- Amendments to the professional indemnity insurance arrangements registration standard

Optometry Board

- General registration (to come into effect 1 December 2014)
- Limited registration for postgraduate training or supervised practice

Physiotherapy Board

- Limited registration for supervised practice and postgraduate training
- Limited registration for teaching or research
- Limited registration in the public interest

Psychology Board

- Amendments to the provisional registration standard to include details of the 5+1 internship
- Amendments to the professional indemnity insurance arrangements registration standard

Welcoming new professions in 2012

From 1 July 2012, we welcome four new National Boards into the National Scheme. During 2011/12 we have worked with the new board members, practitioners, employers, governments and universities to prepare for the national regulation of the four professions: Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation therapy and occupational therapy.

Transitioning the four new professions

Ministerial Council publicly announced the size, constitution and appointment of four new National Boards on 18 July 2011:

Board	Number of people on the National Board
Aboriginal and Torres Strait Islander Health Practice Board of Australia	9 (6 practitioner members, 3 community members)
Chinese Medicine Board of Australia	9 (6 practitioner members, 3 community members)
Medical Radiation Practice Board of Australia	12 (8 practitioner members, 4 community members)
Occupational Therapy Board of Australia	9 (6 practitioner members, 3 community members)

The appointment of board members and chairs took effect on 1 July 2011. This enabled the new boards to have 12 months of preparatory work, including developing, consulting on and submitting registration standards for each profession for approval by Ministerial Council; developing, consulting and approving codes and guidelines; and working with AHPRA to establish procedures for the regulation of practitioners from 1 July 2012.

The four National Boards held their inaugural board meetings on 26 July 2011 and met each month during 2011/12 to continue to progress towards national registration.

Draft registration standards were released for public consultation in late August and early September for submission in October 2011. Subsequently, the Boards considered stakeholder feedback and finalised their proposed registration standards in November 2011 for approval by Ministerial Council.

On 13 January 2012, Ministerial Council announced their approval of a suite of core registration standards covering continuing professional development (CPD), criminal history screening, English language skills requirements, professional indemnity insurance arrangements and recency of practice. Profession-specific registration standards were also approved, including grandparenting arrangements for each profession, to ensure appropriate transitional arrangements for practitioners from unregulated jurisdictions. Approval of the registration standards (for effect on 1 July 2012) provided clarity and certainty for the Boards, practitioners seeking registration for the first time, and those automatically transitioning into the National Scheme on the basis of holding state or territory registration.

National registration fees were agreed between the National Boards and AHPRA's Agency Management Committee, and were published on the Board websites in February 2012.

Although national registration could not take effect until 1 July 2012, AHPRA and the National Boards estimated that up to 17,000 new applications for registration would be lodged; all seeking their registration to commence on 1 July 2012. Therefore, practitioners were encouraged, through a variety of communication strategies, to lodge their applications for registration in advance, and by no later than May 2012, to provide AHPRA and the National Boards time to assess and process as many applications as possible before registration began on 1 July 2012. AHPRA allocated specific resources to assess and process applications, supported by government funding.

AHPRA also coordinated a range of activities to ensure the registration details of approximately 17,000 practitioners with state or territory registration with one of the 12 existing local boards automatically transitioned into the National Scheme on 1 July 2012.

There were more than 29,000 practitioners from the four professions expected to be registered by 30 June 2012: nearly 17,000 registrants transitioning from local boards; and more than 12,000 new registrants. There were just over 1,000 applications still to be finalised by the end of June 2012, which is expected to result in about 31,000 new practitioners in the scheme overall.

AHPRA worked with the 12 local registration boards to assist with their decommissioning activities, including: communicating with registrants; data transfer; accommodation transition; financial transition; contracted services; human resources; transition of complaints; and the Service, Assets and Liabilities Transfer (SALT) agreements and accompanying due diligence to allow transfer of assets and liabilities to AHPRA.

In June 2012, AHPRA and the National Boards made the final preparatory arrangements for a smooth transition for these four professions into the National Scheme.

Committees of the four new National Boards for 2012

National Board	Committees
Aboriginal and Torres Strait Islander Health Practice Board of Australia	• Communications • Registration and Notifications
Chinese Medicine Board of Australia	• Accreditation • Communications • Finance • Notifications • Policy • Registration
Medical Radiation Practice Board of Australia	• Communications • Finance and Governance • Accreditation, Policy, Research and Standards • Supervised Practice • Overseas Applications • Notifications • Registration • Immediate Action
Occupational Therapy Board of Australia	• Communications • Finance and Governance • Registration Standards, Codes and Guidelines • Registration and Notifications • Immediate Action

Aboriginal and Torres Strait Islander Health Practice Board of Australia

The establishment of the Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA) marks the creation of a national Aboriginal and Torres Strait Islander health practitioner profession. From 1 July 2012, practitioners must be registered, renew their registration annually, and comply with national registration standards, ethics and codes of practice.

Prior to 1 July 2012, only Aboriginal health workers in the Northern Territory were required to be registered to practice in that jurisdiction.

During 2011/12, the ATSIHPBA has worked hard to ensure that regulations developed for the profession will protect the public from unsafe practitioners and provide the foundations to build a nationally-consistent scope of practice, education and training. Practitioners and the wider community of stakeholders have engaged actively in the Board's consultations on registration standards, codes and guidelines, and participated in forums around the country. The Board has also been involved with major workforce stakeholders in promoting this profession, providing crucial advice to education and training organisations in regards to the Board's qualification standards, and further in regards to the establishment of the Board's Accreditation Committee.

AHPRA staff have made a critical contribution to the work of the Board and the successful implementation of registration on 1 July 2012. The Board looks forward to continuing its active engagement over the next year.

Mr Peter Pangquee
Chair, Aboriginal and Torres Strait Islander Health Practice Board of Australia

Members: Mr Peter Pangquee (Chair and practitioner member from the Northern Territory); Ms Clare Anderson (community member); Ms Karrina DeMasi (community member); Ms Sharon Milera (practitioner member from South Australia); Ms Lisa O'Hara (practitioner member from New South Wales); Ms Renee Owen (practitioner member from Victoria); Mrs Jenny Poelina (practitioner member from Western Australia); Ms Jane Schwager (community member); Ms Karen West (practitioner member from Queensland).

Executive Officer: Kerri Kellett

Chinese Medicine Board of Australia

National registration for Chinese medicine is a major change for the profession, which is now adjusting to new expectations. The profession, however, lobbied for decades to achieve this and the public is the beneficiary. Many people have worked hard to achieve a smooth transition for practitioners already registered in Victoria and to prepare for the large number of applications from unregistered practitioners in the other states and territories.

Special challenges in Chinese medicine include English language; the diversity of qualifications from all over the world; cultural issues; that Chinese medicine is mainly operating through private practices; and that for most of the professions in Australia, regulation is new.

The National Board is very grateful for the high-quality groundwork over the past 10 years of the Chinese Medicine Registration Board of Victoria, on which it will build.

Professor Charlie Xue
Chair, Chinese Medicine Board of Australia

Members: Professor Charlie Xue (Chair and practitioner member from Victoria); Ms Alison Christou (community member); Ms Jenny Chou (practitioner member from South Australia); Mr Stephen Janz (practitioner member from Queensland); Dr Di Wen Lai (practitioner member); Professor Vivian Lin (community member); Mr Haisong Wang (practitioner member from the Australian Capital Territory); Dr Xiaoshu Zhu (practitioner member from New South Wales); Professor Craig Zimitat (community member).

Executive Officer: Debra Gillick

Medical Radiation Practice Board of Australia

The National Scheme means that for the first time medical radiation practitioners in all states and territories are registered under one scheme, with public safety as the common goal.

Medical radiation practitioners have embraced this move, including the advantages that national registration brings, such as better mobility, common standards and a single point of contact for all matters related to the standards, accreditation and notification matters.

Mr Neil Hicks
Chair, Medical Radiation Practice Board of Australia

Members: Mr Neil Hicks (Chair and practitioner member – diagnostic radiographer – from Western Australia); Mrs Susan Baldwin (practitioner member – nuclear medicine technologist – from Queensland); Mrs Liz Benson (community member); Ms Marcia Fleet (practitioner member – radiation therapist – from Victoria); Mr Kar Giam (practitioner member – radiation therapist – from the Northern Territory); Mrs Myrtle Green (community member); Mr Christopher Hicks (practitioner member – diagnostic radiographer – from the Australian Capital Territory); Ms Robyn Hopcroft (community member); Mr Mark Marcenko (practitioner member – nuclear medicine technologist – from Tasmania); Mr Christopher Pilkington (practitioner member – diagnostic radiographer – from South Australia); Ms Rosemary (Rosie) Yeo (community member); Ms Tracy Vitucci (practitioner member – diagnostic radiographer – from New South Wales.

Executive Officer: Adam Reinhard

Occupational Therapy Board of Australia

The entry of occupational therapy into the National Scheme on 1 July 2012 marks a maturing of the regulation of the profession. Previously regulated in three states and one territory, occupational therapists faced differing requirements when moving across jurisdictions. Importantly, the public in unregulated states and territories did not have the protection of regulation to manage issues which arose with practitioners' health, conduct or performance.

The work of previous state and territory boards, professional organisations and many practitioners contributed a strong foundation of awareness of the need for, and purpose of, registration. Occupational therapists have engaged actively in the Board's consultations on registration standards, codes and guidelines; participated in forums around the country; and facilitated the timely processing of thousands of new applications for registration.

AHPRA staff have also made a critical contribution to the work of the Board and the successful implementation of registration. The Board looks forward to continuing its active engagement with the profession to support its regulatory work by ensuring practitioners are well informed about registration and the ways they can support the provision of competent and safe occupational therapy services to the public.

Dr Mary Russell
Chair, Occupational Therapy Board of Australia

Members: Dr Mary Russell (Chair and practitioner member from South Australia); Mrs Amanda Bladen (practitioner member from Victoria); Ms Julie Brayshaw (practitioner member from Western Australia); Mr James (Jim) Carmichael (practitioner member from Queensland); Dr Katherine Moore (practitioner member from New South Wales); Mrs Louisa O'Grady (community member); Mrs Terina Saunders (practitioner member from the Northern Territory); Mr Andrew Taylor (community member); Ms Catherine (Kate) Gauthier (community member to August 2011); Ms Louise Johnson (community member from May 2012).

Executive Officer: Jacqui Barry

More information about each of the four new National Boards is published on their websites:

www.atsihealthpracticeboard.gov.au

www.chinesemedicineboard.gov.au

www.medicalradiationpracticeboard.gov.au

www.occupationaltherapyboard.gov.au

Board reports

Chiropractic Board of Australia

Message from the Chair

The Chiropractic Board of Australia (the Board) and the National Scheme continue to move forward. I must acknowledge the support and assistance provided by both AHPRA and the other National Boards in both the Board's and the Scheme's continued progress. Particularly I must thank Mr Martin Fletcher, CEO of AHPRA, Mr Chris Robertson, Director of Board Services of AHPRA, Ms Helen Townley, Executive Officer Policy of AHPRA, and all of the teams in the state and territory offices for their continued support of the Board and its functions.

All National Boards and AHPRA collectively and collaboratively continue to serve and meet the intent and requirements of the National Law. That is, to carry out our regulatory functions in the public interest and in a consistent, proportionate, fair, accountable and transparent manner. Many thanks must go to Dr Paul Fisher, the Board's Executive Officer, and the Board support team who carry out the day-to-day activities for the Board.

My sincere gratitude must be extended to the committee chairpersons who have taken on the various committee responsibilities, excelling in their achieved outcomes: Dr Mark McEwen for the Registration, Notification and Compliance Committee; Dr Stephen Crean for the Standards, Policies, Codes and Guidelines Committee; Mr Peter Groves and Dr Bevan Goodreid for the Governance, Finance and Administration Committee; Drs Bevan Goodreid and Amanda Kimpton for the CPD Committee; and Ms Margaret Wolf and Dr Geoff Irvine for the Communications and Relationships Committee.

Thanks go out to all of the members of the Board as a whole for their relentless and persistent work toward the Board's obligations and goals. Throughout the year we regretfully had to note the retirement of two inaugural members of the Board. Ms Esther Alter and Mr Peter Groves both served on the Board as community members and their contributions were critical in the establishment and development of this Board. Heartfelt thanks from myself and the Board must go to Esther and Peter for their part in the history of the Board.

The Board's work and interaction with stakeholders this year was very satisfying and productive, and their input into the Board's policies and processes was invaluable. Thanks go out to these groups for their help and support.

In conclusion, substantial work and progress has been achieved by the Board and the National Scheme in 2011/12, and I look forward to seeing another equally successful year in 2012/13.

Dr Phillip Donato OAM
Chair, Chiropractic Board of Australia

Board report

The 2011/12 financial year marked the second operational year of the National Scheme. Whilst the first year was one of transition and development, the second was one of consolidation and ongoing improvement.

The Board must exercise the powers, authorities, duties and functions imposed on it by the National Law. It is responsible to Ministerial Council in its regulation of chiropractors; fulfilling the principles, functions and objectives of the National Law; and maintaining high standards of safety, conduct and performance in the provision of chiropractic services to the public.

Within these confines, the Board was committed to achieving national consistency across professions, where possible, as part of its commitment to the effective functioning and operation of the National Scheme. There have been opportunities for all professions to contribute to a consistent approach across a number of areas of commonality between professions; in many cases the Board has been able to benefit from the experiences of other National Boards and in some cases other National Boards have been able to benefit from the experiences of the Chiropractic Board. The net result for all National Boards is far better than any single National Board could have achieved on their own. The Board acknowledges the tremendous support, assistance and guidance provided to it in the exercise of its functions by AHPRA.

The availability of improved reporting data from AHPRA on registration and notification matters has been of great assistance in planning and directing the Board's efforts. There were 4,462 registered chiropractors at 30 June 2012, which is an increase of 2.57% over last year. The largest group of practitioners continues to be those whose principal place of practice is New South Wales (NSW), followed closely by Victoria, then Queensland. More information on the number of registered chiropractors can be found on page 74.

Over 2011/12, the Board itself met 12 times and there were 27 meetings held by the various working committees of the Board. Several decisions were made out of session under the powers of part 4 section 16 of the National Law, in order to facilitate timely and efficient handling of matters.

The Registration, Notification and Compliance Committee of the Board handled most of the decision-making in relation to registration, notification and compliance matters pertaining to registered practitioners. This single national committee handles matters from all states and territories in Australia in a timely and efficient manner. NSW notification matters are handled by the NSW Chiropractic Council.

A number of the significant projects undertaken by the Board this year were managed by the Standards, Policies, Codes and Guidelines Committee of the Board. This included the final consultation on registration standards for limited registration in the public interest, and limited registration teaching and research; and the revision of the *Code of Conduct for Chiropractors*. These two projects in particular were large bodies of work and the Board is grateful to the committee for their excellent work. In particular, the committee and its work groups did a significant amount of preparatory work for the review of the *Code of Conduct.*

The Board's Governance, Finance and Administration Committee undertook a review of the Board's strategic planning for approval by the Board. As the National Scheme evolves and the type and nature of the work required by the Board also evolves, the Board's strategic plan and work plan will continue to also evolve. The Board has also started the development of a board-specific charter.

The Board's CPD Committees have been an important link between the Board and the profession, and have been critical in assisting the integration of this requirement, which is new for many in the profession. The Board currently publishes a list of formal learning activities as approved by both of the organisations approved to make such assessments. This resource has been useful to practitioners in keeping track of the CPD hours. The CPD Committees of the Board have also been active in assisting the development of fact sheets and other communication items to assist practitioners in their understanding of, and compliance with, the CPD registration standard.

Excellent communication and stakeholder relationships are critical to many of the Board's objectives. To this end, the Board has produced a number of newsletters and communication items to keep the profession and the public informed about various matters.

The Board also conducted a survey of practitioners to gauge the effectiveness of their current communications activities. Among other things, the results of the survey showed that most practitioners (more than 75%) had awareness and understanding of the registration requirements and their professional responsibilities. The results of this survey reaffirmed the Board's commitment and approach to effective communication.

Much other work has been done by the Board and its committees to produce various policies, communication items, FAQ and fact sheets to continue providing support and clarification on specific matters such as: FAQ and fact sheets on advertising; FAQ on testimonials; FAQ on CPD; fact sheet on the English language skills registration standard; and a fact sheet on who needs to be registered under the National Law.

The Board's ongoing commitment to best practice stakeholder engagement has been led by the Standards, Policies, Codes and Guidelines Committee of the Board. As part of the Board's *Code of Conduct* review process, workshops and a forum were held to obtain feedback, and to review and refine board policy on certain areas.

The Board continues to have a positive, productive working relationship with its accreditation authority, the Council on Chiropractic Education Australasia Inc. (CCEA) and other key stakeholder groups. The Board looks forward to further engagement in the development and review of its policies and standards over the next year.

Members of the Board

The members of the Chiropractic Board of Australia are:
Dr Phillip Donato OAM (Chair), Dr Stephen Crean, Dr Graham (Bevan) Goodreid, Dr Geoffrey Irvine, Dr Amanda-Jane Kimpton, Dr Mark McEwan, Ms Margaret Wolf, Mr Peter Groves (resigned January 2012), Ms Esther Alter (resigned September 2011).

During 2011/12, the Board was supported by Executive Officer Dr Paul Fisher.

More information about the work of the Board is available at: www.chiropracticboard.gov.au.

Dental Board of Australia

Message from the Chair

The Dental Board of Australia has completed this year with consultation and consolidation of the Board developed strategic work plan. While the National Law defines the objectives and guiding principles for the National Scheme, board members have also resolved to conduct additional activities in a board-specific fashion. The strategic focus has been to strengthen stakeholder engagement and communication. This has included identifying key organisations, participation in board processes by stakeholders, and encouraging relationships with decision-makers. The goal has been to achieve appropriate outcomes for regulatory policy, including registration standards, codes and guidelines.

The consultation processes with the public and organisation stakeholders has been extensive. This approach is guided by the Australian Government's Office of Best Practice Regulation, which has centred the process on the public interest.

In activating strategies and achieving the goals of the Board's work plan, board members have been diligent and proficient. The commitment of the Board's state and territory committee members must also be recognised. The public and profession should be satisfied with the outcomes.

As the board members move into the final stage of their terms of appointment, reflection on achievements will turn to the required reviews, future terms, membership of the National Board and its committees, and those of the state and territory committees, and the objectives of the National Scheme.

The Board is grateful for the support and dedication of the Executive Officer and support staff, and also recognises the attentive efforts of AHPRA in conducting the business of the National Scheme.

The Board has continued to work closely with its key stakeholders to develop a coherent and consistent approach to national regulation of dental practitioners in Australia. The Board acknowledges the importance of engagement with its stakeholders and would like to thank all those who have contributed to this process, particularly during the consultation phases on a number of key policy areas which have occurred during the year.

This has been the final year of the three year term for the first National Board and, as such, it is a time for reflection on our achievements and future priorities, and to thank our fellow board members for their efforts and in particular acknowledge the contribution of those retiring members. Two practitioner members, Dr John Owen AM and Dr Carmelo Bonanno, who complete their term have provided significantly to the discussions and decisions with their professional knowledge and are gratefully appreciated for their efforts. In addition, as our community members are highly valued, we also acknowledge the work demonstrated to the Board by Mrs Myra Pincott AO and Mr Peter Martin. The board members also appreciate the significant efforts of those other members of state committees and working committees who have been valuable contributors to the role of the Board in the National Scheme.

The Board is keen to continue to further its strategic priorities of consistency in national standards, processes and decision-making, and to work with AHPRA to engender the confidence and respect of dental practitioners and the community in the quality and effectiveness of our decisions, policies and processes.

Dr John Lockwood AM
Chair, Dental Board of Australia

Areas of focus

The Board has continued its work in developing and strengthening nationally-consistent processes, particularly in the areas of:

- **Recency of practice**
  A working group has been established which has developed a professional approach to the processes of assessment of recency of practice and return to practice requirements for dental practitioners.

- **Therapeutics**
  An expert reference group has been established which has been considering a range of matters including Botulinum Toxin and dermal fillers; use of sedative agents by dental practitioners; teeth whitening; and differences in the administration, management and prescribing capacity under drugs and poisons legislation for dental practitioners. The group is also

reviewing the Board's interim policies on the matters of Botulinum Toxin and teeth whitening, and will make recommendations to the Board.

- **Oral medicine and oral pathology**
  The Board's expert working group continued to consider residual issues relating to practitioners in these specialties.
- **Scope of practice**
  In response to the Health Workforce Australia report, the Board has developed a project and committee to consider outcomes and reviews of the registration standard and guidelines.
- **Assessment of overseas qualifications**
  A joint working group has been established with the Australian Dental Council (ADC) to consider a range of matters related to the equivalence of, and recognition of, overseas-qualified dental practitioners for registration in Australia. The ADC has established an interim arrangement approved by the Board for the assessment of overseas-qualified dental hygienists and dental therapists. In addition, some preliminary research has occurred in the area of assessing accrediting authorities in other countries.

Communication/relationships with stakeholders

The Board has continued to develop and maintain its relationships with its stakeholders via a range of methods including the publication of a communiqué after each board meeting outlining key matters considered by the Board; the publication of the inaugural newsletter; regular formal and informal meetings with key stakeholders and information and consultation forums; and the involvement of representatives from outside of the Board and its committees on various working groups.

Board members have also contributed as members of a range of national bodies and reference groups, and through regular contact with stakeholders as presenters and participants at various meetings and forums.

The Board has also agreed a formal Memorandum of Understanding (MoU) with the Dental Council of New Zealand to foster collaboration in areas of mutual interest. Key matters addressed in the MoU include information sharing, collaboration and as consistent an approach as possible to registration and regulation of dental practitioners.

Key outcomes/achievements

The Board's key achievements have been in the area of national consistency and include:

- Development of a protocol and supporting information for practitioners on recency of practice and return to practice requirements.
- Development of registration standards and guidelines related to limited registration.
- Review and now implementation of a more efficient approach to the process of overseas-qualified dental practitioners in conjunction with the ADC. The establishment of a joint working group with the ADC to oversee the significant body of work in the area of evaluation and potential recognition of assessing authorities in other countries.

Registration standards, policies and guidelines developed/published

Registration standards

In December 2011, Ministerial Council approved the Board's registration standards in the following areas:

- General registration for overseas-qualified dental practitioners
- Limited registration for postgraduate training or supervised practice (section 66)
- Limited registration for teaching or research (section 69)

These registration standards were developed after a period of public consultation.

Guidelines

The Board consulted with stakeholders and finalised the following guidelines:

- Guidelines on conscious sedation area of practice endorsement
- Guidelines on limited registration of dental practitioners for postgraduate training or supervised practice (section 66)
- Guidelines on supervision roles and responsibilities of the supervisor and requirements of a supervision plan and supervision report

The Board also consulted on guidelines on supervision for dental practitioners modelled on supervision guidelines developed for use by all National Boards. These will be finalised later in 2012.

Other policies and fact sheets

In conjunction with a number of National Boards, consultation was undertaken on the definition of 'practice'. As a result, the Board developed its statement on *When it is necessary to be registered as a dental practitioner?.* The Board also amended its interim policy (Public interest

limited registration – registration of overseas speakers) to reflect that this new statement is now relevant when considering the need for registration of overseas speakers.

During the year, the Board considered a number of issues related to the implementation and interpretation of its CPD registration standard and guidelines, and released a fact sheet to assist registrants.

Accreditation standards approved

The Board approved the *Accreditation standards: education programs for dental prosthetists,* which were developed by the ADC.

Key issues

The key issues of concern for the Board continue to revolve around establishing compliance with policy and ensuring that dental practitioners and other key stakeholders have a clear understanding of their obligations, responsibilities and rights under the National Scheme and of the Board's primary role, which is to protect the public.

Priorities for the coming year

The Board's key objectives for the coming year are to:

- commence preliminary research and consultation, where relevant, with the other National Boards, in preparation for the review of the Board's registration standards, which is due to commence later in 2012
- undertake the review of the scope of practice registration standard, relevant to all divisions of dental practitioners, and consider the recommendations arising from Health Workforce Australia's report on scope of practice – oral health practitioners
- consolidate policy direction by reviewing interim policies and converting these to formal policies and guidelines as required
- establish a process to manage the endorsement in relation to acupuncture for dental practitioners
- assist AHPRA to carry out an audit of practitioners' compliance with relevant registration standards
- respond effectively to current issues to guide registrants – this includes the development of a social media policy, and
- continue to improve communications with stakeholders via a range of initiatives including a review of website content.

Members of the Board

The members of the Dental Board of Australia are:

Dr John Lockwood AM, Ms Susan Aldenhoven AM, Mrs Jennifer Bishop, Dr Carmelo Bonanno, Dr Gerard Condon, Mr Stephen Herrick, Mr Paul House, Dr Mark Leedham, Mr Peter Martin, Mr Michael Miceli, Dr John Owen AM, Mrs Myra Pincott AO.

During 2011/12, the Board was supported by Executive Officer Tanya Vogt.

More information about the work of the Board is available at: www.dentalboard.gov.au.

Medical Board of Australia

Message from the Chair

The past 12 months has seen the National Scheme move onto more solid ground. The AHPRA national and state and territory offices and the Medical Board of Australia (the Board), through the National Board and the state and territory boards and committees, have settled into their roles and are focusing on delivering contemporary, efficient and robust regulation.

The issues that are emerging are the ones that are known to medical regulators across the world: how to ensure the integrity of the processes to admit individuals to the medical register; how to ensure that those who are on the register practise safely and ethically; and how to deal fairly and effectively with those who fail to meet the required standards. The Board and all its committees have both practitioner and community members working together to discern and articulate the standards that are appropriate for medical practice in 21st century Australia. It consults widely as it develops policy and guidelines. The Board is accountable to both the community and the profession.

A key aspect of this accountability is a commitment to transparency: about the work the Board is doing; the processes underpinning board decisions; the outcomes of those processes where they relate to a serious matter which affects a medical practitioner's registration; and about how the Board and AHPRA use the registration fees collected from the profession. This annual report marks a further step in that transparency.

Dr Joanna Flynn AM
Chair, Medical Board of Australia

Board report

The 12 members of the Board were appointed in August 2009 by Ministerial Council for a period of three years. Eight members are registered medical practitioners, one from each jurisdiction, and four are community members.

The Board, with the assistance of AHPRA, is responsible for administering the National Law. Specific roles of the Board include:

- developing registration standards, codes and guidelines
- approving accreditation standards and programs of study which qualify an individual for registration, and
- negotiating the Health Profession Agreement with AHPRA.

The Board has delegated many of its powers to state and territory boards and committees appointed in every state and territory. The state and territory boards and committees make decisions about registrations and deal with notifications about medical practitioners and students within their jurisdiction. State and territory board members are appointed by the responsible Minister in each jurisdiction. While most of the committees are drawn from the state and territory boards, the Board has also appointed some non-board members to these committees.

In 2011/12, the Board:

- held 11 board meetings: a communiqué is published after each meeting to inform stakeholders of issues that the Board considered and decisions made
- ran the second national conference with state and territory boards of the Board and senior staff from AHPRA: the meeting was an opportunity for state and territory board members to contribute their experience and expertise to the Board's policy agenda and to focus on registration and notifications management
- held a combined meeting with the directors of the Australian Medical Council (AMC)
- ran a workshop with providers of pre-employment structured clinical interviews with the AMC
- held a planning day in July 2011 that included state and territory chairs, and
- participated in a meeting of all National Boards and AHPRA in September 2011.

The Board's committees in each state and territory are:

- Registration Committee
- Health Committee (excluding New South Wales)

- Immediate Action Committee (excluding New South Wales)
- Notifications Assessment Committee (excluding New South Wales), and
- Performance and Professional Standards Committee (excluding New South Wales).

2011/12 areas of focus

Over the past 12 months, the Board has focused on:

- ensuring that there is transparency in its operations and reporting
- continuing to work with AHPRA and state and territory boards and committees to promote consistency – this has included a review of the delegation of powers
- issues related to international medical graduates
- the intern year, including consulting on a registration standard for granting general registration to Australian and New Zealand medical graduates who have completed an internship, and asking the AMC to do a range of work to support the registration standard
- working with the AMC to further develop the structures and processes to integrate the accreditation functions and the role of the Board under the National Law, and
- undertaking consultations and developing guidance on relevant issues.

Key outcomes/achievements

Transparency and accountability

The Board is aware that it is accountable to the community and the medical profession, and it has a responsibility to use practitioners' registration fees wisely in regulating the profession in the public interest. An important focus for the Board in 2011/12 has been to work on ways to demonstrate this commitment. The Board has agreed to publish the Health Profession Agreement between AHPRA and the Board, which sets out the services AHPRA will provide in supporting the Board to regulate the medical profession. As the National Scheme's reporting capability strengthens, the Board and AHPRA will publish more detailed information about the Board's financial operations to complement the audited data published in each year's annual report.

Definition of practice

Over the course of 2011/12, the Board consulted on the definition of 'practice'. The Board has defined 'practice' in a number of its registration standards. That definition is very broad and allows medical graduates who are doing any work related to medicine to register if they can meet the Board's registration standards. Stakeholders had provided feedback to the Board that this had caused some confusion, particularly from medical practitioners who were no longer seeing patients but were involved in teaching and assessing activities.

The Board, together with six other National Boards, consulted on the definition of 'practice' to help them decide whether or not a change to the definition was necessary.

After considering feedback from stakeholders, the Board decided not to amend the definition but to issue advice to help individuals decide whether or not they should be registered, including advice about which activities require registration. This advice is available at www.medicalboard.gov.au at 'codes, guidelines and policies'.

The National Specialist International Medical Graduate Committee

The Board has established the National Specialist International Medical Graduate (IMG) Committee to provide the Board with policy advice on the assessment of specialist IMGs. This committee includes representatives from the Board, AHPRA, specialist medical colleges, the AMC, consumer groups, jurisdictional governments, the Commonwealth government, Health Workforce Australia and recruiters of IMGs.

The committee met twice during 2011/12 and agreed on a work plan for 2012/13. The key focus of the work plan is to review the processes for assessing specialist IMGs, with the aim of streamlining and making them more efficient, whilst ensuring appropriate standards are met. The committee publishes a communiqué after each meeting to inform stakeholders of issues considered and decisions made.

Response to the House of Representatives' inquiry into registration processes and support for overseas-trained doctors

In the previous annual report, the Board reported that it had made a submission to the House of Representatives' inquiry into the registration processes and support for overseas-trained doctors. The Chair of the Board appeared before the inquiry and provided further evidence during this reporting year.

The House of Representatives Standing Committee on Health and Ageing released its report on the inquiry in March 2012. The report makes 45 recommendations, many of which require action from the Board, AHPRA, the AMC and the specialist medical colleges.

The Board, AHPRA, the AMC and the Committee of Presidents of Medical Colleges (CPMC), which represents

the specialist medical colleges, established a working party to consider how to respond to the recommendations in the report. The AMC, specialist medical colleges, the Board and AHPRA have started reviewing processes for the assessment and registration of IMGs and will continue to work together cooperatively in the next year. This work also links to the work of the National Specialist IMG Committee.

Activities related to interns

The Board consulted on and finalised a registration standard for granting general registration to Australian and New Zealand medical graduates who have completed an internship. The registration standard will be submitted for approval to Ministerial Council in 2012/13. The registration standard provides clarity for interns, their supervisors and their employers on what an intern needs to do to be granted general registration. Requirements will be consistent across all states and territories.

The Board has also asked the AMC to do further work that will support the registration standard. The AMC will:

- set learning objectives for the intern year, building on existing work
- develop a process to confirm interns have met the requirements for the intern year, including developing term supervisor reports, and
- developing a national framework for intern training accreditation.

Accreditation

The AMC has been appointed as the accreditation authority for medicine. All the accreditation authorities appointed by Ministerial Council have been appointed until 30 June 2013. The National Boards and AHPRA have worked with accreditation authorities to establish a process to review the accreditation arrangements for the provision of accreditation functions from 1 July 2013.

An important objective of the National Law is to facilitate the provision of high-quality education and training of health practitioners. The accreditation function is the primary way of achieving this objective. The National Law defines the respective roles of the Board and its appointed accreditation authority, the AMC, in the accreditation of medical schools and medical specialist colleges.

The AMC is responsible for developing accreditation standards for the approval of the Board. Accreditation standards are used to assess whether a program of study, and the education provider of the program, gives people who complete the program the knowledge, skills and professional attributes to practise the profession.

Based on the accreditation advice from the AMC, the Board approved the following during 2012:

1. Medical programs as providing a qualification for the purposes of registration in the medical profession:
   - University of New South Wales Faculty of Medicine – to 31 December 2013
   - Faculty of Health Sciences MBBS program, University of Adelaide – to 31 December 2014
   - School of Medicine, University of Tasmania – to 31 December 2016
   - Graduate School of Medicine, University of Wollongong – to 31 December 2016
   - University of Notre Dame Australia, School of Medicine Sydney – to 31 December 2013
2. Specialist college education and training programs and their CPD programs for the purpose of specialist registration in the medical profession:
   - Australasian College of Dermatologists – to 31 December 2013
   - College of Intensive Care Medicine of Australia and New Zealand – to 31 December 2015
   - Royal Australian and New Zealand College of Ophthalmologists – to 31 December 2016
   - Royal Australian and New Zealand College of Psychiatrists – to 31 December 2015
   - Royal Australasian College of Surgeons (specified areas of specialty) – to 31 December 2017
   - Australasian College of Sports Physicians – to 31 December 2014

Proposed registration standards developed during 2011/12

After consultation with stakeholders, the Board has developed the following two proposed registration standards for the approval of Ministerial Council:

- proposed registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training, and
- proposed registration standard for endorsement of registration for acupuncture for registered medical practitioners.

Registration standards, policies and guidelines developed/published

The Board has consulted on and has published the following guidelines and statements in 2011/12:

- Medical registration – What does it mean? Who should be registered?
- A revised version of Guidelines: Supervised practice for limited registration
- Sexual boundaries: Guidelines for doctors
- Guidelines: Technology-based patient consultations
- Statement: Eligibility for specialist registration

Key issues addressed

The Board focused on several key issues in 2011/12:

- From 1 July 2012, medical practitioners who wish to use the title 'acupuncturist' must be registered by the Chinese Medicine Board of Australia or have their registration endorsed for acupuncture by the Medical Board of Australia. After consultation with stakeholders, the Medical Board has approved a proposed registration standard for acupuncture which will be submitted to Ministerial Council for approval.
- Ministerial Council asked the Board to consult on, and consider funding, external health programs for medical practitioners. The Board consulted on whether the Board had a role in funding of external doctors programs and, if so, what services should be provided and how they should be funded. The Board will be undertaking further work in this area in 2012/13.
- IMGs who are intending to practise in non-specialist positions which are not highly supervised, such as in general practice, may be required to have a pre-employment structured clinical interview (PESCI) to determine whether they are suitable for the positions. There are a number of providers of PESCIs who are all accredited by the AMC. Work has started with the AMC to review PESCIs to establish more consistent processes and reporting across jurisdictions.
- The Board received a referral from Ministerial Council about a report endorsed by the Australian Health Ministers' Conference (AHMC) titled 'Cosmetic medical and surgical procedures – A national framework'. The report contains a number of key recommendations directed to the Medical Board about medical practitioners who perform cosmetic medical and surgical procedures. The working party that prepared the report has drafted supplementary guidelines on cosmetic medical and surgical procedures to the Board's code of conduct 'Good Medical Practice' and the Board has consulted on these draft guidelines. The Board is considering the submissions made to its consultation and will be undertaking further work on this matter during 2012/13.
- All health practitioners registered under the National Law are required to declare that they have met the relevant registration standards, including CPD and professional indemnity insurance, each time they renew their registration. AHPRA, in consultation with National Boards, is developing a process to audit compliance with these standards. The Board has been working with AHPRA to develop an audit tool for medical practitioners to confirm compliance with the Board's registration standards.

Priorities for the coming year

The Board will:

- start the review of the registration standards that are due for review by mid-2013
- finalise the current work on the intern year and start its implementation in preparation for commencement in the 2014 year
- work on streamlining registration processes for IMGs including improving the efficiency of the competent authority pathway and the specialist pathway
- review the supervision arrangements for IMGs
- continue to oversee management of notifications to support robust decisions and efficient processes
- refine the approach to the assessment and management of medical practitioners or medical students who may be impaired
- develop guidance on the regulatory management of the practitioner who may be cognitively impaired
- develop guidelines on medical practitioners and medical students infected with a blood-borne virus
- review tools used to assess performance and further guidance on performance assessments to support state and territory boards, committees and AHPRA when requiring a practitioner to undergo a performance assessment, and
- continue policy development, including a social media policy and a policy for international criminal history checks.

Members of the Board

The members of the Medical Board of Australia are:

Dr Joanna Flynn AM, Professor Belinda Bennett, Dr Stephen Bradshaw, Dr E Mary Cohn, Ms Prudence Ford, Dr Fiona Joske, Dr Charles Kilburn, Mr Paul Laris, Professor Mark K McKenna, Dr Trevor Mudge, Ms Sophia Panagiotidis and Associate Professor Peter Procopis AM.

The members of the state and territory boards and committees of the Medical Board of Australia are:

ACT:
Dr Stephen Bradshaw (Chair), Dr Kerrie Bradbury, Ms Pamela Brown, Dr William Burke, Ms Megan Lauder, Dr Timothy McKenzie, Dr Sally Somi, Dr Vida Viliunas, Mr Don Malcolmson, Ms Kay Barralet, Dr Lev Fridgant.

NSW:
Dr Gregory Kesby (Chair), Dr Denis Smith, Mr Antony Carpentieri, Ms Rosemary Kusuma, Dr Stephen Adelstein, Dr Annette Carruthers (from 1/01/2012), Associate Professor Peter Procopis AM (Chair - NSW Board until 31/12/2011), Dr Anthony Eyers (until 31/12/2011), Professor Belinda Bennett (until 31/12/2011), Dr Choong-Siew Yong (until 31/12/2011), Dr Kendra Sundquist (until 31/12/2011), Mr Michael Christodoulou (until 31/12/2011), Professor Allan Spigelman (until 31/12/2011), Dr Robyn Napier (until 31/12/2011), Dr Susan Ieraci (until 31/12/2011), Professor Kathleen (Kay) Wilhelm (until 31/12/2011), Dr Kerry Chant (until 31/12/2011), Ms Lorraine Poulos (until 31/12/2011), Associate Professor Rod McMachon (until 31/12/2011), Professor Peter Klineberg, Dr Martin Mackertich, Associate Professor John Palmer, Dr Jennifer Davidson (from 27/06/2012), Dr Frances Black, Dr Joanna Hely.

NT:
Dr Charles Kilburn (Chair), Ms Diane Walsh, Dr Paul Helliwell, Dr Christine Watson, Ms Judith Dikstein, Ms Helen Egan, Dr Verushka Krigovsky, Dr Jennifer Delima, Dr Ameeta Patel (from 26/5/2012), Dr Len Notaras, Dr Anuja Kulatunga.

Qld:
Associate Professor Peter Woodruff (Chair), Dr Christopher Kennedy, Associate Professor David Henderson, Ms Fiona Chapman, Dr Jeannette Young, Mr Michael Clare, Dr Nicola Murdock, Ms Peta Frampton, Professor Richard Hays, Professor Tarun Sen Gupta, Mr Terrence Selva, Dr Warwick Carter, Dr Roger Rosser, Professor Malcolm Parker, Dr Geraldine Chew, Dr Donna O'Sullivan, Ms Donna Hancock, Ms Melinda Zerner, Dr John Fraser (from 22/02/2012).

SA:
Dr Philip Henschke (Chair), Mr Paul Laris, Dr Christine Putland, Dr Stephen Stranks, Ms Katherine (Kate) Sullivan, Professor Anne Tonkin, Dr Mary White, Professor John Turnidge, Dr Rakesh Mohindra, Dr Peter Joseph (from 28/08/2011), Dr Lynne Rainey, Mr Mark Bodycoat, Dr Carlien Kimber (until 27/08/2011), Dr Carolyn Edmonds, Dr Leslie Stephan, Dr Charlie Murray, Ms Patricia Rayner, Dr Susan Brady.

Tas:
Associate Professor Peter Sexton (Chair), Dr Fiona Joske, Dr Kim Rooney, Dr Brian Bowring, Dr Philip Moore, Professor Peter Mudge, Dr Andrew Mulcahy, Dr John O'Sullivan, Ms Leigh Mackey, Ms Dee Potter, Ms Christine Fraser, Mr David Brereton.

Vic:
Dr Laurie Warfe (Chair), Dr Mitchell Chipman, Dr Peter Dohrmann, Dr Felicity Hawker, Dr Bernadette White, Mrs Paula Davey, Ms Kerren Clark, Associate Professor Abdul Khalid, Dr John Carnie (from 4/10/2011), Dr William Kelly (from 4/10/2011), Dr Miriam Weisz (from 4/10/2011), Mr Kevin Ekendahl (from 4/10/2011), Mr Sean Lusk (until 30/09/2011), Ms Sophia Panagiotidis (until 30/09/2011), Dr Leon Shapero (until 30/09/2011), Ms Christine Heazlewood (until 30/09/2011).

WA:
Professor Con Michael (Chair), Professor Bryant Stokes, Dr Simon Towler, Adjuvant Professor Peter Wallace OAM, Dr Michael McComish, Dr Steven Patchett, Ms Prudence Ford, Professor Mark K McKenna, Ms Virginia Rivalland, Ms Nicoletta Ciffolilli, Dr Frank Kubicek (from 25/11/2011), Professor Stephan Millett (from 26/03/2012), Dr Felicity Jefferies (until 24/11/2011), Ms Anne Driscoll (until 25/03/2012).

The members of the National Specialist IMG Committee are:

Dr Joanna Flynn AM (Chair), Dr Mary Cohn, Dr Denis Smith, Dr Peter Dohrmann, Dr Patrick Giddings, Professor Claire Jackson, Dr Richard Willis, Professor Ajay Rane, Ms Patricia (Patti) Warn, Ms Kym Ayscough, Dr Joanne Katsoris, Mr Ian Frank, Dr Christine Tippett, Dr Susan O'Dwyer, Dr Paddy Phillips, Dr Andrew Singer, Mr Stephen Bott, Ms Claire Austin.

During 2011/12, the Board was supported by Executive Officer Dr Joanne Katsoris.

More information about the work of the Board is available at: www.medicalboard.gov.au.

Nursing and Midwifery Board of Australia

Message from the Chair

The Nursing and Midwifery Board of Australia (the NMBA or National Board) has continued to work diligently during the past 12 months to fulfil the objectives of the National Scheme.

One significant decision made during this time was to increase the annual registration fee to $160. This increase will enable the National Board to continue its important work in regulating more than 330,000 registered and enrolled nurses, nurse practitioners, midwives, eligible midwives and students of nursing and midwifery, as well as meet the NMBA strategic objectives. In setting the fees for 2012, the National Board committed to limiting future fee increases to the consumer price index (CPI), unless in exceptional circumstances such as a significant change to the scope of the National Board's operations and regulatory responsibilities.

During the year, the NMBA participated in state, territory, national and international activities related to the regulation of the nursing and midwifery professions. These activities have enhanced stakeholder engagement and improvements to systems and processes in many ways. The NMBA looks forward to continuing to review and actively participate in matters for the betterment of public safety.

Lastly, I would like to thank the NMBA's key partners, AHPRA and the Australian Nursing and Midwifery Accreditation Council (ANMAC), members of the National Board as well as the state and territory boards of the NMBA for their efforts. I would also like to acknowledge an inaugural member of the National Board and Tasmanian Board of the NMBA, Gillie Anderson, for her valuable contribution.

Ms Anne Copeland
Chair, Nursing and Midwifery Board of Australia

Areas of focus

The NMBA approved a strategic plan that prioritised a significant work program relating to the core regulatory functions of registration, accreditation and notifications, as well as professional nursing and midwifery policy. The initiatives identified in the NMBA Strategic Plan for 2011-2012 have been undertaken in partnership with AHPRA.

The NMBA vision, mission and strategic themes complement the National Scheme vision, mission and strategic directions.

National Scheme vision: A competent and flexible health workforce that meets the current and future needs of the Australian community.

NMBA vision: To be viewed by Australian and international nursing and midwifery professions, the public, and other key stakeholders as a capable and visionary national board that regulates nurses and midwives with integrity in the interest of public safety.

National Scheme mission: To regulate health practitioners in Australia in the public interest.

NMBA mission: To work in partnership with health professions, the education sector and the community by exhibiting a willingness and common desire to make the regulation of nurses and midwives nationally successful so that the public is safe.

The five key strategic themes are:

- **Key strategy 1**: Working together as a National Board with state and territory boards of the NMBA, nursing and midwifery professional groups, the education sector, AHPRA and other key stakeholders to ensure informed decision-making and appropriate direction-setting.
- **Key strategy 2**: Demonstrate proactive leadership to positively influence the direction of nursing and midwifery practice in relation to the protection of the public in Australia and, where applicable, international arenas.
- **Key strategy 3**: Continuously and effectively improve the quality of corporate activities.
- **Key strategy 4**: Monitor the political environment, nationally and internationally, as relevant to nursing and midwifery, and respond to emerging issues.
- **Key strategy 5**: Appropriate application of the National Law, as in force in each state and territory.

