Ahpra & National Boards

Annual report 2020/21

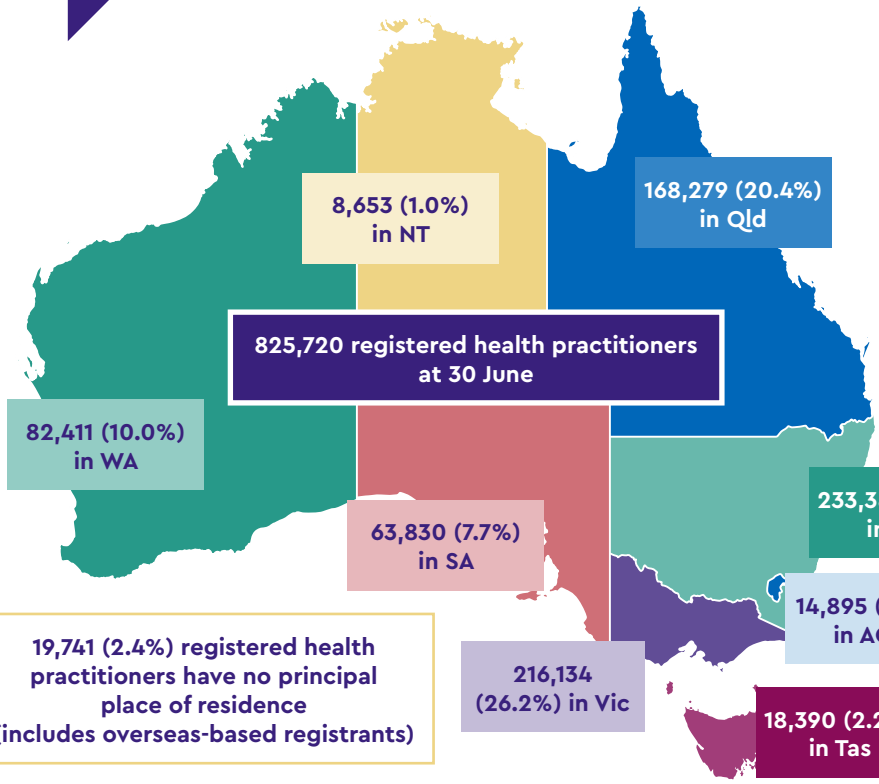
Your National Scheme:
For safer healthcare

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

Ahpra acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past, present and emerging.

The regulated health workforce in 2020/21

825,720 registered health practitioners



19,741 (2.4%) registered health practitioners have no principal place of residence (includes overseas-based registrants)

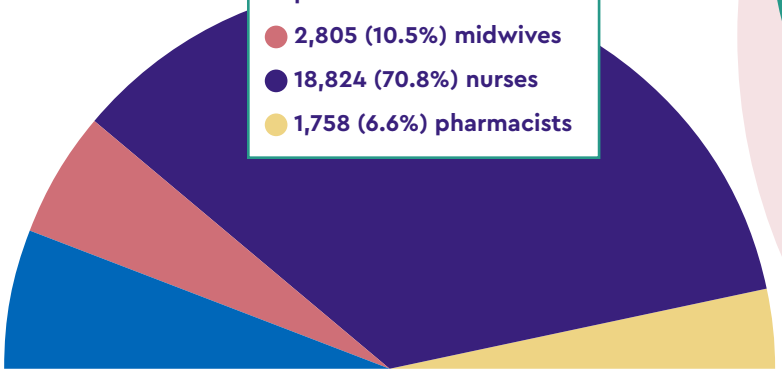
Age

<25	5.2%
25–34	28.2%
35–44	23.6%
45–54	19.1%
55–64	16.4%
65–74	6.6%
>75	1.0%

1 in 16 people employed in Australia is a registered health practitioner

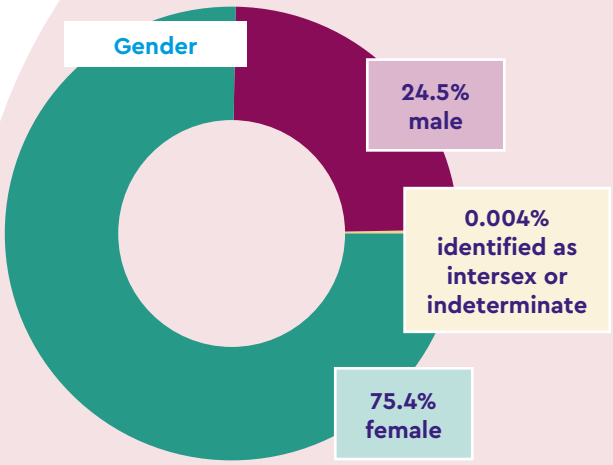
Pandemic sub-register 2020

26,595 total practitioners:



- 22 (0.1%) Aboriginal and Torres Strait Islander Health Practitioners
- 3,186 (12.0%) medical practitioners
- 2,805 (10.5%) midwives
- 18,824 (70.8%) nurses
- 1,758 (6.6%) pharmacists

Gender



About us

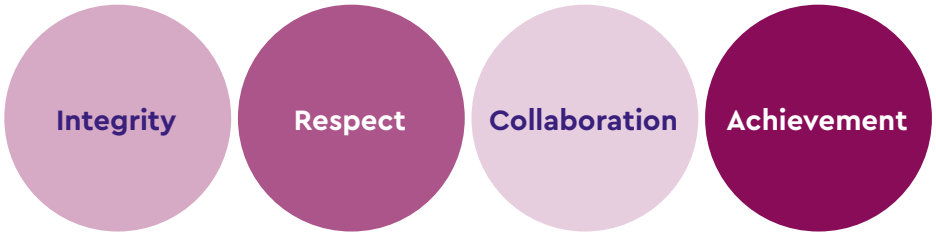
Our purpose

Safe and professional health practitioners for Australia

Our vision

Our communities have trust and confidence in regulated health practitioners

Our values



Working in partnership with 15 National Boards, the Australian Health Practitioner Regulation Agency (Ahpra) implements the National Registration and Accreditation Scheme (the National Scheme). The National Scheme regulates 16 health professions.

Public safety is our priority. Every decision we make is guided by the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

What we do

Ahpra has five core functions.

Professional standards

We provide policy advice to the National Boards about registration standards, codes and guidelines that they establish for health practitioners.

Notifications

We manage complaints and concerns raised about the health, performance and conduct of individual health practitioners.

Accreditation

We work with accreditation authorities and committees to ensure graduating students are suitably qualified and skilled to apply to register as a health practitioner.

Compliance

We monitor and audit registered health practitioners to make sure they are complying with Board requirements.

Registration

We ensure that only health practitioners with the skills and qualifications to provide competent and ethical care are registered to practise.

For more information visit www.ahpra.gov.au and the linked National Board websites.

This report provides Ahpra data, unless stated otherwise. As in 2019/20, the 2020/21 data include practitioners registered on the temporary pandemic sub-register. This affects some percentages.

Supplementary data tables are available online and are the source for some of the statistics cited. Some other statistics are drawn from internal reports.

Due to rounding (to one decimal place), percentages may not add up exactly to 100%.

The 'Most common types of complaint' bar graphs in the Board reports are based on the main reason for a notification. In the notifications section we also report on multiple concerns in a notification.

We refine our data collection and reporting each year so data may not directly correlate across annual reports.

For definitions of words and phrases, refer to *Common abbreviations* and the *Glossary*.

You will see photos of some of the health practitioners who serve our community and some of our staff on the pages throughout this report. For staff in some offices these were rare days in the office.

In 2020/21

Registration

825,720 registered health practitioners in Australia, across 16 professions

24,061 (3.0%) more registrants than last year

26,595 registrants on the pandemic sub-register

8,311 health practitioners identify as Aboriginal and/or Torres Strait Islander

84,607 applications for registration

189,786 students studying to be health practitioners

69,571 criminal history checks made

Accreditation

Over 860 approved programs of study delivered by more than 130 education providers

Compliance

3,516 practitioners were monitored by Ahpra for health, performance and/or conduct during the year

Notifications

13,483 practitioners had a notification made about them nationally

1.6% of all registered health practitioners

10,147 notifications about 7,858 practitioners were received by Ahpra

The most common complaints:

- clinical care
- medication
- communication

597 immediate actions were taken

Legal

121 matters determined by tribunals

96.7% resulted in disciplinary action

106 appeals lodged in tribunals

95 appeals finalised:

- 15 no change
- 47 withdrawn
- 16 amended or substituted
- 17 dismissed

16 successful prosecutions

386 advertising complaints

343 title protection complaints

Contents

Tables

Figures

Health practitioner regulation in Australia

The National Scheme

The National Scheme operates Australia-wide and is a vital part of the Australian health system. It is governed by a nationally consistent law passed by each state and territory parliament – the National Law. There is oversight by a Ministerial Council made up of all Australia's Health Ministers.

The National Scheme regulates individual health practitioners, not health services themselves.

Ahpra and the National Boards

Fifteen National Boards are responsible for the regulation of 16 health professions. Supported by Ahpra, the Boards' responsibilities include setting standards that practitioners must meet to be registered, developing regulatory policy and guidance, and regulatory decision-making about complaints and concerns raised about registered health practitioners.

Ahpra and the National Boards are responsible for the registration of every practitioner in the registered health professions across Australia.

If someone wants to make a complaint or raise a concern about a registered health practitioner in most states and territories, they can visit our complaints portal. However, in New South Wales (NSW) or Queensland the process is different.

New South Wales

Fifteen health professional councils – supported by the Health Professional Councils Authority (HPCA) and working with the Health Care Complaints Commission (HCCC) – assess and manage complaints about registered health practitioners' conduct, health and performance.

The National Boards don't handle notifications in NSW. Ahpra has a limited role in accepting mandatory notifications and referring them to the HCCC.

Queensland

The Office of the Health Ombudsman (OHO) receives complaints about registered health practitioners that arise in Queensland. It may refer a complaint to Ahpra and the National Boards.

Ahpra ensures that all NSW and Queensland notifications and their outcomes are recorded to ensure the national register is accurate and complete.

In addition to receiving complaints about registered health practitioners, the HCCC and OHO also handle complaints about unregistered health practitioners and can provide a range of outcomes not available to National Boards.

Other states and territories

Ahpra and the National Boards work with health complaints entities (HCEs) to decide which organisation should take responsibility for, and manage, a complaint or concern.

HCEs also handle complaints about unregistered health practitioners, and can provide outcomes that Ahpra and the National Boards cannot, such as:

- an apology or explanation
- access to health records
- compensation or a refund
- an improvement for a hospital, clinic, pharmacy or community health service.

HCEs in these states and territories are:

Australian Capital Territory Health Services, Discrimination, Disability and Community Services Commissioner

Northern Territory Health and Community Services Complaints Commission

South Australia Health and Community Services Complaints Commission

Tasmania Health Complaints Commissioner

Victoria Health Complaints Commissioner

Western Australia Health and Disability Services Complaints Office.