While not without its challenges at times, the National Board – through its three committees: the Policy Committee, Accreditation Committee and Finance and

Governance Committee – has continued to work in accordance with the agreed action plan to achieve the desired outcomes while maintaining flexibility to address important emerging issues in a timely and effective manner.

Key achievements

- Successfully engaged with the members of each state and territory board of the NMBA and key AHPRA staff through monthly National Board meetings being held in each state and territory.
- Improved communication, information sharing and identification of opportunities for improvement between the National Board and the state and territory boards of the NMBA, obtained through the establishment of a regular monthly meeting between the Chair of the NMBA and the Chairs (or their delegate) of the state and territory boards of the NMBA.
- Further established the National Board's role and relationship with the independent accrediting authority for nursing and midwifery, ANMAC. In partnership with ANMAC and AHPRA, effectively addressed the myriad of issues related to the establishment and implementation of a nationally-consistent accreditation function under the National Law.
- Completed a significant quality improvement project to enhance the accuracy of the information and ability to search the NMBA approved list of programs of study leading to registration and endorsement for nursing and midwifery that have been accredited by ANMAC and approved by the NMBA.
- Implemented a framework for communication activities that makes it easier for nurses, midwives and students of nursing and midwifery, education providers, employers and other key stakeholders to engage with the National Board and keep informed about nursing and midwifery practice in Australia. Additional communication activities included staffing NMBA booths in states and territories at Royal College of Nursing Australia Careers Expo events and national nursing and midwifery conferences; publication of the first of three annual e-newsletters for nurses, midwives, students of nursing and midwifery and stakeholders; and development of a communication plan when implementing new initiatives.
- Funded a study entitled *The comparative study on services available to support impaired nurses and midwives in Australia* by Siggins Miller to undertake a comparative study of the services provided to support impaired nurses and midwives across Australia and to consult with relevant professional stakeholders. The report assisted the National Board in fully considering the viability of health programs including the Nurses and Midwives Health Program, Victoria (NMHPV) and determining whether a national health program is appropriate from a regulatory perspective.
- Undertook a targeted stakeholder forum to determine the need for a review of the NMBA competency standards for nurse practitioners.
- Via AHPRA, appointed a project team led by Professor Andrew Cashin from Southern Cross University, NSW to review the NMBA national competency standards for nurse practitioners through rigorous evidence-based research, analysis and stakeholder consultation to revalidate and, where appropriate, revise the competency standards and thereby inform the contemporary scope of practice of the nurse practitioner.
- Via AHPRA, appointed a project team led by Professor Wendy Cross, Head of the School of Nursing and Midwifery, Monash University, Victoria with Curtin University, Western Australia, to review the NMBA national competency standards for enrolled nurses. The primary purpose of this 18 month project is to revise the current competency standards for relevance and currency against the contemporary role and scope of practice of enrolled nurses. These competency standards are to be revised using the best available evidence to ensure a strong foundation for the education and assessment of enrolled nurses into the future.
- Participated in the second meeting in Switzerland of the *International Nurse Regulator Collaborative* comprising representatives from Australia, Canada, Ireland, New Zealand, Singapore, United Kingdom and the United States. The meeting considered the progress on the international project whereby each participating organisation compiled de-identified data in relation to decisions made about registered nurses' health, performance and/or professional conduct matters for 12 months from 1 July 2010 to 30 June 2011. Analysis of these cases is aimed at helping to identify possible trends and issues as well as potential strategies to address them. The project also aimed to help develop a disciplinary lexicon and explore opportunities for future cross-country research.
- Engaged in international nursing and midwifery regulatory events including the International Council of Nurses (ICN) Credentialing and Regulators Forum in Taiwan, as well as the ICN and International Council of Midwives (ICM) Credentialing and Regulators Forum and the ICN, ICM and WHO Triad meeting in Switzerland.

Registration standards, policies and guidelines developed and published

Approval was granted by Ministerial Council to two revised registration standards:

1. Nursing and Midwifery *English Language Skills Registration Standard* effective from 19 September 2011 and the *Fact Sheet and FAQ for English Language Skills* – 19 September 2011.
2. Nursing and Midwifery *Professional Indemnity Insurance Arrangements Registration Standard* and *Guidelines for Professional Indemnity Insurance Arrangements for Midwives* – 10 January 2012.

The National Board also developed and approved a number of position statements and policies to provide guidance to the midwifery and nursing professions which included:

1. Position Statement: *Scope of practice of nurse practitioners* – 27 October 2011
2. Position Statement: *Midwives in private practice* – 2 September 2011
3. *National Prescribing Formulary for Midwives* – 12 September 2011
4. *Re-entry to practice policy for nursing and midwifery* – 29 March 2012

The National Board acknowledges the outstanding contribution of all its stakeholders in providing constructive feedback to the numerous NMBA consultations required to develop new, or improve existing registration standards as well as a range of professional guidelines and position statements.

Key issues

Key issues for the National Board include the:

- enhancement of the National Board's stakeholder engagement through the implementation of a comprehensive and effective communications plan
- continued improvement to the approach for the effective and efficient management of important nursing and midwifery projects and the business of regulating nurses, midwives and students in partnership with AHPRA, and
- national consistency in the decision-making process by state and territory boards of the NMBA, Immediate Action Committees, and Registration and Notifications Committees through a shared understanding and involvement in the development and application of agreed principles for decision-making.

Priorities for the coming year

The National Board has determined the Health Profession Agreement between the NMBA and AHPRA, the budget for 2012/13, and identification and prioritisation of the projects and initiatives to be achieved in the National Board's work plan.

In the coming year, the National Board will continue its work to embed the requirements of the National Scheme while undertaking major initiatives in accordance with the National Law, prior to the end of the first three years of the National Scheme. These initiatives include a wide-ranging review of the:

- arrangements for the accreditation function for nursing and midwifery, and
- NMBA registration standards that are scheduled for review by 1 July 2013. This will include the review of the registration standards for criminal history, recency of practice and CPD, as well as the registration standards for the notation as an eligible midwife and endorsement of an eligible midwife to prescribe scheduled medicines.

The National Board will establish a new NMBA Strategic Plan for the next three years prior to the end of 2012.

Members of the NMBA

The members of the Nursing and Midwifery Board of Australia are:

Ms Anne Copeland (Chair), Ms Angela Brannelly, Professor Elizabeth (Mary) Chiarella, Dr Lynette Cusack, Professor Denise Fassett, Mrs Lynne Geri, Ms Louise Horgan, Ms Mary Kirk, Dr Christine Murphy, Ms Heather Sjoberg, Ms Margaret Winn, Ms Gillie Anderson (up to 29/02/12).

The members of the state and territory boards of the NMBA are:

ACT:
Ms Emma Baldock (Chair), Ms Alison Chandra, Ms Tina Calisto, Ms Felicity Dalzell, Ms Jane Ferry, Ms Kate Gauthier, Ms Eileen Jerga AM, Ms Natalie Robinson, Mr Alan Merritt.

NSW:
Mr Eric Daniels (Chair) (from 01/01/12), Ms Kathryn Adams, Ms Susan Hendy, Mr Steven Jeffs, Ms Betty Johnson, Mr Ian Linwood, Ms Rebecca Roseby, Mr Bruce Brown (from 01/01/12), Ms Melissa Maimann (from 01/01/12), Adjunct Professor Debra Thoms, Ms Margaret Winn, Mr Charles Linsell (until November 2011).

NT:
Ms Angela Brannelly (Chair), Ms Angela Bull (Deputy Chair; from 15/06/12), Mr Ross Ashcroft (from 21/10/11), Ms Denise Brewster-Webb (from 21/10/11), Ms Gay Lavery (from 28/06/12), Dr Brian Phillips, Ms Kim Packer (nee Ball; from 21/10/11), Ms Therese Kearns (from 14/05/12), Ms Heather Sjoberg.

Qld:
Professor Donald Gorman (Chair), Ms Veronica Casey, Mr John Chambers, Mr Terence Selva, Dr Virginia Thorley, Ms Michelle Hill, Ms Leanne Smith, Professor Patsy Yates, Mr Philip Shade.

SA:
Associate Professor Linda Starr (Chair), Ms Jennifer Byrne, Ms Susie Duggin, Dr Janina Gipslis, Ms Jeannette Hall (until 26/06/12), Ms Wendy Harvey (until 06/10/11), Dr Stephen Parker, Ms Nicole Ratanen, Mr Michael Salt (from 7/10/2011), Ms Sally Hampel, Ms Maria Barredo (from 6/02/2012).

Tas:
Ms Catherine Schofield (Chair), Mrs Robyn Hopcroft, Ms Susan Hughes, Ms Elizabeth van der Linde-Keep, Ms Kim Gabriel, Professor Andrew Robinson, Reverend Douglas Edmonds, Dr Helen Pratt, Ms Gillie Anderson (until 29/02/2012).

Vic:
Mr Gregory Miller (Chair), Ms Kathryn Hough (from 1/10/2011), Ms Leanne Satherley (from 1/10/2011), Dr Leslie Cannold (from 1/10/2011), Mr Timothy Wilson (from 1/10/2011), Ms Virginia Rogers (from 1/10/2011), Ms Naomi Dobroff, Ms Katrina Swire, Ms Deborah Rogers.

WA:
Ms Marie-Louise Macdonald, Professor Selma Alliex (from 18/03/2012), Mr Anthony Dolan (from 26/03/2012) Ms Virginia Seymour (from 26/03/2012), Adjunct A/Professor Karen Gullick, Adjunct A/Professor Christine Hanna, Ms Lynn Hudson, Mr Kenneth Bradley, Ms Jennifer Wood.

During 2011/12, the NMBA was supported by Executive Officer Alyson Smith.

More information about the work of the Board is available at: www.nursingmidwiferyboard.gov.au.

Optometry Board of Australia

Message from the Chair

This year has seen a remarkable maturing and refinement of the administration and processes of the National Scheme, allowing the Optometry Board of Australia (the Board) to concentrate on policy, accreditation, workforce, registration and notification refinements. The overall National Scheme has made remarkable progress in a short timeframe against significant odds. The Agency Management Committee and the AHPRA team are to be congratulated on the major advances made in consistency of processes, communication and data collection.

There have been significant successes for optometry, highlighted by the approval of the new registration standard for general registration. This entrenches therapeutic education as an integral part of optometry practice, with all new registrants being required to be therapeutically qualified from 2014.

The review of the CPD standard and guidelines has been a success story with excellent support from our professional stakeholders and registrants. This further recognition of the importance of relevant, easily accessible, high-quality professional development is a major benefit to the consumers of optometric services and to the professions' practice standards.

We are developing relationships with Health Workforce Australia and ensuring that our regulatory decisions have positive effects on the progression of a sustainable and accessible workforce, with no barriers to professional development, to ensure access to primary eye healthcare by all Australians.

International relationships have been another priority with a visit to New Zealand to develop an MoU and consult on common approaches to trans-Tasman mutual recognition and accreditation. Also, attendance at the Association of Regulatory Boards of Optometry (USA and Canada) annual meeting has allowed the Board to compare areas of expertise and forge closer relationships for the future. Our support for international regulatory progress was highlighted with involvement in the World Council of Optometry Annual Meeting.

One area of particular concern for the coming year is to review our advertising guidelines to ensure that consumers are treated in an honest and open manner. In conjunction with AHPRA, we are also establishing relationships with the Australian Competition and Consumer Commission, the Therapeutic Goods Administration and Medicare, as well as contact with the Professional Services Review office.

All National Boards will be reviewing their accreditation arrangements. The Optometry Board has had very positive communication with the Optometry Council of Australia and New Zealand (OCANZ) in preliminary work for the review. OCANZ has very competently performed its role for the Board and has a very challenging year ahead with the accreditation of two new schools and a review of postgraduate therapeutic standards.

This coming year will also see a comprehensive review of all the Board's standards, guidelines and policies.

Effective communication with all our stakeholders is one of the continuing goals of the Board, with regular newsletters and communiqués being issued. Consideration is also being given to registrant and community information meetings.

Mr Colin Waldron
Chair, Optometry Board of Australia

Areas of focus

The main area of focus for the Board in the past year has been finalising the registration standard for general registration. The standard was approved by health ministers in April 2012. With this, training in ocular therapeutics is the agreed minimum education standard for all those applying for registration for the first time from 1 December 2014, when the standard comes into effect.

A registration standard for limited registration for postgraduate training or supervised practice was also approved. This allows overseas-trained practitioners to practise under supervision whilst preparing for the clinical OCANZ examination process and postgraduate training in therapeutics after 2014. Overseas-trained optometrists are still required to qualify for and pass both the written and clinical OCANZ examinations and meet the Board's registration standards before they are eligible for general registration with the Board.

The registration standards were developed by the Board after extensive consultation, and support the continuous strengthening of the Australian optometric workforce and its regulatory framework. The new standards encourage greater efficiency as optometrists, ophthalmologists and other health professionals work together to meet the increasing demands for eye care services as the population grows and ages.

To support the introduction of the limited registration standard, the Board has also approved and published supervision guidelines for optometrists. These guidelines have been written to apply to a range of regulatory needs including those holding limited registration and those returning to the profession after a significant absence from practice.

Key outcomes/achievements

The approval of the two registration standards is a significant regulatory achievement for the Board.

The Board revised the structure of its Registration and Notification Committee. The smaller membership will allow for consistency in decision-making regardless of the state or territory in which the matter is lodged.

The Board has also conducted an extensive review of its CPD registration standard and guidelines. The Board has submitted the standard for approval by health ministers and, if approved, will publish the new standard and revised guidelines in early 2013.

Registration standards, policies and guidelines developed/published

In 2011/12, the Board published the following new documents:

Registration standards:

- General registration (to come into effect 1 December 2014)
- Limited registration for postgraduate training or supervised practice

Codes and guidelines:

- Supervision guidelines for optometrists

Policies:

- Interim policy on infection control for optometrists, including hand hygiene
- Policy on health records

Other:

- CPD provider manual
- Information sheet for optometrists returning to practice or significantly changing their scope of practice (revised)
- Fact sheet: Limited registration for postgraduate training or supervised practice.

Key issues

The current guidelines for advertising of regulated health services have been in focus in the first half of 2012. This has arisen from the advertisement of optometry products and services which test these current guidelines. The Board, in conjunction with other National Boards and AHPRA, have commenced a review of these guidelines.

Priorities for the coming year

The year ahead will be one of review for the Board. The Board will commence the review of all its registration standards, codes and guidelines. In conducting the review, the Board will work closely with other National Boards to ensure there is consistency across common standards and guidelines.

The Board will be consulting with the profession on all reviewed documents.

Members of the Board

The members of the Optometry Board of Australia are:
Mr Colin Waldron (Chair), Mr Garry Fitzpatrick, Mr Ian Bluntish, Ms Jane Duffy, Mr John Davis, Ms Judith Dikstein, Mr Derek Fails, Mr Lawson Lobb and Ms Peta Frampton.

The members of the national committees of the Optometry Board of Australia are:
Dr Phillip Anderton, Mr Mitchell Anjou, Mrs Nancy Atkinson, Mr Michael Burnside, Mr Alan Lance Chin Quan, Dr Mark Feltham, Ms Lisa Jansen, Mr John Kingshott, Mr Stephen Leslie, Ms Stephanie Bahler, Associate Professor David Pye, Ms Susan Sluce, Mr Greg Strachan, Ms Joanne Thomas, Dr Ann Webber, Mr David Welch, Associate Professor Peter Hendicott, Mr Jared Slater, Mr Ken Thomas, Mr Joe Chakman, Dr Alex Gentle, Mr Stephen Marty, Professor Peter McIntyre, Dr Lisa Nissen, Associate Professor Mark Roth, Professor Fiona Stapleton and Dr Diane Webster.

During 2011/12, the Board was supported by Executive Officer Ms Michelle Thomas.

More information about the work of the Board is available at: www.optometryboard.gov.au.

Osteopathy Board of Australia

Message from the Chair

The focus for 2011/12 for the Osteopathy Board of Australia (the Board) was building on the achievements of previous years and increased engagement. In that period, the Board has consolidated projects it had commenced and also developed a number of new guidelines for the profession. The guidelines were developed through extensive consultation with stakeholder groups, and registered osteopaths were informed directly through the new channel of regular electronic newsletters.

The Board was pleased to give approval for the first time to accreditation of a new osteopathy program taught at Southern Cross University at Lismore. The growth of the education sector and the profession is important. In 2012/13, the Board will look at more pathways for overseas-trained graduates to register to practice in Australia after receiving advice from its accreditation council, the Australian and New Zealand Osteopathic Council (ANZOC), and then conducting wide-ranging public consultation. There will be continuing interaction with international regulators to address the registration process for overseas-qualified osteopaths through the forum for international osteopathy regulatory authorities of the Osteopathic International Alliance (OIA).

As the end of the first term for all members draws near, I would like to acknowledge the hard work and dedication of all the practitioner and community members of the Board, who have worked very well together as a team for three years to implement and oversee the new National Scheme. We can all look back with pride on the incredible achievements of the first years and see a mature and established system in place at the end of June 2012.

Dr Robert Fendall
Chair, Osteopathy Board of Australia

Areas of focus

- During 2011/12, the Board met monthly with extra meetings in the period with the Board of Directors of the accreditation council, ANZOC. The latter focused on the progress of issues such as the constitution of ANZOC, the examinations conducted for the Board by ANZOC, the assessment of equivalence of overseas-qualified osteopaths, and various other accreditation matters. These meetings with ANZOC were held outside of the usual cycle for the monthly board meetings.
- The Board has a Registration and Notification Committee which meets monthly to make key registration and notification decisions that are beyond the routine functions delegated to AHPRA. The members of the Registration and Notification Committee are: Dr Robert Fendall (Chair), Dr Melissa Coulter, Ms Helen Egan and Ms Karen Stott. The administrative support for this committee is provided by the Victorian state office through support from National Committees, AHPRA.
- In 2011/12, the Board approved terms of reference for a Finance Committee, which met three times to develop the 2012/13 budget. The members of the Finance Committee are: Dr Robert Fendall (Chair), Dr Natalie Rutsche and Ms Helen Egan.
- The Chair of the Osteopathy Board attends monthly National Board Chairs' meetings.
- Monthly teleconferences are held with the chairs and executive officers of the Board and ANZOC on issues of mutual concern, particularly the development of ANZOC exams for overseas-trained osteopaths and local graduates from unapproved courses; the potential development of pathways for overseas-qualified osteopaths; and accreditation. Also, the Board and ANZOC met regarding governance and financial issues, including the nomination by the Board of a member of ANZOC in March 2012; discussion of the 2012/13 budget and projects; finalisation of the accreditation agreement which ANZOC and AHPRA signed in June 2012; and the forthcoming review of accreditation functions.

Key outcomes/achievements

The key achievements for the Board in 2011/12 have included:

- Instigating regular monthly teleconferences with the chairs and executive officers of the Board and ANZOC.

- Nominating a member, Ms Judith Dikstein, under the constitution of ANZOC. The former sole member of ANZOC, the Osteopathic Council of New Zealand (OCNZ), ceased to be a member on 31 March 2012.
- Publishing regular electronic or paper copy (to those without email addresses) newsletters to all registered osteopath practitioners.
- Holding regular two-monthly teleconferences with both the Australian Osteopathic Association (AOA) and the Chiropractic and Osteopathic College of Australasia (COCA), which have been welcomed by all participants as a forum for information sharing, feedback and developing stakeholder relationships.
- Finalising the tender process for the further development of capabilities for experienced osteopathic practice; and awarding the tender to Victoria University.
- Consulting on and developing new guidelines and fact sheets on board standards and policies.
- Approval of accreditation of osteopathy programs at RMIT and Southern Cross University.
- Strengthening international stakeholder relationships in teleconference meetings with the General Osteopathic Council (GOsC) in the UK, and two meetings with OCNZ (by teleconference and face-to-face).
- Presenting transition to practice information in seminars to final year students and heads of program in all osteopathy programs on the requirements for registration, the work of the Board and the role of AHPRA.

Registration standards, policies and guidelines developed/published

- After wide-ranging public consultations in 2011/12, the Board published new guidelines including:
  - > Revised CPD guidelines
  - > Guidelines for infection control
  - > Guidelines on clinical records
- Public consultations were conducted in July and August 2011 on draft registration standards for limited registration in the public interest, and limited registration for postgraduate training and supervised practice; and draft guidelines for supervised practice. The Board decided in September 2011 to defer further work on these proposals.
- The Board conducted public consultations on the definition of ‘practice’ in conjunction with six other National Boards.
- Fact sheets were published on the Board’s website on the following:
  - > CPD
  - > Infection control
  - > Endorsement for acupuncture
  - > Advertising.

Key issues

- Accreditation work is continuing and developing. ANZOC is appointed as the accreditation authority for the osteopathy profession for three years until June 2013. Under the National Law, AHPRA entered into a new agreement with ANZOC for the performance of the accreditation function for osteopathy in June 2012.
- In the past few years, ANZOC has conducted exams for overseas-trained osteopaths and for local students from an unapproved course. In 2012/13, it is anticipated that the Board will continue to receive applications for registration from overseas-trained osteopaths who have passed the ANZOC examination process.
- The key issue regarding accreditation for 2012/13 is the assessment of equivalency by ANZOC. ANZOC have been requested to develop a policy to establish criteria and processes to enable the assessment and recognition of selected authorities in other countries who conduct examinations for registration in osteopathy or accredit programs of study relevant to registration, to decide whether persons who successfully complete the programs/examinations conducted or accredited by the authority have the knowledge, skills and professional attributes necessary to practice the profession in Australia.
- Now that the recency of practice registration standard has been phased in for osteopaths, the Board will concentrate on providing more information and guidelines to those practitioners returning to practice after an absence, and to practitioners who are nominated as their supervisors (if necessary).
- The Board will continue to work with other boards on a consistent approach to the regulation of the title ‘acupuncturist’.

Priorities for the coming year

- Consulting on options for more streamlined pathways for the assessment of equivalence for overseas-trained osteopaths.
- Building on the guidelines for clinical records by consulting on and developing guidelines for informed consent.
- Identifying issues which arise from notifications, such as the need for guidelines on sexual and professional boundaries.
- Information development on return to practice and supervision.
- Ongoing recruiting of panel members as necessary.
- Receiving the final version of the revised capabilities for experienced osteopathic practice.
- Developing international regulatory links to address making portability more accessible for the profession.
- Participating with other National Boards to undertake a major review of the Board's five registration standards.
- Working with other National Boards to ensure consistency in registration standards, endorsements, guidelines and policies.
- Working with other National Boards and accreditation councils to develop shared perspectives on roles and responsibilities under the National Law.

Members of the Board

The members of the Osteopathy Board of Australia are: Dr Robert Fendall, Dr Melissa Coulter, Ms Helen Egan, Dr Amanda Heyes, Dr Luke Rickards, Dr Natalie Rutsche, Ms Karen Stott, Adjunct Professor Philip Tehan, Ms Belinda Webster.

During 2011/12, the Board was supported by Executive Officer Dr Cathy Woodward.

More information about the work of the Board is available at: www.osteopathyboard.gov.au.

Pharmacy Board of Australia

Message from the Chair

The past 12 months has been a period of consolidation, building on the developmental work of the first 12 months.

The Pharmacy Board of Australia's (the Board) committees, led by a team of dedicated chairs, have concentrated on pursuing their roles to ensure timely, accurate consideration of agenda items including matters outstanding from transition.

Committee members have made substantial contributions to the work of the committees so that the processes have been improved and compliance with the National Law is achieved and transparency improved.

I acknowledge and sincerely thank senior AHPRA staff for their assistance in helping the Board to meet its strategic goals and work plan.

I also congratulate and sincerely thank board members for their contributions and support throughout the year.

I also thank the Board's Executive Officer, Mr Joe Brizzi. Mr Brizzi, through his professional skill and knowledge, made significant contributions to the policy, codes and development work and administration of the Board throughout the year.

Adjunct Associate Professor Stephen Marty
Chair, Pharmacy Board of Australia

Board report

The members of the Board were appointed on 31 August 2009. During 2011/12, the Board met 12 times.

The Board has established committees to advise it and to make decisions when the Board has delegated powers under the National Law.

The Board's committees are:

- Registration and Examinations Committee
- Finance and Governance Committee
- Policies, Codes and Guidelines Committee
- Notifications Committee

As required, an Immediate Action Committee is convened by the Chair to consider matters that because of a registered pharmacist's conduct, performance or health, may require immediate action, if the pharmacist is considered to pose a serious risk to persons and it is necessary to take immediate action to protect public health or safety.

Areas of focus

Review of extemporaneous dispensing (compounding) guideline

The Board has formed a Compounding Working Party for the purpose of revising its *Extemporaneous dispensing (compounding) guideline* in its *Guidelines for dispensing of medicines.* The Board intends to expand the guideline to address complex compounding and minimum training requirements to be completed by practitioners involved in this area of practice.

Review of accreditation standards for pharmacy programs

The Australian Pharmacy Council (APC) is the accreditation authority for the pharmacy profession and accredits pharmacy programs in Australia. Under the National Law, the Board receives accreditation reports on pharmacy programs provided by APC, assessed against accreditation standards, and considers these reports for the purpose of deciding whether to approve accredited courses as providing qualifications for registration. The Board directed APC to conduct a review of the accreditation standards used since prior to the commencement of the National Scheme. This is to include a review against international standards.

Publication of electronic newsletters

In line with its communication strategy, the Board sought to increase communication with registrants. It achieved this in addition to its monthly communiqués by means of regular electronic newsletters to registrants. This was enabled by the high proportion of pharmacists who maintain up-to-date contact details including email addresses with AHPRA. The Board is able to effectively and efficiently communicate issues of importance to a significant proportion of registrants though its electronic newsletters, which it also publishes on its website.

Key outcomes/achievements

Pilot audit

In January 2012, a sample group of pharmacists were randomly selected for the Board's pilot audit of the

following mandatory registration standards:

- criminal history (via CrimTrac)
- recency of practice
- CPD, and
- professional indemnity insurance.

The audit was conducted by AHPRA on behalf of the Board. The audit was a pilot for the health professions registered under the National Scheme for the purpose of identifying any areas where changes to the audit of health practitioners would be required.

See page 62 for further information on this pilot audit project.

Interstate meetings

The Board normally meets at the AHPRA national office in Melbourne. On two occasions, the Board conducted its monthly meetings interstate (Western Australia and Tasmania). This provided the Board with an opportunity to meet with local stakeholder groups and pharmacists to discuss issues affecting pharmacy practice and progress of the National Scheme.

Board attendance at major pharmacy conferences

The Board was represented at three major pharmacy conferences (Pharmacy Australia Conference 2011, the Society of Hospital Pharmacists of Australia National Conference 2011 and Australian Pharmacy Professional Conference and Trade Exhibition 2012). Delegate members of the Board and the Board's Executive Officer attended these conferences and liaised with attendees to discuss new requirements under the National Scheme and to answer questions. The Board will continue to provide representation at major conferences during the coming year.

MoU with PCNZ signed at the 20 April 2012 meeting

In recognition of the benefits of professional mobility made possible by the trans-Tasman mutual recognition arrangement, and the legislation giving effect to this arrangement in New Zealand and Australia, the Board and the Pharmacy Council of New Zealand (PCNZ) signed an MoU. The Board and the PCNZ aim to, in so far as possible, establish 'essentially equivalent' standards for the pharmacy profession which are consistent and equivalent. The purpose of the MoU is to formalise the terms of this cooperation. The MoU has been signed by the Chair of the Pharmacy Board of Australia and the Chair of the Pharmacy Council of New Zealand.

Registration standards, policies and guidelines developed/published

In accordance with the National Law, the Board conducted wide-ranging consultation on its guidelines on practice-specific issues – guideline 1 (list of references).

The Board also started consultation on a revision of the *Code of conduct for registered health practitioners* in relation to the inclusion of clearer reference to the specific codes of ethics published by pharmacy professional organisations.

The Board also published extensive information to support registrants in relation to its guidelines on CPD and its CPD registration standard in the form of FAQs.

The Board is also in the process of conducting a review of its guidelines on dispensary assistants/dispensary technicians and hospital pharmacy technicians for consultation during the latter part of 2012.

Priorities for the coming year

Ongoing participation in the audit of pharmacists against registration standards

The Board has agreed to continue to participate in the second phase of an audit of a random sample of pharmacists against mandatory registration standards to be conducted by AHPRA.

Review of registration standards and guidelines

The Board will commence a review of its registration standards and guidelines by 30 June 2013. This will include wide-ranging consultation with stakeholders, the profession and the public.

Members of the Board

The members of the Pharmacy Board of Australia for the year were:
Adjunct Associate Professor Stephen Marty (Chair), Mrs Rachel Carr, Mr Trevor Draysey, Mr John Finlay, Ms Laila Hakansson Ware, Mr Ian Huett, Mr William Kelly, Mr Timothy Logan, Mr Gerard McInerney, Ms Karen O'Keefe, Ms Bhavini Patel and Dr Rod Wellard.

The members of the national committees appointed by the Pharmacy Board of Australia were:
Mrs Helen Dowling, Mr Ken Cox, Ms Jennifer Bergin, Mr Andrew Tooms, Mr Peter Clarke, Mr Peter Mayne, Ms Elspeth Gorring-Baker, Mr Vaughn Eaton, Ms Sia Hassouros, Ms Suzanne Hickey, Mr Mark Dunn, Ms Karen Samuel, Mr Anthony Tassone, Professor Michael Garlepp and Mrs Manal Oz.

Information on membership of the Board and its delegates is published at www.pharmacyboard.gov.au.

The Board was supported in 2011/12 by Executive Officer Mr Joe Brizzi.

More information about the work of the Board is available at: www.pharmacyboard.gov.au.

Physiotherapy Board of Australia

Message from the Chair

During 2011/12, the Physiotherapy Board of Australia (the Board) continued to consolidate projects it had started and to develop new work, and to strengthen its relationships with stakeholders. The Board takes an active role in the work of its state and territory boards and is working to enhance their integration and inclusion into the scheme, making the most of the Board's chosen model of having state and territory boards to undertake its registration and notifications work at a local level.

Mr Glenn Ruscoe
Chair, Physiotherapy Board of Australia

Areas of focus

The limited registration standards project commenced in the previous year and the review of the existing supervision guidelines for physiotherapy has been successfully completed and rolled out to all AHPRA offices, and is in use by new applicants and renewing registrants where supervision is a requirement of registration.

The Board has continued its focus on consistency across its state and territory boards. This work is principally undertaken by the Board's Continuous Improvement Committee, which meets once a month to review the decisions and actions documents from each of the state and territory boards. General improvements have been noticed in consistency of reporting and the Board has continued to develop a standardised template decision and action document for the consideration of AHPRA for roll-out across the country.

Key outcomes/achievements

The Board finalised its 2012-2014 strategic plan and work plan. The Board also strengthened its relationships with key stakeholders.

A meeting of chairs plus one delegate from each of the state and territory boards was held at the completion of the National Scheme combined conference in September. This included detailed consideration of the Board's instrument of delegation and how this relates to the states, territories and AHPRA, as well as laying the groundwork for consistent reporting from state and territory boards to the National Board.

The Board held a training day for its state and territory board chairs, which included a substantial training package from the Australian Institute of Company Directors. The day was very well received and has resulted in a measurable improvement in consistency of reporting from these boards.

The most noticeable achievements during 2011/12 have been the development of strategic objectives for the Board and the start of a project with our New Zealand counterparts to review the *Australian Standards for Physiotherapy,* with a view of establishing shared entry level standards/competencies as a first step to exploring bolder possibilities further afield.

Registration standards, policies and guidelines developed/published

The Board published three new registration standards in 2011/12: limited registration for postgraduate training or supervised practice, limited registration in public interest, and limited registration for teaching and research. Accompanying these new standards are revised supervision guidelines for physiotherapy for use wherever supervision is a requirement for registration.

The Board developed a number of internal policies such as a policy for managing return to practice applications from physiotherapists who do not meet the recency of practice registration standard. Because the Board has state and territory boards, it is necessary to provide criteria for assessment of individual cases to ensure consistent approaches to decision-making are utilised across the jurisdictions.

The Board produces a newsletter to staff after each board meeting and includes a copy of the confirmed decisions and actions from the previous month.

The Board distributes a newsletter to registrants four times a year and has received good feedback from that communications strategy so far.

Key issues

The Board is keen to pursue an application for specialist recognition once the process and criteria that will be utilised by health ministers when considering such applications are finalised.

Another key issue in this reporting year has been the continued drive for consistency of process and decision-making across the AHPRA jurisdictions via the state and territory boards and for forging stronger links with those boards.

The Board has met in Hobart, Sydney and Brisbane this year, and the Chair and Executive Officer have attended state/territory board meetings in Hobart and Darwin.

Priorities for the coming year

As well as continuing to strengthen ties with its stakeholders, the Board will continue to analyse registrations and notifications data collected by AHPRA, to inform collaborative work with the other professions in the National Scheme, to develop common standards, codes and guidelines where appropriate.

Members of the Board

The members of the Physiotherapy Board of Australia have not changed since first appointed by Ministers in 2009. They are:
Mr Glenn Ruscoe, (Chair), Ms Alison Bell, Mr Tim Benson, Dr Susan Brady, Ms Anne Deans, Dr Charles Flynn, Mrs Kathryn Grudzinskas, Mrs Libby Kosmala OAM, Ms Joanne Muller, Mrs Karen Murphy, Mr Paul Shinkfield, Ms Philippa (Pippa) Tessmann.

The members of the state and territory boards of the Physiotherapy Board of Australia are:

NSW:
At 30 June 2012: Mr David Cross (Chair), Ms Anne Deans, Ms Virginia Binns, Ms Christine Campbell, Ms Margo Gill, Mr Sean Mungovan, Ms Frances Taylor.
Until December 2011, members of the board were: Ms Anne Deans (Chair), Ms Virgina Binns, Professor Ian Cameron, Ms Christine Campbell, Mr David Cross, Ms Maria Quinlivan, Ms Debra Shirley, Ms Helen Stirling, Ms Vicki Williams, Ms Lai Wong.

SA:
Ms Josephine Bills (Chair), Mr John Camens, Ms Jane Coffee, Mrs Elizabeth (Libby) Kosmala, Ms Kerry Peek, Ms Elizabeth (Ann) Nelson, Mrs Janene Piip.

ACT:
Ms Karen Murphy (Chair), Ms Louise Bannister, Ms Kerry Boyd, Ms Mary Brennan, Ms Lisa Gilmore.

Tas:
Mr Paul Shinkfield (Chair), Ms Chelsea Trubody-Jager, Ms Margaret Archer, Mr Malcolm Upston, Dr Marie-Louise Bird.

Vic:
Dr Charles Flynn (Chair), Ms Fiona McKinnon, Mr Brian Coughlan, Mr Mark Hindson, Ms Catherine Nall, Mr Michael Ralston, Dr Leslie Cannold, Mrs Maureen Capp, Ms Jennifer Jaeger.

NT:
Ms Philippa (Pippa) Tessmann (Chair), Ms Heather Malcolm, Mr David Blair, Ms Margaret Seccafien, Ms Bernadette Petzel.

WA:
Mr Glenn Ruscoe (Chair), Mr Tim Benson, Mr Michael Piu, Ms Shelley Hatton, Ms Kim Gibson, Associate Professor Shane Patman, Professor Anthony Wright.

Qld:
Mr Robert Thams (Chair), Ms Glenys Cockfield, Ms Kathryn Grudzinskas, Ms Cherie Hearn, Ms Jane Leow, Mr Robert Longland, Mr Geoff Rowe, Ms Margaret Sifter, Ms Tracy Spencer.

During 2011/12, the Board was supported by Executive Officer Ms Jill Humphreys.

More information about the work of the Board is available at: www.physiotherapyboard.gov.au.

Podiatry Board of Australia

Message from the Chair

The 2011/12 year has been one of consolidation.

During this 12 month period, the Podiatry Board of Australia (the Board) has been able to assess the implementation of standards and guidelines developed as part of the National Scheme. By meeting in Hobart and Perth, the Board has had the opportunity to meet with registrants and stakeholders, to listen and learn of the impact of the Board's actions and decisions. Additional interstate meetings are being planned in 2012/13 and I would encourage registrants to attend the forums. Fortunately, 96% of registrants have provided the Board with their email address. This enables the Board to communicate directly with each registrant, for example, to send a personal invitation to attend a forum and the electronic newsletter.

I hope that you enjoy reading the Board's annual report. It provides a snapshot of the achievements and challenges for the Board. As the National Scheme matures, the relationships between AHPRA, the Board and the Australian and New Zealand Podiatry Accreditation Council (ANZPAC; the accreditation authority for the podiatry profession) continue to develop.

On 1 July 2012, four new professions joined the scheme: occupational therapy, Chinese medicine, medical radiation practice, and Aboriginal and Torres Strait Islander health practice. It has provided a great opportunity for chairs and board members to welcome and support these professions into the National Scheme. The growth of professions adds to the diversity of health practitioners and demonstrates how important it is for one National Law to regulate these professions; to provide for the independent accreditation of programs of study; to be part of one register for health practitioners; and to be supported by one national organisation (AHPRA) to assist health practitioners and members of the public to communicate with the Boards.

The objective of the Board has been to be a partner in the establishment of the National Scheme and to ultimately provide protection for the public by ensuring that only podiatrists who are suitably trained and qualified to practise in a competent and ethical manner are registered.

It has been my great honour to chair the Board during this inaugural term. I extend my thanks to each of the board members for their support, hard-work and dedication. On behalf of the Board, I would like to acknowledge the dedication and expertise of the Board's Executive Officer, Jenny Collis, and also the professionalism of the AHPRA staff who support the Board.

Mr Jason Warnock
Chair, Podiatry Board of Australia

Areas of focus

A key area of focus for the Board in the past year has been a commitment to ongoing communication with registrants and other key stakeholders of the Board with a view to improving their understanding of the requirements for registration and regulation under the National Scheme.

The Board continues to publish a monthly communiqué following each board meeting to inform stakeholders of key matters considered by the Board, and has published two e-newsletters, the first in November 2011 and the second in June 2012. The Board also held four board meetings in cities other than Melbourne which provided the opportunity to meet with local stakeholders, including the professional association in those jurisdictions. The Board also held forums for registrants during the Board's visits to Hobart and Perth, which provided the opportunity for podiatrists to meet members of the Board and discuss issues relating to the registration and regulation of podiatrists under the National Law.

In the latter part of 2011, leading up to the renewal of registration period at the end of November, the focus of communication was on ensuring podiatrists renewed their registration on time and understood the Board's requirements for renewal of registration, including meeting the requirements for CPD by the time they renewed their registration. The Board was pleased to note that 93% of podiatrists had lodged their applications for renewal of registration by the due date of 30 November 2011.

The Board has continued to work cooperatively with its accreditation authority, ANZPAC, to facilitate the provision of high-quality education and training for the podiatry profession, and meets at least quarterly with ANZPAC to discuss issues relating to accreditation. The Board and

ANZPAC undertake complementary functions under the National Scheme. ANZPAC's functions include developing accreditation standards for approval by the Board; assessing podiatry programs of study and education providers against approved accreditation standards; accrediting podiatry programs of study for approval of the Board; and assessing the knowledge, clinical skills and professional attributes of overseas-trained podiatrists who don't hold qualifications approved by the Board for registration in Australia.

In July 2011, the Board considered a report from ANZPAC on its accreditation of the podiatry programs at the University of Western Australia and approved the Bachelor of Podiatric Medicine (Pass & Hons) four year degree program as providing a qualification for the purposes of registration in the podiatry profession for a period of five years.

The Board has approval from Ministerial Council for specialist registration for the podiatry specialty of podiatric surgery and the Board requested ANZPAC to develop accreditation standards for podiatric surgery programs of study. Accreditation standards are used to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes to practise the profession. In developing the accreditation standard, ANZPAC undertook wide ranging consultation about the content of the accreditation standard and considered the feedback received from stakeholders during the public consultation when finalising the standards.

The Board approved the accreditation standards for podiatric surgery programs developed by ANZPAC and has published them on the Board's website.

The Board also has Ministerial Council approval to endorse the registration of a podiatrist for scheduled medicines. ANZPAC is in the process of developing accreditation standards for endorsement for scheduled medicines and has undertaken wide ranging consultation as part of the process.

Another key area of focus for the Board has been developing policies to supplement the Board's endorsement for scheduled medicines registration standard, guidelines and information package with a view to providing further guidance to practitioners who are working towards an endorsement for scheduled medicines.

The Board's Registration and Notifications Committee (RNC) has delegated power to deal with notifications about podiatrists and matters relating to the registration of podiatrists, including endorsement for scheduled medicines. The RNC is assisted by the Board's Endorsement for Scheduled Medicines Working Party, which considers applications for endorsement for scheduled medicines and provides advice to the RNC. The RNC meet monthly to coincide with the Board meeting.

The Board held a planning day in November 2011 to develop the Board's strategic plan and action plan. The high-level strategic plan sets out the Board's key strategic priorities for 2011-2014 and board members have been working hard to achieve these priorities.

The Board continued to work in partnership with AHPRA and the other National Boards to ensure the National Scheme continues to operate in a transparent, efficient and effective way. The Board recognises the important initiatives introduced by AHPRA in the last year which have led to significant efficiencies in the operation of the National Scheme.

With the assistance of the education providers and AHPRA, the Board keeps a student register that includes the name of all persons currently registered as students by the Board. The Board and AHPRA continue to communicate with students to ensure graduates are aware of the requirements for registration and how graduating students can apply for registration in a timely and efficient manner.

Key outcomes/achievements

- Development of a three-year strategic plan which sets out the Board's key strategic priorities for 2011-2014.
- The Board held registrant forums in Hobart and Perth which provided an opportunity for podiatrists to meet members of the Board in an informal setting and discuss issues relating to regulation of the profession, and for the Board to answer questions from registrants about various matters including requirements for registration.
- Development of policies and information to provide additional guidance and further clarity to assist podiatrists and supervisors in relation to the Board's requirements for an endorsement for scheduled medicines. For example, the publication of a sample log sheet and sample prescription provides guidance for podiatrists and podiatric surgeons who are undertaking clinical experience with a supervisor as part of a pathway towards an application for an endorsement for scheduled medicines.
- Publication of an information sheet to provide information to practitioners returning to practice after an absence. The Board has also published a template plan for professional development and re-entry to practice which makes provision for the elements that should be included in a plan for professional development and re-entry to practice.

- The Board approved accreditation standards for podiatric surgery programs of study, which were developed by ANZPAC. ANZPAC will use the approved accreditation standards to assess whether a podiatric surgery program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes to practise podiatric surgery.
- The Board has developed a mutually beneficial relationship with the Podiatrists Board of New Zealand (PBNZ). The Board hosted a meeting in Melbourne with representatives of the PBNZ, which provided an opportunity for useful discussion on common issues and experiences with the PBNZ. The Board looks forward to ongoing dialogue with the PBNZ regarding common policies and issues.
- Podiatric surgeons may hold specialist registration as a podiatric surgeon as well as general registration as a podiatrist or specialist registration as a podiatric surgeon only. The Board decided to change the fee structure for specialist registration effective from 1 July 2012 so that the fee for specialist registration will be the same as the fee for general registration, and when a registrant renews their registration only one fee is payable, even if they hold more than one type of registration. The result of these changes is that a practitioner who holds both specialist registration as a podiatric surgeon and general registration as a podiatrist will pay the same fee as a practitioner who holds specialist registration only or general registration only. Before the change, a podiatric surgeon who held both specialist registration and general registration was required to pay an annual registration fee for general registration as well as an annual fee for specialist registration.
- Publication of quarterly data profiling Australia's podiatry workforce, including a number of statistical breakdowns about registrants, including a breakdown of registered podiatrists by state; registration type; age group; and gender.

Registration standards, policies and guidelines developed/published

The Board developed and consulted on a number of proposed documents including:

- Specialist registration standard for the podiatry specialty of podiatric surgery, which sets out the Board's requirements for registration as a podiatric surgeon. Once finalised the Board will submit the registration standard to Ministerial Council for approval.
- The following limited registration standards:
  - > Limited registration for postgraduate training or supervised practice
  - > Limited registration in the public interest
  - > Limited registration for teaching or research

  The proposed registration standards set out the requirements that apply to an applicant for limited registration. Once finalised, the Board will submit the limited registration standards to Ministerial Council for approval.
- Guidelines for supervision of podiatrists, which set out the principles the Board considers central to safe and effective supervision for a range of regulatory needs. Once finalised and approved by the Board, the guidelines will be published on the Board's website.
- In conjunction with six other National Boards (Chiropractic, Dental, Medical, Optometry, Osteopathy and Physiotherapy), the Board consulted on the definition of 'practice'.
- All National Boards released a consultation paper seeking feedback on options for refining international criminal history checks used by AHPRA in assessing applications for registration for the health professions regulated under the National Law.

The Board developed and published the following policies and guidance documents:

- When it is necessary to be registered as a podiatrist.
- Policy on exemption from CPD requirements.
- Information sheet for podiatrists returning to practice and template plan for professional development and re-entry to practice.
- Policies/information relating to endorsement for scheduled medicines:
  - > Policy on extension of time to complete pathway 2 for endorsement for scheduled medicines
  - > Policy on log sheets for endorsement for scheduled medicines and sample log sheet
  - > Revised information package for endorsement for scheduled medicines to provide additional guidance and further clarity to assist podiatrists and supervisors in relation to the Board's requirements for an endorsement for scheduled medicines.

Key issues

Key issues for the Board in the past year have included:

- ensuring registrants are well informed of the Board's requirements for registration
- development of policies and information to guide and assist podiatrists working towards an endorsement for scheduled medicines
- developing a cooperative and effective relationship with AHPRA and ANZPAC, to ensure robust and effective accreditation processes are in place for quality delivery of the National Scheme
- improving the effectiveness of the Board's RNC, including how the RNC communicates with each of the AHPRA offices and with registrants
- strengthening relationships with key stakeholders, and
- ensuring the Board's financial obligations, budget and risks are effectively and diligently managed.

Priorities for the coming year

- The Board will continue its commitment to communication and engagement with registrants and other key stakeholders, and will endeavour to hold meetings in all jurisdictions and hold forums for registrants to coincide with those meetings. The Board will hold its October 2012 meeting in Brisbane; the December 2012 meeting in Adelaide; and the March 2013 meeting in Canberra.
- The Board will undertake the substantial task of reviewing its current registration standards, guidelines and policies, and will undertake wide ranging consultation as part of the review. Review of the registration standards that are common among National Boards (CPD, recency of practice, English language skills, professional indemnity insurance and criminal history) will be undertaken consultatively with AHPRA and the other National Boards. In preparation for the review, research has been commissioned by AHPRA and the National Boards on English language skills testing, including the scope of exemptions from testing requirements. This research will inform the review of English language skills registration standards.
- Develop further resources to improve and streamline the process for endorsement for scheduled medicines.

Members of the Board

The members of the Podiatry Board of Australia are:
Mr Jason Warnock (Chair), Ms Catherine Loughry, Mr Ebenezer Banful, Associate Professor Laurie Foley, Mr Mark Gilheany, Mrs Anne-Marie Hunter, Ms Helen Matthews,
Ms Margaret (Joan) Russell, Associate Professor Paul Tinley.

During 2011/12, the Board was supported by Executive Officer Ms Jenny Collis.

More information about the work of the Board is available at: www.podiatryboard.gov.au.

Psychology Board of Australia

Message from the Chair

The work of the Psychology Board of Australia (the Board) during the second year since being appointed has consolidated the initiatives and policies introduced since the start of the National Scheme on 1 July 2010.

Excellent support from staff of AHPRA enabled the achievement of goals. For example, the Board has now established the standard for the '5+1' program as a new flexible pathway to registration, and is working to enhance competency-based registration through the implementation of the national psychology examination, improved supervision support and better internship experiences.

A major revision to the professional indemnity insurance standard and guideline has been completed to better reflect the different public and private settings in which psychologists work.

An ongoing strategy has been to enhance communication between the Board, registrants and stakeholders with regards the benefits and opportunities that the National Scheme provides the public and psychologists. First, national forums have been held in every state and territory, with more than 1,500 attendees having had the opportunity to hear about and provide feedback on the Board's work. Second, the Board has established and now publishes a quarterly newsletter *Connections*. As of the second edition, this is now delivered electronically to all of the 29,000 psychology registrants who have notified the Board of an email address. Third, the Board has now published 13 public consultation papers in relation to standards, codes and guidelines. All three strategies have significantly improved the voice of the public, stakeholders and registrants in shaping the regulation of psychology in Australia.

Professor Brin Grenyer
Chair, Psychology Board of Australia

Areas of focus

During this reporting period, the Board's areas of focus included:

- streamlining processes, policies, guidelines and standards for registrants to be regulated successfully under the National Scheme
- working towards national consistency across jurisdictions in the regulation of psychologists
- working with the Australian Psychology Accreditation Council (APAC) to improve the approval process of psychology courses, develop accreditation standards, and to work towards ensuring that the accreditation authority carries out its accreditation operations independently
- improving communication with registrants through the publication of the quarterly online *Connections* newsletter, and
- developing four main strategic foci for the Board:
  - > professional capability
  - > quality assurance
  - > dynamic change
  - > board governance – driving continuous improvement in the Board's functions.

Key outcomes and achievements

The Board has undertaken an ambitious workload during this reporting period, and has achieved the following significant key outcomes:

- Renewing the registration for all general and non-practising registrants together on 30 November 2011 for the first time under the National Scheme.
- Review and amendment of two registration standards.
- Consulting widely on a range of codes and guidelines.
- Developing a range of new policies.
- Developing internal policies to assist delegated authorities to improve national consistency.
- National forums in Darwin, Canberra, Hobart, Launceston and Sydney.
- Stakeholder meetings in every jurisdiction across the country to inform the community and registrants on the operation of the National Scheme.
- Publication of national registration data that profile in detail Australia's psychology workforce.

- Monitoring trends in the training and registration across the country of psychologists with an area of practice endorsement.
- Publication of the national supervisors list that supports registrants undertaking supervision to search for board-approved supervisors.
- Approval of numerous programs of study based on the advice of APAC, including approval of the first Postgraduate Diploma of Professional Psychology for registration via the 5+1 internship pathway.
- Decreasing the complexity and improving the usability of registration forms.
- Redesign of the Board's website.
- Meeting with the other health profession boards at the annual joint meeting of boards.
- Meeting with the New Zealand Psychology Board to discuss international benchmarking, and to facilitate regulation of psychologists in the south pacific region.

Registration standards, policies and guidelines developed and published

Registration standards approved by Ministerial Council

The following registration standards were approved by Ministerial Council in 2011/12:

- Amendments to the provisional registration standard to include details of the 5+1 internship
- Amendments to the professional indemnity insurance arrangements registration standard

Codes and guidelines

The Board consulted on and published the following guidelines:

- Guideline for supervisors and supervisor training providers
- Guidelines on professional indemnity insurance for psychologists
- National psychology examination curriculum

All of the National Boards, including the Psychology Board, are currently consulting on options for refining international criminal history checks used to assess applications for registration as a health practitioner in Australia.

New standards, policies and guidelines

To assist with the Board's codes and guidelines, the Board has published the following policies on its website:

- Policy for recency of practice requirements
- Policy for unsatisfactory progress in the 4+2 internship program: case reports, supervision and case studies
- Extension of the policy on working in addition to placements to apply to provisional psychologists enrolled in an accredited fifth year degree in the 5+1 pathway
- Policy for provisional psychologists with qualifications more than 10 years old
- Policy on recognition of prior supervised practice for approval of a registrar program
- Policy for exemption of CPD requirements
- Policy for higher degree students applying for general registration
- Policy on applications for an extension to complete the requirements for area of practice endorsement under transition provisions.
- Policy on applications for an extension to complete Western Australian specialist title supervision programs
- The management of notifications concerning single court appointed expert psychologists in family court proceedings: interim policy

The Board also published FAQs and numerous fact sheets (such as a fact sheet on preparation of case studies, a fact sheet for supervisors, an advertising fact sheet and a fact sheet for when is it necessary to be registered as a psychologist).

Key issues

In addition to the regular forums, stakeholder meetings, and undertaking the functions of a National Board under the National Law, the Board has been progressing the following four priority projects:

- Development of the supervisor training guidelines and process
- Development of the 5+1 internship program guidelines
- Development of the national psychology examination
- Review of the 4+2 internship guidelines

The Board has developed committees, working parties and portfolios to support the progress of these important and ambitious projects, as follows:

- Finance and Management Committee
- National Examination Committee
- Supervisor Training Working Party
- Internship Review Working Party

The Board has also been working with other National Boards and AHPRA on a number of other issues including:

- developing a framework to ensure a consistent approach across professions and jurisdictions to the auditing of practitioner compliance with registration standards
- succession planning for National Board members to ensure continuity of valuable corporate knowledge
- developing a social media policy, and
- developing information and educating stakeholders on notifications, particularly mandatory notifications.

Priorities for the coming year

Areas of focus for the Board for 2012/13 and beyond include:

- development of the 5+1 pathway to general registration
- development of the supervisor training program for supervisors for the 4+2 internship program, 5+1 internship program and registrar program
- development of the national psychology exam
- review of the registration standards
- review of the accreditation authority for psychology, and the development and approval of new accreditation standards, and
- international benchmarking.

Members of the Board

The members of the Psychology Board of Australia were appointed in August 2009 for a term of three years. Over the 2011/12 period, the Board met 11 times and held one joint board meeting with the New Zealand Psychology Board. There have been no changes to board membership during the reporting time period. There have been new requirements under the National Law for regional boards during this reporting period. The Board reviewed and provided advice to the health ministers from each jurisdiction on the effective composition of the psychology regional boards, and a re-appointment process was undertaken for regional board members. From 1 July 2011, the Northern Territory became part of the Northern Territory, South Australia and Western Australia Board of the Psychology Board of Australia.

The following regional boards of the Psychology Board of Australia are continuing to meet and have been delegated powers by the Board to deal with matters related to individual registration and notification issues:

- Australian Capital Territory, Tasmania and Victoria
- New South Wales
- Northern Territory, South Australia and Western Australia
- Queensland

The Chair of the National Board and the Chairs of the regional boards for psychology meet monthly to improve internal communications with the aim of achieving national consistency in processes and decision-making.

National Board members

Professor Brin Grenyer (Chair), Ms Ann Stark (Deputy Chair), Professor Alfred Allan, Ms Antonia Dunne, Ms Kaye Frankcom, Mr Geoff Gallas, Professor Gina Geffen AM, Dr Shirley Grace, Mrs Irene Hancock, Ms Fiona McLeod, Mr Christopher O'Brien, Mr Radomir Stratil.

The members of the regional boards of the Psychology Board of Australia are:

ACT/Tas/Vic:
Professor Barry Fallon (Chair), Dr Robin Brown, Associate Professor Sabine Hammond, Ms Anne Horner, Mr Simon Kinsella, Dr Patricia Mehegan, Dr Cristian Torres, Dr Kathryn von Treuer, Dr Jenn Scott.

NSW:
Dr Caroline Hunt (Chair), Trisha Cashmere, Ms Margo Gill, Mr Robert Horton, Associate Professor Michael Kiernan, Ms Wendy McCartney, Ms Anne Wignall, Ms Soo See Yeo, Mr David McGrath, Associate Professor Bill Warren, Mr Geoffrey Graham.

NT/SA/WA:
Dr Jennifer Thornton (Chair), Ms Alison Bell, Ms Angela Davis, Ms Ann Gannoni, Ms Vidula Garde, Ms Dianne Mayo, Ms Judith Dickstein, Mr Theodore Sharp, Dr Neil James McLean, Associate Professor David Leach.

Qld:
Dr Robert Schweitzer (Chair), Mr Kingsley Bedwell, Mrs Jeanette Jifkins, Professor Kevin Ronan, Mr Barry Sheehan, Dr Haydn Till.

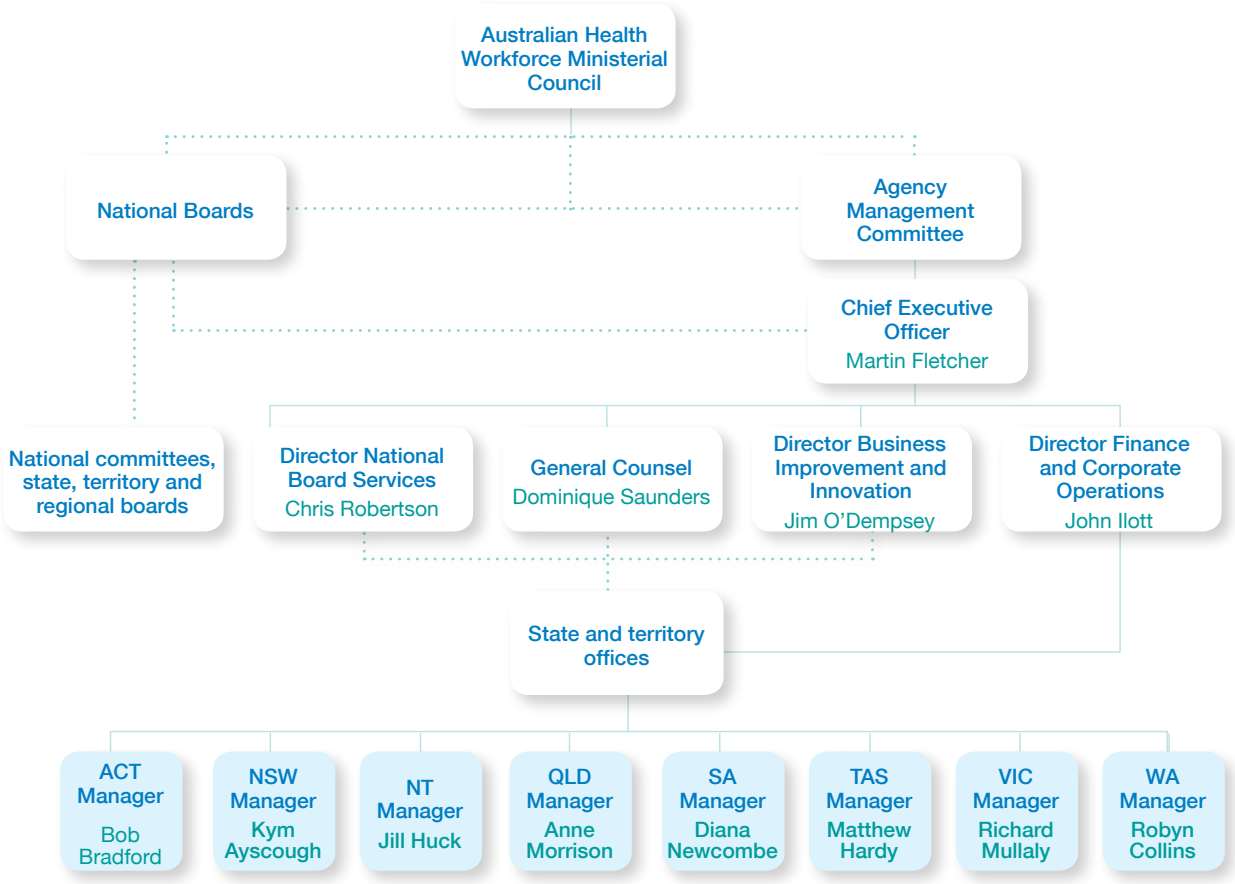
Information on membership of the Board and its delegates is published at www.psychologyboard.gov.au.

The Board was supported in 2011/12 by Executive Officer Dr Jillian Bull.

More information about the work of the Board is available at: www.psychologyboard.gov.au.

AHPRA – supporting the National Boards

AHPRA organisational structure



AHPRA provides services to each of the National Boards and aims to deliver efficiencies in the regulation of health practitioners through operational standardisation, when appropriate. AHPRA continues to monitor its operations and make improvements that support service, consistency and capability.

AHPRA delivers its functions through a national network that encompasses:

State and territory offices – providing the local delivery network based in every capital city.

Board services and board support – managing and supporting the relationship with the National Boards.

Business improvement and information technology – providing policy, process and technology support and development, as well as leading innovation, improvement and reporting.

Legal services – providing and coordinating legal advice and services to AHPRA and the boards and committees, through expert legal teams in every office.

Finance and corporate operations – delivering key enabling functions such as finance, human resources, risk management and planning.

Core regulatory functions

AHPRA works with National Boards to deliver a range of core regulatory functions.

Registration

The registration function ensures that only practitioners with the skills, qualifications and suitability to provide safe care are registered to practise their profession. The bulk of registration activity relates to managing applications from new applicants and renewal applications. However, the registration function also oversees other activities, from managing practitioners with limited and provisional registration, to issuing certificates of registration status.

National renewals

A small team operates the national renewal process that involves the annual distribution of around 1,500,000 emails, 450,000 letters, 550,000 certificates of registration and the automated processing of around 490,000 online renewals and payments. Staff in AHPRA's local offices support the assessment and processing of applications.

Student register

There are currently more than 110,000 students studying to be health practitioners in Australia. AHPRA maintains a register of currently enrolled students as an unpublished part of the national register. Details are collected from 145 education providers.

Notifications

Notifications teams in each AHPRA state and territory office[1] manage concerns that are raised about the health, performance or conduct of individual practitioners. Anyone can make a notification to AHPRA, which it receives on behalf of the National Boards.

Compliance

AHPRA is responsible for monitoring and audit, to ensure practitioners are complying with the requirements placed upon them by the National Boards. Compliance monitoring involves working with, and actively monitoring, practitioners who have a specific requirement that is placed upon their registration after either a registration or notification outcome. This may include supervised practice, restricted scope of practice, regular health tests or other requirements.

Practitioner audit involves the random checking of practitioner compliance with the National Boards' registration standards, in areas such as CPD, recency of practice, insurance or criminal history requirements.

Professional standards

National Board Services provide services to the National Boards including policy development, secretariat and administrative support; development of registration standards, codes and guidelines; communications, stakeholder engagement and government relations, including liaison with Health Workforce Principal Committee; National Board appointments; and governance and coordination on whole of scheme policy issues such as accreditation and community engagement.

Accreditation

The National Boards and AHPRA work with independent accreditation authorities to accredit education programs and providers to ensure graduating students are suitably qualified and skilled to apply to register as health practitioners.

Enabling core regulatory functions

There is a wide range of enabling functions that support AHPRA and the National Boards in meeting their responsibilities: to protect the public and facilitate access to health services. AHPRA's enabling functions are essential to regulating the health professions in Australia in the public interest. Specialist teams provide services and support to ensure the organisation operates effectively. Without these AHPRA would not be able to operate.

1 In NSW, notifications are dealt with by separate health professional councils (which are supported by the Health Professional Councils Authority) and the Health Care Complaints Commission.

Enabling functions include:

Board support

Board support involves providing administrative and operational support and coordination to National Boards and their committees, and to state, territory and regional boards and national registration and notification committees. This includes coordinating legal and other expert advice about the National Law and making recommendations about board and committee decisions. There have been significant developments in board support in 2011/12, details of which are set out in the 'Capability' section of this annual report on page 63.

Legal advice

The General Counsel is responsible for managing legal risk to AHPRA and the National Boards, and is accountable for the definitive interpretation of the National Law. This is achieved by supporting nationally-consistent legal advice and legal services to AHPRA and the National Boards. The General Counsel is also responsible for managing the interests of AHPRA, including compliance with corporate and other relevant legislation, managing risks and maximising the effectiveness and consistency of legal activities across the organisation.

Design and improvement of core systems

The core systems of AHPRA continue to evolve, with many improvements both large and small continuing to lead to consistency and efficiencies. Identifying and defining these opportunities is enabled by a specialist team with both regulatory and system expertise, with staged implementation.

Data and information technology

Data exchange

AHPRA plays a key enabling role in the operations of Medicare, National E-Health Transition Authority (NEHTA), Australia's larger health employers, Health Workforce Australian (HWA) and other stakeholders. As the trusted national source of registration and workforce data, AHPRA provides secure and managed access to key data required for these other important organisations to perform their own roles in Australian healthcare (see page 63).

Reporting

AHPRA manages an enormous amount of information, which is of use to policy-makers and other stakeholders. A data reporting framework has been developed during 2011/12 and is progressively being implemented.

Information technology

AHPRA has a complex infrastructure that includes business systems, servers and security. The information technology (IT) team maintains and develops the core business systems, including design, development, testing and change management. Teams across AHPRA make around 12,000 service requests of the IT team per year. Our IT services team prioritises these based on importance to AHPRA's effective operation and scope of the challenge to be addressed. Some issues can be fixed rapidly and some require significant effort and investigation to resolve.

Information management

The information management team is responsible for data quality and the management of electronic and physical records. AHPRA is the custodian of high volumes of sensitive data with significant responsibilities in relation to electronic and physical security, that must comply with a number of regulatory standards.

Corporate services

Human resources

AHPRA is a large organisation, with a human resource team supporting staff across the organisation with work level standards, policy performance development and training.

Finance

The finance function ensures that the financial systems and records of AHPRA are well managed, accurate and compliant with legislation, as well as providing financial reporting and guidance to the organisation and the National Boards.

Risk management

AHPRA manages risks carefully, with the Audit and Risk Committee governing the risk management program. Risks are categorised and reported to the National Executive and Agency Management Committee as appropriate. An annual internal audit program is delivered by a professional services firm.

Planning

AHPRA is establishing a planning function to align National Board and AHPRA strategic planning. This important enabling function will ensure our strategic planning efforts are coordinated, effective and enable the National Boards and AHPRA to meet their regulatory responsibilities, while bringing out the best of the National Scheme.

Customer service

A team of approximately 60 staff throughout Australia responded to more than 500,000 phone calls, 50,000 web enquiries and almost 39,000 counter enquiries over the year.

Project delivery

AHPRA has been running a significant program of project work since March 2011. This is expected to continue for several years as AHPRA continues to evolve into a leading national regulator.

Communications

AHPRA's communications team works across the organisation and with the National Boards to support the

flow of accurate and accessible information about the National Scheme and the work of AHPRA and the National Boards. Stakeholder engagement, supporting consultation with the community and the profession, media interaction, and improving access to accurate and reliable information are key areas of focus. Internally, AHPRA's communications aim to support staff understanding of new initiatives, and support work to build consistency, service and capability.

Web management

A small team of web content managers and developers maintains and improves the 15 websites of AHPRA and the National Boards, along with a comprehensive intranet that is being improved and will increasingly be used by staff to support operations.

Process management

AHPRA has adopted a business process oriented approach to improving capability, consistency and maturity of its key regulatory functions. To support this approach, several projects to develop key processes have been undertaken and an ongoing business process team has been established.

2011/12 in review

Following our first year of operation, during which we concentrated on transition and early implementation of the National Scheme, 2011/12 saw AHPRA make substantial developments in ensuring the system of national regulation is fit-for-purpose, efficient, consistent, reliable and transparent. The year has seen a number of significant achievements made, all of which support the overall goal of protecting the public and facilitating access to health services.

The objectives for 2011/12 were set out in our Business Plan 2011/12:

- National Boards and AHPRA to work in partnership to provide authoritative leadership on professional regulation.
- Clear governance and operational arrangements to be in place so that boards, committees, panels and agency staff operate consistently and within legislative requirements.
- Facilitate understanding and awareness of key stakeholders and health practitioners in the work of the National Scheme.
- Develop and maintain formal arrangements between AHPRA and accrediting agencies on behalf of the National Boards.
- Demonstrate the completeness and accuracy of health practitioner data on the national registers.
- Systems and processes to meet performance specifications and continually improve.
- Being publicly accountable for performance and demonstrating improvements against key indicators within notification processes and registration services.
- Improve consistency of services across all state and territory offices.
- Ensure the public protection impact of national legislation is maximised and measured.
- Implement an AHPRA project management approach to systematically deliver business improvement objectives.
- Ensure new features of the National Law are effectively implemented and evaluated.
- Ensure data generated by AHPRA processes are used to support the wider objectives of the National Scheme.
- Implement effective organisational design and resource management to improve the efficiency of AHPRA and reduce operating costs.
- Invest in leading communication technologies.
- Implement an enterprise agreement that will enable organisational flexibility and deliver benefits to staff.
- Deliver a human resource program that will enable improved organisational flexibility and productivity, as well as benefits to staff and the building of a skilled and capable workforce.

Each achievement that is set out in this annual report is aligned to one or more of the three cornerstones of AHPRA's overriding commitment:

- **Consistency**
- **Service**
- **Capability**

The following section sets out the work that we have done during 2011/12 to achieve improvements in these three areas.

Consistency

Consistency: This means ensuring no unnecessary variation in administering the National Scheme through standardised national processes.

Establishing national consistency of standards, processes and decision-making brings benefits to the community, individual practitioners and the health professions, and is one of the key priorities for AHPRA and the National Boards.

A major emphasis in 2011/12 has been to implement initiatives which support this, including introducing common policies, procedures and processes; building a consistent way of working across AHPRA's national and state and territory offices; and supporting the National Boards to provide a consistent national approach to regulation.

Process establishment

2011/12 has seen work continue on the establishment of nationally-consistent processes for all AHPRA's core regulatory functions. This will enable significant quality and productivity improvements to be realised in the future, as we continue to mature as an organisation.

A small specialist process team supports the ongoing management and improvement of the national processes and related policy.

Notifications process implementation

We have continued our focus on implementing nationally-consistent processes for managing notifications about practitioners' conduct, performance or health. A program of work involving notifications staff across AHPRA has culminated in a comprehensive set of updated guidance and tools for managing notifications.

The procedures bring greater clarity to our work in notifications and will support the continued application of nationally-consistent processes in all our state and territory offices. By the end of May 2012, all staff working in notifications in every state and territory had received training on the updated tools.

While every notification is unique, AHPRA wants to ensure that the service we provide doesn't vary simply because of where practitioners live in Australia.

It is expected that this development will provide significant quality and productivity benefits, particularly as system support and enhancements to the national processes are progressively implemented during 2012/13 and beyond.

Forms

AHPRA maintains a suite of around 300 forms that support registration activities. During 2011/12, we have improved the usability and consistency of these forms to better meet the needs of National Boards and address issues identified by practitioners who use them.

The updated forms now automatically display the fee amount for any application or renewal type that attracts a fee. Without this, applicants had to insert the amount required, which led to errors and then delays in finalising applications when incorrect information had been provided.

The improvements will provide a better service to applicants and reduce re-work by our customer service teams and registration staff. The new forms have improved the interaction between AHPRA and practitioners and will help make sure the application process is streamlined and consistent.

National committees and board support

A new role of Director of National Committees was established in late 2011 to improve service delivery to national registration and notification committees, where these had been established by the National Boards.

This role oversees the provision of secretariat services to national committees; drives consistency and quality in service delivery; has an ongoing relationship with the national committees and National Board executive officers; and provides high-level advice to those committees. This work has benefited state and regional boards through the development of cooperative and collaborative working relationships across the AHPRA offices.

Since the introduction of the new role, the following achievements have been made:

- Established a single secretariat in the Victorian state office to support all national committees.
- Developed a standard format for 'Decisions and Actions' which meets profession-specific needs and requests within a common structure.
- Began work on the standardisation of a number of other committee documents, including agendas and supporting documentation, and introduced more rigorous procedures around the administrative conduct of meetings.
- Ensured the accessibility of state and territory office AHPRA staff at all meetings to address and inform all registration and notification matters.

- Developed and facilitated delivery of professional development workshops on the registration and notification functions to the four new professions that will enter the National Scheme in July 2012 (see page 19 for more information about the introduction of these new professions to the National Scheme).
- Provided advice and guidance to national committees and their chairs on due process and ensuring the integrity of their governance and decision-making processes, and adherence to the requirements of the National Law.
- Collaborated nationally on other projects to further standardise and streamline the decision-making processes, including: the introduction of template reports and papers arising from the notifications process implementation project; board support guidelines review; the roll-out of electronic agenda delivery (see page 65); and better online access to information for National Boards and their committees.

A multi-profession approach

The National Boards and AHPRA are committed to exploring multi-profession approaches to regulation, where appropriate, to maximise efficiency and consistency. The aim is to increase collaboration and the effective use of resources while supporting profession-specific approaches where required.

During 2011/12, AHPRA has developed a cross-Board policy work plan, in consultation with the National Boards, involving a range of projects on common issues for all Boards. For example, in 2012 all National Boards consulted on options for international criminal history checks. A common consultation paper was developed and published on the AHPRA website and on each National Board's website, as well as being circulated to key stakeholders. The consultation process was coordinated with the aim of contacting common stakeholders once on behalf of all boards, with individual boards contacting their key profession-specific stakeholders. This coordinated approach is a model for future National Board consultation processes and areas of common interest.

Developing a consistent framework for internationally qualified nurses and midwives

Internationally qualified nurses and midwives (IQNMs) have posed a unique set of challenges for national consistency. The Nursing and Midwifery Board of Australia has endorsed a framework for the assessment of IQNMs applying for registration. AHPRA is responsible for the effective and efficient operationalisation of that framework.

The current process for assessing applicants against the requirement that they meet current education standards set for Australian-qualified registered nurses, enrolled nurses and midwives, does not incorporate an evaluation by a national accreditation authority, as it does with most other National Boards. The aim is that, in future, this task will be performed by the Australian Nursing and Midwifery Accreditation Council (ANMAC).

AHPRA has established systems and processes to provide a structure that:

- supports the provision of high-quality information to the Nursing and Midwifery Board and AHPRA registration staff about the evaluation of education and experience against current Australian education standards
- ensures greater consistency in registration decisions about individual international registration applications across Australia, and
- aims to facilitate a smooth transition to accreditation evaluation by ANMAC.

These aims are achieved through a reference group made up of senior staff with relevant expertise, together with a representative from ANMAC. The group is chaired by the State Manager of AHPRA Queensland. Although it is not a formal decision-making body, the group considers applications referred from all over Australia.

The reference group provides technical advice to support registration staff in the exercise of the assessment of qualifications and experience against current Australian education standards.

The group has developed a consistent approach to the management of decisions for IQNMs that draws on a wide range of experience. It has established processes for decision-making that support consistent practice across Australia and pave the way for ANMAC to take on the evaluation process in future. The Nursing and Midwifery Board supports the work of the reference group.

The reference group has proved to be a successful model for discussing these challenging issues and has reached a strongly reasoned approach that can successfully be applied across all jurisdictions.

Service

Service: Improving customer experience for the public, health practitioners, employers and other stakeholders.

AHPRA and the National Boards provide a service to practitioners, patients, the community and employers. We exist to protect patients and the public, and to provide a clear and transparent regulatory system. We want each person or organisation that comes into contact with AHPRA to experience professional, capable service. This year we have put in place various processes and procedures that aim to further improve the service AHPRA provides and the experience of these stakeholders.

Our values

In fulfilling our role:

- we act in the interest of public health and safety
- we work collaboratively to deliver high-quality health practitioner regulation
- we promote safety and quality in health practice
- our decisions are fair and just
- we are accountable for our decisions and actions
- our processes are transparent and consistent.

Services to practitioners

During our first year of operation, our focus on serving practitioners involved providing information about how the National Scheme works and what it means for them; ensuring practitioners were aware of when and how they were to renew their registration; strengthening the integrity of the information published in the national registers; and, smoothing the path from study to work.

During our second year, we have concentrated on ensuring these solid foundations were strengthened, and that the experience of AHPRA for practitioners continues to improve. We have put in place systems and processes that make registration and renewal easier for practitioners, and have improved the accuracy and completeness of the information we hold and publish about practitioners.

We have particularly focused on online improvements and additions to streamline, simplify and speed up our services. It is encouraging to see that practitioners are taking up these opportunities. For example, there has been a significant increase in the proportion of practitioners renewing their registration online in 2011/12, compared to 2010/11.

Service Charter to guide our services

During 2011/12, we worked on developing a Service Charter, which sets out the values that guide AHPRA's service; the standards of service our stakeholders can expect from us; and the steps they can take if these standards are not met.

The charter explains how we work together with registered practitioners, members of the public and employers; all of whom can help AHPRA to provide good service.

The charter, which will be published in August 2012, will be reviewed after 12 months, in consultation with our stakeholders.

Excerpt from the Service Charter:

You can expect our staff to be knowledgeable, respectful and helpful. We aim to:

- *answer your questions in a timely way and provide clear and accurate information*
- *answer 70% of phone calls in 90 seconds*
- *assess and process your application for registration as quickly as possible*
- *process complete, straightforward applications within four to six weeks (complex applications, including those from overseas, will take more time)*
- *handle notifications fairly, respectfully, consistently and as efficiently as possible*
- *provide clear and straightforward information about our processes, including notification, registration, and monitoring, compliance and auditing*
- *acknowledge your enquiry or request for information in a timely way, and*
- *acknowledge online enquiries within two business days.*

Contacting AHPRA

In 2011/12, we have continued to develop our customer service provision. A team of approximately 60 staff across the AHPRA state and territory offices responded to more than 500,000 phone calls, 50,000 web enquiries and almost 39,000 counter enquiries during 2011/12. Of the telephone calls received, more than 80% were answered within 90 seconds. The most common enquiries were requests for updates on existing applications; which accounts for approximately 40% of enquiries over the year.

Online developments

AHPRA continues to see an increase in uptake of online renewals, as the preferred renewal channel for registrants. Whereas prior to the new National Scheme most boards used paper-based systems, AHPRA is now achieving around 85% uptake of online registration renewal. As these new online systems become established, registration processes should become more efficient, reducing administrative costs for both practitioners and AHPRA. Available information suggests that the cost of online processing of routine applications is around $0.35 per application; compared to $4.60 for paper-based applications.

AHPRA continues to increase the range of applications that can be completed online. During 2011/12, we embedded online registration for new graduates to smooth the path from study to work, and for pharmacy and medical interns with provisional registration to apply for general registration. Other online tools have been developed to help practitioners meet the requirements of registration, including templates for CPD logs in podiatry, chiropractic and psychology, and a search function for approved supervisors for psychology practitioners.

The uptake of online registration applications is lower than for online renewals, with around 35% applying online in 2011/12. AHPRA expects more practitioners will apply online in 2012/13. Each routine online application requires 15 minutes less processing time for AHPRA staff than a paper-based application.

A new online facility was launched in April 2012 that enables registrants to choose to not renew one or all of their registrations that were due for renewal, through an online form. Once selected and processed, registrants no longer receive renewal reminders and their registration expires at its natural end, following the lapse date. This capability also improves our reporting data as we can now differentiate between practitioners who consciously opt to not renew and those who intend to but do not renew on time.

National registers to improve transparency

AHPRA publishes information online about the registration status of all registered practitioners, which is searchable by name or registration number. The national registers are a real-time source of registration information for the community, health practitioners and employers, and are a core element of the role of AHPRA and the National Boards.

We have built on the hard work done in our first year of operation to consolidate into a single database information from 85 different sources. The focus this year has been on making the information published on the registers as robust and accurate as possible.

AHPRA manages and stores registration, notification and compliance data relating to more than 548,000 Australian health practitioners. This involves:

- maintenance of a complex database with hundreds of tables, thousands of fields and many millions of records
- handling of tens of thousands of physical documents, large proportions of which contain information that is sensitive
- sharing of data and intelligence with Australia's broader health industry
- management of complex workflows and information sharing between hundreds of AHPRA staff across Australia, and
- reporting to diverse audiences internally and externally.

During 2012, AHPRA systematically reviewed the way information is published on the register to ensure it is not only accurate, complete and up-to-date, but that there are systems in place to mitigate risk, address areas of weakness, meet legislative responsibilities and establish an appropriate governance framework so that accountability for this core feature of the National Scheme is clear. Out of this review AHPRA took a number of actions to strengthen the way information on the register is published.

The transparency of the national registers has been improved through recent revisions to the online glossary that explains common terms such as 'condition', 'undertaking', 'reprimand' and 'caution'. Direct links from the national registers to the glossary aim to improve the overall clarity and readability of the registers for the community.

Medical specialists register

Work on finalising a national medical specialists register was undertaken in 2011/12. The register includes details of practitioners' specialty and field of specialty practice, and helps the community to recognise the expertise of practitioners eligible for specialist registration.

Establishing the specialists register has been a complex process. Initial information about practitioners' specialty and fields of specialty practice was collated from a number of sources. This included information from the previous four medical boards that registered specialists, Medicare Australia, the specialist colleges and information from practitioners.

AHPRA and the Medical Board of Australia have worked to ensure the quality and completeness of the information published on the specialists register. In 2011, AHPRA wrote to all medical practitioners with general and/or specialist registration and asked them to provide feedback if their details on the specialists register were not correct. This direct mail phase of the project was completed in 2012 and we have updated the register details for approximately 14,700 specialists.

AHPRA has established an ongoing facility for practitioners to contact AHPRA if they are concerned their specialist qualifications are not published accurately.

Also see page 67 for details of the Australian Capital Territory office's involvement in the specialists register.

Registration renewal

In May 2012, the largest health practitioner registration renewal undertaken in Australia was conducted. More than 333,000 nurses and midwives were due to renew their registration – 100,000 more than were due to renew at the same time in 2011. The extra 100,000 practitioners is explained by synchronised renewal dates and a small net increase in total registered practitioner numbers. This is the largest single renewal ever undertaken in Australia.

Ninety-three per cent of the nurses and midwives due to renew did so on time, and 92% renewed online. This compares to 90% of nurses and midwives renewing on time in 2011; and 85% renewing online. This extra 7% in online renewals amounts to 24,000 fewer paper applications being assessed and processed by AHPRA.

AHPRA's online service for the 2012 renewal also gave nurses and midwives the ability to 'opt out' of renewing their registration. This helps us to better understand the number of practitioners who have actively opted out of registration, compared to those who did not apply on time. Nurses or midwives who 'opt out' of renewing their registration or who allow it to lapse must submit a new application for registration with the Nursing and Midwifery Board of Australia if they wish to practise again.

This renewal process demonstrated the systematic benefits of national regulation in providing practitioners with a smooth and simple renewal experience.

The renewal of close to 80,000 medical practitioners by 30 September and 105,000 other registered health practitioners by 30 November was also implemented smoothly and efficiently during the year.

Certificates of registration

AHPRA distributed approximately 550,000 certificates of registration during 2011/12. These were for new registrations, renewals and reprints.

We have introduced an integrated certificate, receipt and registration details card, which has significantly reduced production and distribution costs, and the consumption of paper, while also decreasing production cycle time from registration/renewal to certificate delivery to three weeks.

Since July 2011, we have made it possible for practitioners to print a copy of their certificate of registration from the AHPRA website, with more than 214,000 certificates being printed in this way between July 2011 and June 2012.

Registration lifecycle

In 2012, AHPRA made structural data changes to the registration system so that practitioners registered with AHPRA would have the same registration number for life for each profession in which they were registered. Previously, if a practitioner took a break from their registration, they were issued with a new number on re-registration and could have been allocated with multiple numbers over time.

These numbers have now been consolidated into the practitioner's current single registration number. Practitioners will now only have one registration number for each profession in which they are registered.

Service to employers

Large-scale employers of health practitioners can subscribe to our online Multiple Registration Check Service. This enables them to check the registration status of multiple employees at the same time. In 2011/12, there were 713 employers who used this service, which enabled them to make sure their employees were registered and to remind their employees to renew their registration on time.

Pilot to inform practitioner compliance framework

A pilot audit of pharmacy practitioners' compliance with registration standards was undertaken in 2012. The pilot aimed to help the National Boards meet their regulatory responsibilities and protect the public, by developing a rigorous and practical approach to auditing practitioner compliance with registration standards. AHPRA worked with the National Boards to establish a pilot as a first stage in developing an audit framework for the National Scheme.

The pilot, run jointly by AHPRA and the Pharmacy Board of Australia (also see page 42), involved a number of registered pharmacists being randomly selected between February and April 2012. The process was administered by a team of registration officers based in the New South Wales AHPRA office (see page 68 for further details of the New South Wales office's involvement in the pilot).

The audit checked practitioner compliance with the following registration standards: criminal history, CPD, professional indemnity insurance and recency of practice.

Important lessons were also identified that will inform the development of a comprehensive framework to audit practitioner compliance with National Board registration standards.

Professions Reference Group

To establish constructive dialogue and engage effectively with the professions included in the National Scheme, AHPRA provided ongoing support to a Professions Reference Group. It is made up of representatives of the professional associations for the professions included in the National Scheme, with participation from AHPRA's CEO and senior staff.

The group meets quarterly, including two face-to-face meetings each year. During 2012, responsibility for chairing meetings was rotated between professional associations; an arrangement that is expected to continue.

Meetings provide an opportunity for AHPRA to brief the professions about its work and emerging improvements in service, consistency and capability; and for professional associations to ask questions and raise issues relevant to the regulation of their professions. The group also provides expert advice and invaluable assistance to AHPRA in developing a range of information for practitioners.

During the year, AHPRA consulted with the Professions Reference Group on the development of the service charter (see page 59); and advice on the nature and scope of information for practitioners about the notifications process. By working with the group, AHPRA has also been able to establish a practitioner consultative group, made up of individual practitioners willing to provide feedback on proposals and systems improvements, to inform change and improve services ahead of large-scale implementation.

Information and engagement

AHPRA has continued to implement comprehensive engagement and communication strategies throughout the year; aiming to ensure that the public, practitioners, employers, professional associations, education providers and students were informed about developments at AHPRA that impacted on their work.

AHPRA and the National Boards regularly publish information about their work in newsletters and published records of board meetings, and communicate directly in a range of ways.

The websites of AHPRA and the National Boards provide comprehensive information, news and updates on registration standards, as well as professional practice standards, codes, guidelines and position statements that guide registered practitioners. One way of encouraging health practitioners to visit these websites is the distribution of AHPRA and National Board media releases to mainstream and health publications; to key stakeholders such as government, education providers and insurers; and to professional member organisations. Online communication remains a core communications channel for AHPRA and the National Boards, in the interests of accessibility and cost effectiveness.

The AHPRA communications team also regularly responds to individual media queries (more than 1,300 separate enquiries during the year) and has established an ongoing dialogue with journalists and publications interested in the work of AHPRA and the National Boards.

During the year, the National Boards and AHPRA also endorsed and began to implement a community engagement strategy. Aimed at improving community awareness of the National Scheme and enabling community input into National Board consultations and policy development, the strategy includes a series of community briefings around Australia; the establishment of a digital 'community of interest' which AHPRA and the National Boards can consult about a range of issues; and the establishment of a community reference group to mirror the advice provided and function performed by the Professions Reference Group.

AHPRA held the first community briefings in Western Australia in June 2012, including a face-to-face meeting in Perth and a video-conference with community members from nine remote sites around rural and regional Western Australia. There were 45 attendees at the face-to-face meeting and nine locations dialled in to the video-conference.

AHPRA will continue to implement the community engagement strategy endorsed by National Boards during 2012/13. It recognises that community awareness of regulation and comprehensive community engagement will remain long-term goals.

Capability

Capability: Working as a team and building our organisation, skills and capacity to deliver our regulatory responsibilities.

The foundations that were constructed during AHPRA's first year of operation have provided us with a solid platform upon which to build. During the second year it has been important to keep up the momentum and ensure we are continuing to develop capability in our people, processes and systems. This includes developing our ability to maintain, change and improve core processes, as well as introducing new ways of working that further strengthen our ability to deliver the National Scheme effectively and efficiently.

Collaboration

Data provision service

The data collected under the National Law enable the precise number of practitioners in each profession to be identified, as well as important demographic information about these practitioners, which is extremely valuable for workforce planning purposes.

More complete and consistent workforce data is an important benefit of national registration and AHPRA is a trusted national data source. Arrangements have been formalised for data exchange with Health Workforce Australia (HWA), the Australian Institute of Health and Welfare (AIHW), and Medicare Australia. AHPRA provides these agencies with de-identified information on all registrants, such as age, gender and location, by profession, and registration details. Our MoU with these organisations is published on our website at www.ahpra.gov.au.

Most practitioners completing online renewal also complete the Workforce Survey, which collects more detailed workforce information such as practice setting on behalf of HWA and AIHW. The AIHW analyses and publishes reports on individual professions, and HWA maintains national workforce statistics.

The analysis of these data by these organisations supports robust and informed decision-making about policy matters relating to Australia's health workforce.

The National Boards have recently started publishing regular snapshots of data about registered practitioners (see page 17 for further information).

Data access and research

In 2011/12, the National Boards and AHPRA began exploring how to maximise the potential of the data collected under the National Law. We have continued to identify innovative ways of using the data to better inform workforce planning and link with other statistical collections, and have undertaken a number of important activities relating to data and research.

We have established formal data access and research governance arrangements, including:

- a data access and research policy which sets out the governance arrangements and related procedures
- a data access and research committee which provides advice to the National Boards and AHPRA about research requests involving data from the National Scheme or involvement of National Boards or AHPRA in research projects, and
- a data requests review committee which provides advice on data requests such as the circulation of material to practitioners about, for example, CPD opportunities or invitations to participate in research.

A priority for this work is to ensure appropriate privacy protection for practitioners and ensure their contact information is not disclosed to researchers. In the coming year, we will be publishing information about our data and research governance arrangements and procedures, which will assist researchers to better understand the framework within which requests for data and research will be considered.

Medicare

During 2011/12, a web service was implemented to provide practitioner data to a number of organisations (including Medicare Australia), consistent with the National Law. The service provides a very secure, high-speed process to automatically update practitioner data consistent with the legal requirements of the National Scheme and the responsibilities of AHPRA and the other organisations.

The first release of data through this service was to provide limited details of the changes to 200,000 practitioners for Medicare's Practitioner Directory Service, to support Medicare's provider numbers and other mandated Department of Human Services purposes.

Health Workforce Australia (HWA)

In 2011/12, the National Boards and AHPRA established new collaborative approaches to working with HWA on shared issues.

The HWA's Health Professions Prescribing Pathway (HPPP) project is an example of this approach. HPPP aims to develop a nationally-consistent approach to prescribing by health professionals other than medical practitioners that supports safe practice, quality use of medicines and effectiveness of healthcare service.