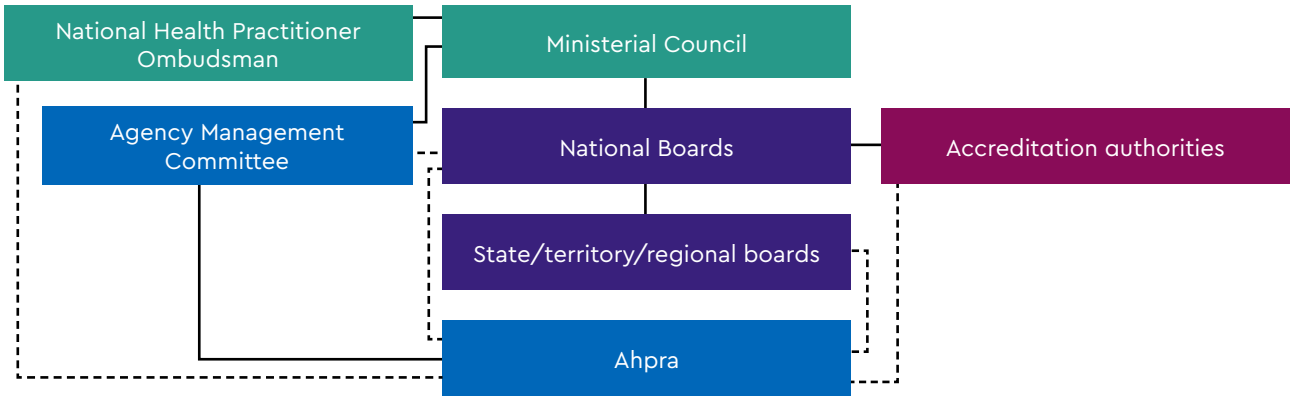
Accreditation authorities

Each profession has an accreditation authority, either an external council or a committee established by a National Board, that accredits programs of study.

Independent ombudsman

The National Health Practitioner Ombudsman (NHPO) provides an independent ombudsman, privacy and freedom of information oversight of the National Scheme, the work of Ahpra and the National Boards, and the administrative processes experienced by practitioners and the public.

Figure 1. Who's who in the National Scheme



Introduction

The COVID-19 pandemic had significant implications for our work as a national regulatory scheme. We've done everything we can to continue our focus on patient and public safety, while supporting health practitioners and the health systems in which they work.

We've made many operational and policy changes to ensure we are responsive and regulating health practitioners effectively. Many of our hardworking staff have continued to work remotely through lockdowns. National Boards and committees have worked online throughout the year.

Despite these challenges, the number of registered health practitioners has increased by 3% to 825,720. Through partnerships with education providers, accreditation authorities and National Boards, students have been able to graduate with the required clinical experience. More than 41,500 graduates were registered in our most successful graduate registration campaign ever.

We continued our temporary pandemic sub-register, which has shifted in focus to provide access to health practitioners to support the vaccine program. Border restrictions have meant fewer internationally trained health practitioners were able to come to Australia. We continued to work closely with governments, professional groups and other stakeholders to respond to workforce needs.

Registered health practitioners are rightly some of the most trusted professions in Australia. Most health practitioners practise safely and well – 98.4% of all registered health practitioners did not have any concerns reported about their conduct, health or performance.

The number of notifications we received decreased by just under 1% to just over 10,000. After assessment, and investigation when required, regulatory action was taken on 14.2% of all notifications completed. Of practitioners with notifications received this year, nearly 62% were the subject of one for the first time; around 38% had had a notification made about them before.

We recognise the significant stress experienced by health practitioners who have a notification made about them and by those who make that notification. We continue to implement improvements to our processes, communication, timeframes and access to information and support services. We improved the confidentiality safeguards for notifiers. We published a framework for identifying and dealing with vexatious notifications. Also we significantly overhauled our approach to assessment and investigation to ensure a sharper focus on risks that may require regulatory action.

Students are the health practitioners of the future and our work with accreditation authorities is an important focus. We embraced the policy direction from the Ministerial Health Council to establish a new accreditation committee to provide independent and expert advice on accreditation systems reform.

Improving cultural safety and eliminating racism in the health system is a vital part of our commitment to improve health outcomes for Aboriginal and Torres Strait Islander Peoples. We are enormously proud that we were able to start to roll out the Moong-moong-gak Aboriginal and Torres Strait Islander health and cultural safety training for staff and Board and committee members.

Registered health practitioners have done exceptional work in very challenging times.

The work of the National Scheme not only involves close partnership between Ahpra and the 15 National Boards, but also collaboration with governments, professional and consumer organisations, and health services to keep the public safe.

Board and committee members have gone to great effort to ensure flexible and appropriate regulatory decisions to support the health workforce.

We particularly want to acknowledge and thank Ahpra staff who have demonstrated such commitment, resilience and flexibility in a challenging and uncertain year. Tested by the pandemic, we have seen teams come together like never before, collaborating to solve problems at pace. You will read some of their stories and achievements throughout this report.

Staff and Board and committee members have demonstrated a deep commitment to doing all they can to meet our mandate to protect the public and sustain a health workforce for Australia.

Few of us could have anticipated COVID-19 and its ongoing impact. In so many ways registered health practitioners have done exceptional work in very challenging times. They have our admiration and thanks.

Mr Martin Fletcher

Chief Executive Officer, Ahpra

Ms Gill Callister PSM

Co-convenor, Forum of National Registration and Accreditation Chairs

Chair, Agency Management Committee, Ahpra

Mr Brett Simmonds

Co-convenor, Forum of National Registration and Accreditation Chairs

Chair, Pharmacy Board of Australia

Agency Management Committee

Our Agency Management Committee is our governing body

The Agency Management Committee is the governing board for Ahpra and members are appointed by the Ministerial Council.

The Committee ensures that Ahpra performs its functions in a proper, effective and efficient way. It is responsible for determining Ahpra policies, setting the strategic direction for the National Scheme and assuring its performance. This year we farewelled one member and welcomed three.

Agency Management Committee members

Ms Gill Callister PSM
Chair

Dr Peggy Brown AO

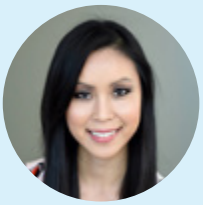
Adjunct Professor Karen Crawshaw PSM

Emeritus Professor Arie Freiberg AM
(from Oct)

Mr Jeff Moffet
(from Oct)

Mr Lynton Norris
(from Oct)

Ms Philippa Smith AM
(to Sep)



Ms Jenny Taing OAM

Ms Barbara Yeoh AM

Dr Susan Young

What stands out

Few of us could have anticipated COVID-19 and its ongoing impact. In so many ways registered health practitioners have done exceptional work in very challenging times.

Through partnerships with education providers, accreditation authorities and National Boards, students have been able to graduate with the required clinical experience.

We are enormously proud that we could roll out the Moong-moong-gak Aboriginal and Torres Strait Islander health and cultural safety training for staff and Board and committee members.

National Boards for the regulated health professions

The National Boards work to ensure safe, quality healthcare across Australia. All Chairs are registered health practitioners in their profession. We farewelled two Chairs and welcomed two this year.

Ms Renee Owen
Chair, Aboriginal and Torres Strait Islander Health Practice Board of Australia

Distinguished Professor Charlie C. Xue
Chair to 8 Feb, Chinese Medicine Board of Australia

Professor Chi Eung Danforn Lim
Chair from 17 Feb, Chinese Medicine Board of Australia

Dr Wayne Minter AM
Chair, Chiropractic Board of Australia

Dr Murray Thomas
Chair, Dental Board of Australia

Dr Anne Tonkin
Chair, Medical Board of Australia

Mr Mark Marcenko
Chair, Medical Radiation Practice Board of Australia

Associate Professor Lynette Cusack
Chair to 2 Oct, Nursing and Midwifery Board of Australia

Adjunct Professor Veronica Casey AM
Chair from 2 Oct, Nursing and Midwifery Board of Australia

Ms Julie Brayshaw
Chair, Occupational Therapy Board of Australia

Mr Ian Bluntish
Chair, Optometry Board of Australia

Dr Nikole Grbin
Chair, Osteopathy Board of Australia

Professor Stephen Gough ASM
Chair, Paramedicine Board of Australia

Mr Brett Simmonds
Chair, Pharmacy Board of Australia

Ms Kim Gibson
Chair, Physiotherapy Board of Australia

Associate Professor Cylie Williams
Chair, Podiatry Board of Australia

Ms Rachel Phillips
Chair, Psychology Board of Australia

Aboriginal and Torres Strait Islander Health Practitioners

From the Chair

Issues this year

During this pandemic year, we have seen Aboriginal and Torres Strait Islander Health Practitioners utilised in flexible roles, both clinical and non-clinical, that suit the needs of the service provider, as was intended when the profession was first regulated nationally.

Our registrants' involvement in the COVID-19 vaccine roll-out illustrates the unique nature of how Australia regulates its health professions by not defining what a practitioner can or cannot do in their practice, and so facilitates a flexible and mobile health workforce that can pivot and be used in a broad range of clinical and non-clinical roles to suit service needs. As long as the employer is satisfied that an Aboriginal and Torres Strait Islander Health Practitioner whom they employ is qualified and competent to practise in the role they want them to (e.g. by successfully completing the government training programs for vaccinating), from the regulator's point of view, that is that practitioner's chosen scope of practice.

Aboriginal and Torres Strait Islander Health Practitioners are central to providing culturally safe health services that strengthen health outcomes for Aboriginal and Torres Strait Islander Peoples.

All Australians should know that Aboriginal and Torres Strait Islander Health Practitioners and workers build trust and understanding in the communities they serve and can practise in very diverse roles, both clinical and non-clinical, in every health setting. Aboriginal and Torres Strait Islander Health Practitioners are central to providing culturally safe health services that strengthen health outcomes for Aboriginal and Torres Strait Islander Peoples.

Regulatory response to COVID-19

Our profession was highlighted by governments as a priority workforce to be ready to respond to COVID-19 outbreaks in the communities where Aboriginal and Torres Strait Islander Health Practitioners work. We established a sub-register of eligible practitioners who were no longer registered but had been recently. Those practitioners who opted in to the sub-register were re-registered for up to 12 months.

The sub-register has now been extended for those practitioners wishing to continue to work in a role related to the COVID-19 vaccination roll-out across the country.

Accreditation

The Aboriginal and Torres Strait Islander Health Practice Board of Australia approved a revised accreditation standard for implementation from 1 July. The revised standard expands the eligibility criteria for programs of study to seek accreditation for courses leading to registration for practitioners.

The Aboriginal and Torres Strait Islander Health Practice Accreditation Committee (ATSIHPAC) is a committee of the Board. The ATSIHPAC monitored and reported to the Board on the accredited programs of study. Guidance for clinical placements during the pandemic year was published on the Board's website.

New standards, codes or guidelines

The Board contributed to the work of revising its *Code of conduct*, which is shared with 11 other regulated health professions. No new or revised standards, codes or guidelines were published.

The Board acknowledged the extensive work and thought that went into developing the agreed definition of cultural safety that is being included in all professions' codes of conduct. This means that all registered health practitioners' professional obligations will include providing culturally safe care and ensuring they can be held to account if a complaint is made.

Stakeholder engagement

The Board conducts extensive visits and engagements when it is able to meet face-to-face four times a year. We look forward to re-engaging with our stakeholders in person when we can.

The Board publishes three newsletters a year for its stakeholders and students.

Ms Renee Owen

Aboriginal and Torres Strait Islander Health Practice Board members

- **Ms Renee Owen (practitioner), Chair**
- Mr Bruce Brown (community)
- Ms Karrina DeMasi (community), Deputy Chair – to 8 Feb
- Ms Celia Harnas (practitioner) – to 8 Feb
- Ms Veronica (Bonny) King (practitioner) – to 15 Dec
- Ms Margaret McCallum (community)
- Mr David Nicholls (practitioner)
- Mr Christopher O'Brien (practitioner) – from 22 Feb
- Ms Leanne Quirino (practitioner)
- Ms Kim Schellnegger (practitioner) – to 8 Feb
- Ms Abbey Shillingford (community) – from 22 Feb
- Mr Kenton Winsley (practitioner) – from 13 Mar

Ms Jill Humphreys is the Executive Officer, Aboriginal and Torres Strait Islander Health Practice.

For more information, see the appendices and www.atsihealthpracticeboard.gov.au.