A key issue for engagement between HWA, the National Boards and AHPRA is the relationship between the HWA project and the provisions about endorsements for scheduled medicines in the National Law. Stephen Marty, Chair of the Forum of National Board Chairs and of the Pharmacy Board of Australia, and Chris Robertson, Director of National Board Services, participate in the advisory committee for the project. There have also been specific mechanisms established to engage all the National Boards.

During the first consultation period, HWA facilitated a workshop with representatives of the National Boards and AHPRA. It included presentations about the current approaches to scheduled medicines endorsements across the nursing and midwifery, dental, podiatry, optometry and pharmacy professions. This provided key insights into the range of current approaches to scheduled medicines endorsements. It also provided an opportunity for cross-profession exploration of the issues involved in establishing a framework for a prescribing pathway.

The intention is to hold similar workshops at key points in the project, to share different perspectives and explore the potential implications of options for the prescribing framework and the relationship to the provisions of the National Law and the National Boards' role in regulating their professions.

Healthcare Identifiers Service and NEHTA

AHPRA provides practitioner data to the Department of Human Services (DHS) Healthcare Identifiers (HI) Service, as required by the Healthcare Identifiers Act. A grant was received from the Department of Health and Ageing to fully automate the data feed provided to the HI Service, and this work is expected to be completed in the next financial year. This work includes ongoing consultation with the National E-Health Transition Authority (NEHTA).

National Authentication of Security in Health

Additional work was started in 2011/12 to support DHS HI Service's National Authentication of Security in Health (NASH) requirements. A 'threat and risk assessment' has been completed to ensure both the current and proposed data feed to DHS HI Service is capable of supporting the NASH requirements. While no major risk issues were found, AHPRA is undertaking further work to improve the data collection processes in conjunction with NEHTA and DHS HI Service.

Collaboration in New South Wales – making it work

New South Wales (NSW) is a co-regulatory jurisdiction under the National Law. Provisions relating to conduct, performance and health are administered by councils for each profession, supported by the Health Professional Councils Authority (HPCA).

The development and maintenance of a strong relationship between AHPRA NSW and the HPCA has been critical to ensuring that, among other things, impaired NSW practitioners are not subject to duplication of process and, potentially, duplication of monitoring and compliance expectations.

The following case study illustrates how the relationship works to ensure the protection of the public and a seamless experience for practitioners:

A practitioner disclosed in his application for registration that he had previously been registered and had a health problem. In accordance with the provisions in the National Law which permit the sharing of information between AHPRA and the HPCA, AHPRA obtained information from the HPCA which indicated that the practitioner had a history of depression which had required frequent hospitalisations and treatment by a psychiatrist. Conditions had in the past been imposed on the practitioner concerning his health and his practice. The practitioner had subsequently allowed his registration to lapse.

The registration committee was able to consider the information provided by the HPCA when considering the application for registration and decided to have the practitioner assessed by a Board-appointed health practitioner. The subsequent report concluded that although the practitioner suffered from an impairment because of his psychiatric history, he could be registered subject to conditions. As the impairment provisions under the National Law are monitored by the HPCA in NSW, AHPRA and the HPCA jointly developed a recommendation regarding appropriate conditions, for consideration by the registration committee and the National Board.

The practitioner was subsequently registered with conditions and his file was transferred to the HPCA in NSW to enrol the practitioner in the NSW Council's health program, and to facilitate monitoring of the practitioner's compliance with conditions.

Data agreements

Arrangements for national health workforce data collection have been agreed under a new MoU signed by AHPRA, HWA and AIHW. See page 55 for further details of our data provision service.

Following Ministerial Council's November 2011 meeting on workforce data release, AHPRA, AIHW and HWA are developing an improved system to gather and publish workforce survey data. Consultation has started with AIHW to ensure the workforce data are provided in a form that meets the National Health Workforces Data Set requirements. Nursing and midwifery data were released using the new format in June 2012.

Information technology

During 2011/12, AHPRA undertook a comprehensive review of its IT operations and refreshed its IT strategy. This was to review the initial infrastructure and systems implemented when AHPRA began operations, and the significant systems functionality delivered over the first two years of operation.

The review identified a number of risks, highlighted key decision points and identified short, medium and long term actions needed to mature AHPRA's infrastructure and systems. A transformational change program in IT is fundamental to both managing risk and supporting future business directions. The scope of change is multi-faceted and spans people, processes and technology.

Work during 2011/12 includes: the establishment of an Governance Committee, chaired by the AHPRA CEO; infrastructure improvements aimed at improving system speed during peak renewal and registration periods; the development of a risk-based information security strategy and policies; and improved focus on supporting the IT customer base through an improved service desk. This work will continue throughout 2012/13, as IT is a critical enabling function within AHPRA.

Improved and expanded forms

AHPRA maintains a suite of around 300 forms to support a wide range of complex and technical interactions between practitioners and AHPRA/National Boards. During 2011/12, the forms team worked to enhance the forms, to make them easier for practitioners to complete and submit (see page 57). This improvement work will be continued in 2012/13.

Board development and governance

In 2011/12, the National Boards and AHPRA established a robust framework for board development and governance. Key elements of the framework are:

- The development of succession planning principles for National Boards (which were submitted to Ministerial Council in late 2011).
- The publication of a governance charter for the National Scheme to support effective and responsive governance of the system for regulating health practitioners in Australia in the public interest. The charter sets out the governance framework, and the roles and responsibilities that ensure sustainable achievement of the legislative and strategic objectives of the National Scheme. The charter applies to AHPRA and the National Boards, and provides key foundations for their functions and activities.
- The development of common 'board member attributes', to assist in a range of board activities, including recruitment, training and development, and evaluation.
- The development of new board evaluation tools, including whole of board and individual assessment processes.
- The review and expansion of the *Manual for National Boards and their committees*, which contains governance policy and administrative procedures common to all National Boards and their members. This will be launched at the 2012 Combined Meeting of National Boards.

The Governance Committee of the Forum of National Board Chairs has led this work, in consultation with the National Boards.

Roll-out of online board papers

In the first year of the National Scheme, AHPRA provided board papers to National Boards and their committees in hard copy. During 2011/12, we made the transition to an online system to replace paper-based documents. With an average of 1,400 National Board agendas created and distributed each year, AHPRA is set to achieve costs savings of up to $140,000 annually by going digital.

The introduction of the online system followed an evaluation of the potential for electronic sharing of board information, supported by tablet devices.

In May and June 2011, a pilot group trialled the system, which allows the user to download meeting agendas in electronic format to their laptop or tablet device.

Implementation of the system started in July 2011, with members of the new professions for 2012 being issued with iPads at their induction session on 26 July 2011.

This was followed in September 2011, when more than 100 iPads were distributed to members of the 10 original National Boards. By June 2012, more than 500 iPads had been distributed to members of state, territory and regional boards and committees, and training sessions for staff and members had been held across all AHPRA offices.

The online system provides a comprehensive method for managing correspondence, tools and resources that can be easily and securely accessed by all national and regional board members. It has been well received and has enabled AHPRA to meet the requirements of the Health Profession Agreements to supply meeting papers at least five working days before a meeting. The system also provides efficiencies for staff as the electronic uploading and distribution of papers takes considerably less time than preparation and postage of paper agendas.

Delivering the National Scheme in each state and territory

AHPRA has an office in each state and territory of Australia, through which most of our services to the public and health practitioners are delivered.

Each local office provides services in registrations, notifications (excluding New South Wales – see page 85 for details), corporate services, customer service and board support, and is led by a state or territory manager. Local offices also provide support for state, territory and regional boards and committees of the National Boards.

The local offices work together and with the national office to support each other in delivering the National Scheme. The structure allows work to be allocated between offices at times of peak demand, according to need.

Along with providing these core services, each local office also takes the lead in managing specific national projects or issues. The pages that follow provide a snapshot of some of these additional responsibilities that have been carried out in 2011/12 by local offices to meet national needs, and are not limited to state or territory boundaries.

Specialists register

The AHPRA Australian Capital Territory (ACT) office took up the challenge of data quality improvement of the Medical Board of Australia's specialists register (also see page 60). Following a mail-out of in excess of 60,000 letters to eligible practitioners, the ACT office updated approximately 14,700 entries on the specialists register, focusing on specialist qualifications but also updating addresses and basic medical qualifications where verified material was received. The process included regular telephone and email contact with specialist colleges to help ensure the veracity of the data being entered.

In addition, the project team also undertook around 2,500 registration reviews on general practitioners who were vocationally registered with Medicare and who, by virtue of that status, were eligible for transition onto the register as specialists.

The AHPRA ACT office, led by **Bob Bradford**, provides services to health practitioners and the community in the ACT, which is home to more than 9,000 health practitioners.

Protecting the public through compliance checks

One of the features of the National Scheme is the requirement for practitioners to demonstrate, at the time of initial registration and at each subsequent renewal, that they have satisfied (among other things) the requirements of approved registration standards relating to CPD, recency of practice and professional indemnity insurance.

Practitioners are required to make declarations about their compliance with these requirements. To protect the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered, the National Boards and AHPRA

have agreed to develop a process to audit compliance with these registration requirements.

During 2011/12, the AHPRA New South Wales (NSW) office hosted the initial pilot for practitioner audit, in which randomly-selected pharmacists were issued audit notices (also see pages 42 and 62). The aims of the pilot were to test the end-to-end processes of the proposed audit framework, and to identify opportunities for improvement and provide data to inform future models and organisational structure.

Three members of staff from the NSW office participated in the pilot; one as a senior assessor and two as assessors. All staff had a background in processing and assessing applications for registration and renewal. Training in the audit assessment process was provided before the start of the pilot and the staff compiled feedback throughout on the proposed audit methodology, communications, practitioner experience of the audit and workload breakdown.

The AHPRA NSW office, led by **Kym Ayscough**, provides services to health practitioners and the community in NSW, which is home to more than 160,000 health practitioners. NSW is a co-regulatory jurisdiction so the NSW office is not involved in managing notifications about the conduct, health or performance of health practitioners.

Supporting the 2012 professions

From 1 July 2012, AHPRA welcomes four new professions into the National Scheme (see page 19). The AHPRA state and territory offices have played a vital role in preparing for the introduction of the new professions.

The Northern Territory (NT) office assisted with the orientation of members of the newly appointed Aboriginal and Torres Strait Islander Health Practice Board of Australia by providing an opportunity for members to observe at a meeting of the Aboriginal Health Workers Board of the NT, and through providing the registration session at a one-day training workshop run for the Board on registration and notification issues.

The NT office took the lead within AHPRA for applications from Aboriginal and Torres Strait Islander health practitioners in the months before the start of national registration for this profession. It also provided the secretariat function for the Aboriginal and Torres Strait Islander Health Practice Board of Australia's Registration and Notification Committee. In filling these functions, the NT office was able to draw on the knowledge it had gained in the support of the Aboriginal Health Workers Board of the NT. The AHPRA NT office's role in this work provided some unique opportunities to facilitate contact between the two boards, including some valuable training opportunities.

The AHPRA NT office, led by **Jill Huck**, provides services to health practitioners and the community in the NT, which is home to more than 5,000 health practitioners.

State and territory offices played a major role in the successful transition of unregistered occupational therapists and medical radiation therapists into the National Scheme. In five states and territories, where one or other, or even both, of these professions were not currently regulated, practitioners were encouraged to make an application for registration by 30 March 2012 so they could be registered to practise their profession from 1 July 2012. Each AHPRA office undertook the 'front-end' work for applications and the AHPRA Queensland office completed the assessment of all the occupational therapy and medical radiation practice applications.

AHPRA expected a large number (around 12,000 nationally) of applications for registration from practitioners in states and territories that did not previously register practitioners from these professions. A project team was established to plan the necessary resources, decisions and process changes. Early in the project, the Queensland office developed a service request workflow model that would be adopted by all offices when processing these applications. The project team also established a comprehensive reporting tool that tracks applications throughout the registration process.

A number of experienced staff from within the Queensland office were selected to lead and manage the registration team during the project, ensuring that applications were processed accurately and efficiently. In addition, these staff were charged with setting up systems of working and reporting, as well as the preparation of training materials and delivery of training to new staff.

A comprehensive data collection and reporting system, which guided the planning and implementation phases of the project, was established. These systems also ensured the management team had timely data on the volume of work at each assessment stage, which enabled the effective movement of resources between tasks, for example moving staff from assessing new applications to preparing agenda papers, or undertaking the final review before granting registration.

The Queensland office assessed just over 11,000 occupational therapy and medical radiation practice applications for all state offices in a 14 week period.

A cooperative and productive relationship was developed with the Tasmania and ACT offices, which provided assistance in the assessment process. In addition, the NSW and Victorian offices provided assistance to the Queensland office by taking on some of their day-to-day business for the existing professions.

The AHPRA Queensland office, led by **Anne Morrison**, provides services to health practitioners and the community in Queensland, which is home to more than 103,000 health practitioners.

The AHPRA South Australia (SA) office managed applications for registration with the Chinese Medicine Board of Australia. The profession was not previously regulated outside Victoria and close to 2,500 practitioners applied for registration before 1 July 2012. Practitioners were able to apply for registration in up to three divisions - acupuncture, Chinese herbal medicine and Chinese herbal dispensing.

AHPRA SA staff developed a targeted process to manage applications, fostering stage specific expertise. In many cases, complex case-record evidence was required for practitioners to demonstrate competence and compliance with the Board's registration standards. The SA team focused on, where possible, personal contact with practitioners to assist them in the registration process. The SA team also worked closely with the Board's Registration Committee to facilitate its consideration of the high volumes of applications requiring a committee decision about the applicant's qualifications.

AHPRA SA liaised with the Chinese Medicine Board to help make sure the FAQs and information published on the website addressed the actual issues emerging through the application process.

The AHPRA South Australia office, led by **Diana Newcombe**, provides services to health practitioners and the community in South Australia, which is home to more than 46,000 health practitioners.

Increasing local engagement

A priority for the National Scheme is increasing engagement with local stakeholders and raising awareness in each state and territory. Positive relationships with local stakeholders are imperative for the acceptance and success of the National Scheme across the country.

In Tasmania, staff have worked to increase this local engagement via, for example, in-service activity at public and private hospitals to reinforce the key objectives of the National Scheme; presentations about the regulatory environment to students of the faculty of health sciences at the University of Tasmania; educational presentations to students enrolled in nursing courses at the Tasmanian Polytechnic; and regular briefing notes and meetings with the office of the Minister for Health in Tasmania.

The AHPRA Tasmania office, led by **Matthew Hardy**, provides services to health practitioners and the community in Tasmania, which is home to more than 12,000 health practitioners.

Innovation

Each state and territory office is constantly looking to improve systems and procedures, and to share the successes that they have in this area.

In the AHPRA Victoria office, a registration support team was established during 2011/12, which involved changing and rationalising processes to a single group of practitioners. This has led to the assessing and processing of all applications from internationally-qualified nurses/midwives within 48 hours and a significant reduction in the time taken to finalise their assessment.

The Victorian office also coordinated the mapping and finalisation of national notifications processes and templates, which has resulted in greater efficiencies and consistency in the management of notifications within AHPRA.

The AHPRA Victoria office, led by **Richard Mullaly,** provides services to health practitioners and the community in Victoria, which is home to more than 143,000 health practitioners.

State board and committee member training

The AHPRA Western Australia (WA) office has developed their state board and committee members' induction program, which now includes face-to-face induction sessions with the state manager and senior staff, an IT session, the distribution of a comprehensive board/committee user manual, an observer session at a board/committee meeting, and the evaluation by the new member of the orientation program following the attendance at three meetings. Evaluation results to date from new members indicate an average rate of 9.3 out of 10 for the induction they received.

In September 2011, it was agreed that a manual of detailed instructions would be developed and implemented to guide board services staff (and AHPRA WA staff) about board and committee membership, agendas, meetings, and decisions and actions. Local executive team and relevant board services staff and managers piloted a trial version and their comments were incorporated into a revised manual, which was distributed to relevant staff in the organisation.

The AHPRA Western Australia office, led by **Robyn Collins,** provides services to health practitioners and the community in Western Australia, which is home to more than 55,000 health practitioners.

Registrations

The core role of AHPRA and the National Boards is to protect the public and facilitate access to health services. One of the ways we do this is by making sure that only those practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

Each National Board considers every application for registration carefully and assesses it against the requirements for registration set in their registration standards and the National Law.

Under the National Law, each board sets registration standards, approved by Ministerial Council, which every registered health practitioner must meet. These standards are designed to ensure patient safety.

All National Boards have registration standards on CPD, criminal history, professional indemnity insurance, recency of practice and English language skills. Many boards have developed additional registration standards, as well as codes, guidelines, policies and other supporting documents relevant to their profession.

The bulk of registration activity relates to managing applications from new applicants and renewal applications. However, the registration function also extends to include a wide range of other activities, from managing practitioners with limited and provisional registration, to issuing registration certificates and certificates of registration status.

A core challenge in health practitioner regulation is balancing the at times competing priorities of workforce supply and the safety and quality of health services delivered to the Australian public. Assessing and making determinations about eligibility for registration is not just an administrative process. To undertake its statutory role responsibly, AHPRA makes sure its processes support a thorough assessment of applications for registration. It aims to do this in a timely way, noting that there are no externally-agreed performance benchmarks for registration processes beyond the maximum period specified in the National Law.

Registration types

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

- **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 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, accreditation authority 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 a number of requirements, including regular reports on their progress from their supervisors before progressing to general registration.
- **Student registration** was launched nationally for the first time in Australia in April 2011. There are currently more than 110,000 students studying to be health practitioners in Australia (see *Table 5* on page 75). A register of these currently enrolled students is maintained by AHPRA as part of the national register, with details collected from 145 education providers. This register is not publicly available.
- **Limited registration** covers a number of subtypes 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 completely from practice, are not practising temporarily (for example, if they are on maternity or paternity leave), or who are not practising in Australia but are practising overseas.

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

The registration process

An application for registration will pass through at least five stages, but may pass through up to eight stages.

Stage 1: Application – When the hard copy or online application form is submitted, it is reviewed by AHPRA staff for completeness.

Stage 2: Assessment – The supplied information is assessed against registration standards.

Stage 3: Recommendation – A recommendation may be to register, register with conditions or refuse. If the application is straightforward and the recommendation is to register, a delegate of the National Board may register the applicant without referring to the relevant National Board. Complicated cases will be referred to the National Board or its committee for resolution. The Board or its delegate may accept the recommendation or take some other action such as requiring the applicant to undergo, for example, an examination or health assessment. When all information is available, the Board's decision will be to register, register with conditions or refuse the application.

Stage 4: Registration – Registration is finalised and relevant letters and certificates are prepared for the applicant.

Stage 5: Submission – If a National Board proposes to register with conditions or refuses the application, the applicant will be informed at this stage. The applicant may then elect to make a submission to the Board.

Stage 6: Submission assessment – The response from the applicant is considered and a final decision is made.

Stage 7: Tribunal – If applicants do not agree with the final decision of the Board, they may take their case to a tribunal for a review.

Stage 8: Withdrawn/incomplete – If a required response from the applicant is not received within a reasonable period, the application is closed as withdrawn and incomplete. In this situation, applicants are not able to take their case to a tribunal for review.

Renewals

Health practitioners in Australia must renew their registration annually. In 2011/12, AHPRA finalised 557,683 renewal applications (see *Table A1* in the Appendix for a full breakdown of renewals by state and territory, and profession).

A small team at AHPRA operates the national renewal process that involves sending about 1,500,000 emails, 450,000 letters, 550,000 certificates of registration and the automated processing of around 490,000 online renewals and payments.

In the National Scheme, the annual registration renewal of the majority of practitioners is coordinated into three key dates:

- nursing and midwifery professions are due to renew by 31 May each year
- most of the medical profession is due to renew by 30 September each year, and
- all other professions in the National Scheme, including the four new professions to join from July 2012, are due to renew by 30 November each year.

The annual nursing and midwifery renewal cycle was completed in the last quarter of 2011/12. Online renewals increased by approximately 10% compared to last year's renewal cycle. AHPRA distributed more than one million emails to nurses and midwives reminding them to renew their registration, and decreased the distribution of hard copy renewal applications by 12%.

Criminal record checks

Under the National Law, applicants for initial registration must undergo a criminal record check. National Boards may also require criminal record checks at other times. Applicants seeking registration must disclose any criminal history information when they apply for registration, and practitioners renewing their registration are required to disclose if there has been a change to their criminal history status within the preceding 12 months.

While a failure to disclose a criminal history by a registered health practitioner does not constitute an offence under the National Law, such a failure may constitute behaviour for which a National Board may take health, conduct or performance action.

The criminal record check is undertaken by an independent agency which provides a criminal history report. AHPRA may also seek a report from a police commissioner or an entity in a jurisdiction outside Australia that has access to records about the criminal history of people in that jurisdiction.

The criminal history reports are used as one part of assessing an applicant's suitability to hold registration.

Results of criminal history checks

In 2011/12, AHPRA requested 68,627 criminal record checks of practitioners – 16,182 more than last year. Reasons for this increase include assessing more than 16,000 applications for registration from practitioners in the four professions due to join the scheme in July 2012; all of which required criminal record checks.

Of the 68,627 criminal record checks conducted, 4,067 (6%) of results indicated that the applicant had a criminal history. This is comparable to 2010/11, as recorded in *Table 1: National comparison of criminal history checks 2010/11 and 2011/12.*

Of the 4,067 results with a criminal history, 404 were assessed as having the potential to affect registration. After consideration by the relevant National Board, nine of the 404 assessed as having the potential to affect registration led to action on the applications as follows:

- three applications refused: two medical; one nursing and midwifery
- six had conditions imposed or undertakings accepted on registration: three nursing and midwifery; two medical; one dental.

Table 1: National comparison of criminal history checks 2010/11 and 2011/12

Financial year	Number of criminal history checks conducted	Number of 'disclosable court outcomes' (DCOs)	% of DCOs resulting from criminal record checks submitted
2010/11	52,445	2,992	6%
2011/12	68,627	4,067	6%

The National Law (sections 79 and 135) requires all criminal history to be released, regardless of where or when it originated. However, this is still affected by the definition in each relevant state or territory of what constitutes 'criminal history'.

The 4,067 results indicating the applicant had a criminal history were released to AHPRA as 'disclosable court outcomes' (DCOs). While the exact definition of a releasable 'criminal history' and the nature of DCOs released varies between policing and law enforcement bodies in each state and territory (for example some but not all jurisdictions include traffic offences in their definition of 'criminal history'), definitions and release of DCOs is largely consistent in the more serious offence categories. More detail on DCOs arising from criminal history checks by each state and territory is recorded in *Table 2: Disclosable court outcomes by jurisdiction.*

Table 2: Disclosable court outcomes by jurisdiction

State/ territory	Number of criminal history checks conducted	Number of DCOs	% of DCOs resulting from criminal record checks submitted
NT	481	38	8%
ACT	812	46	6%
TAS	1,352	193	14%
SA	4,659	443	10%
WA	5,904	586	10%
QLD	10,534	732	7%
VIC	21,134	549	3%
NSW	23,751	1,480	6%
Total	68,627	4,067	6%

If a certain offence does not fall within the jurisdiction's definition of 'criminal history', it will not be released. For example, Tasmanian police include traffic offences in their definition of 'criminal history' and will release offences such as speeding and seatbelt use. Queensland police, on the other hand, do not include traffic offences in their definition of 'criminal history' and will not release information on these offences in response to AHPRA's requests for criminal history checks. AHPRA is considering options to manage this variation in 'criminal history' definitions and information release across jurisdictions.

While NSW recorded the highest number of DCOs arising from criminal record checks, Tasmania recorded the highest proportion of DCOs returned (193 out of 1,352, or 14%; compared to an average of 7% across jurisdictions). This is a consequence of the different definitions of criminal history in each state and territory police jurisdiction, as well as different information release policies. This proportional result for Tasmania is also consistent with the results from the previous year.

In Victoria, only 549 (3%) of the 21,134 criminal record checks submitted returned a DCO. This is because Victoria is the nominated 'coordinating jurisdiction' for AHPRA's criminal history checks and, as such, Victoria police has the final vetting authority over information release. The Victorian jurisdiction operates under a comparatively narrower definition of 'criminal history', coupled with a relatively stringent information release policy. As a result, fewer types of information are considered to be 'criminal history' and are not released.

Importantly, AHPRA has been assured by the criminal checking agency and state and territory police that information about more serious offences, and offences with any potential impact on a person's suitability for registration as a health practitioner, is uniformly released in all jurisdictions. Also, importantly, National Boards do not consider criminal history information that is not relevant to registration as a health practitioner. Each National Board refers to the criminal history registration standard that details what the Board expects in relation to criminal history information and how this links to registration.

Advertising

Under the National Scheme, registered health practitioners must meet the advertising requirements of the National Law, which includes a specific section on advertising (section 133) listing what is not acceptable, including (but not limited to):

- making misleading claims
- offering an inducement such as a gift or discount (unless the relevant terms and conditions are also included)
- using testimonials
- creating unreasonable expectations of beneficial treatment, or
- encouraging the indiscriminate or unnecessary use of a service.

The National Boards have also published advertising guidelines to help practitioners understand and meet the Board's expectations.

A registered practitioner, or a business providing a regulated health service, whose advertising breaches the National Law, may be liable for a $5,000 penalty (for an individual) or $10,000 (for a body corporate) if they do not comply.

A National Board has the power to address a persistent advertising breach through its conduct, health or performance pathways. This can lead to restrictions being placed on an individual's registration and their ability to practise.

The approach to managing complaints includes sending an escalating series of written warnings to practitioners, initially reminding them of their obligations in relation to advertising. If the practitioner fails to take corrective action, the National Board considers taking legal action against them for non-compliance with the National Board's standards and guidelines.

The National Boards respond to complaints about advertising and have the power to initiate their own action or investigation without a complaint.

On behalf of the National Boards, AHPRA responds to each complaint as it is received by considering whether the advertising contravenes the National Law and, if it does, advising the person responsible for the advertising to amend the advertisement.

Table 3: Number of advertising-related complaints by profession

Profession	Closed	Enquiry/Assessment	Total
Chiropractor	103	17	120
Dental practitioner	176	24	200
Medical practitioner	42	14	56
Nurse	8	1	9
Optometrist	8	5	19
Osteopath	4	1	5
Pharmacist	9	4	13
Physiotherapist	16	3	19
Podiatrist	8	4	12
Psychologist	8	4	12
Total	382	77	459

During 2011/12, AHPRA received a total of 459 advertising-related complaints. Of these, 382 have been closed after confirmation that the alleged advertising breach was rectified and further action or prosecution was not warranted. There are 77 complaints currently in assessment to determine if the complaint warrants further investigation.

No prosecutions related to advertising breaches were pursued in 2011/12.

Registration data

There were more than 548,000 health practitioners in 10 professions registered to practise in Australia on 30 June 2012; a 3.47% increase on June 2011. Holding registration means that the relevant National Board has assessed that the practitioner is safe and competent to practise in the profession. It does not mean the practitioner is actively working in that profession at the time. Registration is separate from employment.

Registration by profession and principal place of practice

All professions experienced a growth in registration numbers since June 2011. Nursing and midwifery, the professions with most practitioners (with 302,245 nurses, 2,187 midwives and 39,271 practitioners registered as both nurses and midwives) experienced an increase of 3.46% from June 2011.

The number of medical practitioners, the second largest group (with 91,648 practitioners registered), increased by 3.8%. The number of psychologists increased by 1.7% to 29,645 practitioners; pharmacists increased by 2.3% to 26,548 practitioners; physiotherapists increased by 4.99% to 23,501 practitioners; and dentists, dental specialists, dental therapists, dental hygienists, oral health therapists and dental prosthetists, who make up dental practitioners, increased by 4.19% to 19,087.

For the remaining professions: optometry increased by 2.84% to 4,568 practitioners; chiropractic increased by 2.57% to 4,462 practitioners; podiatry increased by 6.62% to 3,690 practitioners; and osteopathy increased by 5.08% to 1,676 practitioners.

NSW has the largest number of registered practitioners, with 160,545 practitioners across the 10 professions. This is followed by Victoria (143,643 practitioners) and Queensland (103,730 practitioners). This trend continues across individual professions except for osteopaths and podiatrists, for which Victoria has the largest numbers of registered practitioners.

See *Table 4: Registered practitioners by profession and principal place of practice*.

Student registration

Student registration was launched nationally for the first time in Australia in April 2011. The register of students is not publicly available and the role of the National Boards in relation to students is limited to student health impairment matters or when there is a criminal conviction of a serious nature, either of which may adversely impact on public safety. National Boards have no role to play in the academic progress or conduct of students. This continues to be a core responsibility of education providers.

There were 111,292 students registered across Australia on 30 June 2012. The largest numbers of students were studying nursing (64,806 students), followed by medicine

Table 4: Registered practitioners by profession and principal place of practice[1]

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]	Total 2011/12	Total 2010/11	% change
Chiropractor	56	1,511	24	692	357	45	1,202	498	77	4,462	4,350	2.57%
Dental practitioner	350	5,989	134	3,728	1,615	336	4,358	2,254	323	19,087	18,319	4.19%
Medical practitioner	1,784	28,972	945	17,682	7,142	2,048	22,365	8,855	1,855	91,648	88,293	3.80%
Midwife	39	418	29	321	343	9	747	229	52	2,187	1,788	22.32%
Nurse	4,848	81,927	3,276	57,491	28,393	7,570	80,982	31,076	6,682	302,245	290,072	4.20%
Nurse and midwife [3]	719	13,491	579	7,321	2,601	723	10,297	3,292	248	39,271	40,325	-2.61%
Optometrist	71	1,553	28	929	234	84	1,163	366	140	4,568	4,442	2.84%
Osteopath	32	510	2	149	29	38	843	52	21	1,676	1,595	5.08%
Pharmacist	420	8,274	186	5,187	1,919	628	6,578	2,852	504	26,548	25,944	2.33%
Physiotherapist	441	6,888	145	4,379	1,928	394	5,904	2,798	624	23,501	22,384	4.99%
Podiatrist	47	946	17	631	370	90	1,195	375	19	3,690	3,461	6.62%
Psychologist	794	10,066	216	5,220	1,466	524	8,009	3,082	268	29,645	29,142	1.73%
Total 2011/12	9,601	160,545	5,581	103,730	46,397	12,489	143,643	55,729	10,813	548,528		3.47%
Total 2010/11 [4]	8,976	156,139	5,121	99,850	44,441	12,407	137,361	52,111	13,709	530,115		

1. Data are based on registered practitioners as at 30 June 2012.
2. No principal place of practice (PPP) will include practitioners with an overseas address.
3. Practitioners who hold dual registration as both a nurse and a midwife.
4. Subsequent to the publication of the 2010/11 annual report, further data cleansing of the 'no PPP' reduced the total number from 16,836 to 13,709.

(19,052 students) and pharmacy (8,160 students). Most students (105,701 students) were undertaking approved programs of study (a course approved by a National Board which leads to general or provisional registration).

Student numbers are derived from student data updates supplied by education providers in March and August each year. As such, numbers are cumulative and reflect the number of students who still have an active registration on 30 June 2012, based on the expected completion date supplied by the education provider. Therefore, in some instances, these numbers may not align with student numbers collected by other entities whose data fluctuates based on student participation. AHPRA continues to work with education providers to ensure that the data they provide for student registration are accurate and complete.

See *Table 5: Registered students by profession*

Table 5: Registered students by profession[1]

Profession	Approved program of study[2]	Clinical training[3]	Annual total
Chiropractor	1,340	254	1,594
Dental practitioner	3,845	9	3,854
Medical practitioner	17,453	1,599	19,052
Midwife	3,776	82	3,858
Nurse	62,965	1,841	64,806
Optometrist	524	278	802
Osteopath	604	42	646
Pharmacist	7,987	173	8,160
Physiotherapist	5,655	1,193	6,848
Podiatrist	1,552	120	1,672
Total	105,701	5,591	111,292

1. Figures have been calculated based on the numbers of students who hold a registration in a profession and not the total number of registrations. This is to try and minimise students who hold multiple registrations in the same profession skewing the numbers. However, registrations that have been incorrectly recorded in the wrong profession, or that should be counted as a clinical training registration rather than an approved program of study registration, and vice versa, have not been able to be corrected at this point in time.
2. Approved program of study refers to those students enrolled in a course that has been approved by a National Board and leads to general or provisional registration.
3. Clinical training has been defined as any form of clinical experience (also known as clinical placements, rotations etc) in a health profession that does not form part of an approved program of study and the person does not hold registration in the health profession in which the clinical training is being undertaken. This obligation is imposed by section 91 of the National Law. This might apply, for example:
   a) when an overseas student arranges a clinical placement as part of the course requirements set out by the education provider in their home country
   b) when an education provider is running a course that is accredited by an accreditation authority but has not yet been approved by a National Board
   c) when an education provider is running a course that has not yet been accredited by an accreditation authority or approved by a National Board (this is the case for a number of physiotherapy courses run at university level, e.g. in 2012 alone, one university reported 197 Clinical Training - Physiotherapist students, with a total of 406 current Clinical Training - Physiotherapy students since student registration commenced in 2011).

   A clinical training education provider could be a university, registered training organisation, hospital, health facility, private practice or retail outlet (e.g. retail pharmacy). Because clinical training providers are unknown to AHPRA, there is no way of verifying whether the clinical training figures are correct. Due to the nature of the clinical training provisions in the National Law, it is likely that numbers will fluctuate each year.

The Psychology Board of Australia does not register students and uses provisional registration for this purpose. Psychologists wishing to apply for provisional registration must do so either at the beginning of the 4+2/5+1 internship program or their higher degree pathway.

Registration by profession, principal place of practice and registration type

There are many types of registration in professions (see page 70 for details), including general registration, specialist registration, provisional registration, student registration, limited registration and non-practising registration.

Most practitioners in Australia hold general registration, although there are more medical practitioners with general and specialist registration (46,409 practitioners) than with general registration only (26,483 practitioners) or specialist registration only (6,188 practitioners).

There are more dental practitioners with general registration (16,870 practitioners) than with general and specialist registration (1,476 practitioners) or specialist registration only (24 practitioners).

There are 5,670 medical practitioners with limited registration – typically international medical graduates working in areas of need or undertaking supervised training as they progress to general registration. NSW continues to have the largest number of medical practitioners with limited registration (1,551 practitioners).

There are 1,239 medical practitioners with limited registration (public interest – occasional practice), a type of registration only available as a one-off transition to the National Scheme and which only applies to practitioners who, on 30 June 2010 (or 18 October 2010 for practitioners in WA), held a type of registration that allowed them to refer and/or prescribe, but not receive a fee for providing that service. The National Law does not allow the National Board to grant this type of registration to new applicants.

Nursing and midwifery has the largest number of practitioners with non-practising registration (2,871), followed by medicine (2,379 practitioners) and psychology (1,038).

See *Table A2* in the Appendix for a full breakdown of registered practitioners by profession, principal place of practice and registration type.

Registration by profession, principal place of practice and age

The largest group of registered practitioners across the 10 professions is aged 50 to 54 years (72,369 practitioners), followed by practitioners aged 40 to 44 years (67,622 practitioners) and practitioners aged 45 to 49 years (64,334 practitioners). The age group 50 to 54 years represents almost 13.2% of the total number of registered practitioners.

The smallest group of registered practitioners across the professions is aged 80-plus years (1,237 practitioners), representing 0.22% of the total number of registered practitioners; nursing is the only profession with practitioners aged 20 years or less (54 practitioners).

The medical profession has the largest proportion of practitioners aged 80-plus years (1.03% of medical practitioners), followed by pharmacy (0.3% of pharmacy practitioners). Podiatry has the largest proportion of practitioners aged 20 to 24 years (8.8% of podiatry practitioners), followed by pharmacy (7.6% of pharmacy practitioners). The proportion of nursing and midwifery practitioners aged under 20 years is 0.015%.

On a per-profession basis, the largest age groups are:

- Chiropractic: 30 to 34 years (16.36% of registered chiropractors)
- Dental: 30 to 34 years (14.92% of registered dental practitioners)
- Medical: 35 to 39 years (13.54% of registered medical practitioners)
- Nursing and midwifery: 50 to 54 years (15% of registered nursing and midwifery practitioners)
- Optometry: 25 to 29 years (14.42% of registered optometrists)
- Osteopathy: 30 to 34 years (22.9% of registered osteopaths)
- Pharmacy: 25 to 29 years (22.23% of registered pharmacists)
- Physiotherapy: 25 to 29 years (20.17% of registered physiotherapists)
- Podiatry: 25 to 29 years (20.16% of registered podiatrists), and
- Psychology: 30 to 34 years (14.6% of registered psychologists).

See *Table A3* in the Appendix for full details of registered practitioners by profession and age range.

Registration by profession, principal place of practice and gender

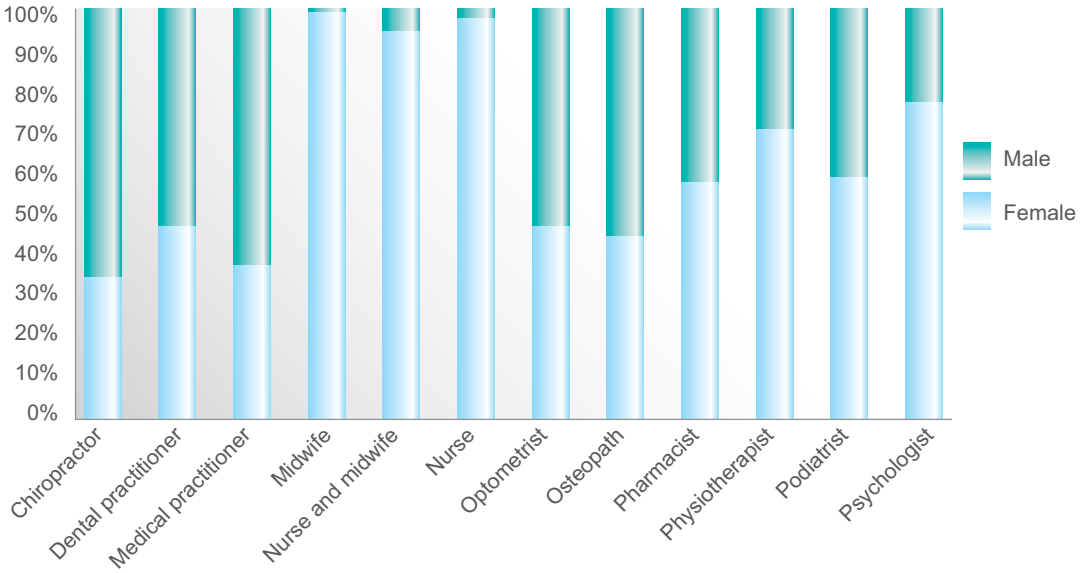
There are more females than males practising psychology, nursing and midwifery, podiatry and physiotherapy. There are more males practising medicine, chiropractic, dental practice, pharmacy, optometry and osteopathy.

In many cases, previous state and territory boards did not record data on gender. Data transition gaps addressed during 2011/12 has resulted in the number of practitioners with no identified gender being reduced from 38,182 to 4,414.

As a proportion of total number of practitioners registered in a profession, males have the highest representation in chiropractic, with 64.39% of chiropractors recorded as male (see *Figure 2*). Females have the highest representation in midwifery, with 99.36% of midwives-only recorded as female.

See *Table A4* in the Appendix for full details of registered practitioners by profession, principal place of practice and gender.

Figure 2: Registered practitioners by profession and gender as a proportion of total profession registrations



Registration by profession, principal place of practice and registration endorsement

Nine of the 10 professions (excluding pharmacy) have endorsements on registration. Endorsement of a practitioner's registration is a legal mechanism under the National Law through which particular groups of practitioners, who have an additional qualification or advanced practice recognised by the relevant National Board, can be identified through the national register. An endorsement on registration indicates that a practitioner has expertise in an advanced area of practice in addition to the level of training required for general registration in the profession.

There are 1,278 optometrists, 784 nurses, one midwife and 47 podiatrists with an endorsement for scheduled medicines.

There are 245 medical practitioners, 38 chiropractors, nine physiotherapists and three osteopaths with an endorsement for acupuncture.

There are 121 eligible midwives in Australia, with Queensland recording the highest number of eligible midwives (54). Having a notation made on the register of midwives as an eligible midwife indicates the applicant is qualified to provide pregnancy, labour, birth and postnatal care to women and their infants, including the capacity to provide associated services and order diagnostic investigations appropriate to the eligible midwife's scope of practice. An eligible midwife may also prescribe scheduled medicines in accordance with relevant state and territory legislation once an endorsement for scheduled medicines under section 94 has been attained.

See *Table 6: Registered practitioners by profession, principal place of practice and endorsement or notation*.

Psychology has the largest number of practitioners with an endorsement on registration (7,163 practitioners), specifically an area of practice endorsement. The approved areas of practice for endorsement of registration for psychologists are detailed in *Table 7: Nature of area of practice endorsements held by psychologists*.

Table 6: Registered practitioners by profession, principal place of practice and endorsement or notation

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [1]	Total 2011/12	Total 2010/11
Chiropractor							38			38	
Acupuncture							38			38	40
Dental practitioner	4	56	2	16	1		3	6	2	90	
Conscious sedation	4	56	2	16	1		3	6	2	90	64
Medical practitioner			1	4		4	226	10		245	
Acupuncture			1	4		4	226	10		245	221
Nurse	32	222	22	846	77	22	158	137	5	1,521	
Nurse practitioner	30	189	11	188	69	20	98	129	2	736	512
Midwife practitioner		1								1	1
Scheduled medicines	2	32	11	658	8	2	60	8	3	784	384
Midwife		21		54	11	4	20	12		122	
Eligible midwives		21		54	11	4	19	12		121	
Scheduled medicines							1			1	
Optometrist	19	238	9	209	76	53	596	67	11	1,278	
Scheduled medicines	19	238	9	209	76	53	596	67	11	1,278	970
Osteopath	-	-	-	-	-	-	3	-	-	3	
Acupuncture							3			3	3
Physiotherapist	-	-	-	-	-	-	9	-	-	9	
Acupuncture							9			9	9
Podiatrist	-	2	-	2	4	-	14	25	-	47	
Scheduled medicines		2		2	4		14	25		47	42
Psychologist [2]	146	2,241	31	918	458	156	2,160	1,011	42	7,163	
Area of practice	146	2,241	31	918	458	156	2,160	1,011	42	7,163	6,391
Total	201	2,780	65	2,049	627	239	3,227	1,268	60	10,516	

1. No PPP will include practitioners with an overseas address.
2. See *Table 7: Nature of area of practice endorsements held by psychologists* for details.

Table 7: Nature of area of practice endorsements held by psychologists

	No. of endorsements	
Area of practice sub-type	Total 2011/12	Total 2010/11
Clinical neuropsychology	462	395
Clinical psychology	5,151	4,523
Community psychology	48	44
Counselling psychology	803	758
Educational and developmental psychology	457	441
Forensic psychology	395	336
Health psychology	223	173
Organisational psychology	359	334
Sport and exercise psychology	69	69
Total	7,967	7,073

Registration by profession, principal place of practice and registration division

Nursing and midwifery, and dental practice each have divisions of practitioners, representing professions of different levels of training and scope of practice contained within these two larger professional groups. Nursing and midwifery is made up of nurses (enrolled nurses and registered nurses) and midwives. Dental practice comprises dental hygienists, dental therapists, oral health therapists, dental prosthetists, dentists (and dental specialists).

The reduction in the number of registrants registered as dual dental hygienists and dental therapists, and the increase in the number of oral health therapists, can be attributed to the Dental Board's policy to allow practitioners who were registered as both dental hygienists and dental therapists before the National Scheme to

change to the division of oral health therapist if their qualifications were approved by the Board and they had recency of practice in both disciplines.

See *Table A5* in the Appendix for full details of registered dental and nursing practitioners by division.

Specialist registration

The National Scheme provides for specialist registration, including approved lists of specialties and protected specialist titles for medical specialists, dental specialists and podiatric surgeons.

In September 2011, all medical practitioners on the specialists register were asked to confirm the sub-specialty relevant to their specialist registration (see page 60 for further details). As a result, the sub-specialty totals vary from those published in the 2010/11 annual report.

There were 58,620 practitioners with specialist registration across three professions (dental practice, medical practice and podiatry) registered to practise in Australia at 30 June 2012. Of these, 1,541 practitioners were registered to practise in a dental specialty; 57,056 practitioners were registered to practise in a medical specialty; and 23 practitioners were registered to practise as podiatric surgeons.

NSW was the principal place of practice nominated by the largest groups of dental and medical specialists (nominated by 485 dental specialists and 18,139 medical specialists).

WA was the principal place of practice nominated by the largest group of podiatric surgeons (nine practitioners). The largest group of practitioners with a dental specialty was registered to practise orthodontics (569 practitioners), with the largest group of these nominating NSW as the principal place of practice (184 practitioners). The smallest group of practitioners with a dental specialty was registered to practise dento-maxillofacial radiology (nine practitioners).

The largest group of practitioners with a medical specialty was registered to practise in the specialty of general practice (22,804 practitioners), with the largest group of these nominating NSW as the principal place of practice (7,311 practitioners).