Snapshot

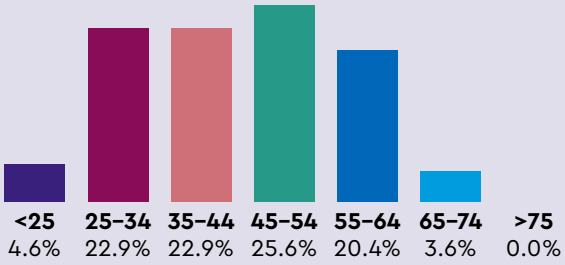
829 Aboriginal and Torres Strait Islander Health Practitioners

- → Up **2.1%** from 2019/20
- → **0.1%** of all registered health practitioners

100% identified as Aboriginal and/or Torres Strait Islander

77.3% female; **22.7%** male

Figure 2. Age



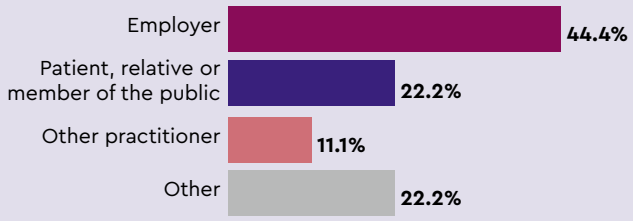
Regulating

Notifications

9 notifications lodged with Ahpra

- → **9** registered Aboriginal and Torres Strait Islander Health Practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.1%** of the profession

Figure 3. Sources of notifications



No immediate action taken

4 mandatory notifications received

- → **3** about professional standards

Figure 4. Most common types of complaints

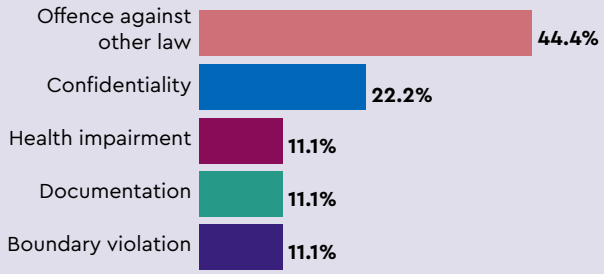


Figure 5. Notifications closed

9 notifications closed

- **55.6%** received a caution or reprimand
- **33.3%** registration suspended
- **11.1%** no further action

Monitoring

6 practitioners monitored for health, performance and/or conduct during the year

3 cases being monitored at 30 June:

- → **1** for health reasons
- → **2** for prohibited practitioner/student

Criminal offence complaints

1 criminal offence complaint made

- → about advertising breaches

2 were closed

Referred to an adjudication body

3 matters decided by a tribunal

No matters decided by a panel

No appeals

Chinese medicine practitioners

From the Chair

Issues this year

This year saw the reshaping of the Chinese Medicine Board of Australia and its way of working, due to both the ongoing disruption of COVID-19 and the appointment of five new Board members, including a new Board Chair. The new membership of the Board continued improving clinical practice standards and working towards greater integration with other health professions.

This year saw the reshaping of the Chinese Medicine Board of Australia ... and the appointment of five new Board members, including a new Board Chair.

Regulatory response to COVID-19

COVID-19 affected the Board's work, with the usual roadshows being replaced by a virtual webinar in October. In July, the Board published guidance on how Chinese medicine practitioners can use telehealth in the context of the COVID-19 pandemic and in March the Board, together with Ahpra, published a joint statement on expectations of practitioners for the COVID-19 vaccination.

Policy updates

In Sydney in February, the Board held a pilot of the multiple-choice exam that forms part of the Board's new regulatory examinations. While the project continued to be impacted with COVID-19 closing examination centres across the globe, the Examination Committee met for the first time in April.

In May, the Board published its revised statement on use of the protected title 'acupuncturist'.

Accreditation

The Chinese Medicine Accreditation Committee carried out accreditation functions for Chinese medicine. Following public consultation, the accreditation committee's new Chinese medicine accreditation standards, *Accreditation standards 2019*, took effect on 1 June, superseding the 2013 standards. All education providers wishing to seek accreditation of Chinese medicine programs of study will be assessed against these accreditation standards and the professional capabilities for Chinese medicine practitioners.

Stakeholder engagement

In October, the Board held a webinar on Chinese medicine regulation in Australia. This webinar was attended by more than 550 practitioners and replaced the Board's usual annual stakeholder engagement roadshow, which could not go ahead due to the COVID-19 restrictions.

Other news

The Board's membership substantially changed in February, with the appointment of five new Board members, including myself as the new Board Chair. We warmly welcomed practitioner members Ms Dina Tsiopelas, Mr Luke Hubbard and Dr Johannah Shergis, and community member Ms Sophy Athan. Mr Roderick Martin and Mr David Brereton were also reappointed for a further three-year term in February.

The Board thanks outgoing chair Distinguished Professor Charlie Xue for his outstanding commitment, leadership, dedication and contribution to the National Scheme and health practitioner regulation. We recognise also the contributions of retiring members Ms Di Wen Lai, Dr David Graham, Dr Liang Zhong Chen and Ms Christine Berle.

The Board also bade farewell to its long-time Executive Officer Ms Debra Gillick, who retired after almost 20 years' service to the Chinese medicine profession.

Professor Danforn Lim

Chinese Medicine Board members

- **Professor Chi Eung Danforn Lim (practitioner), Chair from 17 Feb**
- **Distinguished Professor Charlie C. Xue (practitioner), Chair to 8 Feb**
- Ms Sophy Athan (community) – from 18 Feb
- Ms Christine Berle (practitioner) – to 8 Feb
- Mr David Brereton (community)
- Ms Stephanie Campbell (community)
- Dr Liang Zhong Chen PhD (practitioner) – to 8 Feb
- Dr David Graham PhD (community) – to 8 Feb
- Mr Luke Hubbard (practitioner) – from 17 Feb
- Dr Di Wen Lai (practitioner) – to 8 Feb
- Mr Roderick Martin (practitioner)
- Dr Johannah Shergis (practitioner) – from 18 Feb
- Mrs Bing Tian (practitioner)
- Ms Dina Tsiopelas (practitioner) – from 18 Feb

Ms Sangeetha Masilamani was the Acting Executive Officer from April to October 2020, Ms Jill Humphries from October to November and Ms Sylvia Sanders was appointed to the position in December.

For more information, see the appendices and www.chinesemedicineboard.gov.au.

Snapshot

4,863 Chinese medicine practitioners
- → Down **1.2%** from 2019/20
- → **0.6%** of all registered health practitioners

0.5% identified as Aboriginal and/or Torres Strait Islander

57.3% female; **42.7%** male

Figure 6. Age

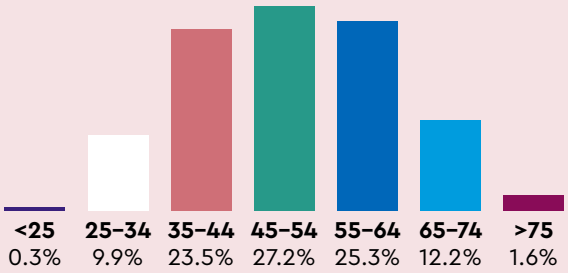


Figure 7. Divisions

Registered as:

Acupuncturist	**98.0%**
Chinese herbal medicine practitioner	**64.1%**
Chinese herbal dispenser	**22.4%**

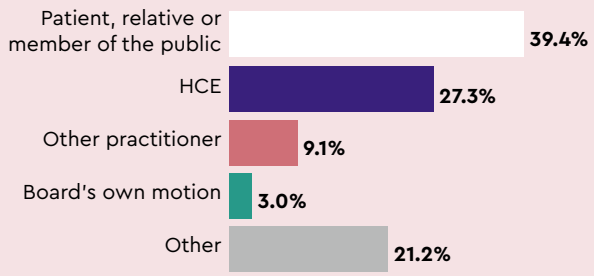
Registered in one division	**36.8%**
Registered in two divisions	**42.0%**
Registered in three divisions	**21.2%**

Regulating

Notifications

33 notifications lodged with Ahpra
- → **49** registered Chinese medicine practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.0%** of the profession

Figure 8. Sources of notifications



2 immediate actions taken

1 mandatory notification received
- → about professional standards

Figure 9. Most common types of complaints

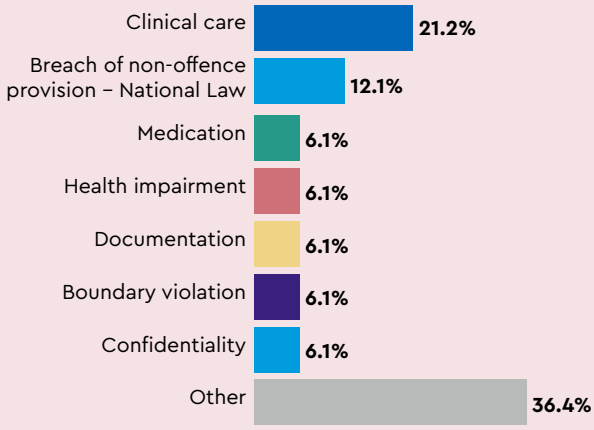
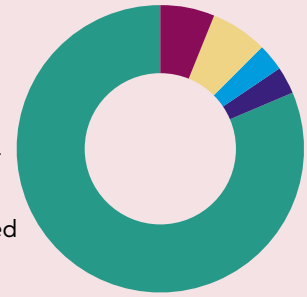


Figure 10. Notifications closed

32 notifications closed
- **6.3%** conditions imposed on registration or an undertaking accepted
- **6.3%** received a caution or reprimand
- **3.1%** registration suspended
- **3.1%** retained by a health complaints entity
- **81.3%** no further action



Monitoring

27 practitioners monitored for health, performance and/or conduct during the year

786 cases being monitored at 30 June:
- → **5** for conduct
- → **1** for health reasons
- → **2** for performance
- → **5** for prohibited practitioner/student
- → **773** for suitability/eligibility for registration

Criminal offence complaints

9 criminal offence complaints made
- → **8** about title protection
- → **1** about advertising breaches

14 were closed

Referred to an adjudication body

1 matter decided by a tribunal

No matters decided by a panel

No appeals

Chiropractors

From the Chair

The Chiropractic Board of Australia continued to build on initiatives from the previous year to meet our strategic objectives. After considering several analyses, the Board announced a reduced registration fee while ensuring that finances were sustainable.

Regulatory response to COVID-19

The Board continued to work with Ahpra to provide information to the profession. Together with the other 14 National Boards and Ahpra, the Board published a joint vaccination position statement to help practitioners and students understand what's expected of them in giving, receiving, advising on and sharing information about COVID-19 vaccines.

The Board released a video about what is expected of chiropractors, with a focus on continuing professional development, advertising and use of social media.

In response to the initial national COVID-19 emergency, the Board eased the requirements for continuing professional development and recency of practice for the 2020 renewal year.

The Board received regular updates from its stakeholders and regulatory partners, including professional associations, the Chiropractic Council of NSW and the Council on Chiropractic Education Australasia, about the impact of the pandemic on the profession, approved programs and students.

Standards, codes, guidelines and policies

Together with National Boards and Ahpra, the Board jointly revised the *Guidelines for advertising a regulated health service* and the *Advertising and compliance enforcement strategy for the National Scheme*. The guidelines were finalised after an extensive review, including public consultation, to ensure they effectively and clearly explain the requirements for advertising a regulated health service.

The Board began public consultation on a revised *Code of conduct*, jointly with 11 National Boards and Ahpra. The *Code of conduct* sets out the expected professional behaviour and conduct for chiropractors and promotes safe care to help protect the public. Chiropractors were part of multi-profession focus groups to provide feedback on the *Code of conduct*.

The Board, jointly with National Boards and Ahpra, carried out a public consultation on revised *Regulatory principles for the National Scheme* and released a position statement: *No place for sexism, sexual harassment or violence in healthcare*.

Stakeholder engagement

The Board held two virtual information forums during May for chiropractors in Queensland, South Australia and the Northern Territory. To support the information forums, the Board released a video to provide information about what is expected of chiropractors, with a focus on continuing professional development, advertising and use of social media. The virtual forums gave chiropractors an opportunity to engage with the Board after the face-to-face forums were cancelled due to COVID-19 restrictions.