The smallest groups of practitioners with a medical specialty were registered to practise sports and exercise medicine (113 practitioners) and sexual health medicine (112 practitioners).

Sub-specialties of the specialty of paediatrics and child health, namely the sub-specialties of paediatric clinical pharmacology (one practitioner) and paediatric nephrology (one practitioner), were the smallest groups of specialist registrations within a specialty.

See *Table A6* in the Appendix for a full breakdown of health practitioners with specialties.

Applications for registration

In 2011/12, AHPRA received 79,355 applications for registration across all professions. The highest number of applications was received from nurse and midwifery applicants, with 43.8% or 34,793 applications. This was followed by medicine with 18% or 14,331 applications; psychology with 5.48% or 4,348 applications; pharmacy with 4.7% or 3,728 applications; dental with 2.87% or 2,281 applications; physiotherapy with 3.1% or 2,434 applications; chiropractic with 0.64% or 507 applications; podiatry with 0.5% or 409 applications; optometry with 0.35% or 280 applications; and osteopathy with 0.27% or 219 applications.

Of these applications, 20.2% or 16,025 were received from practitioners from the four new professions entering the National Scheme from July 1012 (see page 19). There were 4,804 applications received from Chinese medicine practitioners; 4,567 from medical radiation practitioners; 6,628 from occupational therapy practitioners; and 26 from Aboriginal and Torres Strait Islander health practitioners.

See *Table A7* in the Appendix for a breakdown of applications for registration received by type and state/territory.

Notifications

The core role of the National Boards and AHPRA is to protect the public and facilitate public access to health services in the public interest. One of the ways in which the National Boards act to protect the community is by investigating concerns raised about individual practitioners. When necessary, this can involve restricting the registration of practitioners who have been found to have engaged in unprofessional conduct or unsatisfactory professional performance; or managing practitioners, through health programs, when their health is impaired and may place the public at risk.

The National Boards are 'notified' of an issue. The word 'notification' is deliberate and reflects that a board is not a complaints resolution agency. It is a protective jurisdiction. The role of the National Scheme is to protect the public by dealing with practitioners who may be putting the public at risk as a result of their conduct, professional performance or health.

Notifications are dealt with by the National Boards through formal delegations to their committees, and working with AHPRA state and territory offices. For medicine, nursing and midwifery, and physiotherapy, notifications are dealt with by state or territory boards in each jurisdiction. For psychology, notifications are dealt with through regional boards which combine states and territories. For chiropractic, dental, optometry, osteopathy, pharmacy and podiatry, notifications are dealt with through national or regional notifications committees.

In NSW, notifications are dealt with by separate health professional councils (which are supported by the Health Professional Councils Authority (HPCA)) and the Health Care Complaints Commission (HCCC).

See www.hpca.nsw.gov.au or www.hccc.nsw.gov.au for further information.

Who can make a notification?

Anyone can make a notification to AHPRA, which receives it on behalf of a board. There are two types of notifications: mandatory (under section 140 of the National Law) and voluntary (under sections 144 and 145 of the National Law). More detail and data on mandatory notifications can be found from page 93.

While registered health practitioners, employers and education providers may have mandatory reporting obligations imposed by the National Law, the majority of reports made to AHPRA are voluntary.

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

The National Law provides protection from legal liability for anyone who makes a notification in good faith.

Case study: notifications

A registered nurse recorded an abnormal observation of a patient, noting that the oxygen saturation level was 80%. The practitioner took no further action to alert a supervisor or doctor of this observation. The practitioner did not apply oxygen therapy to the patient.

The patient reported chest pain to another nurse approximately 2.5 hours later. The nurse noted the oxygen saturation level and applied oxygen therapy. The patient went on to have a cardiac event.

On hearing about this matter, the Nursing and Midwifery Board of Australia was concerned about the registered nurse's safety to practice and used its powers under the National Law to order the practitioner to 'show cause' why she should not have her registration limited in some way to protect the public, pending a further investigation.

When responding to the Board's order to 'show cause', the registered nurse referred to the patient's age to explain why her actions were appropriate in the circumstances. She said her notes also stated that the patient's oxygen level was actually 86%.

However, the Board was not persuaded that the practitioner accepted the gravity of her failure to act. The practitioner worked unsupervised in a nursing home.

The Board's Immediate Action Committee formed the belief that the performance issues identified in the notification indicated that the practitioner posed a serious risk, and found it was necessary to take immediate action to place conditions on her registration to protect public health or safety.

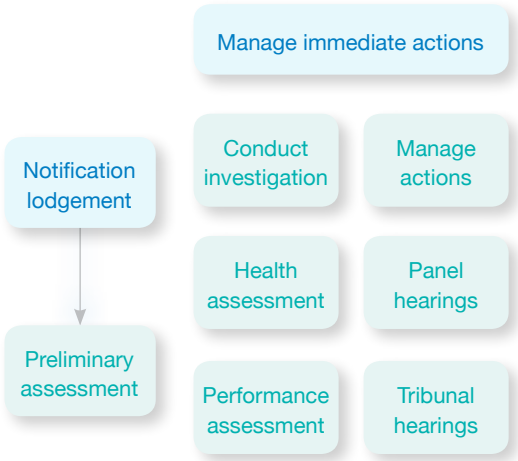
Conditions on practice were placed on the registered nurse's registration and published on the national register, restricting her to providing clinical care only under the indirect onsite supervision of a suitably qualified registered nurse. An approved supervisor is to provide supervision reports to the Board.

Grounds for voluntary notifications

Grounds (or reasons) for voluntary notifications about registered practitioners include that:

- the practitioner's professional conduct is, or may be, of a lesser standard than that expected by the public or the practitioner's professional peers
- the knowledge, skill or judgement possessed, or care exercised by the practitioner is, or may be, below the standard reasonably expected
- the practitioner is not, or may not be, a suitable person to hold registration
- the practitioner has, or may have, an impairment
- the practitioner has, or may have, contravened the National Law
- the practitioner has, or may have, contravened a condition of his or her registration or an undertaking given to the Board, and/or
- the practitioner's registration was, or may have been, obtained improperly.

Notifications process – stages



The stages in the notifications process do not necessarily apply to all notifications and are not completed in a linear sequence. In complex cases, a notification can be involved in more than one stage at the same time.

Preliminary assessment

AHPRA and the National Boards take all notifications seriously. After AHPRA receives a notification, a preliminary assessment is conducted to decide whether or not:

- the notification relates to a registered practitioner
- the notification relates to a matter that is a ground for notification, and
- it is a notification that could also be made to a health complaints entity.

The National Boards also have the power to consider taking immediate action to limit a practitioner's registration if it believes there may be a serious risk to the health and

safety of the community. More detail on this can be found on page 85.

In deciding that a matter is grounds for a notification, a board can consider a single notification or a number of notifications that suggest a pattern of conduct. A board can also consider notifications made to a health complaints entity.

If the notification relates to a health practitioner from NSW, it is passed directly to the NSW HCCC for action. The National Boards and AHPRA have no role in relation to handling notifications in NSW.

Relationship with the health complaints entities

The National Law requires the National Boards and the relevant health complaints entity in each state and territory to share complaints and notifications and try to agree on how to deal with each complaint or notification. If the health complaints entity and the board cannot agree, the most serious action proposed must be taken.

The health complaints entities in each state and territory are:

- Australian Capital Territory Human Rights Commission
- New South Wales Health Care Complaints Commission (HCCC)
- Northern Territory Health and Community Services Complaints Commission
- Queensland Health Quality and Complaints Commission
- South Australia Health and Community Services Complaints Commissioner
- Tasmania Health Complaints Commissioner
- Victoria Office of the Health Services Commissioner
- Western Australia Health and Disability Services Complaints Office.

AHPRA has worked with the health complaints entities across Australia to develop an MoU which sets out roles, responsibilities and ways of working. The MoU is available on the AHPRA website at www.ahpra.gov.au.

Board can decide to take no further action

A board may decide to take no further action in relation to a notification if:

- the board believes the notification is frivolous, vexatious, misconceived or lacking in substance, or
- it is not practicable for the board to investigate or deal with the notification, given the amount of time that has elapsed since the matter that is the subject of the notification occurred, or
- the person to whom the notification relates has not been, or is no longer, registered and it is not in the public interest to investigate or deal with the notification, or
- the subject matter of the notification has already been dealt with adequately by the board, or
- the subject matter of the notification is being dealt with, or has already been dealt with, adequately by another entity.

The decision to take no further action can be made at any time during the assessment or investigation of a notification, but only after careful consideration of the issues raised.

A decision by a board to take no further action in relation to a notification does not prevent the board or a tribunal (the independent authority in the courts system in each state and territory) taking the notification into consideration at a later time, as part of a pattern of conduct or practice by the practitioner. The board analyses the concerns raised in all types of notifications and uses this information to help educate the profession and share the lessons from the concerns raised.

Investigations

A board may decide to investigate a registered practitioner if it believes that:

- the practitioner has, or may have, an impairment, or
- the way the practitioner practises is, or may be, unsatisfactory, or
- the practitioner's conduct is, or may be, unsatisfactory.

A board may also investigate to ensure that a practitioner is complying with conditions imposed on his or her registration, or an undertaking given by the practitioner to the board.

The investigation is conducted by an investigator appointed by the board, usually an AHPRA staff member.

How the investigation is conducted depends on the facts of the case. It will usually involve the investigator seeking extra information to inform the board's decision. This may include:

- further information from the person who raised their concern with the board (the notifier)

- responses and explanations from the practitioner about whom the notification was made
- examination of patient records
- information from other practitioners involved in the care of the patient or client
- information from other relevant people (family members/receptionist)
- expert opinions
- police reports, and/or
- data from other sources such as pharmacy records, Medicare Australia, and so on.

In almost every case, practitioners and students who are being investigated will know about the investigation. They are given notice of the investigation and information about what is being investigated. The only exceptions are when a board believes that giving notice may seriously prejudice the investigation, or may place someone's health or safety at risk, or may place someone at risk of harassment or intimidation.

After analysing the facts of the case, the investigator prepares a report for the board's consideration.

Case study: notifications

A practitioner came to the National Board's attention due to an alcohol abuse disorder. A health assessment required by the Board indicated that he was not fit to practise as he suffered from brain damage, and was not engaging in appropriate treatment.

Reports provided to the Board from the practitioner's treating psychiatrist revealed that the practitioner had been hospitalised for alcohol abuse, had significant brain damage and was not fit to practise. The Board had requested an independent health assessment and the health assessor's report confirmed that the practitioner was unfit to practise. The assessor noted that the practitioner had commenced making house calls after his discharge from hospital.

Exercising its power under section 178 of the National Law, the Board suspended the practitioner's registration in a 'show cause' process and referred the matter to the tribunal for hearing. This suspension was published on the register.

Health assessment

A board may require a practitioner to undergo a health assessment if it believes that the practitioner may have an impairment.

The health assessment is conducted by an experienced and appropriately-qualified, independent practitioner. The board pays for the assessment and the assessor writes a report for the board. The practitioner who was assessed is given a copy of the report, unless the report contains information that may be prejudicial to his or her health or wellbeing, in which case it is given to a medical practitioner or psychologist nominated by the practitioner.

After receiving the report, the practitioner who was assessed must discuss the report, and ways of dealing with any adverse findings, with a person nominated by the board.

Performance assessment

Performance assessment allows a board to determine whether or not a practitioner is performing satisfactorily. It acknowledges that practitioners do not generally perform unsatisfactorily intentionally and the cause of unsatisfactory professional performance is usually a combination of lack of knowledge, skill and experience, as well as systemic and personal factors.

Performance assessment is a supportive process that does not intend to punish the practitioner. However, outcomes can have a high impact and require significant action on the part of the practitioner. It is an alternative approach to the traditional disciplinary model. It identifies strengths and weaknesses in professional practice and is tailored to individual practitioners and practice settings. It is designed to address patterns of practice rather than one-off incidents.

A board may require a practitioner to undergo a performance assessment if it believes that the way the practitioner practises the profession is, or may be, unsatisfactory. Performance assessments will usually be conducted by two (or more) independent practitioners who have the expertise to assess a practitioner in a particular field of practice. The board pays for the assessment and the assessors write a report.

The practitioner who has been assessed is given a copy of the report, unless it contains information that may be prejudicial to his or her health or wellbeing.

After receiving the report, the practitioner who was assessed must discuss the report, and ways of dealing with any adverse findings, with a person nominated by the board, who must be a registered practitioner.

Case study: performance assessment

A practitioner, a rural optometrist, was the subject of a number of notifications over a period of about two years. The issues identified were:

- *poor quality clinical notes and inadequate retention of clinical information*
- *possible deficits in clinical assessment, and*
- *possible deficits in professional communication with clients.*

The Registrations and Notifications Committee of the Optometry Board of Australia determined that the practitioner undergo a performance assessment. This matter required the practitioner's privacy and professional reputation to be protected, while ensuring the protection of the public through a thorough and objective assessment of clinical performance.

Due to the rural nature of the practitioner's practice, an interstate assessor was appointed who performed the assessment at the practitioner's principal place of practice. The assessment consisted of direct observation of clinical consultations and review of a random sample of client case notes from the preceding six months.

The assessment found that the practitioner had identified and successfully addressed several practice model issues which had been impacting on clinical practice. These mainly related to the retail aspect of optometry and the institution of a comprehensive record keeping system which also encompassed appropriate retention and disposal schedules.

The practitioner was also able to demonstrate thorough and efficient clinical assessment techniques and appropriate rationales for prescribing or referring, across a range of clients; communication with a range of clients, including the elderly, young children and persons from various ethnic backgrounds; and the use appropriate professional referral networks and collegial engagement. The practitioner had reflected on their practice and instituted strategies to address deficiencies.

As a result, the Board determined that no further action was required and the matter was closed.

Actions a board can take

A board has the power to take a range of actions at any time after receiving a notification or after an investigation or a health or performance assessment.

These actions include:

- a decision to take no further action, or
- referral to another entity such as a health complaints entity.

If a board believes that a practitioner's conduct or performance was unsatisfactory, or his or her health was impaired, it can:

- caution the practitioner, and/or
- accept an undertaking from the practitioner, and/or
- impose conditions on registration.

Alternatively, a board may decide to refer matters to:

- A panel, which can be:
  - > a health panel, or
  - > a performance and professional standards panel.
- A tribunal. There are tribunals in each state and territory:
  - > Australian Capital Territory Civil and Administrative Tribunal
  - > Northern Territory Health Professional Review Tribunal
  - > Queensland Civil and Administrative Tribunal
  - > South Australian Health Practitioners Tribunal
  - > Tasmanian Health Practitioners Tribunal
  - > Victorian Civil and Administrative Tribunal
  - > State Administrative Tribunal (Western Australia).

  The NSW Health Professional Councils can refer matters to the following tribunals:
  - > Chiropractic Tribunal of New South Wales
  - > Dental Tribunal of New South Wales
  - > Medical Tribunal of New South Wales
  - > Nursing and Midwifery Tribunal of New South Wales
  - > Optometry Tribunal of New South Wales
  - > Osteopathy Tribunal of New South Wales
  - > Pharmacy Tribunal of New South Wales
  - > Physiotherapy Tribunal of New South Wales

> Podiatry Tribunal of New South Wales

> Psychology Tribunal of New South Wales.

All notifications received by the National Boards and AHPRA are treated seriously and managed in line with legal requirements and due process, including confidentiality, privacy and natural justice provisions. More detail about the steps in an investigation is published on the AHPRA website at www.ahpra.gov.au.

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 health or safety of the public because of a practitioner's conduct, performance or health.

Immediate action means:

- suspension or imposition of a condition on the registration of a practitioner or student, or
- accepting an undertaking from the practitioner or student, or
- accepting the surrender of the registration of the practitioner or student.

Before taking immediate action, the board must give the registrant notice of the proposed immediate action and invite the registrant to make submissions to the board.

The board must then have regard to any submissions made when deciding whether or not to take immediate action.

2011/12 notifications

We have continued our focus on implementing nationally-consistent processes for managing notifications about practitioners' conduct, performance or health Australia-wide. A program of work involving notifications staff across AHPRA has culminated in a comprehensive set of updated guidance and tools for managing notifications (see page 57 for further details).

The data published in this annual report detail the notifications received in the National Scheme from 1 July 2011 to 30 June 2012. The notifications relate to the conduct, performance and health of more than 548,000 practitioners registered under the National Scheme.

Context

During the second year of the National Scheme, AHPRA and the National Boards have continued to manage notifications made since the start of the National Scheme, as well as the diminishing number of 'legacy' notifications made to state and territory boards before 1 July 2010, which transferred as ongoing cases into the National Scheme.

The 'legacy' notifications must be handled in ways consistent with the legislation previously in place in each state and territory. The exception is South Australia, where the law requires all continuing matters to be dealt with under the National Law, except those which were the subject of formal proceedings before a board or tribunal.

Outside South Australia, managing these legacy matters involves 65 different acts of parliament, each with different investigative requirements, possible outcomes and sanctions. As a result, this annual report provides only general information about the actions of the boards in managing legacy notifications during 2011/12.

NSW is a co-regulatory jurisdiction. Notifications in NSW are handled by the HCCC and the NSW health professional councils supported by the HPCA. Data on notifications have been provided by the HPCA, wherever comparable data are available, to enable AHPRA to present a high-level, Australia-wide picture of 2011/12 notifications. Information about notifications in NSW is published by the HPCA and the HCCC. Some detailed analysis of notifications data managed by AHPRA and the National Boards in this annual report does not include analysis of NSW cases. Each table indicates whether or not NSW data are included. AHPRA and the HPCA continue to work jointly to align data and definitions for future national reporting purposes.

In this second year of operation, the report is able to include comparative data for 2010/11 to enable trend analysis (noting that where state-based data are provided for 2010/11, the first year of the National Scheme in WA was less than a full calendar year, with WA entering the scheme on 18 October 2010).

AHPRA has an extensive program of work underway to ensure that common definitions and data sets are applied across AHPRA's work on notifications and to support comparability of data across time. This has resulted in some tightening of the reporting data this year, and means there is not always direct comparability between years. A significant change is the exclusive focus on notifications in the data, whereas the 2010/11 data included some inquiries that did not result in notifications. A new typology to categorise the issue leading to a notification was also introduced in the 2011/12 year. This more accurately describes the range of issues underpinning notifications.

With the second year of operation under the National Law, a more comprehensive national picture of notifications and outcomes under the National Law is emerging. The HPCA in NSW has provided more extensive data about

notifications about NSW practitioners than was possible in 2011. This has enabled a national snapshot to be presented. Although notifications about practitioners in NSW are managed separately, the standards set by the National Boards also apply in NSW, so the expectations of practitioners are consistent across Australia.

Highlights

The overall pattern of voluntary notifications appears to be broadly consistent with the previous year, with some variability within professions. There has been an increase in mandatory notifications.

There were 7,594 notifications received about health practitioners between 1 July 2011 and 30 June 2012 (compared to 8,139 received during 2010/11). However, the year-on-year data set is not directly comparable. In 2011/12, more than 580 inquiries that did not ultimately progress to become formal notifications were recorded and reported. There were also more than 400 complaints received during the year in relation to advertising breaches, some of which were included in the 2011 notifications data. This year, these categories are not included. Concerns about advertising are reported separately (see page 73).

Strengthening in AHPRA's IT and software platforms, along with staff training and initiatives supporting national consistency, are enabling more specific data entry and therefore will enable more accurate future comparisons.

The notifications received relate to 1.2% of the 548,528 health practitioners registered under the National Scheme as at 30 June 2012. *Table 8: Notifications received in 2011/12 by profession and state or territory* details these.

There was a 40% increase in the number of mandatory notifications made during the year. There is substantial variation in the rate of mandatory reporting between states and territories, and across professions. For the first time, mandatory reporting data for NSW are included in this year's report. This means direct year-on-year comparisons are not possible at this time.

The National Law gives the National Boards flexibility in managing notifications and in the options available to safeguard the public. The data on closed notifications indicate that boards are starting to apply these options in dealing with the notifications and in making decisions to safeguard the public.

Medical practitioners continue to be a major focus of notifications in the National Scheme, which is unsurprising given the complexity of modern medicine. The proportion of practitioners in each profession who are the subject of a notification is broadly consistent with the previous year, except dental where there has been a decrease.

'Clinical care' is the issue most cited as the basis for the notifications. Broadly, the geographic distribution of notifications reflects the size and distribution of registrants across states and territories.

Table 8: Notifications received in 2011/12 by profession and state or territory[1]

Profession	ACT	NT	QLD	SA	TAS	VIC	WA[3]	2012 Sub Total[4]	NSW	2012 Total[4]	2011 Total[4]
Chiropractor	6	0	26	19	0	29	8	88	27	115	104
Dental practitioner	15	8	162	32	15	195	49	476	516	992	1,322
Medical practitioner	100	45	866	207	145	743	267	2,373	1,628	4,001	4,122
Midwife	3	0	34	2	0	2	9	50	1	51	62
Nurse	23	20	296	160	39	326	114	978	423	1,401	1,238
Optometrist	1	0	6	3	1	14	3	28	26	54	55
Osteopath	0	0	1	1	0	4	0	6	11	17	19
Pharmacist	13	1	57	16	9	88	32	216	171	387	419
Physiotherapist	4	4	15	13	0	20	5	61	27	88	111
Podiatrist	0	1	6	4	1	10	3	25	18	43	55
Psychologist	11	6	62	26	8	96	28	237	130	367	390
Not identified[2]	0	1	17	14	1	44	1	78		78	242
2012 Total	176	86	1,548	497	219	1,571	519	4,616	2,978	7,594	
2011 Total	175	108	1,924	771	230	1,712	377	5,297			8,139

1. Based on the state and territory where the notification is handled for registrants who do not reside in Australia.
2. Profession of registrant is not always identifiable in the early stages of a notification.
3. 2011 data for WA are from 18 October 2010 when WA joined the National Scheme.
4. Data for 2011 include some inquiries and some advertising complaints. Data for 2012 include only notifications.

Table 9: Percentage of registrant base with notifications received in 2011/12 by profession and state or territory[1]

Profession	ACT	NT	QLD	SA	TAS	VIC	WA [3]	2012 Sub Total	NSW	2012 Total	2011 Total
Chiropractor	8.9%	0.0%	3.6%	2.8%	0.0%	1.8%	1.6%	2.4%	1.4%	2.0%	1.8%
Dental practitioner	3.7%	2.2%	3.7%	1.9%	3.6%	4.0%	1.9%	3.3%	6.0%	4.1%	5.8%
Medical practitioner	4.9%	4.7%	4.2%	2.7%	6.1%	2.8%	2.7%	3.4%	4.0%	3.5%	4.0%
Midwife[2]	0.4%	0.0%	0.5%	0.1%	0.0%	0.0%	0.3%	0.2%	0.0%	0.1%	0.1%
Nurse[3]	0.4%	0.5%	0.5%	0.5%	0.5%	0.3%	0.3%	0.4%	0.5%	0.4%	0.3%
Optometrist	1.4%	0.0%	0.6%	1.3%	1.2%	1.0%	0.8%	0.9%	1.7%	1.2%	1.1%
Osteopath	0.0%	0.0%	0.7%	3.4%	0.0%	0.4%	0.0%	0.4%	1.4%	0.7%	1.0%
Pharmacist	2.9%	0.5%	1.0%	0.8%	1.4%	1.2%	1.1%	1.1%	1.2%	1.1%	1.4%
Physiotherapist	0.9%	2.8%	0.3%	0.6%	0.0%	0.3%	0.2%	0.4%	0.3%	0.3%	0.5%
Podiatrist	0.0%	5.9%	0.8%	1.1%	1.1%	0.8%	0.8%	0.9%	2.4%	1.3%	1.4%
Psychologist	1.3%	2.8%	1.1%	1.6%	1.3%	1.0%	0.9%	1.1%	1.0%	1.0%	1.2%
2012 Total	1.7%	1.4%	1.4%	1.0%	1.6%	1.0%	0.9%	1.1%	1.5%	1.2%	
2011 Total	2.0%	2.0%	1.6%	1.5%	1.6%	1.0%	0.6%		1.5%		1.3%

1. Percentages for each state and profession are based on registrants whose profession has been identified and whose principal place of practice is an Australian state or territory. Notifications when the profession of the registrant has not been identified and registrants whose principal place of practice is not in Australia are only represented in the state and profession totals above.
2. The registrant base used for midwives includes registrants with midwifery or with nursing and midwifery registration.
3. The registrant base for nurses includes registrants with nursing registration or with nursing and midwifery registration.

National Law: Notifications received

Just more than half of the notifications (4,001) in the National Scheme were received about medical practitioners, who represent 17% of registered health practitioners.

Notifications about nurses/midwives account for 19% of the total notifications made during the year, with 1,452 notifications about nurses and midwives, who represent 63% of registered practitioners. This is an increase of 12% compared to the previous year.

Notifications about dental practitioners accounted for 13% (992 notifications), which represents 3.5% of registered practitioners. This is a decrease in the relative number of notifications against dental practitioners compared to the previous year. Dental practitioners include dentists, dental therapists, dental hygienists, dental prosthetists and oral health therapists.

The smallest number of notifications received in 2011/12 involved osteopaths (17 notifications), which is the regulated profession with fewest registrants (1,676 practitioners).

In 2011/12, NSW was the state that recorded the highest number of notifications (2,978), and is the state which the highest percentage of practitioners cited as their principal place of practice. This excludes the professions of midwifery, osteopathy and podiatry, in which there are more registered practitioners based in Victoria than in NSW.

The Northern Territory recorded the fewest notifications (86 notifications) in 2011/12 and is the jurisdiction with the smallest number of health practitioners across all professions excluding midwifery.

Proportion of registrants subject to a notification

Table 9: Percentage of registrant base with notifications received in 2011/12 by profession and state or territory shows for each profession the percentage of registered health practitioners for whom a notification has been received nationally. The proportions are generally consistent with the patterns from 2010/11.

Dental practitioners recorded the highest proportion of notifications in 2011/12 relative to the number of registrants, with notifications relating to 4.1% of the dental registrant base. This is lower than the previous year. For the medical profession, there were notifications relating to 3.5% of the registrant base. For all other professions, except the chiropractic profession, notifications against practitioners represent less than 1.3% of the registrant base; for chiropractic, notifications received relate to 2% of the registrant base.

Table 10: Notifications received in 2011/12 by profession and stream (including NSW data) [1,2]

	Conduct		Health		Performance		Not recorded[3]		2012 Total		2011 Total	
Profession	National (excl. NSW)	NSW	National (excl. NSW)	NSW	National (excl. NSW)	NSW	National (excl. NSW)	NSW	National (excl. NSW)	NSW	National (excl. NSW)	NSW
Chiropractor	70	18	3		15	9			88	27	75	29
Dental practitioner	293	124	9	3	172	389	1		476	516	653	669
Medical practitioner	1,372	327	131	113	862	1,140	2	48	2,373	1,628	2,667	1,455
Midwife	21		11		18	1			50	1	51	11
Nurse	568	167	224	84	183	172	2		978	423	905	334
Optometrist	20	4	1		7	22			28	26	28	27
Osteopath	5	7	0		1	4			6	11	12	7
Pharmacist	156	55	10	4	49	112			216	171	281	138
Physiotherapist	38	8	7	2	16	17			61	27	76	38
Podiatrist	21	7	1	1	3	10			25	18	33	23
Psychologist	200	67	13	12	24	51			237	130	274	116
Not stated	65		5		8		9		78		242	0
2012 Total	2,829	784	415	219	1,358	1,927	14	48	4,616	2,978		
2011 Total	3,672		319		1,306						5,297	2,847

1. Part 8 of the Health Practitioner Regulation National Law, as in force in each state and territory, provides for notifications related to health, performance or conduct.
2. NSW data are identified in separate columns.
3. The stream for the notifications has not always been recorded.

Reasons for the notifications

National Boards are responsible for overseeing investigations about the conduct, health and performance of Australia's registered health practitioners, except in NSW. AHPRA categorises all notifications into one of these streams.

In 2011/12, AHPRA received 4,616 notifications about the conduct, health and performance of practitioners across professions and states and territories, excluding NSW. As in the previous year, the majority of these notifications relate to practitioner conduct:

- 2,829 notifications received related to the conduct of health practitioners
- 415 notifications received related to the health of health practitioners, and
- 1,358 notifications received related to the performance of health practitioners.

Table 10: Notifications received in 2011/12 by profession and stream provides a breakdown of these data by profession. This table also provides comparative data for NSW.

Types of concerns

In the first 12 months of the National Scheme, AHPRA applied a classification system to categorise the issues of concern identified by the person making a notification, which was generally consistent with the classification system used by health complaints entities in Australia. In early 2011, AHPRA and the National Boards developed a new classification system for notifications that reflects more accurately the issues of concern about health practitioners that are notified to the Boards. This new classification system has been in use throughout 2011/12 and provides the basis for this report. The HPCA in NSW has also adopted this classification system, with some modifications, and the NSW data is also provided. *Table A8: Notifications received in 2011/12 by profession and issue category* in the Appendix provides details of the issues category relating to notifications received in 2011/12, by profession.

The 4,616 notifications lodged during 2011/12 span all issue categories across all professions.

Notifications received by AHPRA were most commonly about clinical care (1,774 notifications). Other areas of concern include communication (303 notifications), health impairment of the practitioner (412 notifications) and pharmacy/medication (373 notifications).

Who made notifications?

Anyone can make a notification to AHPRA, which receives it on behalf of the National Boards. While registered health practitioners, employers and education providers have mandatory reporting obligations required by the National

Table 11: Notifications lodged under the National Law and closed in 2011/12 by profession and state or territory (including NSW data)

Profession	ACT	NT	QLD	SA	TAS	VIC	WA	2012 Sub Total	NSW	2012 Total	2011[2] Total
Chiropractor	1	-	19	9	-	25	6	60	28	88	31 (27)
Dental practitioner	21	6	146	43	13	146	35	410	455	865	735 (651)
Medical practitioner	101	47	685	200	126	588	180	1,927	1,452	3,379	2,359 (1,503)
Midwife	3	1	18	2	-	5	4	33	5	38	16 (19)
Nurse	19	23	152	162	27	216	59	659	354	1,013	554 (311)
Optometrist	1	-	6	4	2	12	2	27	23	50	37 (22)
Osteopath	-	-	-	1	-	2	-	3	7	10	8 (7)
Pharmacist	4	1	31	15	4	64	18	137	150	287	203 (159)
Physiotherapist	3	4	14	7	1	19	5	53	26	79	64 (40)
Podiatrist	-	1	5	2	1	10	2	21	15	36	36 (21)
Psychologist	13	5	53	15	5	75	18	184	119	303	180 (108)
Not stated[1]	-	1	18	11	1	29	1	61		61	65
2012 Total	166	89	1,148	471	180	1,191	330	3,575	2,634	6,209	
2011 Total	21	27	805	376	137	839	76	2,281	2,007		4,288 (2,868)

1. Practitioner profession may not have been identified in early stages of a notification.
2. 2011 NSW data are provided in brackets ().

Law, the majority of reports are voluntary. The National Law provides protection from legal liability for persons who make a notification in good faith. Privacy obligations under the National Law prevent the identification of notifiers who report concerns about health practitioners' conduct, health or performance.

In 2011/12, the largest number of notifications received by AHPRA (1,525 notifications or 33%) and excluding NSW came directly from the community (patients, relatives or the public). A total of 1,250 notifications (27%) across all professions were received from health complaints entities (HCEs) in each state or territory, reflecting the joint consideration of notifications between the National Boards and HCEs in the National Scheme. The HCEs were not the primary source of the concern. Data on the source of notifications are provided in *Table A9*: *Notifications received in 2011/12 by profession and notification source* (in the Appendix) and includes information about the source of notifications received in the NSW jurisdiction.

National Law: Notifications closed in 2011/12

Table 11: Notifications lodged under the National Law and closed in 2011/12 by profession and state or territory details by jurisdiction and profession the number of notifications under the National Law that were finalised and closed. Matters managed in NSW that were closed in 2011/12 are included in this table.

In relation to AHPRA managed notifications, the 3,575 notifications closed in 2011/12 represent an increase of 57% on the number closed in 2010/11 (2,281). This is consistent with the second year of operation of the National Scheme as the volume of 'legacy' notifications decreases and the number of National Law notifications increases. The closures relate to both notifications received in the current financial year and some received in the previous year.

Managing notifications: Stage at closure

Table 12: National Law notifications closed in 2011/12 by profession and stage at closure shows the stage of closure for notifications received by AHPRA.

During the year, there were five stages in managing a notification (matter). These include assessment, investigation, health or performance, panel and tribunal. Under the National Law, a National Board has the power to decide no further action is required at any stage during the assessment or investigation of a notification. A matter can also be closed at any stage, and can be closed after a range of actions has been taken or sanctions applied.

Assessment

An assessment determines whether an investigation is warranted, or if another course of action is more appropriate. This assessment usually includes a review of the substantive issues involved, made after further information which may be necessary (and which can be sought at this stage under the National Law) has been sought from both the notifier and the practitioner. Matters closed at this stage usually do not reach the threshold

Table 12: National Law notifications closed in 2011/12 by profession and stage at closure (including NSW data)[1]

Profession	Assessment		Investigation		Health or performance assessment		Panel hearing		Tribunal hearing		Total 2012		Total 2011[2]
	National (excl. NSW)	NSW	National (excl. NSW)	NSW	National (excl. NSW)	NSW	National (excl. NSW)	NSW	National (excl. NSW)	NSW	National (excl. NSW)	NSW	
Chiropractor	37	21	19	7	1		2		1		60	28	18
Dental practitioner	272	356	113	2	5	64	19	32	1	1	410	455	263
Medical practitioner	1,389	1,113	438	29	62	206	29	82	9	22	1,927	1,452	1,284
Midwife	25	2	7	1	1	2					33	5	13
Nurse	352	199	209	78	70	59	19	15	9	3	659	354	346
Optometrist	17	22	8		1		1			1	27	23	15
Osteopath		4	3	3							3	7	3
Pharmacist	77	138	44	5	4	3	11	4	1		137	150	115
Physio-therapist	29	25	22		1	1			1		53	26	33
Podiatrist	11	11	7	3	1	1	2				21	15	19
Psychologist	119	87	52	19	4	9	9	4			184	119	107
Not identified	61		-								61		65
Total 2012	2,389	1,978	922	147	150	345	92	137	22	27	3,575	2,634	
Total 2011[2,3]	1,644		216		41		8		7				2,281

1. 2012 NSW data are provided in identified columns.
2. 2011 Total does not include NSW.
3. The 2010/11 annual report included details of 365 cases closed at the 'lodged' stage. These were inquiries which are not included in the 2011/12 figures.

under the National Law for potential unsatisfactory professional conduct. Of the total number of notifications closed in 2011/12, the majority (2,389) were closed after assessment.

Investigation

At the end of an investigation, a board has a range of options, including whether to take no further action, or to refer a matter to a panel or tribunal hearing. Outcomes from closure at this stage of the process can include undertakings, cautions and conditions on registration, as well as no further action. There were 922 notifications in 2011/12 closed by a National Board at the end of this stage.

Health or performance assessment

Matters can be closed after a National Board has referred a practitioner for a health or performance assessment. In 2011/12, 150 notifications were closed by a National Board at this stage.

Panel and tribunal hearings

Under the National Law, allegations about the most serious unprofessional conduct, health or performance can be referred for hearing by panels or tribunals. Allegations of the most serious unprofessional conduct are often the most complex and take the most time to investigate. In 2011/12, 92 notifications were closed by a National Board following a panel hearing and 22 after a tribunal hearing.

Outcomes: Closed notifications

There are different outcomes for different notifications. Most do not lead to a restriction on a practitioner's registration. However, the fact that a notification has been made in many cases indicates that not everything has gone well for the notifier in the consultation. In most cases, the boards inform practitioners that notifications have been made about them so they can learn from the experience and, where necessary, can alter the way they practise so that other patients do not face the same issues in the future.

When deciding to close a matter, a board has a number of options, including:

- referring all or part of the notification to another body; this usually involves matters over which the board does not have jurisdiction under the National Law
- no further action; a board can decide to take no further action at any time during the assessment or

investigation of a notification, but only after careful consideration of the issues raised

- accepting an undertaking, when a practitioner agrees to specific limitations or restrictions on practice; undertakings are recorded on the national register in accordance with the National Law and the practitioner is subject to monitoring to ensure compliance
- issuing a caution to the practitioner to practise in a particular way
- issuing a reprimand to the practitioner; a reprimand is a chastisement for conduct– a formal rebuke.
- imposing conditions limiting the practice of the practitioner; the existence of conditions are recorded under the practitioner's name on the national register in accordance with the National Law and the practitioner is subject to monitoring to ensure compliance, or
- suspending registration though immediate action; a power which a board may use at any time under the National Law if it has evidence there is a serious risk to the health and safety of the public. A board's decision to take immediate action, to impose conditions or suspend a practitioner's registration is a serious interim action to protect the health or safety of the public. Only a tribunal has the power to apply a long-term suspension or cancellation of a practitioner's registration.

Table 13 provides details by profession of the outcome at closure for notifications closed in 2011/12. Data for NSW are provided in *Table 14*.

In most cases (2,868 cases or 80%) managed by AHPRA, the National Board determined that no further action was required; compared to 86% last year. The proportion of cases closed with no further action remains relatively high. AHPRA and the National Boards will continue to closely monitor these data over the coming year to understand the contributing factors.

A board decision to take no further action is only made after careful consideration of the concerns raised. Under the National Law, a board can decide to take no further action in relation to a notification if:

- the board believes the notification is frivolous, vexatious, misconceived or lacking in substance, or
- it is not practicable for the board to investigate or deal with the notification, given the amount of time that has elapsed since the matter that is the subject of the notification occurred, or
- the person to whom the notification relates has not been, or is no longer, registered and it is not in the public interest to investigate or deal with the notification, or
- the subject matter of the notification has already been dealt with adequately by the board, or
- the subject matter of the notification is being dealt with, or has already been dealt with, adequately by another entity.

Under the National Law, the registration of 14 practitioners was suspended (11) or cancelled (three) in 2011/12 as a result of action by a panel or tribunal, or as a result of a health assessment; the surrender of registration was accepted for a further six practitioners. Suspensions as a result of immediate action taken by a National Board are summarised later in this section. Details about most restrictions placed on a practitioner's registration, including suspensions, conditions, undertakings and reprimands, are published on the register of practitioners. The only restrictions not usually published relate to conditions on a practitioner's registration related to their health.

The registration of a further 11 practitioners was cancelled as a result of 'legacy' notifications that transitioned into the National Scheme from previous state and territory boards in 2010.

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 health or safety of the public because of a practitioner's conduct, performance or health. Immediate action means:

- suspension or imposition of a condition on the registration of a practitioner or student, or
- accepting an undertaking from the practitioner or student, or
- accepting the surrender of the registration of the practitioner or student.

Before taking immediate action, a board must give the registrant notice of the proposed immediate action and invite him or her to make submissions to the board. The board must then have regard to any submissions when deciding whether or not to take immediate action.

The National Boards initiated immediate action in 251 matters during the year, not including NSW. In 196 (78%) of these cases, the practitioner's registration was restricted in some way as a result, usually pending the outcome of an investigation. When restricting a practitioner's registration, the National Law requires the National Boards to do as little as possible, and as much as needed to protect the public. The number of instances in which immediate action was initiated is more than the number of instances in 2010/11 (209 immediate action matters).

Table 13: National Law notifications closed in 2011/12 by outcome at closure (excluding NSW)[1]

Profession	No further action	Refer all or part of the notification to another body	Accept undertaking	Caution or reprimand	Impose conditions	Cancel registration	Accept surrender of registration	Suspend registration	2012 Total	2011 Total
Chiropractor	53	1		4	1			1	60	18
Dental practitioner	321	24	18	29	17			1	410	263
Medical practitioner	1,667	98	29	84	48		1		1,927	1,284
Midwife	26	2	1	3	1				33	13
Nurse	432	15	67	54	76	2	5	8	659	346
Optometrist	23	3			1				27	15
Osteopath	2		1						3	3
Pharmacist	76	2		53	5	1			137	115
Physiotherapist	40	2	2	8	1				53	33
Podiatrist	16		2	1	1			1	21	19
Psychologist	160	3	4	9	8				184	107
Not identified	52	9							61	65
2012 Total	2,868	159	124	245	159	3	6	11	3,575	
2011 Total	1,954	228	28	56	10			5		2,281

1. A matter may result in more than one outcome. Only the primary outcome from each closed notification has been noted.

Table 14: NSW jurisdiction notifications closed in 2011/12 by outcome at closure[1,2]

	Chiropractor	Dental practitioner	Medical practitioner	Midwife	Nurse	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Total
No further action	22	311	1,317	2	224	21	6	140	24	4	87	2,158
Discontinued	2		2		16					10		30
Withdrawn		21			8	1		3	1	1	1	36
Orders – no conditions		2	6		1			1				10
Caution		1	3									4
Reprimand			24		3							27
Impose conditions		10	72	2	40	1					10	135
Conditions by consent				1	1			2				4
Conditions removed			6									6
Restored			1									1
Refer all or part of the notification to another body	5	20	28		15		1	3	1		5	78
Resolution/conciliation by HCCC		45			7							52
Cancel registration			4		2		1					7
Suspend			3		2							5
Accept surrender of registration			6		8							14
Counselling	1				28						15	44
Fine			4									4
Refund/payment/withhold fee		45										45
2012 Total	30	455	1,476	5	355	23	8	149	26	15	118	2,660

1. NSW legislation provides for a range of different outcomes for notifications in NSW. Some of these map to outcomes available under the National Law; others are specific to the NSW jurisdiction.
2. A matter may result in more than one outcome. All outcomes from each closed notification have been noted.

Table 15: Immediate action cases (including NSW data)[1,2]

Profession	No action taken	Action taken					Total 2012	Total 2011
		Suspend registration	Accept surrender of registration	Impose conditions	Accept undertaking	Decision pending[3]		
Chiropractor	1			(1)			1 (1)	0 (2)
Dental practitioner	3	(1)	1	1 (2)	9		14 (3)	4 (6)
Medical practitioner	17 (6)	10 (11)	(9)	29 (20)	20	2	78 (46)	62 (53)
Midwife		3	1	2 (1)			6 (1)	3 (0)
Nurse	21 (5)	35 (2)		21 (42)	42	1	120 (49)	112 (49)
Optometrist								0 (1)
Osteopath								0 (3)
Pharmacist	1 (1)	1 (1)		8 (6)	3	2	15 (8)	14 (4)
Physiotherapist	3			1	1		5 (0)	4 (2)
Podiatrist	1	1		(1)			2 (1)	2 (3)
Psychologist	3	2		(2)	5		10 (2)	8 (4)
Total	50 (12)	52 (15)	2 (9)	62 (75)	80	5	251 (111)	
Total 2011	43 (7)	55 (29)	8 (3)	52 (85)	51 (3)			209 (127)

1. Cases where immediate action has been initiated under Part 8, Division 7 of the National Law.
2. NSW data on immediate action cases is provided in brackets ().
3. In these cases where immediate action was initiated towards the close of the reporting year, an outcome decision has not been finalised.

The majority of these related to the nursing profession (120 immediate action cases), followed by the medical profession (78 immediate action cases). This is consistent with the number of practitioners in each profession. *Table 15: Immediate action cases* details the action taken by the National Boards after considering immediate action. Data for NSW are also provided.

Mandatory notifications

Number of notifications

There were 775 mandatory notifications received in 2011/12, including NSW. Outside NSW, AHPRA received 589 mandatory notifications. In addition, 14 mandatory notifications were received about registered students. The overall number of mandatory notifications increased by about 40% compared with 2010/11 when 428 notifications were received.

More than 80% of mandatory notifications related to nurses (54%) or medical practitioners (28%). A further 6% of the notifications related to psychologists. The other mandatory notifications were spread across eight professions that each accounted for fewer than 5% of notifications.

Data on mandatory notifications received in the NSW jurisdiction are incorporated in the reporting tables for this year where available. Comparative data for NSW for the 2010/11 year are not provided.

Compared with last year, there was a decrease in the number of mandatory reports received in Victoria.

Increases in mandatory reports occurred in Queensland, ACT and the Northern Territory. While it is not clear why this is the case, AHPRA and the National Boards will continue to monitor this closely.

There is variation in the rate of mandatory notifications across the states and territories, and across professions. South Australia has the highest rate of mandatory notifications per 10,000 practitioners, with a rate of 24.8; whilst Victoria has the lowest rate at 7.5 per 10,000 practitioners. Amongst the professions, the medical profession has the highest notification rate at 22.3 per 10,000 practitioners on a national basis.

In 2011/12, the rate of mandatory notifications has been calculated based on the number of registrants involved in the notifications. The rate published in 2010/11 cannot be directly compared with the rates published here for 2011/12 as the 2010/11 data were based on rates of notifications and did not include any data for NSW. In 2011/12, in the National Scheme, there were 562 registrants involved in the 589 notifications received, and nationally (including NSW) there were 732 registrants involved in the 775 notifications received.

Table 16: Mandatory notifications received by profession and jurisdiction (including NSW data)

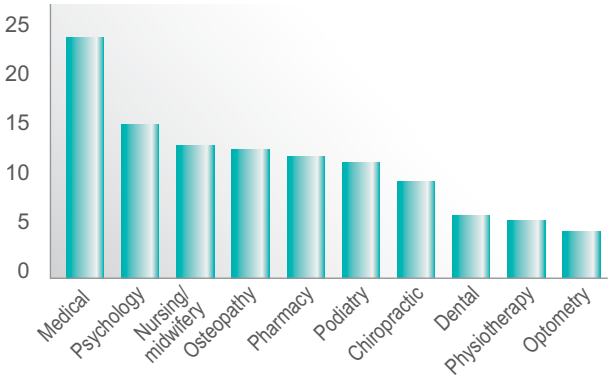
Profession	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total	NSW	Total
Chiropractor			3	1				4		4
Dental practitioner	1		6	2			1	10	1	11
Medical practitioner	10	4	68	22	8	25	12	149	72	221
Midwife			17	2			2	21		21
Nurse	11	7	129	77	8	72	38	342	79	421
Optometrist				1				1	1	2
Osteopath									2	2
Pharmacist	2		8	5	1	6	1	23	8	31
Physio-therapist		1	3	4		4		12	2	14
Podiatrist				2	1			3	1	4
Psychologist		1	11	6		4	2	24	20	44
Total 2012	24	13	245	122	18	111	56	589	186	775
Total 2011	7	3	85	121	15	164	33	428		

Table 17: Registrants involved in mandatory notifications by jurisdiction (including NSW data)

State	2011/12		2010/11	
	No. practitioners[1]	Rate / 10,000 practitioners[2]	No. notifications[3]	Rate / 10,000 practitioners[4]
Queensland	229	22.1	85	8.6
New South Wales	170	10.6	NA	NA
South Australia	115	24.8	121	27.3
Victoria	108	7.5	164	12
Western Australia	56	10	33	6.4
Australian Capital Territory	23	24	7	8.6
Tasmania	18	14.4	15	12.2
Northern Territory	13	23.3	3	6.3
Total Australia	732	13.3	428	8.1

1. Figures in this column present the number of practitioners involved in the mandatory reports received in 2011/12.
2. Practitioners with no PPP are not represented in the calculation of a rate for each state but are included in the calculation of the Total Australia rate.
3. The data for 2010/11 cannot be directly compared with the data for 2011/12 as they are based on the number of notifications, not the number of practitioners and do not include data for notifications received in NSW in that year.
4. Calculation of the rate in 2010/11 was based on the total number of registrants, including registrants in NSW.

Figure 3: Mandatory notifications per 10,000 practitioners (including NSW data)[1]



1. The chart presents the notifications rate per 10,000 practitioners based on the number of practitoners involved in notifications received in 2011/12, including NSW.

Table 18: Registrants involved in cases by profession (including NSW data)

Profession	2011/12						2010/11	
	National (excluding NSW)		NSW		National Total			
	No. practitioners[1]	Rate / 10,000 practitioners[2]	No. practitioners[1]	Rate / 10,000 practitioners[2]	No. practitioners[1]	Rate / 10,000 practitioners[2]	No. notifications[3]	Rate / 10,000 practitioners[4]
Nursing/ midwifery[5]	349	14.5	72	7.5	421	12.2	249	7.5
Medical	140	23	64	22.1	204	22.3	144	16.3
Psychology	23	11.9	19	18.9	42	14.2	9	3.1
Pharmacy	22	12.4	8	9.7	30	11.3	15	5.8
Physiotherapy	10	6.3	2	2.9	12	5.1	5	2.2
Dental	10	7.8	1	1.7	11	5.8	1	0.6
Chiropractic	4	13.9	0	0	4	9	-	-
Podiatry	3	11	1	10.6	4	10.8	-	-
Optometry	1	3.5	1	6.4	2	4.4	-	-
Osteopathy	0	-	2	39.2	2	11.9		
All professions	562	14.9	170	10.6	732	13.3	428	8.1

1. Figures present the number of practitioners involved in the mandatory reports received in 2011/12.
2. Practitioners with no PPP are not represented in the calculation of a rate for each profession but are included in the calculation of the rate for the national total.
3. The data for 2010/11 cannot be directly compared with the data for 2011/12 as they are based on the number of notifications, not the number of practitioners and do not include data for notifications received in NSW in that year.
4. Calculation of the rate in 2010/11 was based on the total number of registrants, including registrants in NSW.
5. Data on notifications for registered nurses and midwives have been combined and compared with the total registrant base across nursing and midwifery.

Reasons for mandatory notifications and source of report

The sources of mandatory notifications about registered practitioners were evenly divided between employers (49%) and practitioners (51%).

Table 19: Grounds for notifications: comparison with notifications received in prior financial year (including NSW data)

	2011/12				2010/11	
	National Scheme [1]	%	NSW [2]	%	National Scheme	%
Standards	315	62	83	48	253	59
Impairment	140	27	67	37	128	30
Alcohol or drugs	33	6	7	3	18	4
Sexual misconduct	24	5	24	12	29	7
Total	512	100	181	100	428	100

1. Grounds for notification not specified for 77 cases in the National Scheme in 2011/12.
2. Grounds for notification not specified in five cases in NSW in 2011/12.

The grounds (reason) for mandatory notifications were broadly consistent with the previous year. More than 60% of mandatory notifications were that a practitioner was placing the public at risk of harm due to practice that constituted a significant departure from accepted professional standards. About a quarter of notifications were based on concerns that a practitioner had an impairment that was placing the public at risk.

The number of notifications alleging that a practitioner had practised under the influence of alcohol or drugs increased from 18 reports in 2010/11, to 33 reports in the current reporting year. There were 24 mandatory notifications related to sexual misconduct in connection with practice; comprising 5% of the notifications received, down from 7% of notifications in the previous year.

Table 20 provides details of the grounds for notifications received in each profession. The pattern is relatively consistent across professions.

Table 20: Grounds for notification by profession (excluding NSW data)

Profession	Standards	Impairment	Alcohol or drugs	Sexual misconduct	Not classified	Total
Chiropractor	2	1			1	4
Dental practitioner	3	2	1	1	3	10
Medical practitioner	89	35	9	8	8	149
Midwife	7	4	1		9	21
Nurse	177	87	22	7	49	342
Optometrist	1					1
Pharmacist	17	5			1	23
Physiotherapist	9	1		2		12
Podiatrist	2			1		3
Psychologist	8	5		5	6	24
Total	315	140	33	24	77	589

Immediate action arising from mandatory notifications (including NSW data)

Immediate action was initiated in 100 of the 589 mandatory notification cases (17%), which is consistent with 2010/11.

Table 21: Immediate action arising from mandatory notifications (including NSW data)

	2011/12				2010/11	
Immediate action taken	National (excluding NSW)	%	NSW	%	National (excluding NSW)	%
No	489	83	154	83	355	83
Yes	100	17	32	17	73	17

Table 22: Outcomes from immediate action initiatives (including NSW data)

	Suspend registration	Impose conditions	Accept undertaking	Not take immediate action	Total
Dental practitioner	(1)	1(1)	1		2(2)
Medical practitioner	5(3)	7(2)	7	3(1)	22(6)
Midwife	2	2			4
Nurse	21(1)	12(19)	16	10(3)	59(23)
Pharmacist	1	3	2		6
Physiotherapist		1			1
Podiatrist	1			1	2
Psychologist	1	(1)	1	2	4(1)
Total	31(5)	26(23)	27	16(4)	100(32)

1. Data for NSW are provided in brackets ().

Immediate action by National Boards resulted in acceptance of an undertaking (27 cases), imposition of conditions (26 cases) and suspension of a practitioner's registration (31 cases). In 16 cases, the Board decided not to proceed with immediate action.

Outcome from assessment in mandatory reporting cases

Table 23: Outcome of assessment by grounds for the notification (excluding NSW data)

	End matter								
Grounds for notification	No further action [1]	Surrender of registration	Caution	Accept undertaking	Impose conditions	Refer to investigation	Refer to health or performance assessment	Refer to tribunal	Total [2]
Standards	45	1	6	6	1	135	20		214
Impairment	19			5	4	31	56		115
Alcohol or drugs	4				1	8	15		28
Sexual misconduct	2					19		1	22
Not classified	5		1			1	1		8
Total	75	1	7	11	6	194	92	1	387

1. One case was referred to a health complaints entity to investigate.
2. Assessment has not been finalised in all cases.

All mandatory notifications are assessed. The outcome of this assessment was completed within the reporting year in 387 of the 589 mandatory notifications. Of these, half (194 out of 387) were referred for investigation; 92 matters (24%) were referred to health or performance assessment; 24 resulted in a caution, imposition of conditions or acceptance of an undertaking; and one was referred to a tribunal for disciplinary proceedings. In 75 matters (19%), no further action was taken, with some of these matters referred for investigation by another body such as a health complaints entity.

In many cases, immediate action is undertaken concurrently with assessment. The case may close following assessment or may continue to another stage such as investigation or health/performance assessment. If immediate action is taken, any limit on a practitioner's registration remains in place while the matter is finalised.

Tables 24 to 28 provide details of the outcome of assessment for each profession. For the medical, nursing and midwifery, pharmacy, and psychology professions, a detailed breakdown is provided of the outcome of assessment based on the grounds for the notification.

Table 24: Outcome of assessment by profession (excluding NSW data)

	End matter								
	No further action	Surrender of registration	Caution	Accept undertaking	Impose conditions	Refer to investigation	Refer to health or performance assessment	Refer to tribunal	Total
Chiropractor	1					1			2
Dental practitioner						1	2		3
Medical practitioner	22		1	2	3	56	18	1	103
Midwife	3					4	3		10
Nurse	42	1	6	7	3	106	62		227
Pharmacist	2			2		8	2		14
Physiotherapist	2					5	2		9
Podiatrist	1					2			3
Psychologist	2					11	3		16
Total	75	1	7	11	6	194	92	1	387

Table 25: Outcome of assessment for medical practitioners by grounds for the notification (excluding NSW data)

	End matter								
Grounds for notification	No further action	Surrender of registration	Caution	Accept undertaking	Impose conditions	Refer to investigation	Refer to health or performance assessment	Refer to tribunal	Total
Standards	12		1	1		40	3		57
Impairment	7			1	2	9	11		30
Sexual misconduct	1					6		1	8
Alcohol or drugs	1				1	1	4		7
Not classified	1								1
Total	22		1	2	3	56	18	1	103

Table 26: Outcome of assessment for nursing and midwifery practitioners by grounds for the notification (excluding NSW data)

	End matter							
Grounds for notification	No further action	Surrender of registration	Caution	Accept undertaking	Impose conditions	Refer to investigation	Refer to health or performance assessment	Total
Standards	27	1	5	4	1	79	15	132
Impairment	10			3	2	18	39	72
Sexual misconduct	1					5		6
Alcohol or drugs	3					7	10	20
Not classified	4		1			1	1	7
Total	45	1	6	7	3	110	65	237

Table 27: Outcome of assessment for pharmacy practitioners by grounds for the notification (excluding NSW data)

	End matter							
Grounds for notification	No further action	Surrender of registration	Caution	Accept undertaking	Impose conditions	Refer to investigation	Refer to health or performance assessment	Total
Standards	1			1		6	1	9
Impairment	1			1		2	1	5
Sexual misconduct								
Alcohol or drugs								
Not classified								
Total	2			2		8	2	14

Table 28: Outcome of assessment for psychology practitioners by grounds for the notification (excluding NSW data)

	End matter							
Grounds for notification	No further action	Surrender of registration	Caution	Accept undertaking	Impose conditions	Refer to investigation	Refer to health or performance assessment	Total
Standards	2					5		7
Impairment						2	3	5
Sexual misconduct						4		4
Alcohol or drugs								
Not classified								
Total	2					11	3	16

Cases closed in 2011/12

A total of 311 mandatory notification cases were closed in 2011/12, including 127 cases received in the 2010/11 year and 184 cases received in the 2011/12 year.

Table 29: Closing stage – all professions (excluding NSW data)

	2011/12	
Stage at closure	Number	%
Assessment	117	38
Health or performance assessment	50	16
Investigation	127	41
Panel or tribunal hearing	17	5
Total	311	100

Most cases (57%) were closed after an investigation was completed or after a health or performance assessment was conducted. A number of cases (38%) were closed when the assessment was completed, and a small number (5%) closed following a panel or tribunal hearing.

Table 30: Outcomes of closed cases – all professions (including NSW data)

	2011/12				2010/11	
Outcome of closed cases	National (excl. NSW)	%	NSW	%	National (excl. NSW)	%
No further action	183	59	64	66	97	74
Conditions imposed	46	15	14	14	15	11
Accepted undertaking	36	12			11	8
Caution or reprimand	29	9	1	1	7	5
Suspension of registration	8	3				
Referred to another body	5	2	7	8	-	-
Surrender of registration	3	1	3	3	1	1
Cancellation of registration	1	<1				
Counselling[1]			8	8		
Total	311	100	97	100	131	100

1. An outcome of counselling is only available in the NSW jurisdiction.

In about 60% of the mandatory notification cases closed in 2011/12, the relevant board determined that no further action was required; compared to 74% in the previous year. The next most common outcomes were imposition of conditions (46 cases), acceptance of an undertaking (36 cases), and a caution or reprimand (29 cases). In 12 of the most serious cases, the practitioner's registration was suspended (eight cases), surrendered (three cases) or

cancelled (one case). In five cases, the issues raised by the mandatory notification were referred to another body for resolution.

Table 31 provides details of the outcomes of closed cases under the National Scheme (excluding NSW) for each profession.

Table 31: Outcome of closed cases by profession (excluding NSW data)

Profession	No further action	Refer all or part to another body	Accept undertaking	Caution	Impose conditions	Surrender of registration	Suspend registration	Cancel registration	Total
Chiropractor	2								2
Dental practitioner					1				1
Medical practitioner	62	2	6	11	12		1		94
Midwife	5			3	1				9
Nurse	96	3	27	10	28	3	6	1	174
Pharmacist	6		1	2	3				12
Physiotherapist	4		1	1	1				7
Podiatrist	2						1		3
Psychologist	6		1	2					9
Total	183	5	36	29	46	3	8	1	311

Students

Fourteen mandatory notifications were received in relation to registered students in 2011/12; compared with seven notifications about students last year. The students involved were studying nursing (nine students), medicine (four students) and physiotherapy (one student); roughly the same proportions as in the previous year.

Table 32: Distribution of mandatory reports about students by jurisdiction and profession (excluding NSW data)

	State or territory				
Profession	Queensland	South Australia	Victoria	Western Australia	Total
Nursing	5	3		1	9
Medicine	2		2		4
Physiotherapy		1			1
Total	7	4	2	1	14

Seven of the mandatory notifications against students received in this reporting year related to an impairment that could place the public at substantial risk of harm. Five mandatory notifications reported concerns about the student's level of knowledge, skill or judgement. Importantly, concerns about a student's level of knowledge, skill or judgement are not grounds for mandatory notification under the National Law. AHPRA continues to work with education providers to increase understanding of the mandatory reporting requirements of the National Law in relation to students.

Immediate action was initiated in response to two of the mandatory notifications against students. In both cases, concerns had been raised about a health impairment and the relevant board accepted an undertaking by the student relating to continuation of the course of study and treatment/monitoring programs.

Closed cases relating to mandatory reports against students

In 2011/12, nine mandatory notification cases involving students were closed, including five cases received in the 2010/11 year and four cases received in the 2011/12 year. Three matters were resolved through acceptance of an undertaking by the student; in the other six matters, no further action was taken following preliminary assessment or investigation.

National Law: Open matters

Every notification received is taken seriously and managed individually. Complex matters take longer to progress through the relevant investigative process.

There were 4,521 notifications under the National Law that remained open at 30 June 2012, including 1,232 in NSW. Some of these open cases were received towards the end of the reporting year, and others are complex matters which require more time to manage. Details of these notifications by profession and jurisdiction are provided in *Table 33*. As expected in the second year of operation, for AHPRA managed cases, there is a marginal increase in the number of open cases at the end of the reporting year from 3,016 in 2010/11 to 3,289 in 2011/12. Also, direct comparisons are difficult, as the 2011 figure included inquiries and some complaints about statutory offences.

Legacy notifications: Matters transferring into the National Scheme

The introduction of the National Scheme in 2010/11 required the National Boards and AHPRA to continue to manage notifications lodged under previous state and territory legislation, as well as new notifications received under the National Law since 1 July 2010. Notifications received by AHPRA from 1 July 2010 are managed under the National Law; notifications received by state and territory boards before 30 June 2010 that transferred into

Table 33: Open notifications at 30 June 2012 under the National Law by profession and state and territory (including NSW data)

	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total 2012	NSW	Total 2012	Total 2011[1]
Chiropractor	3		21	26		20	10	80	16	96	73
Dental practitioner	8	6	82	30	6	120	42	294	240	534	587
Medical practitioner	88	11	517	136	58	448	280	1,538	633	2,171	1,763
Midwife			32	6		1	10	49	2	51	46
Nurse	22	24	281	107	25	248	111	818	195	1,013	684
Optometrist	2		4	2		5		13	7	20	18
Osteopath			3	1		7		11	6	17	11
Pharmacist	10		75	14	8	67	33	207	68	275	216
Physiotherapist	1	1	13	12	1	10	4	42	5	47	47
Podiatrist			5	5		4	3	17	8	25	19
Psychologist	5	3	54	23	6	84	27	202	52	254	210
Not identified			10	3		4	1	18		18	177
Total 2012	139	45	1,097	365	104	1,018	521	3,289	1,232	4,521	
Total 2011[1]	154	81	1,119	395	93	873	301	3,016	835		3,851

1. The notifications reported as 'open' at the end of 2011 include inquiries, which have been excluded from the 2011/12 report.

Table 34: Closed notifications under previous legislation by profession and state and territory (including NSW data)

	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total 2012	NSW	Total 2012	Total 2011
Chiropractor							1	1	8	9	29
Dental practitioner	1	2	13			12	3	31	19	50	249
Medical practitioner	7	35	64		3	46	76	231	61	292	932
Midwife			2			2	2	6		6	18
Nurse	6	8	46		8	43	16	127	50	177	267
Optometrist			1		1			2		2	3
Osteopath			1			2		3		3	5
Pharmacist		2	13		3		2	20	11	31	125
Physiotherapist		2	5			1	1	9	1	10	19
Podiatrist			2					2		2	13
Psychologist	2	3	22			18	13	58	6	64	109
Not identified			1					1		1	10
Total 2012	16	52	170		15	124	114	491	156	647	
Total 2011	29	16	394	10	31	270	165	915	864		1,779

the National Scheme are managed under the legislation in place in each jurisdiction, except in South Australia where the law requires all continuing matters to be dealt with under the National Law, except those which were the subject of formal proceedings before a board or tribunal.

All legacy matters are being progressively resolved by AHPRA and the National Boards.

A further 647 'legacy' notifications (including 156 in NSW) were closed during the year with 517 (including 160 in NSW) still open at the end of the reporting year. Details of the cases closed during the year by profession and jurisdiction are provided in *Table 34*.

Table 35 details the legacy cases remaining open at the end of the reporting year by profession and jurisdiction.

Table 35: Open notifications under previous legislation by profession and state and territory (including NSW data)

	ACT	NT	QLD	SA	TAS	VIC	WA	Sub Total 2012	NSW	Total 2012	Total 2011 [1]
Chiropractor			2			3		5	2	7	18
Dental practitioner	1	2	12			7		22	3	25	79
Medical practitioner	4	18	80		9	34	56	201	123	324	855
Midwife							2	2		2	9
Nurse		12	22			24	11	69	15	84	287
Optometrist											6
Osteopath									1	1	5
Pharmacist			21				1	22	8	30	87
Physiotherapist			3					3	3	6	17
Podiatrist											4
Psychologist			22		1	7	2	32	5	37	132
Not identified						1		1		1	18
Total 2012	5	32	162		10	76	72	357	160	517	
Total 2011[1]	19	95	394	2	40	334	273	1,157	360		1,517

1. Since the 2010/11 report, a review of all 'legacy' cases had identified a number of duplicate cases and closed cases incorrectly transferred in as open cases. These have been rectified in the system since the 2010/11 annual report. The figures quoted in that report, and replicated here for consistency, are an over-estimate of the 'legacy' cases remaining open at the end of that reporting year.

Ongoing work in 2011/12 to review all open notifications that transferred into the scheme identified a number of duplicate cases and cases previously closed but inaccurately recorded as open at the start of the scheme. These issues have been addressed in the reporting system during the year. As a result, there is some discrepancy between the figures published in the 2010/11 annual report about legacy cases that remained open at the end of 2011, and the current reporting data on legacy cases.

Cancelled registrations

Details of the 46 practitioners whose registration has been cancelled since the introduction of the National Scheme are published on the AHPRA website.

Work has continued in the last 12 months to support the integrity and accuracy of the information published on the public register and associated data, including details of cancelled registrations.

The website also publishes a link to a library, hosted by the Australasian Legal Information Institute (Austlii), of publicly available decisions made about registered health practitioners by panels and tribunals.

Students

A total of 27 notifications relating to students were received in 2011/12. The majority of these notifications related to nursing students and were received in Queensland. There were nine notifications received in South Australia, of which six related to nursing students.

A breakdown of these notifications by profession and jurisdiction is provided in *Table 36*.

Table 36: Notifications relating to students, by profession and jurisdiction (excluding NSW data)

Profession	QLD	SA	TAS	VIC	WA	Total
Dental	1	1				2
Medical	3	1		2		6
Nursing	8	6	1		2	17
Physiotherapy	1	1				2
Total	13	9	1	2	2	27

Accreditation overview

The National Boards and AHPRA work with education providers to ensure graduating students are suitably qualified and skilled to apply to register as a health practitioner. The bulk of this accreditation work is undertaken by independent accreditation authorities.

Accreditation authorities recommend accreditation standards to National Boards for approval and accredit programs of study and education providers against the approved accreditation standards. Accreditation authorities are often responsible for assessment of overseas-qualified practitioners and may be responsible for assessing overseas accrediting authorities.

Accreditation is a key element of the National Scheme and the National Law. Under the National Law, accreditation functions for each profession can be exercised by an independent accreditation entity or a committee of the National Board.

Ministerial Council assigned accreditation functions for the professions which entered the National Scheme in 2010 to external accreditation entities. The Forum of Australian Health Professions Councils is a collective of accreditation entities exercising functions under the National Law. National Boards and AHPRA have established the Accreditation Liaison Group with representatives of the Forum, as a subcommittee of the Forum of National Board Chairs, to work on key shared accreditation issues.

In 2011/12, the key work of the National Boards and AHPRA around accreditation focused on establishing a detailed agreement for each profession for the accreditation functions until 30 June 2013 between AHPRA on behalf of the relevant National Board and the accreditation entity. This involved detailed negotiation with each accreditation entity about the scope of work to be undertaken within the accreditation function and the funding to be provided by the National Board. There was substantial work on the core wording of the agreement undertaken through the Accreditation Liaison Group, including establishing agreed policy positions about key issues such as intellectual property.

In 2012, work has also focused on preparing for the review of accreditation arrangements for the 2010 professions required under the National Law by 30 June 2013. The Accreditation Liaison Group developed an agreed approach to the review in consultation with the National Boards and accreditation entities. The proposed review process was discussed at the second joint meeting of accreditation entities, National Boards and AHPRA on 6 June 2012. National Boards will undertake consultation on the review later in 2012.

Another key stream of work for 2011/12 relates to accreditation arrangements for the professions entering the National Scheme on 1 July 2012. The Chinese Medicine and Aboriginal and Torres Strait Islander Health Practice Boards decided to exercise accreditation arrangements through a committee of the National Board. This will require AHPRA to support the committees to deliver accreditation functions, including the need to

build capacity and processes. Preparatory work has been undertaken during 2011/12, including work to establish the committees.

The Occupational Therapy and Medical Radiation Practice Boards are determining how to assign accreditation functions. Work is continuing to focus on clarifying requirements and establishing effective accreditation models, in preparation for the entry of these professions to the National Scheme from 1 July 2012.

Legislative reporting and other matters

Administrative complaints

This section provides statistical information and commentary about administrative complaints received in 2011/12.

Anyone can make a complaint about AHPRA, the Agency Management Committee or a National Board. A complaints form is available on the AHPRA website, along with the AHPRA *Complaint handling policy and procedure*.

If anyone believes that they have been treated unfairly in our administrative processes or in our handling of freedom of information processes, a complaint can also be lodged with the independent National Health Practitioner Ombudsman (NHP Ombudsman), who will receive complaints and help people who believe they have been treated unfairly by the bodies within the National Scheme.

The NHP Ombudsman will usually only deal with complaints that have already been lodged with AHPRA, and when AHPRA has been given a reasonable opportunity to resolve the complaint. AHPRA is committed to resolving complaints and to learning from what has happened and, where appropriate, making demonstrable improvements to services.

Complaints are considered at a senior level in AHPRA, in recognition of their importance. There is a designated complaints officer in each AHPRA office. The CEO reviews weekly summaries of complaints that remain unresolved.

Complaint trends are reported quarterly to the Agency Management Committee, the National Executive and the National Boards in regard to monitoring complaints, actions taken and any learning.

This year there has been a focus on continuing to improve the quality and timeliness of responses.

There were two key events in complaints management this year:

- AHPRA's *Complaint handling policy and procedure* has been reviewed and a revised policy was endorsed by the Agency Management Committee and the National Boards, and
- the complaints management information system has been enhanced with improved functional capability to assist complaints officers in meeting their obligations under the *Complaint handling policy and procedure*. The system enhancements include improved processes for tracking and escalating complaints to ensure a timely response to all matters raised.

These changes have resulted in a marked improvement in the timeliness of complaints resolution.

A database records all complaints received by AHPRA and all complaints directed to AHPRA from the Ombudsman.

In the year ending 30 June 2012, AHPRA directly received a total of 464 complaints. Of those, 436 complaints were resolved, with 28 complaints pending.

AHPRA directly received 73 complaints from the NHP Ombudsman. Of those, 71 were resolved, with two pending.

Major issues included:

- Complaints related to registration fees
- Complaints related to the English language requirements
- Time to assess and process a new registration
- Time to assess and process a renewal
- Time to assess and process an overseas application or renewal
- Lack of communication regarding registration
- Due process of investigations not followed
- Inadequate communication regarding a notification matter
- Delay in investigation of a notification

Freedom of information

Section 215 of the National Law provides that the Commonwealth *Freedom of Information Act 1982* (FOI Act) applies to the National Law.

In the year to 30 June 2012, AHPRA received 162 applications under the FOI Act. These were handled as follows:

Granted in full	27
Granted in part	65
Access refused	28
Withdrawn	1
On hand at 30 June 2012	41
Total	162

There were 15 applications for internal review during the year: three applications resulted in greater access in part; 10 other applications resulted in the decision of the FOI officer being affirmed on review. There are two outstanding internal reviews.

Application fees of $2,930 and processing charges of $7,390 covering the cost of FOI requests and related responsibilities were collected in 2011/12.

During the period 1 July 2011 to 30 June 2012, all FOI officers participated in interactive workshops focusing on making the application process more effective and advanced training on providing FOI applicants with better decisions that reflect the intent and spirit of the FOI legislation.

Freedom of Information Act, section 8

Organisation and functions

AHPRA:

- supports the 10 (14 from 1 July 2012) National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme
- provides support to the National Boards in their primary role of protecting the public to manage the registration processes for health practitioners and students around Australia
- has offices in each state and territory where the public can make notifications about a registered health practitioner or student
- on behalf of the National Boards, manages investigations into the professional conduct, performance or health of registered health practitioners, except in NSW where this is undertaken by the Health Professional Councils Authority and the Health Care Complaints Commission
- on behalf of the National Boards, publishes national registers of practitioners so important information about the registration of individual health practitioners is available to the public
- works with the Health Care Complaints Commissions in each state and territory to make sure the appropriate organisation investigates community concerns about individual, registered health practitioners
- supports the National Boards in the development of registration standards, and codes and guidelines, and
- provides advice to Ministerial Council about the administration of the National Registration and Accreditation Scheme.

Consultative arrangements

The public release of documents is not a legislative requirement under the National Law or the FOI Act; however, the Agency Management Committee and the National Boards have decided to make available to a wider audience documents released under FOI applications that are relevant to the functions of the National Scheme and that may be of interest to the public. A disclosure log is available on the AHPRA website at www.ahpra.gov.au.

The National Law requires the National Boards to undertake wide-ranging public consultation about the content of proposed registration standards, codes and guidelines. The consultation process provides a framework for the development and/or review of registration standards, codes and guidelines. The Boards may vary

each consultation process to ensure all stakeholders can provide effective input.

To promote awareness of the National Law and functions of the National Law entities, AHPRA and the National Boards publish detailed websites that include standards, codes and guidelines, policies and communiqués in relation to its functions and the National Boards.

Categories of documents

The categories of documents maintained by AHPRA include those relating to:

- corporate organisation and administration
- AHPRA's financial management
- management of assets
- internal administration including policy development and program administration, reports, briefings, correspondence, minutes, submissions, statistics and other documents
- Agency Management Committee's recommendations relating to the business of AHPRA
- reference material used by staff including guidelines and manuals
- working files, and
- legal advice.

The categories of documents listed above are maintained by AHPRA in a variety of formats. Some of these documents, along with information on AHPRA's organisation, structure and activities, can be obtained free of charge by accessing AHPRA's website at www.ahpra.gov.au.

Compliance with state and territory laws

AHPRA has implemented a review of AHPRA's compliance with key legislation in states and territories.

Key legislation was identified as legislation where the main purpose is to protect the public and where an obligation is placed on AHPRA.

The key legislation considered was:

- The Health Acts
- Equal Opportunity Acts
- Children and Community Services Acts including Working with Children
- Public Interest/Whistleblowers Disclosure Acts
- Drug and Poison Acts
- Records Acts
- Procurement Acts

Ongoing work is underway to ensure that AHPRA meets its obligations in relation to these pieces of legislation.

Requests for telecommunications data

During 2011/12, there were four requests made for access to telecommunications data.

Authorisation was given for these requests, which were for access to existing information or documents in enforcement of a law imposing a pecuniary penalty.

Risk management

Risk management is the process of making and carrying out decisions that will minimise the adverse effect of loss or disruption upon AHPRA. It is also the process by which we identify opportunities to improve and capitalise on our strengths. The risk management process is vital to the personal health and safety of employees.

Strategically, we recognise that sound risk management practices are linked to our ability to meet our goals, commence and operate programs, and perform duties in an efficient and professional manner.

As a maturing organisation, AHPRA's senior management have identified the need to embed a comprehensive management program that will underpin risk mitigation activities for the National Boards and AHPRA.

To achieve this, the National Executive appointed a risk working group to formalise AHPRA's risk management processes and framework. The group has developed a detailed 12 month project plan that will ensure the following goals are met:

1. Implementation of a risk management framework and governance principles based on the Australian/New Zealand Risk Management Standard (AS/NZS ISO 31000:2009).
2. Development of training, tools, templates and resources that help management identify and mitigate areas of significant risk.
3. Raising the awareness of National Board members, senior managers, employees, contractors and volunteers concerning risk management within AHPRA and the National Boards.

To meet these goals, the group reports progress to the Audit and Risk Committee on a quarterly basis.

HR initiatives

The second year of AHPRA's operations has focused on developing common people management policies and processes, and ensuring we have a solid platform on which to build a national HR capability that supports our staff and enables AHPRA to meet it regulatory responsibilities.

A major milestone was the launch of the Code of Conduct. This is the umbrella policy that sets out AHPRA's expectations of all staff and contractors, and draws together a number of related policies. The Code supports the AHPRA corporate plan and references the organisation's mission and values. It has been supported by the implementation of online compliance training on workplace behaviour related topics. Further modules with a focus on workplace safety and wellbeing are scheduled for release in the coming year.

AHPRA has made a commitment to all staff that they will be provided with regular feedback culminating in an annual performance appraisal. A common approach to performance appraisal and all its supporting processes was designed during the year, in consultation with staff. This will be progressively implemented with links to the 2012/13 business plan.

A major program of work was undertaken in support of national and state board appointments. The focus for the second half of the year was the recruitment to more than 100 positions on 10 of the National Boards. This has been complemented by the implementation of processes to support ongoing recruitment to regional and state and territory boards.

More widely, the year has seen many AHPRA staff take advantage of the benefits of working in a national organisation and take up opportunities in different offices. This provides individual staff with new opportunities within the organisation, and supports AHPRA's work to embed national consistency across offices. Ongoing staff participation in helping shape new national processes – both in HR and operationally – has strengthened the outcome and benefited individual participating staff through collaboration, knowledge sharing and the development of a national perspective.

On 30 June 2012, AHPRA employed about 570 full-time equivalent members of staff and about 100 contractors. The number of contractors fluctuates based on varied project requirements.

Enterprise Agreement signals consistency in employment terms and conditions

Consistency has been a hallmark of the AHPRA approach to developing and implementing human resource planning and procedures.

During the year, we took major steps to implement AHPRA's Enterprise Agreement strategy. This aims to set out nationally-consistent employment terms and conditions where possible and applicable.

At the establishment of AHPRA, there were numerous differences in terms and conditions for our staff. This was the result of variations between the 34 former regulatory authorities (as employers) in Australia's states and territories before the National Scheme came into effect.

AHPRA is working towards a consistent work level structure. This is enabling us to build a comprehensive platform for work being undertaken by staff in different offices performing similar functions within AHPRA. This process complements our efforts to streamline and improve our business processes, and to improve consistency.

In February 2012, staff in each of the Australian Capital Territory, Northern Territory and Victorian offices voted in favour of a single Enterprise Agreement. These states/territories have arrangements under the Fair Work Act 2009 (Cth). The Enterprise Agreement, after it was approved in April 2012, is being implemented in these jurisdictions. Bargaining began in Western Australia during the year and will follow in other states and territories in 2012/13.

Financial statements for the year ended 30 June 2012

Contents

Board report

Who We Are

The Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for supporting the National Health Practitioner Boards in the administration of the National Registration and Accreditation Scheme across Australia.

AHPRA's operations are governed by the *Health Practitioner Regulation National Law Act 2009*, as in force in each state and territory. The National Law came into effect on 1 July 2010 except in Western Australia where it came into effect on 18 October 2010. This law means that for the first time in Australia, 10 health professions are regulated by nationally consistent legislation. On 1 July 2012, a further four professions joined the National Registration and Accreditation Scheme.

AHPRA supports the National Health Practitioner Boards that are responsible for regulating registered health practitioners. The primary role of the Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

The Agency Management Committee oversees the work of AHPRA. The Chair is Mr Peter Allen. The Chief Executive Officer is Mr Martin Fletcher.

What We Do

AHPRA supports the National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme.

The National Registration and Accreditation Scheme Strategy 2011-2014 sets out the vision, mission and strategic priorities. This statement has been developed jointly by the National Boards and AHPRA.

AHPRA:

- supports the National Boards in their primary role of protecting the public
- manages the registration processes for health practitioners and students around Australia
- has an office in each state and territory where the public can make notifications about a registered health practitioner or student
- on behalf of the Boards, manages investigations into the professional conduct, performance or health of registered health practitioners, except in NSW where this is undertaken by the Health Professional Councils Authority and the Health Care Complaints Commission
- on behalf of the National Boards, publishes national registers of practitioners so important information about the registration of individual health practitioners is available to the public
- works with the Health Care Complaints Commission in each state and territory to make sure the appropriate organisation investigates notifications about individual registered health practitioners
- supports the Boards in the development of registration standards, and codes and guidelines
- provides advice to the Australian Health Workforce Ministerial Council about the administration of the National Registration and Accreditation Scheme.

National Boards

Each health profession that is part of the National Registration and Accreditation Scheme is represented through a National Board.

The primary role of the Boards is to protect the public. The Boards are responsible for registering practitioners and students, dealing with notifications about the health, performance and conduct of health practitioners as well as setting standards, policies and guidelines for their professions.

The 10 National Boards are:

- Chiropractic Board of Australia
- Dental Board of Australia
- Medical Board of Australia
- Nursing and Midwifery Board of Australia
- Optometry Board of Australia
- Osteopathy Board of Australia
- Pharmacy Board of Australia
- Physiotherapy Board of Australia
- Podiatry Board of Australia
- Psychology Board of Australia

All Boards are supported by AHPRA. On 1 July 2012, four additional health professions have been included in the national scheme and are represented by the following National Boards:

- Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Chinese Medicine Board of Australia
- Medical Radiation Practice Board of Australia
- Occupational Therapy Board of Australia.

From 1 July 2011 the new National Boards commenced preparations for the introduction of the four professions to the National Scheme.

State, territory and regional boards

The National Law provides for a National Board to establish state, territory and regional boards to exercise its functions in the jurisdiction in a way that provides an effective and timely local response to health practitioners and other persons in the jurisdiction. Some National Boards have state or territory boards in all jurisdictions; one has a multi-jurisdictional regional board; and others do not have state or territory boards but have national committees.

These boards and committees make individual registration and notification decisions according to delegations from each National Board and based on national policies and standards set by the relevant National Board.

Notifications for health practitioners in New South Wales are dealt with through the NSW Health Professional Councils.

Agency Management Committee

The Agency Management Committee was appointed by the Ministerial Council in March 2009 in accordance with the Health Practitioner Regulation (Administrative Arrangements) National Law Act 2008.

The role of the Agency Management Committee is to oversee the affairs of AHPRA, to decide the policies of AHPRA and to ensure that AHPRA functions properly, effectively and efficiently in working with the National Health Practitioner Boards.

The Committee comprises at least 5 people:

- a Chair who is not a registered health practitioner and has not been a health practitioner in the last 5 years
- at least 2 people with expertise in health and/or education and training
- at least 2 people with business or administrative expertise who are not current or previously registered health practitioners.

Mr Peter Allen, Chairperson

Peter Allen is Chair of the Agency Management Committee, and has been since March 2009.

Mr Allen is Deputy Dean of the Australia and New Zealand School of Government (ANZSOG), and Victoria's Public Sector Standards Commissioner. He joined ANZSOG after more than 20 years in the Victorian Public Service, during which time he held several positions including Under Secretary in the Department of Human Services; Victoria's Chief Drug Strategy Officer; Secretary of the Department of Tourism, Sport and the Commonwealth Games; Secretary of the Department of Education; Director of Schools; and Deputy Secretary, Community Services.

Between 2001 and 2003, Mr Allen was a Vice-Chancellor's Fellow at the University of Melbourne, and prior to joining the public service, he was Director of Social Policy and Research at The Brotherhood of St Laurence.

Mr Allen holds a Bachelor of Arts and a Diploma in Journalism and was awarded a Centenary Medal in 2001.

Professor Constantine (Con) Michael AO

Con Michael was appointed to the Agency Management Committee in March 2009 as a member with expertise in health, education and training.

Professor Michael is the Principal Adviser of Medical Workforce for the Western Australia Health Department, Consultant Medical Adviser for St John of God Health Care Inc. and Emeritus Professor of Obstetrics and Gynaecology at the University of Western Australia (UWA).

Professor Michael is the current Chair of the Western Australian Board of the Medical Board of Australia, Director of the Australian Medical Council, a member of various state and national medical committees and Chair of the St John of God National Ethics Committee and Chair of the Reproductive Technology Council of Western Australia. He is a Director and Governor of the University of Notre Dame Australia and Chair of its Advisory Board of the School of Medicine Fremantle.

Professor Michael holds a Bachelor of Medicine and Bachelor of Surgery (UWA), Doctor of Medicine (UWA) and Diploma of Diagnostic Ultrasound. He is a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (a past President) and Fellow of the Royal College of Obstetricians and Gynaecologists, London (a previous Sims Black Professor).

Among his numerous awards, Professor Michael was named an Officer of the Order of Australia (AO) in 2001 for service to medicine, particularly in the field of obstetrics and gynaecology, as a contributor to the administration of the profession nationally and internationally, and medical education.

Professor Genevieve Gray

Genevieve Gray was appointed to the Agency Management Committee in March 2009 as a member with expertise in health or education and training.

Professor Gray is Professor of Nursing at the Queensland University of Technology (QUT), and Professor Emeritus University of Alberta. In recent years she has been a Nurse Scholar for the World Health Organization, Geneva, and worked in Canada as a Professor of Nursing, Dean & Director, WHO Collaborating Centre in Nursing & Mental Health for the University of Alberta and the World Health Organization. Professor Gray is currently Director of QUT's Vietnam Nursing Capacity Building Program.

Professor Gray was previously Inaugural Chair of the International Academic Nursing Alliance, a member of the Multidisciplinary Board of the International Council of Women's Health Issues and member of the Deans Council, General Faculties Committee and Health Sciences Council of the University of Alberta.

Professor Gray has a General Nursing Certificate, Midwifery Certificate, diplomas in Nursing Education and Advanced Nursing Studies, a Master of Science (Nursing), a Distinguished Life Fellowship from the Royal College of Nursing Australia and Honorary Professorship from Hanoi Medical University, Vietnam.

Mr Michael Gorton AM

Michael Gorton was appointed to the Agency Management Committee in March 2009 as a member with business and administrative expertise.

Mr Gorton is a commercial lawyer with considerable experience providing legal advice on medical registration, training, education and administrative practice. As a principal of Russell Kennedy Solicitors, he has significant experience in business management and administration. He is a Board member of Melbourne Health (Royal Melbourne Hospital). He is a former Chair of the Victorian Equal Opportunity & Human Rights Commission and former Chair of the Code of Conduct Committee of Medicines Australia.

Mr Gorton is the Chair of the Patient Review Panel (Victoria) and chairs the Minister's Expert Panel to review health complaints legislation in Victoria. He has extensive experience in governance for a wide range of organisations including health and ethics committees.

Mr Gorton holds a Bachelor of Laws and Bachelor of Commerce.

In 2004, Mr Gorton received the Member of the Order of Australia (AM) for community service.

Professor Merrilyn Walton

Professor Walton was appointed to the Agency Management Committee in March 2009 as a member with business and administrative expertise.

Professor Walton is Professor of Medical Education (Patient Safety), Sydney School of Public Health and Associate Dean International, Faculty of Medicine, University of Sydney. She is a leading patient safety academic who works nationally and internationally in the field. For the last four years she has been a lead writer and editor for the WHO patient safety curricula guides for multi professionals and medical schools.

Professor Walton is currently assisting universities in Vietnam, Timor Leste and China to build capacity in patient safety and curriculum development. She is the author of two books and co-authored her latest, *Safety and Ethics in Health Care*, with Professors Runciman and Merry.

Professor Walton was a member of the Australian Health Ethics Committee of the National Health and Medical Research Council (NHMRC) (2009-2012). She is a visiting professor and affiliate of The Buehler Center on Aging, Health and Society at Northwestern University in the USA. Prior to her academic role Professor Walton was the first Health Care Complaints Commissioner in NSW (1993-2000).

Overview of results for 2011/12

Overall

The consolidated result for AHPRA and National Boards was a surplus of $7.2 million.

The results year on year are shown below.

2009-10 ($4.5 million) (establishment)

2010-11 ($6.4 million) (first year of operations)

2011-12 $7.2 million

Total ($3.7 million)

Nine of the ten National Boards recorded a surplus for 2011-12 with the Nursing and Midwifery Board of Australia recording a deficit.

Equity

Equity increased by $7.2 million in 2011-12 to $35.7 million at 30 June 2012.

It is expected that National Boards both as a group and individually will have reasonable and sufficient equity to cover expected commitments although there can be no cross subsidisation between National Boards. An assessment at 30 June 2012 confirms that this is the case.

All National Boards have an equity objective which they expect to achieve in the first three years of operation (30 June 2013). National fees have been set or reviewed on this basis.

Income

Total income was $157 million in 2011-12, a $34.7 million increase from 2010-11 and was consistent with expectations.

The increase was due to the following key factors

- The registration fee income was based on the national fee for the first time (in 2010-11 income was based on a combination of the national fees and the fees collected in advance by the legacy boards).
- Government funding income was recognised in relation to the 2012 NRAS project involving the introduction of the four health professions commencing on 1 July 2012.

Expenditure

Total expenditure was $150 million in 2011-12, a $20 million increase from 2010-11 and was consistent with expectations.

Cash Flow

Cash and cash equivalents decreased from $3.1 million to $1.7 million at 30 June 2012. Where cash and cash equivalents exceeded AHPRA's at call requirements, they were transferred to investments.

Overall registration receipts were less than those in 2010-11. In 2010-11 practitioners were progressively aligned with consistent renewal dates. This resulted in some practitioners paying their registration fee initially for a pro rata period for the year and then paying a registration fee for a further 12 months at the new renewal date. Due to timing, these receipts were in some instances received in the same financial year (though part of the receipt covered future financial years).

Overall payments to suppliers, employees and other increased during 2011-12 as expected.

Balance Sheet

Total equity increased by $7.2 million to $35.7 million at 30 June 2012. Investments increased by $29.5 million due to the timing of receipts relating to the Nursing and Midwifery Board of Australia renewal which was due on 31 May 2012 as 100,000 more practitioners renewed in May 2012 than in May 2011 due to the realignment of renewal dates from legacy boards, and an increase in the registration fee compared to May 2011. As a result Income in Advance increased by $17 million.