We continued our program of presentations to final-year students throughout the year to welcome them to the profession and help them understand the expectations and requirements. Students of chiropractic programs now receive the Board's newsletter, which is issued to practitioners three times per year.

The Board was pleased to be asked to participate in the *Responsible advertising by regulated health services* episode of Ahpra's *Taking care* podcast to highlight the importance of responsible advertising and the risks and opportunities in advertising a regulated health service.

Other news

The Board supports the *National Scheme's Aboriginal and Torres Strait Islander health and cultural strategy 2020–2025* and is pleased that members have had the opportunity to start the Moong-moong-gak cultural safety training program.

Dr Wayne Minter AM

Chiropractic Board members

- **Dr Wayne Minter AM (practitioner), Chair**
- Dr Michael Badham (practitioner)
- Ms Anne Burgess AM (community)
- Dr Abbey Chilcott (practitioner)
- Mr Frank Ederle (community)
- Associate Professor Anna Ryan (practitioner and medical practitioner)
- Dr Arcady Turczynowicz (practitioner)
- Ms Alison von Bibra (community)
- Dr Ailsa Wood (practitioner)

Ms Kirsten Hibberd is the Executive Officer, Chiropractic.

For more information, see the appendices and www.chiropracticboard.gov.au.

Snapshot

5,968 chiropractors

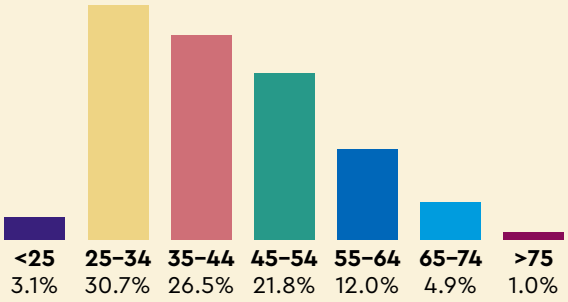
Up **3.3%** from 2019/20

→ **0.7%** of all registered health practitioners

0.6% identified as Aboriginal and/or Torres Strait Islander

41.6% female; **58.4%** male

Figure 11. Age



Regulating

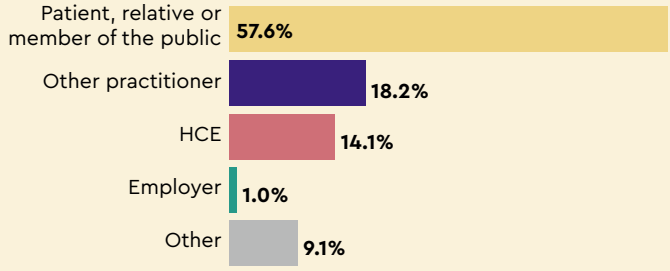
Notifications

99 notifications lodged with Ahpra

→ **140** registered chiropractors Australia-wide, including HPCA and OHO data, had notifications made about them

→ **2.3%** of the profession

Figure 12. Sources of notifications



12 immediate actions taken

5 mandatory notifications received

→ **3** about professional standards

Figure 13. Most common types of complaints

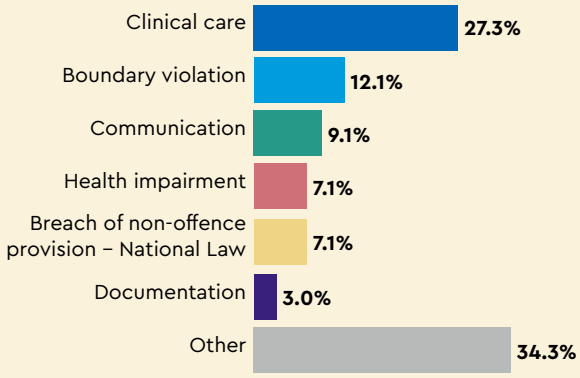
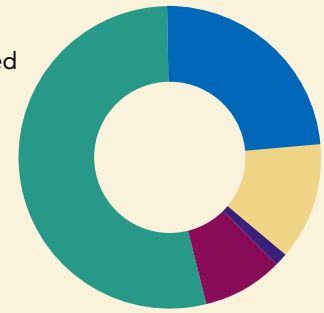


Figure 14. Notifications closed

80 notifications closed

- **23.8%** conditions imposed on registration or an undertaking accepted
- **12.5%** received a caution or reprimand
- **1.3%** registration cancelled
- **8.8%** referred to another body or retained by a health complaints entity
- **53.8%** no further action



Monitoring

53 practitioners monitored for health, performance and/or conduct during the year

41 cases being monitored at 30 June:

→ **9** for conduct

→ **4** for health reasons

→ **9** for performance

→ **8** for prohibited practitioner/student

→ **11** for suitability/eligibility for registration

Criminal offence complaints

18 criminal offence complaints made

→ **10** about title protection

→ **4** about practice protection

→ **4** about advertising breaches

15 were closed

Referred to an adjudication body

2 matters decided by a tribunal

No matters decided by a panel

1 appeal

Dental practitioners

From the Chair

This year the Dental Board of Australia improved collaboration and coordination with our stakeholders and partners to build better understanding of regulation and our role in protecting the public. A focus has been on working together to support professional practice.

Highlights this year

The Board reviewed several standards and guidelines, released guidance and information, and launched a national health and wellbeing support service for dental practitioners. A review of the Board's decision-making committees resulted in a new national structure, contributing to greater regulatory effectiveness. The Board focused on improving how guidance is presented, with a plain English review of its fact sheets. Updated versions will be released in 2021/22, starting with a fact sheet on teeth whitening.

A focus has been on working together to support professional practice.

Regulatory response to COVID-19

Our response to the COVID-19 pandemic and support for practitioners to comply with their regulatory obligations in a rapidly changing environment continued this year. The Board contacted practitioners directly to explain the evolving advice about state and territory governments' public health orders and our response to COVID-19 and the challenges it continues to present.

Dental Practitioner Support

Dental Practitioner Support, launched on 6 July, is the first 24/7, free, confidential, nationwide telephone and online service for all dental practitioners and students.

Dental Practitioner Support

Stakeholder engagement

The Dental Stakeholder Liaison Group was established due to COVID-19 and the extraordinary challenges it posed. These challenges continued into 2020/21. The group stayed active, meeting under a broader scope to include topics beyond COVID-19 and of interest and relevance to the group.

The past year also saw the first in a series of planned roundtables, held on 21 March, to discuss how we could collectively clarify for practitioners our roles and the role of practitioner regulation.

Accreditation

In 2020, the Australian Dental Council (ADC) reviewed the accreditation standards. The Board approved the standards with effect from 1 January. Any dental practitioner program submitted for accreditation after this date will be assessed using the revised standards.

An ADC review of the competencies for newly qualified dental practitioners is due to be finalised in 2021/22.

Standards, guidelines and codes

The revised *Scope of practice registration standard* came into effect on 1 July, following approval by Ministerial Council. A 'Know your scope' online hub was launched to hold information and resources to support dental practitioners' understanding of their obligations under the revised standard.

Following a review, the *Guidelines for dental records* were retired, as the *Code of conduct* contains adequate guidance about health record management. A fact sheet and self-reflective tool were published to support practitioners practising safely.

New *Guidelines for blood-borne viruses for registered health practitioners and students* came into effect on 6 July. The Board's guidelines (for practitioners and students who perform exposure-prone procedures) apply to health practitioners who treat registered health practitioners or students living with a blood-borne virus.

The review of the *Guidelines on infection control* was begun, with a public consultation scheduled for late 2021.

Dr Murray Thomas

Dental Board members

- **Dr Murray Thomas (practitioner), Chair**
- Winthrop Professor Paul Abbott AO (practitioner)
- Mr Robin Brown (community)
- Dr Penelope Burns (practitioner)
- Ms Alison Faigniez (community)
- Ms Jacqui Gibson-Roos (community)
- Mrs Kim Jones (community)
- Professor Richard Logan (practitioner)
- Mr Tan Nguyen (practitioner)
- Mrs Janice Okine (practitioner)
- Dr Kate Raymond (practitioner)
- Ms Carolynne Smith (practitioner)

Ms Luisa Interligi is the Executive Officer, Dental.

For more information, see the appendices and www.dentalboard.gov.au.

Snapshot

24,984 dental practitioners
- → Up **2.4%** from 2019/20
- → **3.0%** of all registered health practitioners

0.5% identified as Aboriginal and/or Torres Strait Islander

53.4% female; **46.6%**male

Figure 15. Age

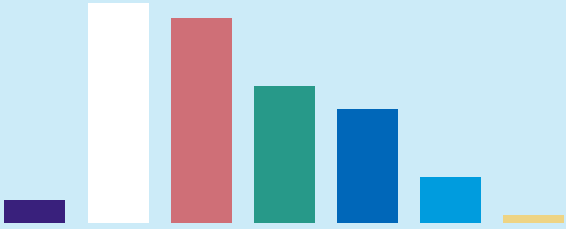
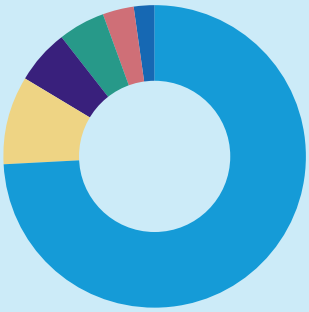


Figure 16. Divisions

- **74.4%** dentists
- **9.4%** oral health therapists
- **5.9%** dental hygienists
- **5.1%** dental prosthetists
- **3.2%** dental therapists
- **2.2%** registered in multiple divisions

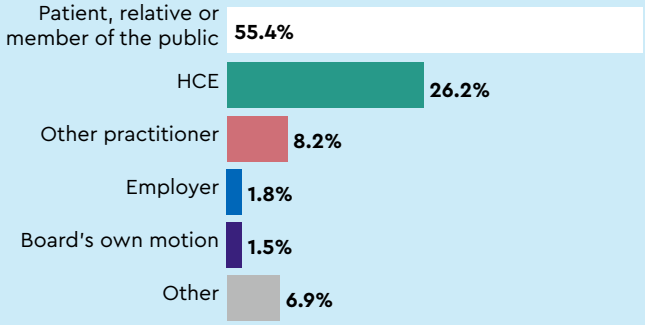


Regulating

Notifications

710 notifications lodged with Ahpra
- → **1,035** registered dental practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **4.1%** of the profession

Figure 17. Sources of notifications



25 immediate actions taken

38 mandatory notifications received
- → **19** about professional standards

Figure 18. Most common types of complaints

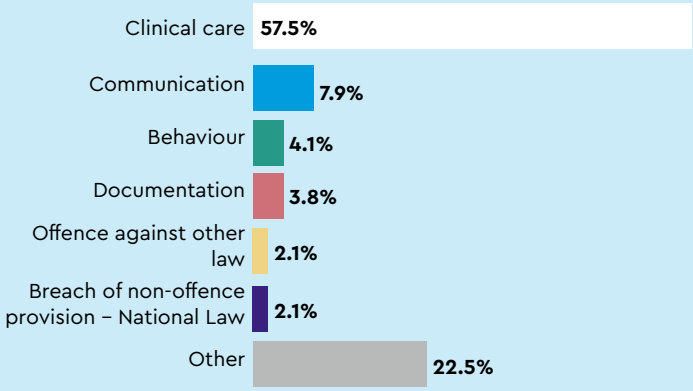
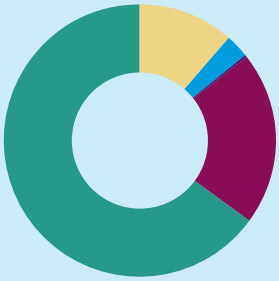


Figure 19. Notifications closed

757 notifications closed
- **11.4%** conditions imposed on registration or an undertaking accepted
- **3.0%** received a caution or reprimand
- **0.1%** registration cancelled
- **20.7%** referred to another body or retained by a health complaints entity
- **64.7%** no further action



Monitoring

233 practitioners monitored for health, performance and/or conduct during the year

165 cases being monitored at 30 June:
- → **14** for conduct
- → **17** for health reasons
- → **86** for performance
- → **9** for prohibited practitioner/student
- → **39** for suitability/eligibility for registration

Criminal offence complaints

22 criminal offence complaints made
- → **14** about title protection
- → **2** about practice protection
- → **6** about advertising breaches

32 were closed

Referred to an adjudication body

4 matters decided by a tribunal

1 matter decided by a panel

9 appeals

Medical practitioners

From the Chair

Issues this year

The Medical Board of Australia is proud to have run another successful Medical Training Survey and we are grateful for the support of doctors in training and other stakeholders. The results will help to improve medical training and the culture of medicine in Australia.