The year ahead

It is expected a small surplus will be recorded with twelve of the fourteen National Boards expected to record a break-even or small surplus for 2012-13. Two National Boards expected to return to a surplus in 2013-14 following a deficit in 2012-13.

Income and expenditure is expected to increase as four National Boards commence operations on 1 July 2012.

Equity increased on 1 July 2012 as the four National Boards which commenced operation on that date transferred their reserves (where they existed) to the National Scheme on 1 July 2012.

It is expected that AHPRA will continue to be financially solvent throughout 2012-13.

Australian Health Practitioner Regulation Agency

Declaration by Agency Management Committee, Chief Executive Officer & Director, Finance and Corporate Operations

We certify that the attached financial statements for the Australian Health Practitioner Regulation Agency have been prepared in accordance with Schedule 3, Part 3 of the *Health Practitioner Regulation National Law Act 2009* as in force in each State and Territory (the National Law), Australian Accounting Standards, Australian Accounting Interpretations and other mandatory professional reporting requirements.

We further state that in our opinion, the information set out in the Comprehensive Income Statement, Balance Sheet, Statement of Changes in Equity, Cash Flow Statement and notes to and forming part of the financial statements, presents fairly the financial transactions for the year ended 30 June 2012 and the financial position of the Australian Health Practitioner Regulation Agency as at 30 June 2012.

We are not aware of any circumstance which would render any particulars included in the financial statements to be misleading or inaccurate.

We authorise the attached financial statements for issue on this day.

Peter Allen
Chair, Agency Management Committee
14 September 2012

Martin Fletcher
Chief Executive Officer
14 September 2012

John Ilott
Director, Finance and Corporate Operations
14 September 2012

Australian Health Practitioner Regulation Agency
Comprehensive Income Statement
For the year ended 30 June 2012

	Notes	2012	2011
Continuing operations		**$'000**	**$'000**
Income from transactions			
Registrant fee income	2a, 13	137,814	115,165
Interest	13	5,806	3,490
Other income	2b, 13	13,779	4,006
Total income from transactions		**157,399**	**122,661**
Expenses from transactions			
Board sitting fees and direct board costs	13	10,966	9,874
Legal cost	13	10,791	11,324
NSW HPCA regulatory fee	1f, 13	18,771	15,349
Accreditation	13	4,357	3,095
Staffing costs		76,040	53,022
Travel and accommodation		2,862	2,071
Systems and communications		7,875	6,656
Property expenses		7,317	5,792
Strategic and project costs		2,578	3,630
Depreciation and amortisation	3b, 8& 9	1,221	705
Decommissioning and transition costs		0	10,756
Administration expenses	3a	7,418	6,805
Total expenses from transactions		**150,196**	**129,079**
Net result for the year		**7,203**	**(6,418)**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency
Balance Sheet
As at 30 June 2012

	Notes	2012	2011
		$'000	$'000
Current assets			
Cash and cash equivalents	4a	1,713	3,096
Investments	4b	112,000	82,500
Prepayments		715	110
Receivables	5	2,632	2,667
Accrued income	6	2,310	964
Asset held for sale	7	0	2,049
Total current assets		**119,370**	**91,386**
Non-current assets			
Property, plant & equipment	8	7,084	6,456
Intangible assets	9	1,653	86
Total non-current assets		**8,737**	**6,542**
Total assets		**128,107**	**97,928**
Current liabilities			
Payables and accruals	10	12,665	8,769
Equity in advance	13	1,503	0
Income in advance	11	71,321	54,754
Employee benefits	12	5,811	4,784
Total current liabilities		**91,300**	**68,307**
Non-current liabilities			
Employee benefits	12	1,067	1,084
Total non-current liabilities		**1,067**	**1,084**
Total liabilities		**92,367**	**69,391**
Net assets		**35,740**	**28,537**
Contributed capital	13	**39,472**	**39,472**
Accumulated surplus / (deficit)	13	**(3,732)**	**(10,935)**
Total equity		**35,740**	**28,537**
Commitments	16		
Contingent liabilities	17		

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency
Statement of Changes in Equity
For the year ended 30 June 2012

	Note	Contributed Capital	Accumulated Surplus / (Deficit)	Total
		$'000	$'000	$'000
Balance at 1 July 2010		5,842	(4,517)	**1,325**
Comprehensive result for the year		0	(6,418)	(6,418)
Contribution by legacy health boards	13	33,630	-	**33,630**
Balance at 30 June 2011		**39,472**	**(10,935)**	**28,537**
Comprehensive result for the year		0	7,203	7,203
Balance at 30 June 2012		**39,472**	**(3,732)**	**35,740**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency
Cash Flow Statement
For the year ended 30 June 2012

	Notes	2012	2011
		$'000	$'000
Cash flows from operating activities			
Payments to suppliers, employees and others		(150,090)	(130,081)
Receipts relating to registrant fees	18b	152,349	167,796
GST received from ATO		5,417	6,176
Other receipts		15,621	4,894
Interest received		4,460	2,526
Net cash flows from operating activities	18a	**27,757**	**51,311**
Cash flows from investing activities			
Payments for property, plant & equipment		(3,416)	(6,495)
Receipts from the disposal of assets held for sale		2,273	3,934
Acquisition of investments		(29,500)	(82,500)
Net cash flows from investing activities		**(30,643)**	**(85,061)**
Cash flows from financing activities			
Remaining receipts from health boards		1,503	17,306
Net cash flows from financing activities		**1,503**	**17,306**
Net increase / (decrease) in cash held		(1,383)	(16,444)
Cash at the beginning of the year		3,096	19,540
Cash at end of the year	4a	**1,713**	**3,096**

All amounts are inclusive of GST

This statement should be read in conjunction with the accompanying notes.

Note 1 - Summary of significant accounting policies

(a) Statement of compliance

These financial statements are a general purpose financial report which have been prepared in accordance with the applicable Australian Accounting Standards and Interpretations (AASs) and other mandatory requirements. AASs include Australian equivalents to International Financial Reporting Standards.

The Financial Statements have also been prepared in accordance with the relevant requirements under the *Health Practitioner Regulation National Law Act 2009*.

(b) Basis of accounting preparation and measurement

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2012.

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

The financial statements have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate.

The financial report is prepared in accordance with the historical cost convention. Cost is based on the fair values of the consideration given in exchange for assets.

In the application of AASs, management is required to make judgments, estimates and assumptions about carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and associate assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making judgments. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis.

These financial statements were authorised by the Agency Management Committee on the 14th day of September 2012.

(c) Reporting entity

The Australian Health Practitioner Regulation Agency (AHPRA) is given the authority to operate by way of the *Health Practitioner Regulation National Law Act 2009*.

AHPRA's principal address is 111 Bourke Street, Melbourne 3000.

The financial statements include all the controlled activities of AHPRA.

AHPRA is the organisation responsible for the administration of the National Registration and Accreditation Scheme across Australia.

AHPRA's operations are governed by the *Health Practitioner Regulation National Law Act 2009* as in force in each State and Territory which came into effect on 1 July 2010 and on 18 October 2010 in Western Australia.

AHPRA supports the National Health Practitioner Boards that are responsible for regulating their health professions. The primary role of the Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

The Agency Management Committee oversees the work of AHPRA. The Chair is Mr Peter Allen. The Chief Executive Officer is Mr Martin Fletcher.

AHPRA supports the National Health Practitioner Boards in the administration of the National Registration and Accreditation Scheme.

(d) Corporate structure

AHPRA is a statutory body governed by the *Health Practitioner Regulation National Law Act 2009* as in force in each State and Territory (the National Law).

(e) Income from transactions

Income is recognised to the extent that it is probable that the economic benefits will flow to AHPRA and that it can be reliably measured.

Registrant fees

Registrations are payable periodically in advance. Only those registration fees that are attributable to the current financial year are recognised as income. Registration fees that relate to future periods are shown in the balance sheet as Income in Advance under the heading of Current Liabilities.

Where a registrant pays an application fee, the fee is recognised in the financial year in which it is received.

Application fees received from the NRAS 2012 professions in 2012 financial year are recognised as project income and form part of the project funding in the 2012 financial year. Registration fees received from the NRAS 2012 professions are shown in the balance sheet as Income in Advance and will be recognised as income from 1 July 2012 over the registration period.

Interest

Interest income is accrued on a time basis by reference to the principal outstanding and at the effective interest rate applicable.

Other income

Other income includes income that is not registrant fees or interest. Key items of other income include certificates of registration status requested by registrants, government grants received and fees related to examinations.

Sale of non-current assets

The net gain or loss of non-current asset sales are included as revenue or expenses at the date control passes to the buyer, usually when an unconditional contract of sale is signed.

The net gain or loss on disposal is calculated as the difference between the carrying amount of the asset at the time of the disposal and the net proceeds on disposal.

Assets which satisfy the criteria in AASB 5 *Non-current Assets Held for Sale and Discontinued Operations* as assets held for sale are transferred to current assets and separately disclosed as non-current assets held for sale on the face of the balance sheet. These assets are measured at the lower of carrying amount and fair value less costs to sell. These assets cease to be depreciated from the date which they satisfy the held for sale criteria.

(f) Expenses from transactions

Board sitting fees and direct board costs

Board sitting fees and direct board costs includes all national, state and regional board expenditure relating to meetings held by the boards and their committees and for projects commissioned by the boards.

Legal costs

Legal costs include costs relating to the managing the notification (complaint) process. These costs include legal fees paid to external firms and costs of civil tribunals. They do not include the cost associated with AHPRA staff in the assessment and investigation of notifications.

HPCA regulatory fee

The HPCA regulatory fee is the amount paid to the Health Professional Councils Authority in NSW to support the co-regulatory model in that state.

Accreditation

Accreditation relates to payments to external accreditation bodies to exercise accreditation functions on behalf of the National Boards.

AHPRA allocated costs

AHPRA incurs the following expenses and then allocates 100% of the expenditure to the national boards in agreed proportions, based on an agreed formula. The percentages are based on an analysis of historical and financial data to estimate the proportion of AHPRA costs. AHPRA supports the work of the national boards by employing all staff and providing systems and infrastructure to manage registration and notifications functions, as well as the support services necessary to run a national organisation with eight state and territory offices. The allocation to each National Board will be reviewed on a regular basis.

(i) Staffing costs

Staffing costs relate to AHPRA employee costs including on-costs and contractors.

(ii) Travel and accommodation

Travel and accommodation relates to flights, taxis, parking and hotel costs incurred by AHPRA.

(iii) Systems and communication

Systems and communication costs relate to the external cost of supporting the technology systems of AHPRA.

(iv) Property expenses

Property expenses include rental, outgoings and maintenance of all leased and owned properties.

(v) Strategic and project costs

Strategic and project costs relate to one-off project costs incurred in the year.

(vi) Administration expenses

Administration expenses include any expenses not listed above. The major component of administration expenses are corporate legal, bank charges and merchant fees, postage, freight & couriers, printing & stationery, insurance and recruitment.

(g) Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at call, and other short term liquid deposits.

(h) Investments

Investments include term deposits held at fixed interest rates.

(i) Receivables

The terms of trade are 30 days from invoice date. Receivables are recognised and carried at original invoice amount less any allowance for any uncollectable amounts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off when identified.

(j) Impairment of financial assets

At the end of each reporting period, AHPRA assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through profit and loss are subject to annual review for impairment.

(k) Plant, equipment and intangible assets, depreciation and amortisation

Plant and equipment from the former boards are valued at the amounts transferred to AHPRA. Plant and equipment and intangibles procured in 2011-12 are measured at cost less accumulated depreciation and impairment. These assets are depreciated and amortised at rates based on their expected useful lives, using the straight-line method, which is reviewed annually.

The depreciation rates used for major assets in each class are as follows:

	2012	2011
Furniture and fittings	13%	13%
Computer equipment	20% to 40%	20% to 40%
Intangibles	10% to 40%	10% to 40%
Office equipment	15%	15%

Leasehold improvements are amortised over the term of the lease.

Work in progress (WIP) is not depreciated until it reaches service delivery capacity.

(l) Revaluations of non-current physical assets

AHPRA's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required. This revaluation process normally occurs at least every five years, based upon the asset's classification, but may occur more frequently if fair value assessments indicate material changes in values.

(m) Prepayments

Prepaid expenditure is recognised as a prepayment when the expenditure relates to future periods. It is then recognised as expenditure to the period in which the service relates.

(n) Impairment of non-financial assets

All non-financial assets are assessed annually for indications of impairment. If there is an indication of impairment, the assets concerned are tested as to whether their carrying value exceeds their possible recoverable amount. The difference is written-off as an expense except to the extent that the write-down can be debited to an asset revaluation surplus amount applicable to that same class of asset.

(o) Payables and accruals

Payables are initially recognised at fair value, subsequently carried at amortised cost and represent liabilities for goods and services provided to AHPRA prior to the end of the financial year that are unpaid, and arise when AHPRA is obliged to make future payments in respect of the purchase of goods and services. Terms of settlement are generally 30 days from the date of invoice.

(p) Employee benefits

(i) Annual leave

Liabilities for wages and salaries, including non-monetary benefits and annual leave expected to be settled within 12 months of the reporting date are recognised in the provision for employee benefits in respect of employees' service up to the reporting date and are classified as current liabilities and measured at their nominal values.

Those liabilities not expected to be settled within 12 months are recognised in the provision for employee benefits as current liabilities, measured at the present value of the amounts expected to be paid when the liabilities are settled using remuneration rates expected to apply at the time of settlement.

(ii) Long service leave

The long service leave entitlement under existing arrangements is recognised from an employee's commencement date and becomes payable according to the employment arrangements in place. The valuation of long service leave for employees who have met the conditions of service to take long service leave is recognised as a current liability whilst the valuation for those employees still to meet the conditions of service is measured as a non-current liability.

The liability is measured as the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given to expected future wage and salary levels, experience of employee departures and periods of service. Expected future payments are discounted using interest rates on national government guaranteed securities with terms to maturity that match, as closely as possible, the estimated future cash outflows.

(iii)Termination benefits

Termination benefits are payable when employment is terminated before the normal retirement date or when an employee accepts voluntary redundancy in exchange for these benefits. AHPRA recognises termination benefits when has it demonstrably committed to either terminating the employment of current employees according to a detailed formal plan without possibility of withdrawal or providing termination benefits as a result of an offer made to encourage voluntary redundancy. Benefits falling due more than 12 months after the end of the reporting period are discounted to present value.

(iv) Defined superannuation plans

The amount charged to the Comprehensive Income Statement in respect of superannuation represents the contribution by AHPRA to the superannuation fund. Contributions to defined contribution superannuation plans are expensed when incurred and paid at the required rate.

(q) Employee benefits on costs

Employee benefits on-costs, including payroll tax, work cover insurance premiums and superannuation entitlements are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities.

(r) Goods and service tax (GST)

All application, registration and late fees are exempt from Goods and Services Tax legislation. Revenues, expenses and assets are recognised net of GST except where the amount of GST incurred is not recoverable, in which case it is recognised as part of the cost of acquisition of an asset or part of an item of expense or revenue. GST receivable from and payable to the Australian Taxation Office is included in the balance sheet. The GST component of a receipt or payment is recognised on a gross basis in the "statement of cash flows" in accordance with Accounting Standard AASB 107.

(s) Income tax

Tax effect accounting has not been applied as AHPRA is exempt from income tax under section 50-25 of the Income Tax Assessment Act 1997.

(t) Leases

Operating lease payments are recognised as an expense in the Comprehensive Income Statement on a straight line basis over the lease term.

(u) Commitments

Commitments are disclosed to include those operating and capital commitments arising from non-cancellable contractual or statutory obligations. All amounts shown in the commitments note are inclusive of GST.

(v) Contingent assets and contingent liabilities

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

(w) Equity

Opening equity includes equity opening balance from 30 June 2011.

(x) Comparative amounts

When required by accounting standards, comparative figures have been adjusted to conform to changes in presentation for the current financial year.

(y) Functional and presentation currency

All amounts specified in these statements are presented in Australian dollars.

(z) Rounding of amounts

Amounts in the financial report have been rounded to the nearest thousand dollars or in other cases to the nearest dollar.

(aa) Abbreviations

CHI	Chiropractic Board of Australia	OST	Osteopathy Board of Australia
DEN	Dental Board of Australia	PHA	Pharmacy Board of Australia
MBA	Medical Board of Australia	PHY	Physiotherapy Board of Australia
NMBA	Nursing and Midwifery Board of Australia	POD	Podiatry Board of Australia
OPT	Optometry Board of Australia	PSY	Psychology Board of Australia

(bb) New accounting standards and interpretations

Certain new Australian accounting standards and interpretations that are not mandatory for 30 June 2012 reporting period have been published.

As at 30 June 2012, the following standards and interpretations had been issued but were not mandatory for the reporting ended 30 June 2012. AHPRA has not and does not intend to adopt these standards early.

AASB 108 requires disclosure of the impact on AHPRA's financial statements of these changes. These are set out below.

Standard/Interpretation	***Summary***	***Applicable for annual reporting periods beginning on***	***Impact on AHPRA financial statements***
AASB-9 Financial Instruments	This standard revised requirements for the classification and measurement of financial liabilities, and carrying over of the existing derecognition requirement from AASB 139 *Financial Instruments*: *Recognition and Measurement.*	Beginning 1 Jan 2013	Expected to have no significant impact. New requirements apply when an entity choses to measure a liability at fair value through profit or loss.
AASB-13 *Fair Value Measurement*	This standard outlines the requirements for measuring the fair value of assets and liabilities and replaces the existing fair value definition and guidance in other AASs. AASB 13 includes a 'fair value hierarchy' which ranks the valuation technique inputs into three levels using unadjusted quoted prices in active markets for identical assets or liabilities; other observable inputs; and unobservable inputs.	Beginning 1 Jan 2013	The introduction of a "fair value hierarchy" may increase the disclosures that have assets measured using depreciated replacement cost. Detail of impact is still being assessed.
AASB-119 *Employee Benefits*	This standard changes the methodology applied to calculation of superannuation expenses relating to defined superannuation plans. It also changes the definition of short term employee benefits. Only benefits that are expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service are classified as short-term employee benefits.	Beginning 1 Jan 2013	Expect to have no significant impact. Under the revised AASB 119, annual leave classified as long term will need to be discounted.
AASB 1053 *Application of Tiers of Australian Accounting Standards*	This standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements.	1 July 2013	Details of impact is still being assessed.

AASB 2009-11 Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 121, 127, 128, 131, 132, 136, 139, 1023 and 1038 and Interpretations 10 and 12]	This standard gives effect to consequential changes arising from the issuance of AASB 9.	1 Jan 2013	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2010-2 Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements	This standard makes amendments to many Australian Accounting Standards, including Interpretations, to introduce reduced disclosure requirements to the pronouncements for application by certain types of entities.	1 July 2013	Detail of impact is still being assessed.
AASB 2010-7 Amendments to Australian Accounting Standards arising from AASB 9 (December 2010) [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 120, 121, 127, 128, 131, 132, 136, 137, 139, 1023 & 1038 and Interpretations 2, 5, 10, 12, 19 & 127]	These consequential amendments are in relation to the introduction of AASB 9.	1 Jan 2013	No significant impact is expected from these consequential amendments on entity reporting.
AASB 2010-8 Amendments to Australian Accounting Standards – Deferred Tax: Recovery of Underlying Assets [AASB 112]	This amendment provides a practical approach for measuring deferred tax assets and deferred tax liabilities when measuring investment property by using the fair value model in AASB 140 Investment Property.	Beginning 1 Jan 2012	This amendment provides additional clarification through practical guidance.
AASB 2010-10 Further Amendments to Australian Accounting Standards – Removal of Fixed Dates for First-time Adopters [AASB 2009-11 & AASB 2010-7]	The amendments ultimately affect AASB 1 First-time Adoption of Australian Accounting Standards and provide relief for first-time adopters of Australian Accounting Standards from having to reconstruct transactions that occurred before their date of transition to Australian Accounting Standards.	1 Jan 2013	Expected to have no significant impact.
AASB 2011-2 Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements [AASB 101 & AASB 1054]	The objective of this amendment is to include some additional disclosure from the Trans-Tasman Convergence Project and to reduce disclosure requirements for entities preparing general purpose financial statements under Australian Accounting Standards – Reduced Disclosure Requirements.	1 July 2013	Detail of impact is still being assessed.
AASB 2011-4 Amendments to Australian Accounting Standards to Remove Individual Key Management Personnel Disclosure Requirements [AASB 124]	This standard amends AASB 124 Related Party Disclosures by removing the disclosure requirements in AASB 124 in relation to individual key management personnel (KMP).	1 July 2013	Expected to have no significant impact.

AASB 2011-7 Amendments to Australian Accounting Standards arising from the Consolidation and Joint Arrangements Standards [AASB 1, 2, 3, 5, 7, 9, 2009-11, 101, 107, 112, 118, 121, 124, 132, 133, 136, 138, 139, 1023 & 1038 and Interpretations 5, 9, 16 & 17]	This standard outlines consequential changes arising from the issuance of the five 'new Standards' to other Standards. For example, references to AASB 127 Consolidated and Separate Financial Statements are amended to AASB 10 Consolidated Financial Statements or AASB 127 Separate Financial Statements, and references to AASB 131 Interests in Joint Ventures are deleted as that standard has been superseded by AASB 11 and AASB 128 (August 2011).	1 Jan 2013	No significant impact is expected.
AASB 2011-8 Amendments to Australian Accounting Standards arising from AASB 13 [AASB 1, 2, 3, 4, 5, 7, 9, 2009-11, 2010-7, 101, 102, 108, 110, 116, 117, 118, 119, 120, 121, 128, 131, 132, 133, 134, 136, 138, 139, 140, 141, 1004, 1023 & 1038 and Interpretations 2, 4, 12, 13, 14, 17, 19, 131 & 132]	This amending standard makes consequentical changes to a range of standards and interpretations arising from the issuance of AASB 13. In particular, this Standard replaces the existing definition and guidance of fair value measurements in other Australian Accounting Standards and Interpretations.	1 Jan 2013	Disclosures for fair value measurements using unobservable inputs is potentially onerous, and may increase disclosures for assets measured using depreciated replacement cost.
AASB 2011-9 Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive Income [AASB 1, 5, 7, 101, 112, 120, 121, 132, 133, 134, 1039 & 1049]	The main change resulting from this standard is a requirement for entities to group items presented in other comprehensive income (OCI) on the basis of whether they are potentially reclassifiable to profit or loss subsequently (reclassification adjustments). These amendments do not remove the option to present profit or loss and other comprehensive income in two statements, nor change the option to present items of OCI either before tax or net of tax.	1 July 2012	No significant impact will be expected.
AASB 2011-10 Amendments to Australian Accounting Standards arising from AASB 119 (September 2011) [AASB 1, AASB 8, AASB 101, AASB 124, AASB 134, AASB 1049 & AASB 2011-8 and Interpretation 14]	This standard makes consequential changes to a range of other Australian Accounting Standards and Interpretaion arising from the issuance of AASB 119 Employee Benefits.	1 Jan 2013	No significant impact is expected.
AASB 2011-11 Amendments to AASB 119 (September 2011) arising from Reduced Disclosure Requirements	This standard makes amendments to AASB 119 Employee Benefits (September 2011), to incorporate reduced disclosure requirements into the standard for entities applying Tier 2 requirements in preparing general purpose financial statements.	1 July 2013	Detail of impact is still being assessed.
AASB 2011-12 Amendments to Australian Accounting Standards arising from Interpretation 20 [AASB 1]	This standard makes amendments to AASB 1 First-time Adoption of Australian Accounting Standards, as a consequence of the issuance of IFRIC Interpretation 20 Stripping Costs in the Production Phase of a Surface Mine. This standard allows the first-time adopters to apply the transitional provisions contained in	1 Jan 2013	No significant impact is expected.

	Interpretation 20.		
2012-1 Amendments to Australian Accounting Standards - Fair Value Measurement - Reduced Disclosure Requirements [AASB 3, AASB 7, AASB 13, AASB 140 & AASB 141]	This amending standard prescribes the reduced disclosure requirements in a number of Australian Accounting Standards as a consequence of the issuance of AASB 13 Fair Value Measurement.	1 July 2013	No significant impact is expeced.

Note 2a - Registration fee income	2012 $'000	2011 $'000
Registration fee income recognised from legacy boards	0	38,789
Registration fee income received and recognised during the year	125,023	65,313
Application fee income	12,791	11,063
Total registration fee income	**137,814**	**115,165**

Note 2b - Other income	2012 $'000	2011 $'000
Government grant income	5,985	602
Certificate of registration status	302	307
Pharmacy Board of Australia examinations	653	593
NRAS 2012 Boards' fees	3,999	0
Gain on disposal of assets held for sale	224	0
Other income	2,616	2,504
Total other income	**13,779**	**4,006**

Note 3a - Administration expenses	2012 $'000	2011 $'000
Legal – corporate	448	701
Bank charges and merchant fees	789	666
Postage, freight and courier	787	1,337
Printing and stationery	1,123	629
Insurance	558	471
Recruitment	1,538	1,039
Other	2,175	1,962
Total administration expenses	**7,418**	**6,805**

Note 3b - Depreciation and amortisation	2012 $'000	2011 $'000
Depreciation		
Leasehold improvements	877	491
Furniture and fittings	61	39
Computer equipment	130	161
Office equipment	17	12
Motor vehicles	4	2
Amortisation		
Computer software	132	0
Total depreciation and amortisation	**1,221**	**705**

Note 4 - Cash and cash equivalents and investments

Note 4a - Cash and cash equivalents	2012 $'000	2011 $'000
Cash on hand , at bank and term deposits less than 30 days	1,713	3,096
Total cash and cash equivalents	**1,713**	**3,096**

Note 4b - Investments	2012 $'000	2011 $'000
Less than 90 day bank term deposits	2,500	12,500
Bank term deposits greater than 90 days	109,500	70,000
Total investments	**112,000**	**82,500**

Note 5 - Receivables	2012 $'000	2011 $'000
Trade receivables	1,712	2,170
GST receivable	954	576
Less allowances for doubtful debts	(34)	(79)
Total receivables	**2,632**	**2,667**

Movement in the allowance for doubtful debts	2012 $'000	2011 $'000
Balance at beginning of year	79	0
Increase/ (decrease) in allowance recognised in net result	(45)	79
Balance at end of year	**34**	**79**

Note 6 - Accrued income	2012 $'000	2011 $'000
Accrued interest on term deposits	**2,310**	**964**

Note 7 - Assets held for sale

All buildings transferred by the former Health Boards to AHPRA were classified as assets held for sale and were sold during the financial year ended 30 June 2011 except 1/165 Adelaide Terrace, East Perth, which was classified as asset held for sale at 30 June 2011 with a written down value of $2.049million. This building was sold for $2.4 million in March 2012 and settlement occurred in May 2012.

Note 8 - Property, plant and equipment (PPE)

	Land and buildings	Leasehold improvements	Furniture and fittings	Computer equipment	Office equipment	Motor vehicle	WIP	Total PPE
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
At cost								
Balance at 30 June 2010	0	388	7	7	69	0	281	752
Additions	0	4,991	403	252	20	30	657	6,353
Transfers from former boards	6,184	642	628	401	190	0	0	8,045
Transfers to asset held for sale	(6,184)	0	0	0	0	0	0	(6,184)
Disposals	0	(642)	(628)	(401)	(190)	0	0	(1,861)
Balance at 30 June 2011	0	5,379	410	259	89	30	938	7,105
Additions	0	570	119	545	48	0	436	1,718
Balance at 30 June 2012	0	5,949	529	804	137	30	1,374	8,823
Accumulated depreciation								
Balance at 30 June 2010	0	0	0	0	0	0	0	0
Depreciation charge during the year	0	(490)	(39)	(105)	(12)	(3)	0	(649)
Balance at 30 June 2011	0	(490)	(39)	(105)	(12)	(3)	0	(649)
Depreciation charge during the year	0	(878)	(61)	(130)	(17)	(4)	0	(1,090)
Balance at 30 June 2012	0	(1,367)	(100)	(235)	(29)	(7)	0	(1,739)
Net book value								
At 30 June 2012	0	4,581	429	569	108	23	1,374	7,084
At 30 June 2011	0	4,889	371	154	77	27	938	6,456

Note 9 - Intangible assets

	Computer Software		Total	
	2012	**2011**	**2012**	**2011**
	$'000	**$'000**	**$'000**	**$'000**
At cost				
Opening balance	142	0	142	0
Additions	1,698	142	1,698	142
Closing balance	1,840	142	1,840	142
Accumulated amortisation				
Opening balance	(56)	0	(56)	0
Amortisation charge during the year	(131)	(56)	(131)	(56)
Closing balance	(187)	(56)	(187)	(56)
Net book value at end of financial year	1,653	86	1,653	86

Note 10 - Payables and accruals

Payables and accruals	2012 $'000	2011 $'000
Trade creditors	6,829	4,601
Accrued expenses	5,836	4,168
Total payables and accruals	**12,665**	**8,769**

Note 11 - Income in advance

11a. Amount received in advance from health boards	2012 $'000	2011 $'000
Amounts received in advance – government grants (i)	1,740	795
Amounts received in advance – registration fees (ii)	1,502	0
Total	**3,242**	**795**

11b. Prepaid income	2012 $'000	2011 $'000
Chiropractic Board of Australia	803	559
Dental Board of Australia	3,218	2,642
Medical Board of Australia	11,659	16,901
Nursing and Midwifery Board of Australia	41,516	24,659
Optometry Board of Australia	657	573
Osteopathy Board of Australia	303	216
Pharmacy Board of Australia	2,683	2,172
Physiotherapy Board of Australia	1,636	1,300
Podiatry Board of Australia	510	389
Psychology Board of Australia	4,182	3,220
Other	912	1,328
Total	**68,079**	**53,959**
Total income in advance	**71,321**	**54,754**

i. In addition to the $795,000 received in 2010-11 from Health Workforce Australia in relation to the establishment of Aboriginal and Torres Strait Islander Health Practice Board of Australia, $945,000 was received from governments in 2011-12 for the establishment of the NRAS 2012 professions' National Boards.

ii. Registration fees (net of HPCA fee) received from the NRAS 2012 professions:

	$'000
Aboriginal and Torres Strait Islander Health Practice Board of Australia	1
Chinese Medicine Board of Australia	404
Medical Radiation Practice Board of Australia	459
Occupational Therapy Board of Australia	638
Total	**1,502**

Note 12 - Employee benefits

Current	2012 $'000	2011 $'000
Unconditional annual leave and expected to be settled within 12 months.	3,111	2,546
Unconditional annual leave expected to be settled after 12 months	814	654
Unconditional long service leave and expected to be settled within 12 months.	1,886	1,584
Total current employee benefits	**5,811**	**4,784**
Non-current		
Conditional long service leave entitlements expected to be settled after 12 months	1,067	1,084
Total non-current employee benefits	**1,067**	**1,084**

Note 13 - Equity

Summary of net result for the year by National Board 2011/12												
	CHI	DEN	MBA	NMBA	OPT	OST	PHA	PHY	POD	PSY	OTHER	TOTAL
	$'000	$'000	$',000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Income from transactions												
Registration fee income	2,070	8,904	54,811	44,724	1,741	820	7,880	4,501	1,311	11,052	0	137,814
Interest	220	557	1,541	1,152	204	192	827	730	118	265	0	5,806
Other income	125	143	1,686	1,016	11	6	846	42	3	205	9,695	13,779
Total income from transactions	2,415	9,604	58,038	46,892	1,957	1,018	9,553	5,273	1,432	11,522	9,695	157,399
Expenses from transactions												
Board and committee sitting fees	297	453	1,836	1,019	243	200	387	467	223	700	0	5,825
Other direct board costs	194	274	1,305	1,145	214	171	942	298	133	464	0	5,141
Legal costs	291	362	6,288	1,676	32	23	817	87	69	1,147	0	10,791
HPCA regulatory fee	185	1,229	7,050	6,947	162	92	1,475	445	119	1,067	0	18,771
Accreditation	192	283	1,383	1,000	205	181	400	206	126	362	20	4,357
AHPRA allocation costs	1,084	6,043	38,444	36,472	828	237	4,909	2,622	473	7,462	6,737	105,311
Total expenses from transactions	2,242	8,645	56,306	48,260	1,684	903	8,930	4,125	1,142	11,202	6,757	150,196
Net result for the year	173	959	1,732	(1,368)	273	115	623	1,148	290	320	2,938	7,203

Each National Board has a Health Profession Agreement with AHPRA. As part of this agreement AHPRA manages a pool of allocated costs on behalf of the National Boards. The pool of allocated costs includes:

- staffing costs
- systems and communication
- strategic and project costs
- administration expenses.
- travel and accommodation
- property expenses
- depreciation and amortisation

In 2011-12 the costs were allocated to each National Board on the percentage allocations shown below.

CHI	DEN	MBA	NMBA	OPT	OST	PHA	PHY	POD	PSY	TOTAL
1.10%	6.13%	39.0%	37.0%	0.84%	0.24%	4.98%	2.66%	0.48%	7.57%	100.0%

These allocations will be reviewed each year and agreed between AHPRA and each National Board.

Equity

	Notes	2012	2011
(A) Contributed capital		**$'000**	**$'000**
Balance at the beginning of financial year		39,472	5,842
Capital contributions from former boards		0	33,630
Balance at end of financial year		**39,472**	**39,472**
(B) Accumulated surplus / (deficit)			
Balance at the beginning of financial year		(10,935)	(4,517)
Surplus/deficit for the year		7,203	(6,418)
Balance at end of financial year		**(3,732)**	**(10,935)**

From 1 July 2012 four additional health professions joined the scheme. The establishment costs for these health professions were partly funded during 2011-12 from grants and application fees received up to 30 June 2012. The project has a net surplus $2,938,351. This surplus is represented on Comprehensive Income Statement as AHPRA equity as at 30 June 2012. The surplus then transferred to the opening equity of these four National Boards on 1 July 2012. Further project costs to be incurred in 2012-13 are estimated to be $880,000, the funding of which comes from income in advance as stated in Note 11b to the financial statements.

Where these four additional health professions are currently regulated in a jurisdiction, the equity of these boards were transferred to the National Boards on 1 July 2012. In preparation for this, up to 30% of equity were transferred prior to 1 July 2012 totalling $1,503,212 and are recorded as liability in the balance sheet as Equity Received in Advance at 30 June 2012. These amounts will be transferred from liabilities to equity on 1 July 2012 on commencement of operations of these National Boards.

Summary of equity by National Board												
	CHI	DEN	MBA	NMBA	OPT	OST	PHA	PHY	POD	PSY	OTHER	TOTAL
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Contributed capital												
2009-10	171	502	1,325	2,142	213	87	666	414	84	238	0	5,842
2010-11	993	2,618	10,932	4,374	848	909	2,050	2,314	336	1,956	6,300	33,630
2011-12	0	0	0	6,300	0	0	0	0	0	0	(6,300)	0
	1,164	3,120	12,257	12,816	1,061	996	2,716	2,728	420	2,194	0	39,472
Accumulated surplus/ (deficit)												
2009-10	(50)	(277)	(1,761)	(1,671)	(38)	(11)	(225)	(120)	(22)	(342)	0	(4,517)
2010-11	(160)	(583)	(5,305)	(716)	(160)	(107)	966	399	34	(786)	0	(6,418)
2011-12	173	959	1,732	(1,368)	273	115	623	1,148	290	320	2,938	7,203
	(37)	99	(5,334)	(3,755)	75	(3)	1,364	1,427	302	(808)	2,938	(3,732)
Equity												
2009-10	121	225	(436)	471	175	76	441	294	62	(104)	0	1,325
2010-11	954	2,260	5,191	4,129	863	878	3,457	3,007	432	1,066	6,300	28,537
2011-12	1,127	3,219	6,923	9,061	1,136	993	4,080	4,155	722	1,386	2,938	35,740

Previously funds totalling $6.3 million had been set aside from the sale of the Nurses Board of Victoria building and have now been transferred to the NMBA following advice from the Victorian government.

Note 14 - Responsible persons and accountable officer

(i) Australian Health Workforce Ministerial Council

The Ministerial Council comprises Ministers of the governments of the participating jurisdictions and the Commonwealth with the portfolio responsibility for Health. The following Ministers were members of the Australian Health Workforce Ministerial Council during the period 1 July 2011 to 30 June 2012.

Name	Position	Jurisdiction
The Hon Nicola Roxon MP (until 14 December 2011)	Minister for Health & Ageing	Federal Minister
The Hon Tanya Plibersek MP (from 14 December 2011)	Minister for Health	Federal Minister
The Hon Jillian Skinner	Minister for Health Minister for Medical Research	New South Wales
The Hon David Davis MLC	Minister for Health Minister for Ageing	Victoria
The Hon Geoff Wilson (until 23 March 2012)	Minister for Health	Queensland
The Hon Lawrence Springborg MP (from 3 April 2012)	Minister for Health	Queensland
The Hon John Hill MP	Minister for Health & Ageing Minister for Mental Health and Substance Abuse Minister for the Arts	South Australia
The Hon Michelle O'Byrne MHA	Minister for Health, Minister for Children Minister for Sport and Recreation	Tasmania
The Hon Dr Kim Hames MLA	Deputy Premier Minister for Health Minister for Tourism	Western Australia
Ms Katy Gallagher MLA	Chief Minister Minister for Health Minister for Territory and Municipal Services	Australian Capital Territory
The Hon Kon Vatskalis MLA	Minister for Health Minister for Children and Families Minister for Child Protection Minister for Primary Industry, Fisheries and Resources	Northern Territory

All dates are from 1 July 2011 to 30 June 2012 unless otherwise stated.

(ii) Agency Management Committee Members

	Period
Mr Peter Allen	1/07/11 – 30/06/12
Professor Con Michael, AO	1/07/11 – 30/06/12
Professor Genevieve Gray	1/07/11 – 30/06/12
Mr Michael Gorton, AM	1/07/11 – 30/06/12
Professor Merrilyn Walton	1/07/11 – 30/06/12

(iii) Remuneration of Agency Management Committee

Income		2012 No.	2011 No.
$10,000 - $19,999		2	3
$20,000 - $29,999		1	1
$30,000 - $39,999		1	0
$40,000 - $49,999		1	1
	Total Numbers	**5**	**5**
	Total Amount	**$123,373**	**$115,211**

Remuneration shown above includes sitting fees for meetings of the Agency Management Committee, its sub-committees or other committees which required the members of the Agency Management Committee. Amounts relating to responsible Ministers are reported in the financial statements of the relevant Minister's jurisdiction.

(iv) Related party transactions

Mr Michael Gorton, AM is a principal of Russell Kennedy Solicitors which provides legal services on notification matters to AHPRA on normal commercial terms and conditions.

2012 $'000	2011 $'000
290	**367**

(v) Remuneration of Chief Executive Officer and National Directors

The Chief Executive Officer (CEO) is Mr Martin Fletcher who held the position for the period 1 July 2011 to 30 June 2012. The aggregate compensation made to the CEO and National Directors is set out below:

	Total Remuneration	
	2012 No.	2011 No.
Income		
$170,000 - $179,999	0	1
$200,000 - $209,999	1	1
$220,000 - $229,999	1	1
$240,000 - $249,999	1	1
$250,000 - $259,999	1	0
$330,000 - $339,999	1	1
Total Numbers	5	5
Total Amount	$1,278,293	$1,182,426

Note 15 - Remuneration of Auditor

	2012 $'000	2011 $'000
Amount payable to VAGO for auditing the statements (excluding GST)	140	162
	140	162

Note 16 - Commitments

Operating lease commitments

Commitments (including GST) in relation to operating leases are payable as:

Non-Cancellable	2012 $'000	2011 $'000
Not later than 1 year	7,562	5,587
Later than 1 year but not later than 5 years	28,313	23,092
Later than 5 years	8,169	11,596
Total operating leases	**44,044**	**40,275**

Note 17 - Contingent liabilities

Contingent liabilities	2012 $'000	2011 $'000
Legal proceedings and disputes	3,129	0

The amount disclosed as a contingent liability is the aggregate liabilities of AHPRA as at 30 June 2012. Claims for damages were lodged during the year in relation to various matters. AHPRA has disclaimed liability and is defending the actions. The extent to which an outflow of funds will be required is dependent on the case(s) outcome being more or less favourable than currently expected.

Note 18 a - Reconciliation of comprehensive result to operating cash flows

	2012 $'000	2011 $'000
Net result for the year	**7,203**	**(6,418)**
Adjustments for:		
Depreciation	1,221	705
(Gain)/loss on disposal of assets held for sale	(224)	1,861
Changes in assets and liabilities		
(Increase) / decrease in receivables	35	(872)
(Increase) / decrease in prepayments	(605)	16
(Increase) / decrease in accrued income	(1,345)	(964)
Increase / (decrease) in prepaid income	16,567	54,754
Increase / (decrease) in payables and accruals	3,896	1,313
Increase / (decrease) in employee benefits	1,009	916
Net cash flows from operating activities	**27,757**	**51,311**

The changes in assets and liabilities exclude items transferred by the former boards and taken up as equity on transfer.

Note 18 b – Receipts relating to registrant fees

	2012 $'000	2011 $'000
Chiropractic Board of Australia	2,314	2,134
Dental Board of Australia	9,480	9,896
Medical Board of Australia	49,570	60,333
Nursing and Midwifery Board of Australia	61,581	65,642
Optometry Board of Australia	1,825	1,942
Osteopathy Board of Australia	906	824
Pharmacy Board of Australia	8,391	9,219
Physiotherapy Board of Australia	4,837	4,948
Podiatry Board of Australia	1,432	1,361
Psychology Board of Australia	12,013	11,495
	152,349	**167,796**

Note 19 - Financial instruments

(a) Financial risk management

AHPRA's principal financial instruments consist of at call variable interest deposits, term deposits and trade receivables and payables. AHPRA has no exposure to exchange rate risk.

Details of the significant accounting policies and methods adopted, including the criteria for recognition, the basis of measurement, and the basis of which income and expenses are recognised, with respect to each class of financial asset, financial liability and equity instrument above are disclosed in note 1 to the financial statements.

(b) Credit risk exposure

Credit risk is the risk that a party will fail to fulfil its obligations to AHPRA resulting in financial loss. The maximum exposure to credit risk, excluding the value of any collateral or other security at balance date to recognised financial assets, is the carrying amount, net of any provisions for impairment of those assets, as disclosed in the balance sheet and notes to the financial statements. AHPRA does not have any material credit risk exposure to any single receivable or group of receivables under financial instruments entered into by the entity.

There are no material amounts of collateral held as security at 30 June 2012.

Credit risk is managed by the entity and reviewed regularly. It arises from exposures to customers as well as through deposits with financial institutions.

The entity monitors the credit risk by actively assessing the rating quality and liquidity of counterparties.

Credit quality of contractual assets that are neither past due nor impaired

	Financial institutions (AA credit rating)	Other	Total
2012	**$ '000**	**$ '000**	**$ '000**
Financial assets			
Cash and cash equivalents	1,713	0	1,713
Investments	112,000	0	112,000
Receivables	0	1,678	1,678
Total	**113,713**	**1,678**	**115,391**

Credit quality of contractual assets that are neither past due nor impaired

	Financial institutions (AA credit rating)	Other	Total
2011	**$ '000**	**$ '000**	**$ '000**
Financial assets			
Cash and cash equivalents	3,096	0	3,096
Investments	82,500	0	82,500
Receivables	0	2,091	2,091
Total	**85,596**	**2091**	**87,687**

Ageing analysis of financial assets

	Carrying Amount	Less than 1 month	1-3 months	3 months – 1 year
2012	**$ '000**	**$ '000**	**$ '000**	**$ '000**
Financial assets				
Cash and cash equivalents	1,713	0	0	0
Investments	112,000	0	0	0
Receivables	1,678	506	45	1,127
Total	**115,391**	**506**	**45**	**1,127**

Ageing analysis of financial assets

	Carrying amount	Less than 1 month	1-3 months	3 months – 1 year
2011	**$ '000**	**$ '000**	**$ '000**	**$ '000**
Financial assets				
Cash and cash equivalents	3,096	0	0	0
Investments	82,500	0	0	0
Receivables	2,091	1,821	56	214
Total	**87,687**	**1,821**	**56**	**214**

(c) Liquidity risk exposure

Liquidity risk is the risk that AHPRA will encounter difficulty in meeting obligations associated with financial liabilities. AHPRA manages liquidity risk by monitoring forecast cash flows and ensuring that adequate liquid funds are available to meet current obligations.

The following tables disclose the maturity analysis of AHPRA's financial liabilities

		Maturity dates		
	Carrying amount	**Less than 1 month**	**1-3 months**	**3 months – 1 year**
2012	**$ '000**	**$ '000**	**$ '000**	**$ '000**
Payables				
Trade creditors	6,829	6,254	552	23
Accrued expenses	5,836	5,836	-	-
Total	**12,665**	**12,090**	**552**	**23**

		Maturity dates		
	Carrying amount	**Less than 1 month**	**1-3 months**	**3 months – 1 year**
2011	**$'000**	**$'000**	**$'000**	**$'000**
Payables				
Trade creditors	4,601	4,539	18	44
Accrued expenses	4,168	4,168	-	-
Total	**8,769**	**8,707**	**18**	**44**

Trade creditors over 30 days still to be paid relate to amounts which are being held for payment until all conditions for payment are met.