The Board continued its work on the Professional Performance Framework, dealt with a number of issues related to COVID-19, and progressed its policy agenda.

Policy updates

Medical Training Survey

We were delighted to more than double the response rate for the second Medical Training Survey (MTS) compared with the first survey in 2019. More than 21,000 (57%) doctors in training provided feedback about the quality of their training. They told us that there is a lot going well in training, with 87% who responded to the survey rating the quality of their clinical supervision and training very highly, and 81% saying that they would recommend their current training position to other doctors.

Revised questions about the culture of medicine painted a disappointing picture: 34% of doctors in training reported they had experienced and/or witnessed bullying, harassment or discrimination. We all need to do more to build a culture of respect in healthcare.

We asked about the effect of the COVID-19 pandemic. About 80% of respondents told us that the pandemic had had an impact on their training with 46% reporting the impact as a mix of positive and negative, while one-third reported it having had only a negative effect.

34% of doctors in training reported they had experienced and/or witnessed bullying, harassment or discrimination. We all need to do more to build a culture of respect in healthcare.

Results can be found at www.medicaltrainingsurvey.gov.au. We published more than 30 reports by jurisdiction, specialty and type of doctor. We also have an online dashboard for anyone to produce customised reports and have published case studies about how stakeholders are using MTS data to improve and strengthen medical training.

Professional Performance Framework

The Board's Professional Performance Framework is a long-term project that, when implemented, will help ensure all registered medical practitioners in Australia practise competently and ethically throughout their careers.

The framework is integrated, builds on existing initiatives and is evidence-based. It has five pillars:

1. strengthened CPD requirements
2. active assurance of safe practice
3. strengthened assessment and management of practitioners with multiple substantiated complaints
4. guidance to support practitioners – regularly updated professional standards that support good medical practice
5. collaborations to foster a culture of medicine that is focused on patient safety, is based on respect and encourages doctors to take care of their own health and wellbeing.

CPD registration standard

The Board submitted a revised registration standard for continuing professional development (CPD) to Health Ministers for approval. The proposed CPD standard includes a requirement for medical practitioners to:

- complete at least 50 hours of CPD each year with a prescribed mix of activities including educational activities, reviewing performance and measuring outcomes
- have a CPD home
- do CPD that is relevant to their scope of practice
- base their CPD on a personal professional development plan.

If approved, there will be a long implementation phase to enable the establishment and accreditation of CPD homes and to support medical practitioners to understand what they need to do to meet the standard.

Health checks for late career practitioners

The Board previously announced a plan to require practitioners aged 70 and over to have regular health checks. This was based on expert advice that increasing age is a known risk factor for poor performance. The Board expects that the vast majority of late career practitioners will continue to practise in their usual way. The Board worked on a registration standard about these health checks. It will consult widely with stakeholders about the proposal.

Complementary and unconventional medicine and emerging treatments

Over six months in 2019, the Board consulted on options for clearer regulation of medical practitioners who provide complementary and unconventional medicine and emerging treatments. It looked at options to best protect patients and minimise the risk of harm to them, without stifling innovation, making a judgement about specific clinical practices or limiting patients' right to choose their healthcare.

The Board received more than 13,000 submissions, the majority of which it published during 2020. The Board considered all the submissions and decided that it will not issue guidelines but rather, continue to rely on the existing standards framework set out in *Good medical practice*.

Through the consultation feedback it became clear that the proposed solution did not match the problem the Board was trying to solve. The persisting issue of patients being offered high-risk treatments that do not have an evidence base of safety and efficacy is not limited to complementary and unconventional medicine and emerging treatments. Also, the problem of vulnerable patients not being provided with the information they need to give genuinely informed consent is not limited to a specific area of practice.

The Board will continue to refine its risk-based regulatory approach, so that regulatory safeguards match the risks to patients across all areas of practice. This work will not be limited to specific areas of practice and will be developed over time.

Standards, codes and guidelines

A code of conduct for doctors in Australia

The Board issued an updated version of *Good medical practice: a code of conduct for doctors in Australia* that took effect on 1 October. It describes what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community.

Good medical practice sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community.

The changes do not significantly change expected professional standards. Updates include:

- strengthened guidance about discrimination, bullying, sexual harassment and vexatious complaints
- an expanded section on cultural safety, including a new definition agreed across the National Scheme
- more information on patient safety and clinical governance
- a new section on career transitions for doctors.

Guidelines for advertising regulated health services

Jointly with the other 14 National Boards, the Medical Board developed *Guidelines for advertising regulated health services* that were issued on 14 December. The guidelines were developed to help practitioners and other advertisers understand their obligations when advertising a regulated health service.

National Boards and Ahpra also published other useful information about advertising for registered health practitioners and consumers in the *Advertising hub* on the Ahpra website.

Standards: Specialist international medical graduates

Revised standards to guide how specialist medical colleges assess international medical graduates (IMGs) took effect on 1 January.

The updated *Standards for specialist medical college assessment of specialist international medical graduates* aim to improve transparency and procedural fairness and make the requirements of the assessment clearer. They do not significantly change the previous approach to the assessment of specialist IMGs.

Consultation: Endorsement of registration for acupuncture for registered medical practitioners

Medical practitioners who want to use the protected title 'acupuncturist' must have their registration endorsed for acupuncture by the Medical Board of Australia, or also be registered with the Chinese Medicine Board of Australia. The Medical Board's registration standard for *Endorsement of registration for acupuncture for registered medical practitioners* defines the requirements for granting endorsement of registration for acupuncture to medical practitioners.

The Board consulted on a revised registration standard as the existing standard was due for review.

Regulatory responses to COVID-19

The Board acknowledges the important role and enormous contribution of doctors as they deal with the COVID-19 pandemic.

Most of the Board's regulatory responses to COVID-19 were made early in the pandemic and aimed to alleviate some of the bureaucratic burden on practitioners. The Board has:

- extended the pandemic response sub-register for a further 12 months at the request of the Australian Governments, to support the national COVID-19 vaccination effort
- with Ahpra and the other National Boards, published a position statement about COVID-19 vaccination
- introduced flexibility for 2021 interns whose internship has been disrupted directly as a result of COVID-19
- confirmed that international medical graduates who were scheduled but unable to sit an examination or assessment from March 2020 will not have their registration refused solely because they have been unable to sit examinations and assessments in 2020.

Stakeholder engagement

Newsletters for medical practitioners

The Board published 10 regular editions of the *Medical Board Update* and one newsletter dedicated to the Medical Training Survey and its results.

Newsletter for medical students

The Board published its first edition of a medical student update in April. This is part of a broader engagement strategy with students. The newsletter included information about student registration, the Medical Training Survey and the importance of looking after yourself.

Media

The Board responds to many media requests for comment on a range of issues. We also receive requests for comment about individual practitioners, but the information we can provide is limited by law.

Meetings with stakeholders

The Board has an active program of stakeholder engagement that includes regular meetings with the:

- Australian Medical Association (AMA)
- Australian Medical Council (AMC)
- Medical Council of New South Wales
- Medical Council of New Zealand
- specialist colleges through the Council of Presidents of Medical Colleges.

The Board held a forum with stakeholders about the results of the MTS and also met with all the professional indemnity insurers. We held our regular annual meeting with representatives of the AMA to discuss initiatives introduced to improve the notifications process.

Internal engagement

The Board has a program of internal stakeholder engagement to promote consistency of decision-making and respond to feedback from our decision-makers. This includes regular meetings with the Chairs of state and territory boards and the Chair of the National Board visiting each state and territory board.

Accreditation

The Board considered each of the AMC's accreditation reports and decided whether to approve the relevant accredited program of study for registration.

Managing complaints

The Medical Board and Ahpra appreciate the enormous stress that many medical practitioners experience when a notification (complaint) is made about them.

The Board has been working with Ahpra to improve the notifications process and, where possible, to deal with low-risk matters quickly to allow us to focus on high-risk matters and to reduce the duration of stress for practitioners.

We employ medically qualified clinical advisors who review all complaints early and apply a clinical lens to each complaint. We also schedule six meetings each week of the Notifications Assessment Committee, which includes medical practitioners and community members, and can deal with notifications quickly.

The Board worked with Ahpra on a revised approach to notifications. While the most serious of cases continue to be investigated in the traditional way, the new approach for lower risk matters (which are the majority of cases we receive) involves speaking directly to the practitioner so we can gather early information about the practitioner's individual practice, reflection and their actions in response to notified events. We assess the notification before deciding whether there is ongoing risk that requires regulatory intervention.

We also commissioned Professor Ron Paterson, who authored the 2017 *Independent review of the use of chaperones to protect patients in Australia*, to assess what had been achieved and identify what more could be done to improve the handling of sexual misconduct allegations. Professor Paterson reported that the processes had greatly improved over the past years.

Dr Anne Tonkin

Medical Board members

- **Dr Anne Tonkin (practitioner), Chair**
- Associate Professor Stephen Adelstein (practitioner)
- Mr Mark Bodycoat (community)
- Dr Kerrie Bradbury (practitioner)
- Professor Richard Doherty (practitioner)
- Dr Samuel Goodwin (practitioner)
- Ms Eileen Jerga AM (community)
- Associate Professor Hannah McGlade (community)
- Professor Constantine Michael AO (practitioner)
- Dr Andrew Mulcahy (practitioner)
- Dr Susan O'Dwyer (practitioner)
- Ms Fearn (Michelle) Wright (community)

Dr Joanne Katsoris is the Executive Officer, Medical.

For more information, see the appendices and www.medicalboard.gov.au.

Snapshot

129,066 medical practitioners

→ Up **2.7%** from 2019/20

→ **15.6%** of all registered health practitioners

0.4% identified as Aboriginal and/or Torres Strait Islander

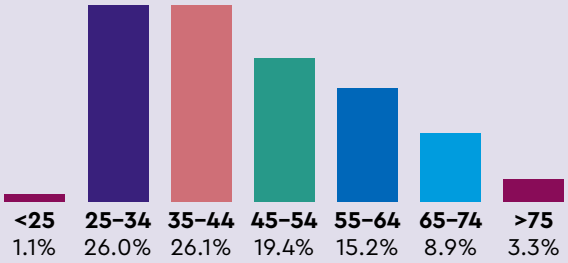
44.4% female; **55.6%** male

Figure 20. Specialties

194	addiction medicine
5,736	anaesthesia
621	dermatology
2,885	emergency medicine
33,896	general practice
1,069	intensive care medicine
356	medical administration
2,250	obstetrics and gynaecology
328	occupational and environmental medicine
1,090	ophthalmology
3,452	paediatrics and child health
357	pain medicine
432	palliative medicine
2,348	pathology
12,364	physician
4,314	psychiatry
457	public health medicine
442	radiation oncology
2,873	radiology
590	rehabilitation medicine
137	sexual health medicine
151	sport and exercise medicine
6,445	surgery
82,787	medical practitioners with specialties

This figure was updated to show the correct numbers for 'Specialties' post-publication.

Figure 21. Age



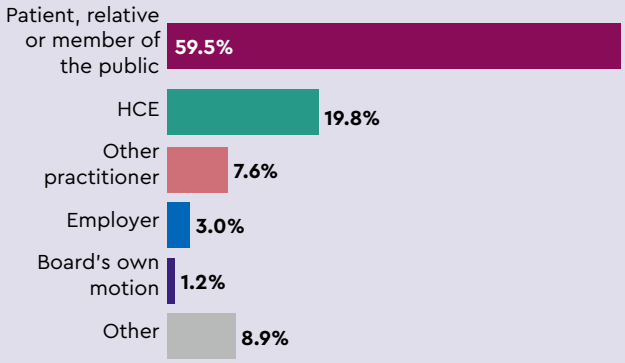
Regulating

Notifications

5,516 notifications lodged with Ahpra

- → **7,379** registered medical practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **5.7%** of the profession

Figure 22. Sources of notifications



195 immediate actions taken

375 mandatory notifications received

- → **164** about professional standards

Figure 23. Most common types of complaints

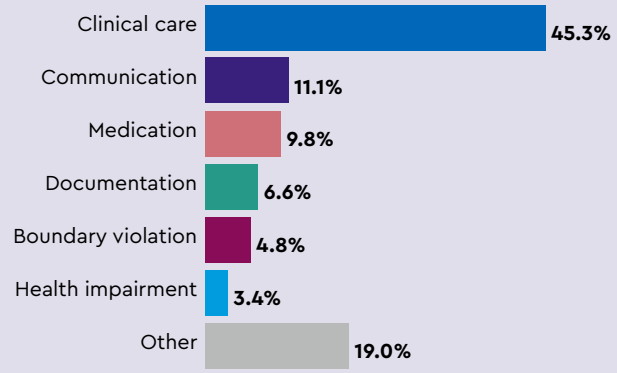
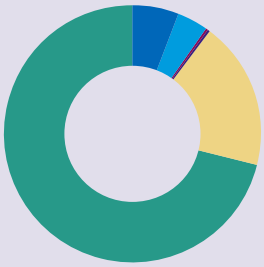


Figure 24. Notifications closed

5,445 notifications closed

- **6.1%** conditions imposed on registration or an undertaking accepted
- **3.7%** received a caution or reprimand
- **0.4%** registration surrendered, suspended or cancelled
- **0.1%** fined
- **18.6%** referred to another body or retained by a health complaints entity
- **71.0%** no further action



Monitoring

1,224 practitioners monitored for health, performance and/or conduct during the year

1,209 cases being monitored at 30 June:

- → **139** for conduct
- → **175** for health reasons
- → **268** for performance
- → **103** for prohibited practitioner/student
- → **524** for suitability/eligibility for registration

Criminal offence complaints

104 criminal offence complaints made

- → **69** about title protection
- → **11** about practice protection
- → **22** about advertising breaches
- → **1** directing or inciting unprofessional conduct/ professional misconduct
- → **1** other offence

105 were closed

Referred to an adjudication body

48 matters decided by a tribunal

9 matters decided by a panel

57 appeals

Medical radiation practitioners

From the Chair

Issues this year

This year was again a busy one, and while we were getting on with the business of regulation it was entwined with the continuing impact of the COVID-19 pandemic. The Medical Radiation Practice Board of Australia conducted its business through video link.

Accreditation

In March, the Board approved updates to accreditation standards relating to the National Scheme's definition of cultural safety, and information relevant to the quality use of medicines. The Board also requested the Accreditation Committee consult on accreditation fees for the purpose of ensuring the costs of accreditation are distributed evenly. The Board approved a revised fee schedule at its May meeting.

The Accreditation Committee annually monitors 25 accredited programs in medical radiation practice from 11 education providers across Australia.

Policy and project updates

Financial hardship policy

To counter some of the impact of COVID-19, the Board established a financial hardship policy. This policy was established to enable those who wished to be registered to practise but may have been disproportionately affected by the COVID-19 pandemic or otherwise have difficulty in paying registration fees.

Supervised practice

The Board modified supervised practice arrangements to allow more flexible arrangements in response to the pandemic. These changes have been retained and allow supervised practitioners to move through the program more quickly while still ensuring that supervised practitioners meet the standards of practice necessary for general registration.

Videos developed to support practice

The Board developed a video on the *Professional capabilities for medical radiation practice requirements* around cultural competency and cultural safety.

Pandemic sub-register for diagnostic radiographers

In April 2020, a pandemic response sub-register for diagnostic radiographers was established to support Australia's health workforce for a period of 12 months. In April 2021, the Board agreed that the sub-register for diagnostic radiographers had fulfilled its purpose and was no longer required. Over 60 practitioners returned to the main register following the closing of the pandemic sub-register.

Stakeholder engagement

Like so many organisations, the way we engaged with stakeholders changed throughout 2020 and 2021 due to limits on movement and in-person meetings. A positive impact of this change is a greater willingness by the Board and its stakeholders to engage through video conferencing, which has significant benefits for time, travel and costs.

The Board met with Medical Radiations Australia, the Australian Society of Medical Imaging and Radiation Therapy, the Australian and New Zealand Society of Nuclear Medicine, Australian Sonographers Association and others to discuss issues in medical radiation practice, particularly the impact of COVID-19 on practice and education.

Like so many organisations, the way we engaged with stakeholders changed throughout 2020 and 2021 due to limits on movement and in-person meetings.

Other news

The ease of video conferencing enabled more regular engagement with some stakeholders. For programs like Teaching on the Run supervisor training, the move to online learning has been both challenging and rewarding for learners and facilitators. The Board thanks the current facilitators for the time and their commitment to helping deliver the program.

Mr Mark Marcenko

Medical Radiation Practice Board members

- **Mr Mark Marcenko (practitioner), Chair**
- Mr Richard Bialkowski (community)
- Ms Joan Burns (community)
- Mr Anthony Buxton (practitioner) – from 22 Feb
- Ms Donisha Duff (community) – to 8 Feb
- Dr Susan Gould PhD (community)
- Mr James Green (practitioner)
- Ms Renea Hart (community) – from 24 Feb
- Mr Christopher Hicks (practitioner) – to 8 Feb
- Mr Brendan McKernan (practitioner)
- Ms Cara Miller (practitioner)
- Mr Travis Pearson (practitioner) – from 26 Feb
- Ms Tracy Vitucci (practitioner) – to 8 Feb
- Mr Roger Weckert (practitioner)
- Dr Caroline Wright PhD (practitioner)

Mr Adam Reinhard is the Executive Officer, Medical Radiation Practice.

For more information, see the appendices and www.medicalradiationpracticeboard.gov.au.

Snapshot

17,844 medical radiation practitioners
- → Down **2.2%** from 2019/20
- → **2.2%** of all registered health practitioners

0.6% identified as Aboriginal and/or Torres Strait Islander

68.5% female; **31.5%** male

Figure 25. Age

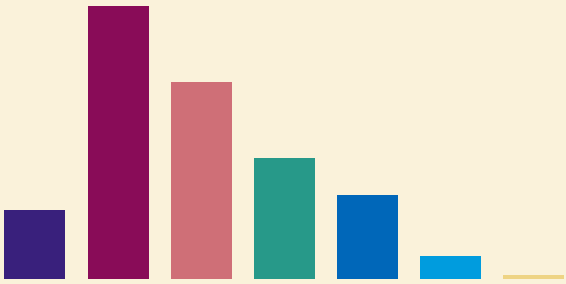


Figure 26. Divisions

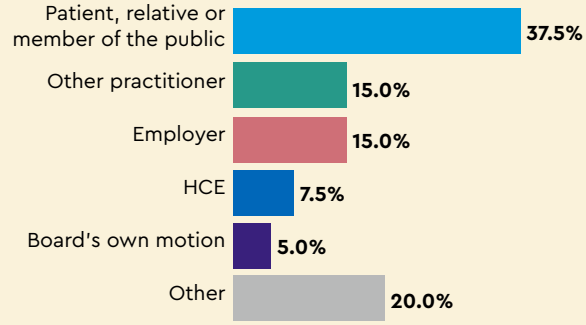
13,946	diagnostic radiographers
13	diagnostic radiographers and nuclear medicine technologists
2	diagnostic radiographers and radiation therapists
1,252	nuclear medicine technologists
2,631	radiation therapists
17,844	**total**

Regulating

Notifications

40 notifications lodged with Ahpra
- → **39** registered medical radiation practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.2%** of the profession

Figure 27. Sources of notifications



6 immediate actions taken

7 mandatory notifications received
- → **2** about professional standards

Figure 28. Most common types of complaints

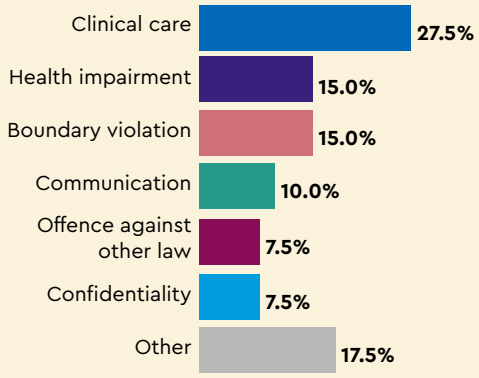


Figure 29. Notifications closed

31 notifications closed
- **16.1%** conditions imposed on registration or an undertaking accepted
- **9.7%** received a caution or reprimand
- **9.7%** referred to another body or retained by a health complaints entity
- **64.5%** no further action

Monitoring

27 practitioners monitored for health, performance and/or conduct during the year

63 cases being monitored at 30 June:
- → **3** for conduct
- → **8** for health reasons
- → **2** for performance
- → **6** for prohibited practitioner/student
- → **44** for suitability/eligibility for registration

Criminal offence complaints

3 criminal offence complaints made
- → **2** about title protection
- → **1** about advertising breaches

6 were closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

1 appeal

Nurses and midwives

From the Chair

New Chair gives thanks in pandemic-affected Year of the Nurse and the Midwife

In October, nurse and midwife Adjunct Professor Veronica Casey AM was appointed Chair of the Nursing and Midwifery Board of Australia (NMBA). Adjunct Professor Casey began her tenure by thanking nurses and midwives for their service to their communities, in recognition of 2020 being the Year of the Nurse and the Midwife.

The NMBA supported the professions and the public health response to COVID-19, working with state and territory health departments to uphold vaccination efforts with a national survey of nurses' and midwives' vaccination experience.

The NMBA also offered consideration of financial hardship for registration renewal fees in 2021 for those affected financially by the pandemic and temporarily amended some registration requirements. The pandemic response sub-register, initially due to end in April, was extended for a year to support the COVID-19 vaccination effort.

The NMBA also offered consideration of financial hardship for registration renewal fees for those impacted financially by the pandemic.

New assessment model for IQNMs

The NMBA successfully delivered the first objective structured clinical exam (OSCE) for registered nurses in February, as part of its new assessment model for internationally qualified nurses and midwives (IQNMs). The OSCE is a clinical exam to assess whether candidates demonstrate the knowledge, skills and competence of a graduate-level nurse or midwife from an Australian NMBA-approved program of study.

The NMBA also released new guidelines for employers on best practice for orienting IQNMs to the Australian healthcare context. Using the NMBA guidelines to shape the content of local (employer-based) orientation programs will enable IQNMs to have the best opportunity to start practice in Australia safely, effectively and professionally. The guidelines, *An employer and manager's guide to registration and orientation for internationally qualified nurses and midwives*, are available on the Orientation Part 1 and Part 2 sections of the NMBA website.

Celebrating four years of national health support for nurses and midwives

Nurses, midwives and students have had access to free nationwide health support for the past four years through Nurse & Midwife Support.

Launched in March 2017, Nurse & Midwife Support offers 24/7 phone and online health support, delivered for and by nurses and midwives. It also provides support for employers of nurses and midwives. The NMBA acknowledged the Nurse & Midwife Support team for their outstanding service to the nursing and midwifery professions in times of most need. To find out more about the service, visit www.nmsupport.org.au.