The maximum exposure to liquidity risk is the total carrying amount of the financial liabilities as shown above.

(d) Market risk exposure

Currency risk

AHPRA has no exposure to currency risk at 30 June 2012.

Equity price risk

AHPRA has no exposure to equity price risk at 30 June 2012.

Interest rate risk

Exposure to interest rate risk is limited to assets bearing variable interest rates. AHPRA has a combination of deposits with floating and fixed interest rates. Exposure to variable interest rate risk is with financial institutions with AA credit rating.

	Interest rate exposure of financial instruments				
2012	**Weighted average interest rate**	**Non-interest bearing $'000**	**Floating interest rate $'000**	**Fixed interest rate 1 year or less $'000**	**Total $'000**
Financial assets					
Cash and cash equivalents	2.67%	10	1,703	-	**1,713**
Investments	5.60%	-	-	112,000	**112,000**
Receivables	-	1,678	-	-	**1,678**
Total	**0**	**1,688**	**1,703**	**112,000**	**115,391**
Financial liabilities					
Payables	-	6,828	-	-	**6,828**
Accrued expenses	-	5,836	-	-	**5,836**
Total	**0**	**12,664**	**0**	**0**	**12,664**

	Interest rate exposure of financial instruments				
2011	**Weighted average interest rate**	**Non-interest bearing $'000**	**Floating interest rate $'000**	**Fixed interest rate 1 year or less $'000**	**Total $'000**
Financial assets					
Cash and cash equivalents	3.88%	14	3,082	-	**3,096**
Investments	6.07%	-	-	82,500	**82,500**
Receivables	-	2,091	-	-	**2,091**
Total	**-**	**2,105**	**3,082**	**82,500**	**87,687**
Financial liabilities					
Payables	-	4,601	-	-	**4,601**
Accrued expenses	-	4,168	-	-	**4,168**
Total	**-**	**8,769**	**-**	**-**	**8,769**

Sensitivity analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, AHPRA believes the following movements are 'reasonably possible' over the next 12 months.

- A parallel shift of +1% and -1% in market interest rates (AUD) from year-end rates of 2.67%

The following table discloses the impact on net operating result and equity for each category of financial instrument held by AHPRA at year end as presented to key management personnel, if changes in the market interest rates occur.

Financial assets	**Carrying amount $'000**	**At -1.0% $'000 Surplus**	**At -1.0% $'000 Equity**	**At +1.0% $'000 Surplus**	**At +1.0% $'000 Equity**
2012					
Cash and cash equivalents	1,713	(17)	(17)	17	17
Investments	112,000	(1,120)	(1,120)	1,120	1,120
Receivables	1,678	-	-	-	-
Financial liabilities					
Payables	6,828	-	-	-	-
Accruals	5,836	-	-	-	-
		(1,137)	**(1,137)**	**1,137**	**1,137**

Financial assets	**Carrying amount $'000**	**at -1.0% $'000 Surplus**	**At -1.0% $'000 Equity**	**At +1.0% $'000 Surplus**	**At +1.0% $'000 Equity**
2011					
Cash and cash equivalents	3,096	(31)	(31)	31	31
Investments	82,500	(825)	(825)	825	825
Receivables	2,091	-	-	-	-
Financial liabilities					
Payables	4,601	-	-	-	-
Accruals	4,168	-	-	-	-
		(856)	**(856)**	**856**	**856**

Other market risk

AHPRA has no exposure to other market risk at 30 June 2012.

(E) Net fair value

The net fair value of all on-balance sheet monetary financial assets and financial liabilities approximates their carrying value. There are no off-balance sheet financial assets or financial liabilities at balance sheet date.

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

- the fair value of financial instrument assets and liabilities with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices; and
- the fair value of other financial instrument assets and liabilities are determined in accordance with generally accepted pricing models based on discounted cash flow analysis.

AHPRA considers that the carrying amount of financial instrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be paid in full.

The following table shows that the fair values of most of the contractual financial assets and liabilities are the same as the carrying amounts.

Comparison between carrying amount and fair value

	Carrying amount 2012 $'000	Fair value 2012 $'000	Carrying amount 2011 $'000	Fair value 2011 $'000
Financial assets				
Cash and cash equivalents	1,713	1,713	3,096	3,096
Investments	112,000	112,000	82,500	82,500
Receivables	1,678	1,678	2,091	2,091
Total financial assets	**115,391**	**115,391**	**87,687**	**87,687**
Financial liabilities				
Payables	6,828	6,828	4,601	4,601
Accrued expenses	5,836	5,836	4,168	4,168
Total financial liabilities	**12,664**	**12,664**	**8,769**	**8,769**

Financial instruments are required to be classified at fair value based upon the reference of the source of inputs used to derive their fair value. Fair value measurements recognised in the balance sheet are categorised into the following levels:

- Level 1: quoted prices in active markets
- Level 2: quoted prices in non-active markets and inputs other than quoted prices that are observable, either directly or indirectly
- Level 3: inputs that are not based on observable market data

All financial assets (excluding receivables) are classified as either cash or investments, and are therefore categorised as Level 1 assets

Note 20 - Events occurring after the balance sheet date

There were no events subsequent to 30 June 2012

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INDEPENDENT AUDITOR'S REPORT

To the Agency Management Committee of the Australian Health Practitioner Regulation Agency

The Financial Report

The accompanying financial report for the year ended 30 June 2012 of the Australian Health Practitioner Regulation Agency which comprises the comprehensive income statement, balance sheet, statement of changes in equity, cash flow statement, notes comprising a summary of significant accounting policies and other explanatory information, and the declaration by the Agency Management Committee, Chief Executive Officer and Director, Finance and Corporate Operations has been audited.

The Agency Management Committee's Responsibility for the Financial Report

The Agency Management Committee of the Australian Health Practitioner Regulation Agency is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards, and the financial reporting requirements of the *Health Practitioner Regulation National Law Act 2009*, and for such internal control as the Agency Management Committee determine is necessary to enable the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on the audit, which has been conducted in accordance with Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit be planned and performed to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The audit procedures selected depend on judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, consideration is given to the internal control relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Agency Management Committee, as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Auditing in the Public Interest

Independent Auditor's Report (continued)

Independence

The Auditor-General's independence is established by the *Constitution Act 1975*. The Auditor-General is not subject to direction by any person about the way in which his powers and responsibilities are to be exercised. In conducting the audit, the Auditor-General, his staff and delegates complied with all applicable independence requirements of the Australian accounting profession.

Opinion

In my opinion, the financial report presents fairly, in all material respects, the financial position of the Australian Health Practitioner Regulation Agency as at 30 June 2012 and of its financial performance and its cash flows for the year then ended in accordance with applicable Australian Accounting Standards, and the financial reporting requirements of the *Health Practitioner Regulation National Law Act 2009*.

Matters Relating to the Electronic Publication of the Audited Financial Report

This auditor's report relates to the financial report of the Australian Health Practitioner Regulation Agency for the year ended 30 June 2011 included both in the Australian Health Practitioner Regulation Agency's annual report and on the website. The Agency Management Committee of the Australian Health Practitioner Regulation Agency is responsible for the integrity of the Australian Health Practitioner Regulation Agency's website. I have not been engaged to report on the integrity of the Australian Health Practitioner Regulation Agency's website. The auditor's report refers only to the subject matter described above. It does not provide an opinion on any other information which may have been hyperlinked to/from these statements. If users of the financial report are concerned with the inherent risks arising from publication on a website, they are advised to refer to the hard copy of the audited financial report to confirm the information contained in the website version of the financial report.

MELBOURNE
14 September 2012

D D R Pearson
Auditor-General

Auditing in the Public Interest

Appendix: data

Contents

Table A1: Renewal applications finalised in financial year 2011/12[1,2]

		Chiropractor	Dental practitioner	Medical practitioner	Midwife	Nurse	Nurse and midwife	Optometrist	Osteopath	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Total
ACT	Online	48	262	1,171	37	4,252	667	63	26	356	371	40	575	7,868
	Other	12	120	489	2	544	89	7	11	60	75	14	235	1,667
ACT Total		60	382	1,669	39	4,796	756	74	33	416	446	54	810	9,535
NSW	Online	1,037	4,499	20,001	390	76,700	13,828	1,290	433	6,662	5,500	807	8,419	139,566
	Other	1,233	1,786	7,885	70	13,535	3,098	257	235	1,616	1,252	298	3,675	34,940
NSW Total		2,270	6,285	27,886	460	90,235	16,926	1,547	668	8,278	6,752	1,105	12,094	174,506
NT	Other	17	110	612	25	3,023	586	26	1	143	126	16	149	4,834
	Online	10	24	260	2	241	40	3		31	14		68	693
NT Total		27	134	872	27	3,264	626	29	1	174	140	16	217	5,527
QLD	Online	518	2,965	2,733	313	53,565	7,666	815	124	4,194	3,726	519	3,840	80,978
	Other	217	780	3,984	27	5,695	798	107	23	845	484	78	1,378	14,416
QLD Total		735	3,745	6,717	340	59,260	8,464	922	147	5,039	4,210	597	5,218	95,394
SA	Online	260	1,234	5,035	328	24,354	2,640	188	22	1,499	1,684	297	1,073	38,614
	Other	105	418	1,799	16	3,896	340	32	8	381	322	57	416	7,790
SA Total		365	1,652	6,834	344	28,250	2,980	220	30	1,880	2,006	354	1,489	46,404
TAS	Online	31	233	1,262	15	10,473	1,141	73	33	482	332	71	374	14,520
	Other	22	137	697		1,992	172	11	9	121	60	14	153	3,388
TAS Total		53	370	1,959	15	12,465	1,313	84	42	603	392	85	527	17,908
VIC	Online	838	3,414	16,011	661	69,221	10,409	1,000	646	5,235	4,878	839	5,587	118,739
	Other	326	825	5,320	80	9,510	1,260	118	134	1,039	705	275	2,232	21,824
VIC Total		1,164	4,239	21,331	741	78,731	11,669	1,118	780	6,274	5,583	1,114	7,819	140,563
WA	Online	364	1,637	5,724	211	27,297	3,512	307	43	2,336	2,476	282	2,457	46,646
	Other	203	651	2,608	15	3,943	483	67	13	611	389	98	893	9,974
WA Total		567	2,288	8,332	226	31,240	3,995	374	56	2,947	2,865	380	3,350	56,620
No PPP	Online	69	307	1,453	50	6,266	234	137	20	502	632	19	295	9,984
	Other	44	78	266	7	567	34	25	1	66	72	4	78	1,242
No PPP Total		113	385	1,719	57	6,833	268	162	21	568	704	23	373	11,226
Total		5,354	19,480	77,319	2,249	315,074	46,997	4,530	1,778	26,179	23,098	3,728	31,897	557,683

1. Includes renewals that had been received prior to the beginning of the 2011/12 year and were finalised after 1 July 2011.
2. Includes renewals for registrants that may be registered in more than one profession.

Table A2: Registered practitioners by profession, principal place of practice and registration type

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2]	Total 2011/12	Total 2010/11	% change
Chiropractor	56	1,511	24	692	357	45	1,202	498	77	4,462	4,350	2.57%
General	55	1,450	22	674	341	45	1,115	482	32	4,216	4,191	0.60%
Limited		1			1		1		1	4	13	-69.23%
Non-practising	1	60	2	18	15		86	16	44	242	146	65.75%
Dental practitioner	350	5,989	134	3,728	1,615	336	4,358	2,254	323	19,087	18,319	4.19%
General	309	5,297	124	3,341	1,425	303	3,793	2,014	264	16,870	16,218	4.02%
General and specialist	39	447	6	289	131	22	368	145	29	1,476	1,427	3.43%
Limited		139	1	53	45	6	95	42	1	382	429	-10.96%
Non-practising	1	99	3	44	11	5	93	51	27	334	209	59.81%
Specialist		7		1	3		9	2	2	24	36	-33.33%
General and limited	1									1	0	
Medical practitioner	1,784	28,972	945	17,682	7,142	2,048	22,365	8,855	1,855	91,648	88,293	3.80%
General	519	8,318	337	5,484	1,944	517	6,425	2,374	565	26,483	23,995	10.37%
General (teaching and assessing)		8		5	5		4	1		23	0	
General (teaching and assessing) and specialist							1			1	0	
General and provisional							2			2	0	
General and specialist	874	15,487	348	8,284	3,885	1,046	12,039	3,956	490	46,409	45,544	1.90%
Limited	106	1,551	123	1,119	505	155	1,236	869	6	5,670	6,221	-8.86%
Limited (public interest - occasional practice)	45	647		177	2	48	8	301	11	1,239	1,695	-26.90%
Non-practising	37	633	4	220	136	28	581	192	548	2,379	2,455	-3.10%
Provisional	74	967	42	726	274	74	780	316		3,253	3,006	8.22%
Provisional and specialist	1									1	0	
Specialist	128	1,361	91	1,667	391	180	1,289	846	235	6,188	5,377	15.08%
Midwife	39	418	29	321	343	9	747	229	52	2,187	1,789	22.25%
General	39	390	29	320	343	9	733	227	52	2,142	1,765	21.36%
Non-practising		28		1			14	2		45	24	87.50%
Nurse	4,848	81,927	3,276	57,491	28,393	7,570	80,982	31,076	6,682	302,245	290,072	4.20%
General	4,802	80,583	3,262	57,312	28,234	7,491	80,587	30,882	6,660	299,813	289,307	3.63%
Non-practising	46	1,344	14	179	159	79	395	164	22	2,432	765	217.91%
Nurse and midwife	719	13,491	579	7,321	2,601	723	10,297	3,292	248	39,271	40,324	-2.61%
General	707	12,804	575	7,261	2,572	709	10,178	3,257	245	38,308	40,142	-4.57%
General and non-practising [1]	7	415	3	34	16	7	71	16		569	82	593.90%
Non-practising	5	272	1	26	13	7	48	19	3	394	100	294.00%
Optometrist	71	1,553	28	929	234	84	1,163	366	140	4,568	4,442	2.84%
General	70	1,516	28	921	233	84	1,136	361	126	4,475	4,378	2.22%
Limited							1			1	0	
Non-practising	1	37		8	1		26	5	14	92	64	43.75%
Osteopath	32	510	2	149	29	38	843	52	21	1,676	1,595	5.08%
General	31	497	2	143	26	35	805	51	16	1,606	1,549	3.68%

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [2]	Total 2011/12	Total 2010/11	% change
Non-practising	1	13		6	3	3	38	1	5	70	46	52.17%
Pharmacist	420	8,274	186	5,187	1,919	628	6,578	2,852	504	26,548	25,944	2.33%
General	383	7,498	164	4,687	1,739	577	5,926	2,568	378	23,920	23,233	2.96%
Limited		7		4	1		2	4		18	7	157.14%
Non-practising	14	239	3	83	53	5	298	62	123	880	817	7.71%
Provisional	23	530	19	413	126	46	352	218	3	1,730	1,887	-8.32%
Physiotherapist	441	6,888	145	4,379	1,928	394	5,904	2,798	624	23,501	22,384	4.99%
General	425	6,633	145	4,281	1,861	385	5,607	2,718	557	22,612	21,701	4.20%
Limited	3	38		27	51	3	91	32	1	246	249	-1.20%
Non-practising	13	217		71	16	6	206	48	66	643	434	48.16%
Podiatrist	47	946	17	631	370	90	1,195	375	19	3,690	3,461	6.62%
General	46	932	17	621	357	90	1,153	362	17	3,595	3,373	6.58%
General and specialist		4		3	4		3	9		23	20	15.00%
Non-practising	1	10		7	9		39	4	2	72	68	5.88%
Psychologist	794	10,066	216	5,220	1,466	524	8,009	3,082	268	29,645	29,142	1.73%
General	645	8,580	177	4,280	1,239	431	6,437	2,531	242	24,563	24,442	0.50%
Limited	1									1	1	0.00%
Non-practising	35	389	6	171	66	27	221	97	26	1,038	415	150.12%
Provisional	113	1,097	33	769	161	66	1,351	453		4,043	4,284	-5.63%
Total 2011/12	9,601	160,545	5,581	103,730	46,397	12,489	143,643	55,729	10,813	548,528	530,115	3.47%

1. Practitioners holding general registration in one profession and non-practising registration in the other profession.
2. No PPP will include practitioners with an overseas address.

Table A3: Registered practitioners by profession and age

Profession	U-20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+	NULL	Total 2011/12	Total 2010/11
Chiropractor		106	658	730	721	667	424	417	270	225	120	78	31	11	4	4,462	4,350
Dental practitioner		618	2,416	2,848	2,279	2,176	2,004	2,270	1,931	1,259	768	287	130	52	49	19,087	18,319
Medical practitioner		747	9,287	11,985	12,406	11,187	10,297	9,888	8,534	6,481	4,917	2,864	1,545	942	568	91,648	88,293
Midwife		208	362	303	319	337	297	161	101	49	40	9	1			2,187	1,789
Nurse	54	13,401	32,745	31,537	34,458	40,029	38,209	43,368	35,746	21,814	8,481	1,869	347	58	129	302,245	290,072
Nurse and midwife		235	1,298	1,623	2,072	3,245	5,087	8,196	8,465	5,884	2,400	600	115	22	29	39,271	40,324
Optometrist		186	659	655	606	627	532	550	426	184	75	41	13	5	9	4,568	4,442
Osteopath		46	329	384	274	178	113	113	93	73	37	23	9	4		1,676	1,595
Pharmacist		2,015	5,901	4,535	2,945	2,425	1,920	1,981	1,646	1,222	905	649	268	82	54	26,548	25,944
Physiotherapist		1,644	4,741	4,041	3,007	2,638	2,215	2,103	1,639	818	425	155	48	11	16	23,501	22,384
Podiatrist		325	744	585	545	486	370	299	164	78	45	16	6	9	18	3,690	3,461
Psychologist		651	3,797	4,327	4,196	3,627	2,866	3,023	2,777	2,459	1,337	400	121	41	23	29,645	29,142
Total 2011/12	54	20,182	62,937	63,553	63,828	67,622	64,334	72,369	61,792	40,546	19,550	6,991	2,634	1,237	899	548,528	530,115

Table A4: Registered practitioners by profession, principal place of practice and gender

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [1]	Total 2011/12	Total 2010/11	% change
Chiropractor	56	1,511	24	692	357	45	1,202	498	77	4,462	4,350	2.57%
Female	27	530	9	212	123	12	455	196	22	1,586	1,519	4.41%
Male	29	979	15	480	234	33	747	301	55	2,873	2,826	1.66%
Not stated or inadequately described		2						1		3	5	-40.00%
Dental practitioner	350	5,989	134	3,728	1,615	336	4,358	2,254	323	19,087	18,319	4.19%
Female	176	2,503	68	1,680	818	59	2,010	1,215	116	8,645	7,417	16.56%
Male	174	3,468	66	2,042	766	176	2,342	935	201	10,170	9,329	9.01%
Not stated or inadequately described		18		6	31	101	6	104	6	272	1,573	-82.71%
Medical practitioner	1,784	28,972	945	17,682	7,142	2,048	22,365	8,855	1,855	91,648	88,293	3.80%
Female	739	11,177	455	6,668	2,665	801	8,870	3,459	609	35,443	33,297	6.45%
Male	1,045	17,792	490	11,014	4,472	1,247	13,493	5,394	1,245	56,192	54,905	2.34%
Not stated or inadequately described		3			5		2	2	1	13	91	-85.71%
Midwife	39	418	29	321	343	9	747	229	52	2,187	1,789	22.25%
Female	39	415	27	320	338	9	744	229	52	2,173	1,518	43.15%
Male		2	2	1			3			8	5	60.00%
Not stated or inadequately described		1			5					6	266	-97.74%
Nurse	4,848	81,927	3,276	57,491	28,393	7,570	80,982	31,076	6,682	302,245	290,072	4.20%
Female	4,330	71,809	2,768	51,222	25,119	6,669	72,474	28,200	5,819	268,410	235,984	13.74%
Male	517	10,056	504	6,251	3,040	901	8,494	2,871	853	33,487	29,078	15.16%
Not stated or inadequately described	1	62	4	18	234		14	5	10	348	25,010	-98.61%
Nurse and midwife	719	13,491	579	7,321	2,601	723	10,297	3,292	248	39,271	40,324	-2.61%
Female	701	13,211	552	7,170	2,518	700	10,171	3,238	238	38,499	37,189	3.52%
Male	18	280	27	151	64	23	126	53	10	752	710	5.92%
Not stated or inadequately described					19			1		20	2,425	-99.18%
Optometrist	71	1,553	28	929	234	84	1,163	366	140	4,568	4,442	2.84%
Female	37	784	15	426	43	28	598	148	62	2,141	2,030	5.47%
Male	34	763	13	501	60	55	562	214	76	2,278	2,228	2.24%
Not stated or inadequately described		6		2	131	1	3	4	2	149	184	-19.02%
Osteopath	32	510	2	149	29	38	843	52	21	1,676	1,595	5.08%
Female	12	208		59	12	24	184	22	4	525	443	18.51%
Male	20	299	2	86	14	12	124	28	9	594	552	7.61%
Not stated or inadequately described		3		4	3	2	535	2	8	557	600	-7.17%
Pharmacist	420	8,274	186	5,187	1,919	628	6,578	2,852	504	26,548	25,944	2.33%
Female	270	4,806	114	3,073	1,123	357	3,463	1,734	292	15,232	14,612	4.24%
Male	147	3,423	71	2,105	792	268	2,486	1,117	196	10,605	10,583	0.21%
Not stated or inadequately described	3	45	1	9	4	3	629	1	16	711	749	-5.07%
Physiotherapist	441	6,888	145	4,379	1,928	394	5,904	2,798	624	23,501	22,384	4.99%
Female	320	4,865	93	3,033	425	304	4,059	2,020	397	15,516	11,452	35.49%
Male	120	2,013	50	1,336	214	89	1,774	768	175	6,539	4,640	40.93%
Not stated or inadequately described	1	10	2	10	1,289	1	71	10	52	1,446	6,292	-77.02%

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP [1]	Total 2011/12	Total 2010/11	% change
Podiatrist	47	946	17	631	370	90	1,195	375	19	3,690	3,461	6.62%
Female	27	538	5	366	220	18	247	232	9	1,662	1,474	12.75%
Male	19	395	10	259	142	13	173	141	7	1,159	1,030	12.52%
Not stated or inadequately described	1	13	2	6	8	59	775	2	3	869	957	-9.20%
Psychologist	794	10,066	216	5,220	1,466	524	8,009	3,082	268	29,645	29,142	1.73%
Female	623	7,858	160	4,076	1,073	421	6,313	2,424	186	23,134	22,606	2.34%
Male	171	2,205	56	1,144	393	103	1,681	657	81	6,491	6,506	-0.23%
Not stated or inadequately described		3					15	1	1	20	30	-33.33%
Total 2011/12	9,601	160,545	5,581	103,730	46,397	12,489	143,643	55,729	10,813	548,528	530,115	3.47%

1. No PPP will include practitioners with an overseas address.

Not stated: in many cases, boards in place prior to 1 July 2012 did not record data on gender of registrant. Reduction in 'Not stated' from 38,182 to 4,414 due to the correction of data transition gaps during 2011/12.

Table A5: Registered dental and nursing practitioners by division

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]	Total 2011/12	Total 2010/11	% change
Dental practitioner	350	5,989	134	3,728	1,615	336	4,358	2,254	323	19,087	18,319	4.19%
Dental hygienist	47	351	7	119	223	16	175	277	15	1,230	1,148	7.14%
Dental hygienist and dental prosthetist[1]		1		1						2	1	100.00%
Dental hygienist and dental prosthetist and dental therapist[1]		1					1			2	2	0.00%
Dental hygienist and dental therapist [1]	10	57	7	177	74	2	131	52	3	513	610	-15.90%
Dental prosthetist	14	414	5	225	54	52	328	89	2	1,183	1,160	1.98%
Dental therapist	17	241	16	208	106	55	176	341	1	1,161	1,206	-3.73%
Dentist	253	4,757	95	2,737	1,099	209	3,428	1,493	301	14,372	13,830	3.92%
Dentist and dental hygienist[1]	1									1	-	
Oral health therapist[3]	8	167	4	261	59	2	119	2	1	623	362	72.10%
Nurse	4,848	81,927	3,276	57,491	28,393	7,570	80,982	31,076	6,682	302,245	290,072	4.20%
Enrolled nurse	734	14,156	401	10,935	7,884	1,312	20,321	5,170	54	60,967	59,901	1.78%
Enrolled nurse and registered nurse[1]	32	952	49	681	382	36	1,451	361	3	3,947	2,057	91.88%
Registered nurse	4,082	66,819	2,826	45,875	20,127	6,222	59,210	25,545	6,625	237,331	228,114	4.04%
Nurse and midwife	719	13,491	579	7,321	2,601	723	10,297	3,292	248	39,271	40,324	-2.61%
Enrolled nurse and midwife	1	6		1	5		20			33	19	73.68%
Enrolled nurse and registered nurse and midwife (Division 1)[1]	1	2		1	1		27	4		36	10	260.00%
Registered nurse and midwife	717	13,483	579	7,319	2,595	723	10,250	3,288	248	39,202	40,295	-2.71%
Total 2011/12	5,917	101,407	3,989	68,540	32,609	8,629	95,637	36,622	7,253	360,603	348,715	3.41%

1. Practitioners who hold dual registration.
2. No PPP will include practitioners with an overseas address.
3. The reduction in the number of registrants registered as dual dental hygienists and dental therapists can be attributed to the Board's policy to allow practitioners who were registered as both dental hygienists and dental therapists prior to the National Scheme to change to the division of oral health therapist if their qualifications were approved by the Board and they had recency of practice in both disciplines.

Table A6: Health practitioners with specialties at 30 June 2012

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total 2011/12	Total 2010/11	% change
Dental practitioner	40	485	7	300	132	22	375	147	33	1,541	1,520	1.38%
Dento-maxillofacial radiology				7			1	1		9	8	12.50%
Endodontics	6	38		29	14	1	37	15	3	143	142	0.70%
Forensic odontology	1	7	1	2	4	2	4	5		26	25	4.00%
Oral and maxillofacial surgery	5	50	2	40	15	3	49	17	4	185	184	0.54%
Oral medicine		8		5			13	3	2	31	32	-3.13%
Oral pathology		8		5	2		5	2	2	24	25	-4.00%
Oral surgery	2	38		3			1		1	45	48	-6.25%
Orthodontics	12	184	3	115	49	12	127	54	13	569	566	0.53%
Paediatric dentistry	2	34		18	8		25	10	1	98	93	5.38%
Periodontics	7	51		39	14	4	50	24	3	192	184	4.35%
Prosthodontics	5	61	1	33	21		49	16	3	189	184	2.72%
Public health dentistry (community dentistry)		4		1	2		7			14	14	0.00%
Special needs dentistry		2		3	3		7		1	16	15	6.67%
Medical practitioner	1,111	18,139	478	10,780	4,743	1,311	14,548	5,169	777	57,056	56,012	1.86%
Addiction medicine	3	64	1	28	13	8	31	14	2	164	164	0.00%
Anaesthesia	65	1,208	24	824	342	107	990	402	93	4,055	3,961	2.37%
Dermatology	5	171	1	75	36	8	114	35	6	451	436	3.44%
Emergency medicine	28	323	19	268	77	32	338	144	35	1,264	1,207	4.72%
General practice	401	7,311	226	4,523	1,844	591	5,608	2,177	123	22,804	22,555	1.10%
Intensive care medicine	19	207	7	146	62	17	155	54	16	683	666	2.55%
Medical administration	12	95	5	88	20	3	62	26	5	316	313	0.96%
Obstetrics and gynaecology	30	508	15	330	133	37	447	141	40	1,681	1,666	0.90%
Gynaecological oncology		14		8	4	1	10	3		40	42	-4.76%
Maternal-fetal medicine	1	13	1	5	3		9	4		36	36	0.00%
Obstetrics and gynaecological ultrasound		13		5	3		55	2	2	80	81	-1.23%
Reproductive endocrinology and infertility		27		4	6	1	15	2		55	53	3.77%
Urogynaecology	1	10		5	1		7	4		28	28	0.00%
No sub-specialty declared	28	431	14	303	116	35	351	126	38	1,442	1,426	1.12%
Occupational and environmental medicine	17	87	2	38	28	6	70	39	8	295	297	-0.67%
Ophthalmology	12	334	4	146	67	17	217	70	12	879	874	0.57%
Oral and maxillofacial surgery				1				1		2		
Paediatrics and child health	38	656	30	348	154	35	498	198	38	1,995	1,894	5.33%
Clinical genetics		7		1			4			12	11	9.09%
Community child health		5		3			2			10	6	66.67%
General paediatrics	30	547	22	293	128	33	402	153	27	1,635	1,619	0.99%

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total 2011/12	Total 2010/11	% change
Neonatal and perinatal medicine	5	24		16	6	1	27	12	1	92	69	33.33%
Paediatric cardiology		4	1	4			4	4	1	18	9	100.00%
Paediatric clinical pharmacology		1								1	1	0.00%
Paediatric emergency medicine		6	1	4	2		4	3		20	9	122.22%
Paediatric endocrinology	1	3	1	2				1		8	3	166.67%
Paediatric gastroenterology and hepatology		2		2	1		5	1		11	6	83.33%
Paediatric haematology		1		1				1		3	1	200.00%
Paediatric immunology and allergy		2		1	2					5	3	66.67%
Paediatric infectious diseases		1		1			5			7	5	40.00%
Paediatric intensive care medicine		2								2	2	0.00%
Paediatric medical oncology		3		2			3	2		10	6	66.67%
Paediatric nephrology							1			1		
Paediatric neurology		8		2	1		3		1	15	7	114.29%
Paediatric rehabilitation medicine		2								2	2	0.00%
Paediatric respiratory and sleep medicine		6		2			3			11	4	175.00%
Paediatric rheumatology		1			1		1			3	2	50.00%
No sub-specialty declared	2	31	5	14	13	1	34	21	8	129	129	0.00%
Pain medicine	1	71		44	27	9	35	27	6	220	213	3.29%
Palliative medicine	6	85	1	44	20	12	49	24	5	246	236	4.24%
Pathology	49	725	8	393	189	49	505	216	19	2,153	2,163	-0.46%
Anatomical pathology (including cytopathology)	14	243	2	154	60	17	170	78	4	742	713	4.07%
Chemical pathology	2	21		15	9	1	19	15	2	84	80	5.00%
Forensic pathology		9	1	11	4	2	9	3		39	36	8.33%
General pathology	11	192	2	90	60	13	138	40	5	551	635	-13.23%
Haematology	10	136	2	68	34	10	114	31	3	408	386	5.70%
Immunology	6	43		10	7	1	17	13		97	95	2.11%
Microbiology	5	71	1	36	15	5	37	27	2	199	187	6.42%
No sub-specialty declared	1	10		9			1	9	3	33	31	6.45%
Physician	171	2,550	60	1,367	751	147	2,379	675	134	8,234	8,004	2.87%
Cardiology	16	340	4	214	94	14	276	76	25	1,059	1,025	3.32%
Clinical genetics		31		8	8		13	5	1	66	62	6.45%
Clinical pharmacology		11		11	9		11	5	2	49	48	2.08%
Endocrinology	8	176	5	96	31	12	156	40	1	525	494	6.28%
Gastroenterology and hepatology	20	218	2	124	56	11	199	58	9	697	676	3.11%
General medicine	39	383	13	303	235	33	548	110	24	1,688	1,703	-0.88%
Geriatric medicine	8	171	1	63	38	8	144	48	4	485	456	6.36%

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total 2011/12	Total 2010/11	% change
Haematology	9	147	3	79	36	9	120	29	7	439	434	1.15%
Immunology and allergy	6	51	1	12	11		26	18	2	127	120	5.83%
Infectious diseases	7	72	12	40	25	6	116	24	6	308	288	6.94%
Medical oncology	9	118	2	75	34	8	160	30	9	445	421	5.70%
Nephrology	6	134	9	66	24	8	128	28	9	412	388	6.19%
Neurology	9	172	1	59	38	6	152	37	7	481	461	4.34%
Nuclear medicine	7	94		29	26	6	56	17	1	236	233	1.29%
Respiratory and sleep medicine	11	178	1	111	46	10	138	50	7	552	522	5.75%
Rheumatology	8	109	1	43	30	7	87	28	7	320	304	5.26%
No sub-specialty declared	8	145	5	34	10	9	49	72	13	345	369	-6.50%
Psychiatry	54	943	13	561	270	60	875	256	44	3,076	3,003	2.43%
Public health medicine	25	134	25	87	33	11	79	38	8	440	431	2.09%
Radiation oncology	10	109	1	60	20	9	94	16	4	323	316	2.22%
Radiology	48	596	4	366	168	45	502	194	100	2,023	1,979	2.22%
Diagnostic radiology	40	537	3	311	151	36	422	181	91	1,772	1,743	1.66%
Diagnostic ultrasound		1					3			4	4	0.00%
Nuclear medicine	3	28		50	13	6	59	4	4	167	173	-3.47%
No sub-specialty declared	5	30	1	5	4	3	18	9	5	80	59	35.59%
Rehabilitation medicine	6	199	2	45	32	6	111	10	3	414	410	0.98%
Sexual health medicine	5	52	1	18	5	1	24	5	1	112	106	5.66%
Sport and exercise medicine	11	40	1	12	5	2	34	8		113	104	8.65%
Surgery	95	1,671	28	968	447	99	1,331	399	75	5,113	2,214	130.94%
Cardio-thoracic surgery	6	53		39	11	2	54	10	5	180	176	2.27%
General surgery	22	607	13	339	158	34	500	121	32	1,826	1,834	-0.44%
Neurosurgery	4	70		36	16	5	57	17	2	207	204	1.47%
Oral and maxillofacial surgery	5	18	2	22	8		20	5	1	81	81	0.00%
Orthopaedic surgery	25	396	7	260	111	21	278	112	17	1,227	1,201	2.16%
Otolaryngology - head and neck surgery	9	150	1	81	44	9	108	39	10	451	441	2.27%
Paediatric surgery	4	32		13	10	2	25	6		92	92	0.00%
Plastic surgery	7	111	2	59	43	9	128	39	2	400	381	4.99%
Urology	7	114	1	75	30	10	92	31		360	348	3.45%
Vascular surgery	3	63	1	43	16	5	54	14	3	202	193	4.66%
No sub-specialty declared	3	57	1	1		2	15	5	3	87	93	-6.45%
Podiatrist		4		3	4		3	9		23	20	15.00%
Podiatric surgeon		4		3	4		3	9		23	20	15.00%
Total 2011/12	1,151	18,628	485	11,083	4,879	1,333	14,926	5,325	810	58,620	57,552	1.86%

1. The data above record the number of practitioners with registration in the specialist fields listed. Individual practitioners may be registered to practise in more than one specialist field.
2. In September 2011, AHPRA communicated with all medical practitioners on the specialists register to improve the accuracy, quality and completeness of the information. As a result of this exercise, the sub-specialty totals may vary from the 2010/11 data.

Table A7: Applications received by registration type and states

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total 2011/12
Chiropractor	1	210	1	55	12	2	129	81	16	507
General	1	159		42	4	2	93	62		363
Limited					1		6		2	9
Non-practising		50	1	13	7		30	19	14	134
Provisional		1								1
Dental practitioner	27	649	12	506	191	24	546	294	32	2,281
General	24	419	9	414	136	20	344	214	26	1,606
General and specialist		2		4				3	2	11
Limited	2	150	1	44	38	2	129	49	1	416
Non-practising		68	2	38	9	2	42	26	3	190
Provisional				1						1
Specialist	1	10		5	8		31	2		57
Medical practitioner	248	4,030	226	3,277	1,070	345	3,440	1,641	54	14,331
General	70	1,295	77	1,144	351	110	1,131	498	8	4,684
General (teaching and assessing)		11		5	2	1	5	2		26
General and specialist	4	42		31		8	19	85	3	192
Limited	76	1,159	65	915	236	88	752	523	9	3,823
Limited (public interest - occasional practice)		4					2			6
Non-practising	3	168	4	74	28	8	126	39	12	462
Provisional	65	1,013	45	749	273	80	802	309	1	3,337
Specialist	30	338	35	359	180	50	603	185	21	1,801
Midwife	49	985	67	440	106	47	569	231	4	2,498
General	46	384	65	357	88	25	449	197	4	1,615
Non-practising	3	601	2	83	18	22	120	34		883
Nurse	630	7,923	531	5,440	2,864	576	7,836	6,358	137	32,295
General	603	6,711	519	5,129	2,730	475	7,449	6,160	124	29,900
Limited		1			1		2	3		7
Non-practising	27	1,211	12	311	133	101	385	195	13	2,388
Optometrist	6	83	1	45	22	4	86	29	4	280
General	6	65		41	21	4	75	24		236
Limited							1			1
Non-practising		18	1	4	1		10	5	4	43
Osteopath	3	51	1	24	1	3	132	3	1	219
General	2	27	1	15	1	1	105	2		154
Limited		11		4			4			19
Non-practising	1	13		5		2	23	1	1	46
Pharmacist	37	1,165	45	816	280	92	814	462	17	3,728
General	14	586	24	395	146	44	442	233	6	1,890
Limited	1	13	1	8	4		16	9	1	53
Non-practising	1	146	1	48	14	4	43	12	8	277
Provisional	21	420	19	365	116	44	313	208	2	1,508

Physiotherapist	42	689	19	406	185	19	682	370	22	2,434
General	36	518	18	351	135	16	554	272	9	1,909
Limited	3	43		28	39	3	86	61	2	265
Non-practising	3	128	1	27	11		42	37	11	260
Podiatrist	1	86	4	66	28	11	157	54	2	409
General	1	76	4	60	27	11	146	51	1	377
Non-practising		10		5	1		11	3	1	31
Specialist				1						1
Psychologist	77	1,559	37	827	216	75	1,035	483	39	4,348
General	32	766	19	417	107	37	460	215	24	2,077
Limited					1			1		2
Non-practising	7	325	8	114	39	20	157	79	14	763
Provisional	38	468	10	296	69	18	418	188	1	1,506
Occupational therapy practitioner	160	3,377	1	26	4	193	2,852	10	5	6,628
General	158	3,344	1	25	4	189	2,832	10	5	6,568
Limited	2	33		1		4	20			60
Aboriginal and Torres Strait Islander health practitioner		2	1	21			1	1		26
General		2	1	21			1	1		26
Chinese medicine practitioner	102	2,959	12	1,073	220	44	66	325	3	4,804
General	88	2,503	11	941	180	34	49	246	3	4,055
Limited	14	456	1	132	40	10	17	79		749
Medical radiation practitioner	2	3,696	5	17	802	1	26	11	7	4,567
General	2	3,518	4	15	795	1	21	11	7	4,374
Provisional		178	1	2	7		5			193
Total	1,385	27,464	963	13,039	6,001	1,436	18,371	10,353	343	79,355

Regulation of four new professions, Aboriginial and Torres Strait Islander, Chinese medicine, medical radiation and occupational therapy practitioners, commenced on 1 July 2012. AHPRA opened applications for these professions in March 2012. States and territories where registers of practitioners existed will be migrated to AHPRA, while states or territories with no registers accepted applications for registration.

Table A8: Notifications received in 2011/12 by profession and issue category[1,2,3]

	Chiropractor		Dental practitioner		Medical practitioner		Midwife		Nurse		Optometrist		Osteopath		Pharmacist		Physiotherapist		Podiatrist		Psychologist		Not identified	Total	
	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	AHPRA	NSW
Behaviour	4	1	13	12	70	27	1		77	35	1		1		8	9		1	2		10	3	2	189	88
Billing	3	2	27	57	30	32			1	1		4			1	12	1	2	1	4	5	6		69	120
Boundary violation	1	7	5	1	77	75			33	28			1	5	1		8	3	2		32	23		160	142
Clinical care	28	8	269	387	1,145	831	21		217	106	13	20	1	3	4	2	21	9	8	9	37	27	10	1,774	1,402
Communication	6	2	18	11	195	109	2	1	28	17	2	1			13	2	4	5			26	11	9	303	159
Confidentiality			1	1	46	22	3		25	13					3	2	2	1			17	12		97	51
Conflict of interest					7	3			1						1	1					1	4		10	8
Discrimination				1	9	5			1	7					0						2	1		12	14
Documentation	10	1	7	2	68	111	1		26	5			2		1	3	2		1		23	17		141	139
Health Impairment	3		8	5	128	116	9		232	117					11	12	7	2	1	1	9	12	4	412	265
Infection/ hygiene			8	11	16	17			4	4		1				7			3				1	32	40
Informed consent	1		12	1	34	21			1					1			1	1			2	1	1	52	25
Medico-legal conduct	1				53	8												2			19			73	10
National Law breach	1	1	5	11	25	12	1		24	11				1	5	2	4		2		3	8		70	46
National Law offence	15	4	9	4	17	21	1		20	10				1	2	5	2	1	2	1	8	3	2	78	50
Offence	1	1	3	8	32	33	2		72	19			1		6	6	3			1	6		2	128	68
Other	7		3		47		1		31						7		1		2		17			116	0
Pharmacy/ medication			1	2	129	115	2		104	40	1				133	107				1			3	373	265
Research/ teaching/ assessment					1				3								1				4			9	0
Response to adverse event				2	5				2	3	1					1				1	1	1		9	8
Teamwork/ supervision	2		4		7	24	1		14	6					1		1							30	30
Not recorded	5		83		232	46	5		62	1	10				19		3		1		15	1	44	479	48
Total	88	27	476	516	2,373	1,628	50	1	978	423	28	26	6	11	216	171	61	27	25	18	237	130	78	4,616	2,978

1. The issue categories reflect the typology developed for implementation from 1 July 2011 and form the basis for current and future reporting.
2. The issue categorisation is based on initial information provided by the notifier. An issue category is not always identified by the notifier.
3. NSW data are provided in identified columns. There are some minor variations in the issue categories used in NSW; the NSW categories have been mapped to the categories used by AHPRA.

Table A9: Notifications received in 2011/12 by profession and notification source[1]

	Chiropractor		Dental practitioner		Medical practitioner		Midwife		Nurse		Optometrist		Osteopath		Pharmacist		Physiotherapist		Podiatrist		Psychologist		Not identified		2012 Total		2012 Total AHPRA[2]
	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	AHPRA	NSW	
AHPRA[3]		1		1						11						1		1				1				16	
Anonymous	2		4		24	4	1		22	29		1		1	6	4	2				8	2	1		70	41	122
Drugs and poisons					23	13			2						8	4									33	17	19
Education provider					10				6	2							2	1			1		4		23	3	16
Employer	2		3	3	78	35	16		431	136				2	8	1	3	2	2	2	7	4	2		552	185	460
Employee				4						4						1		2				1				12	
Government department	2	1	7	4	39	36	3		54	18			2		9	5	1		1		9				127	64	159
HCE	10		229		858		4		56		17				17	1	10		2		9		38		1,250	1	1,401
Health Advisory Service	1		1		6																				8		5
Council		1		16						19				1		6				1		1				45	
Courts/Coroner										5								1								6	
Hospital	1				8	7			16	2					2						1		1		29	9	
Insurance company	1	1			1	2									2		1	1			1				6	4	
Lawyer	2				16	23			4						3		1				7				33	23	33
Medicare					2																				2		2
Member of Parliament					2																				2		1
Member of the public	3		6	1	65		2		18	12		1			16	4					16		3		129	18	144
Ombudsman					3																				3		
Other Board	3		7		62	79	2		19						7		1		2		6		1		110	79	1
Other practitioner	24	2	28	10	223	82	9		157	55	2		1		36	15	17	2	6	1	45	23	12		560	190	635
Patient	22	15	144	412	628	926	3	1	53	32	9	20	2	6	60	95	14	13	9	13	63	58	10		1,017	1,591	1,202
Police	1		1		9	9			3	3					1		2				1		1		19	12	23
Relative	3	2	25	62	218	333	3		50	48		4		1	30	18	1	4	1		45	14	3		379	486	425
Self	1	1	2		33	18	6		48	25					2	1	3		1		2	5			98	50	132
Unclassified	10		19		63	10	1		39				1		9		3		1		16				162	10	246
Not stated		3		3	2	51				22						15				1		21	2		4	116	217
2012 Total	88	27	476	516	2,373	1,628	50	1	978	423	28	26	6	11	216	171	61	27	25	18	237	130	78		4,616	2,978	
2011 Total	75		653		2,667		51		905		28		12		281		76		33		274		242				5,297

1. 2012 NSW data are provided in identified columns.
2. 2011 Total does not include NSW.
3. Relates only to notifications handled in NSW where AHPRA may receive a notification and refer it to the relevant Health Professionals Council.

Notes

Notes

Notes


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achievements
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improvement
performance

Annual Report 2011/12

AHPRA

Australian Health Practitioner Regulation Agency

Chiropractic
Dental
Medical
Nursing and Midwifery
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

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