NP standards for practice

Revised *Nurse practitioner standards for practice* took effect on 1 March. These standards build and expand on the practice standards required of a registered nurse and set the expectations of nurse practitioner (NP) practice in all contexts. The standards inform the education accreditation standards for NPs, the regulation of NPs and determine an NP's capability for practice. The standards are used to guide consumers, employers and other stakeholders on what to reasonably expect from an NP regardless of their area of practice or their years of experience.

Recent developments in the theory and practice of NPs, including the key concepts and definitions, have been incorporated into the revised standards. The revised standards also include culturally safe and respectful practice, and consider the impact the standards could have on people's health and safety, particularly for members of the community with limited support, and Aboriginal and Torres Strait Islander Peoples. The presentation of the revised standards has been improved and aligns with the presentation of the *Registered nurse standards for practice* and the *Midwife standards for practice*.

Recency

The NMBA consulted on the proposed revised *Registration standard: Recency of practice*. The proposed revised standard gives practitioners more flexibility to meet the recency of practice requirements: these can now be met over two, three or five years. This aligns the NMBA with other National Boards and international regulators. The proposed revised standard incorporates changes to recency of practice requirements for recent graduates, clarity for deferred graduates and for those who have been absent from the profession for 10 or more years. The standard is with Health Ministers for approval.

Adjunct Professor Veronica Casey AM

Nursing and Midwifery Board members

- **Adjunct Professor Veronica Casey AM (practitioner), Chair from 2 Oct**
- **Associate Professor Lynette Cusack (practitioner), Chair to 2 Oct**
- Mr David Carpenter (practitioner)
- Ms Nicoletta (Maria) Ciffolilli (community)
- Ms Melodie Heland (practitioner)
- Dr Christopher Helms PhD (practitioner)
- Mr Max Howard (community)
- Dr Jessica (Jessa) Rogers PhD (community)
- Ms Catherine Schofield (practitioner)
- Associate Professor Linda Starr (practitioner) – from 2 Oct
- Ms Annette Symes (practitioner)
- Mrs Allyson Warrington (community)
- Mrs Jennifer Wood (practitioner)

Ms Tanya Vogt is the Executive Officer, Nursing and Midwifery.

For more information, see the appendices and www.nursingmidwiferyboard.gov.au.

Snapshot nursing

458,506 nurses[1]

- → Up **3.0%** from 2019/20
- → **55.5%** of all registered health practitioners
- → **29,248** also hold registration in midwifery

1.3% identified as Aboriginal and/or Torres Strait Islander

The number of nurse-only registered is up **3.3%** from 2019/20

Nurses, including dual registered, **88.4%** female; **11.6%** male

Nurse-only registered, **87.8%** female; **12.2%** male

The number of dual-registered nurses and midwives is down **1.6%** from 2019/20

Dual-registered nurses and midwives are **3.5%** of all registered health practitioners and **98.3%** female; **1.7%** male

Figure 30. Age

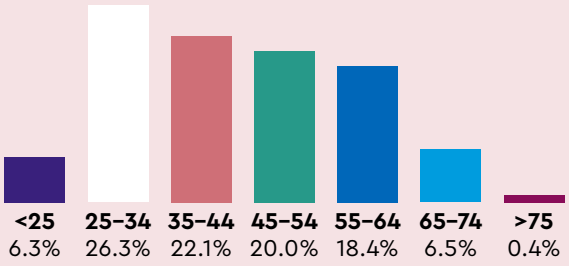


Figure 31. Divisions, dual registration and endorsements

Nurses by division	
74,059	enrolled nurses
10,050	enrolled nurses and registered nurses
345,149	registered nurses
429,258	**total**

Nurses and midwives	
118	enrolled nurses and midwives
91	enrolled nurses and registered nurses and midwives
29,039	registered nurses and midwives
29,248	**total**

Nurses with endorsements	
2,251	nurse practitioners
1,295	scheduled medicines
3,546	**total**

This figure was updated to show the correct categories for 'Nurses with endorsements' post-publication.

1 The 2019/20 annual report omitted dual-registered nurses and midwives from two totals in this corresponding display. The correct figures were 445,169 and 55.5%; 415,433 and 51.8% were nurse-only registered. The tables in the report were correct.

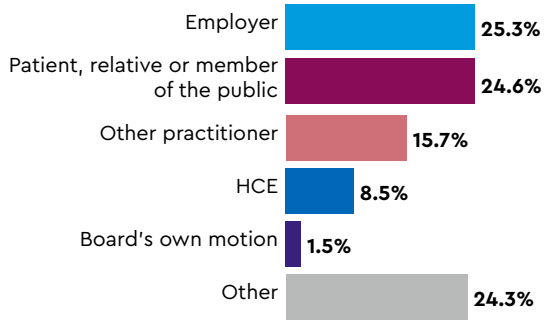
Regulating nurses

Notifications

2,080 notifications lodged with Ahpra

- → **2,483** registered nurses Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.5%** of the profession

Figure 32. Sources of notifications



246 immediate actions taken

602 mandatory notifications received

- → **284** about professional standards

Figure 33. Most common types of complaints

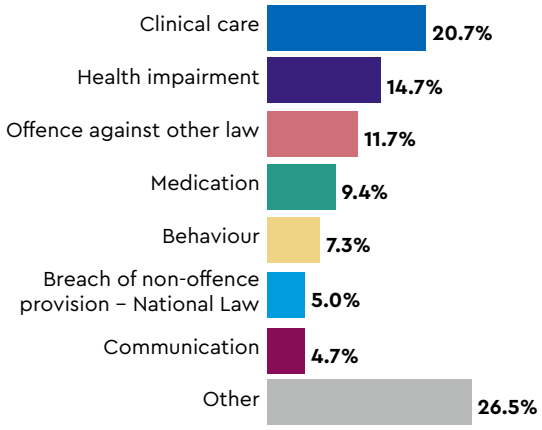
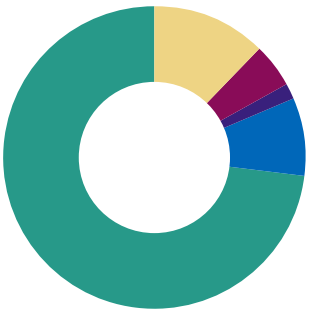


Figure 34. Notifications closed

2,021 notifications closed

- **12.4%** conditions imposed on registration or an undertaking accepted
- **4.8%** received a caution or reprimand
- **1.4%** registration suspended or cancelled
- **8.4%** referred to another body or retained by a health complaints entity
- **72.9%** no further action



Monitoring

1,255 practitioners monitored for health, performance and/or conduct during the year

1,519 cases being monitored at 30 June:

- → **114** for conduct
- → **232** for health reasons
- → **100** for performance
- → **240** for prohibited practitioner/student
- → **833** for suitability/eligibility for registration

Criminal offence complaints

89 criminal offence complaints made

- → **70** about title protection
- → **9** about practice protection
- → **9** about advertising breaches
- → **1** directing or inciting unprofessional conduct/ professional misconduct

72 were closed

Referred to an adjudication body

40 matters decided by a tribunal

4 matters decided by a panel

15 appeals

- → Also **1** appeal from a dual-registered nurse and midwife

Snapshot midwives

36,033 midwives
- → Down **0.03%** from 2019/20
- → **4.4%** of all registered health practitioners
- → **6,785** hold registration as a midwife only
- → **0.8%** of all registered health practitioners

The number of midwife-only registered is up **7.5%** from 2019/20

1.4% identified as Aboriginal and/or Torres Strait Islander

Midwives, including dual-registered, **98.5%** female; **1.5%** male

Midwife-only registered, **99.6%** female; **0.4%** male

Figure 35. Age

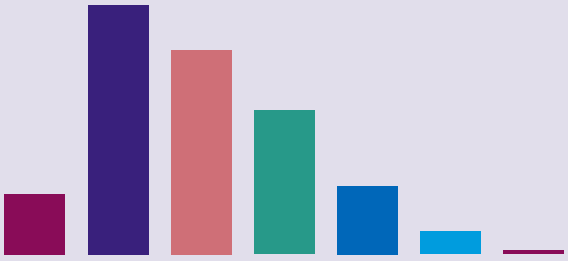


Figure 36. Midwives with endorsements

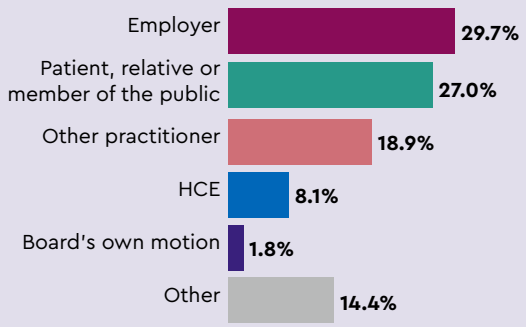
1	midwife practitioner
705	scheduled medicines
706	**total**

Regulating midwives

Notifications

111 notifications lodged with Ahpra
- → **135** registered midwives Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.4%** of the profession

Figure 37. Sources of notifications



10 immediate actions taken

31 mandatory notifications received
- → **12** about professional standards

Figure 38. Most common types of complaints

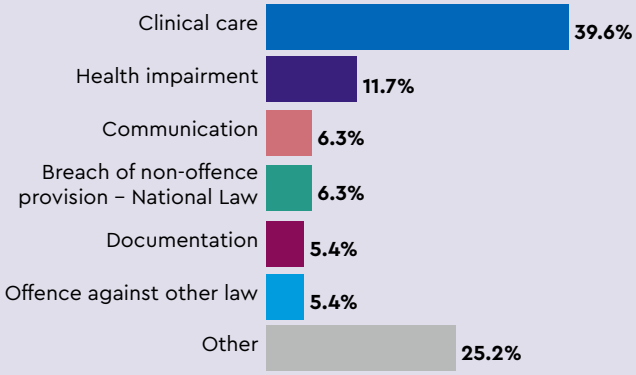
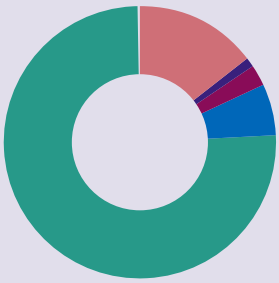


Figure 39. Notifications closed

116 notifications closed
- **14.7%** conditions imposed on registration or an undertaking accepted
- **0.9%** received a caution or reprimand
- **2.6%** registration suspended or cancelled
- **6.0%** referred to another body or retained by a health complaints entity
- **75.9%** no further action



Monitoring

34 practitioners monitored for health, performance and/or conduct during the year

49 cases being monitored at 30 June:
- → **3** for conduct
- → **4** for health reasons
- → **10** for performance
- → **4** for prohibited practitioner/student
- → **28** for suitability/eligibility for registration

Criminal offence complaints

6 criminal offence complaints made
- → about title protection

6 were closed

Referred to an adjudication body

3 matters decided by a tribunal

No matters decided by a panel

1 appeal from a dual-registered nurse and midwife

Occupational therapists

From the Chair

Regulatory response to COVID-19

It's been a challenging time for the profession given the restrictions that practitioners have had to adapt to. The Occupational Therapy Board of Australia supported practitioners in continuing to provide safe care in changing work environments.

Competency standards

The Board developed and published case studies to help practitioners understand how the *Australian occupational therapy competency standards* can be applied in practice. The Board started engagement work with the National Aboriginal and Torres Strait Islander Occupational Therapy Network to better understand how it can promote improved culturally safe occupational therapy practice with Aboriginal and Torres Strait Islander Peoples.

The Board developed and published case studies to help practitioners understand how the Australian occupational therapy competency standards can be applied in practice.

Joint reviews

The Board participated in a joint review of the *Code of conduct* shared with 11 other National Boards. The Board also contributed to the scheduled review of the *Registration standard: English language skills* and to the development of a revised *Supervised practice framework*.

Accreditation

The Board approved one program of study. There are now 44 occupational therapy programs of study delivered across 22 education providers.

Stakeholder engagement

The Board held regular meetings with Occupational Therapy Australia (the national professional association) and the Occupational Therapy Council of Australia Limited. These meetings also provided the opportunity to discuss the impact of the pandemic, and to better understand how the Board could respond to emerging issues.

The Board held a webinar in August on the registration standards for continuing professional development, recency of practice and professional indemnity insurance arrangements. The webinar outlined the changes in the standards and how these will affect the profession. The webinar was attended by almost 800 practitioners and included a live Q&A session with Board members.

In September, the Board held its fifth successful webinar for new and soon-to-be graduates to help them understand their obligations on becoming a registered occupational therapist. The webinar was attended by almost 400 students and provided a valuable opportunity to answer questions about the registration process.

Other news

The Board commissioned Ahpra to conduct a review of notifications about occupational therapists received and closed between 2012 and 2019. The final report, considered by the Board in December, provided some invaluable findings about the main drivers of notifications that may be amenable to regulatory response. The Board is now considering how best to communicate the findings.

The Board supports the *National Scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025*. Members are participating in the Moong-moong-gak cultural safety training program.

Ms Julie Brayshaw

Occupational Therapy Board members

- **Ms Julie Brayshaw (practitioner), Chair**
- Mr Darryl Annett (community) – from 23 Feb
- Mr James Carmichael (practitioner) – to 8 Feb
- Ms Sally Cunningham (practitioner)
- Mrs Rachael Kay (practitioner) – to 8 Feb
- Ms Roxane Marcelle-Shaw (community)
- Dr Areti Metuamate PhD (community) – to 8 Feb
- Miss Jennifer Morris (community)
- Dr Claire Pearce PhD (practitioner) – from 26 Feb
- Mrs Terina Saunders (practitioner) – to 8 Feb
- Dr Justin Scanlan PhD (practitioner)
- Ms Rebecca Singh (practitioner) – from 22 Feb
- Ms Angela Thynne (practitioner) – from 22 Feb

Ms Vathani Shivanandan is the Executive Officer, Occupational Therapy.

For more information, see the appendices and www.occupationaltherapyboard.gov.au.

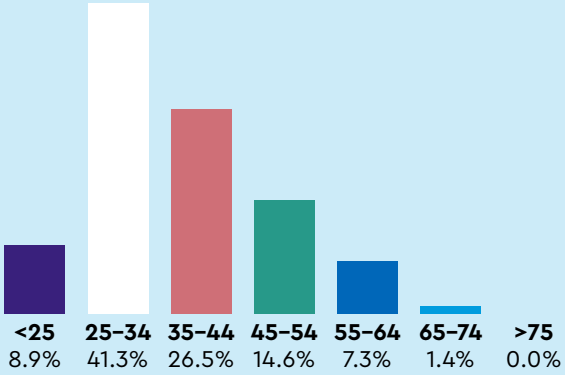
Snapshot

25,632 occupational therapists
- → Up **6.8%** from 2019/20
- → **3.1%** of all registered health practitioners

0.6% identified as Aboriginal and/or Torres Strait Islander

90.4% female; **9.6%** male

Figure 40. Age

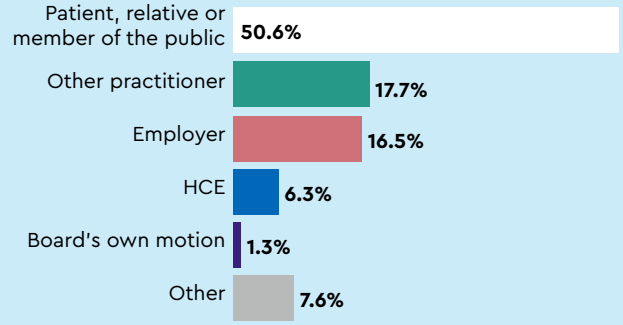


Regulating

Notifications

79 notifications lodged with Ahpra
- → **124** registered occupational therapists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.5%** of the profession

Figure 41. Sources of notifications



3 immediate actions taken

13 mandatory notifications received
- → **7** about professional standards

Figure 42. Most common types of complaints

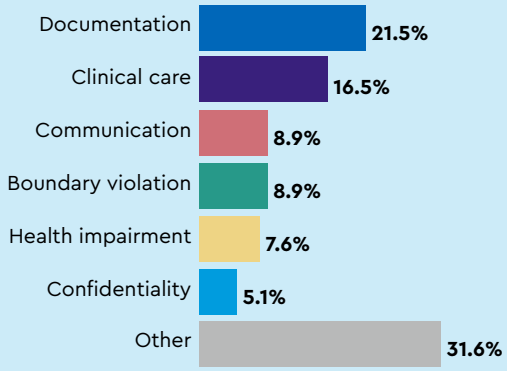
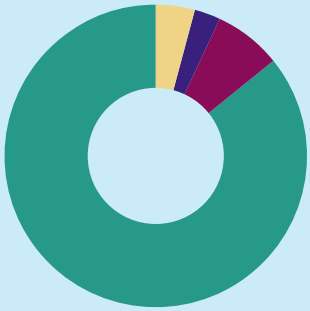


Figure 43. Notifications closed

70 notifications closed
- **4.3%** conditions imposed on registration or an undertaking accepted
- **2.9%** received a caution or reprimand
- **7.1%** referred to another body or retained by a health complaints entity
- **85.7%** no further action



Monitoring

16 practitioners monitored for health, performance and/or conduct during the year

87 cases being monitored at 30 June:
- → **3** for conduct
- → **5** for health reasons
- → **1** for performance
- → **1** for prohibited practitioner/student
- → **77** for suitability/eligibility for registration

Criminal offence complaints

14 criminal offence complaints made
- → **12** about title protection
- → **1** about practice protection
- → **1** about advertising breaches

10 were closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

No appeals

Optometrists

From the Chair

Issues this year

The year was a challenging one for optometrists and students in the face of COVID-19. The Optometry Board of Australia worked with other National Boards and Ahpra to support health practitioners during the pandemic. Regulatory approaches were modified to accommodate exceptional circumstances, and the Board continued to carry out its work remotely.

Regulatory approaches were modified to accommodate exceptional circumstances, and the Board continued to carry out its work remotely.

Regulatory response to COVID-19

The pandemic continued to create issues, including the completion of clinical placements by optometry students. The Board maintained its oversight, ensuring that alternative teaching strategies and equivalent learning experiences deployed by approved programs were fit for purpose.

We encouraged practitioners to continue to complete continuing professional development (CPD), while recognising the difficulty in meeting CPD requirements due to COVID-19. The Board issued an assurance that it would not take action if practitioners could not meet the CPD registration standard due to the pandemic and also introduced a policy on financial hardship due to COVID-19.

Stakeholder engagement

The Board convened its annual meeting of the Optometry Regulatory Reference Group in October. This was the first time that the group had met virtually.

Members of the Board provided virtual lectures on professional obligations to final-year optometry students graduating from a number of Board-approved courses in 2020.

Revised CPD standard

On 1 December, the Board's revised *Continuing professional development registration standard* came into effect. The new requirements were a departure from the points-based system previously used by the profession. The revised CPD registration standard meant that CPD courses were no longer accredited by the Board, but allowed greater flexibility in choice of learning activities. The emphasis on identifying individual learning goals meant that practitioners are able to plan their CPD activities so that they can focus on their individual requirements based on their practice setting, professional interests and patient needs.

Resources included templates, fact sheets and tips sheets, and FAQs were published to help optometrists comply with the requirements.

Revised advertising guidelines

On 14 December, the Board's revised *Guidelines for advertising a regulated health service* came into effect. Resources were published to help make it easier for the public, practitioners and other advertisers to advertise responsibly.

Accreditation

The Board approved its accreditation agreement's third year of funding with the Optometry Council of Australia and New Zealand (OCANZ). The agreement's contemporary framework addresses accreditation issues such as cultural safety, safety and quality, and reducing regulatory burden, and aims to strengthen accountability and transparency of accreditation.

Mr Ian Bluntish

Optometry Board members

- **Mr Ian Bluntish (practitioner), Chair**
- Mr Stuart Aamodt (practitioner)
- Dr Carla Abbott PhD (practitioner)
- Mr Anthony Evans (community)
- Ms Adrienne Farago (community)
- Associate Professor Daryl Guest (practitioner)
- Mrs Judith Hannan (practitioner)
- Associate Professor Rosemary Knight (community)
- Associate Professor Ann Webber (practitioner)

Ms Lynda Pham is the Executive Officer, Optometry.

For more information, see the appendices and www.optometryboard.gov.au.

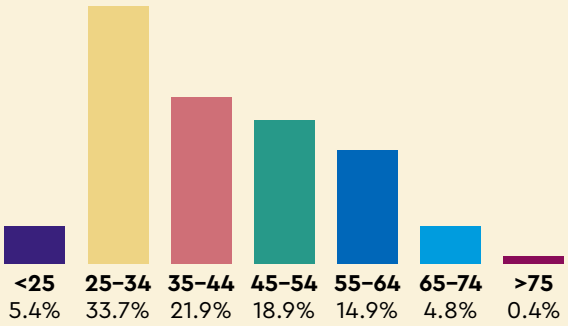
Snapshot

6,288 optometrists
- → Up **4.1%** from 2019/20
- → **0.8%** of all registered health practitioners

0.1% identified as Aboriginal and/or Torres Strait Islander

56.9% female; **43.1%** male

Figure 44. Age

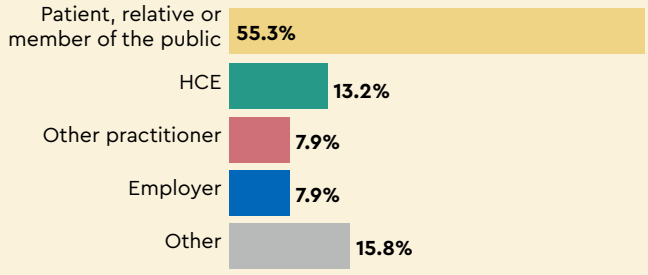


Regulating

Notifications

38 notifications lodged with Ahpra
- → **44** registered optometrists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.7%** of the profession

Figure 45. Sources of notifications



1 immediate action taken

6 mandatory notifications received
- → **2** about professional standards

Figure 46. Most common types of complaints

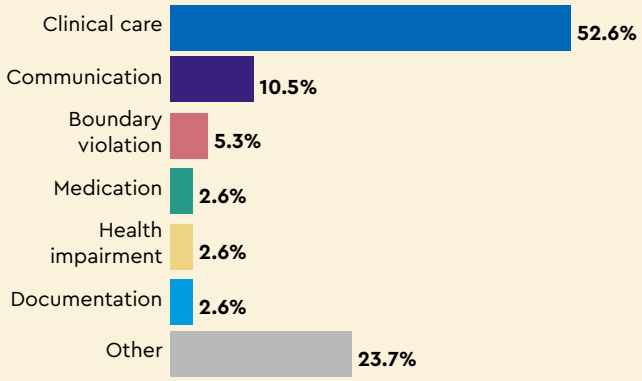
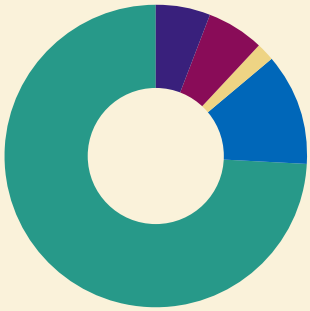


Figure 47. Notifications closed

50 notifications closed
- **6.0%** conditions imposed on registration or an undertaking accepted
- **6.0%** received a caution or reprimand
- **2.0%** registration cancelled
- **12.0%** referred to another body or retained by a health complaints entity
- **74.0%** no further action



Monitoring

12 practitioners monitored for health, performance and/or conduct during the year

13 cases being monitored at 30 June:
- → **2** for conduct
- → **4** for performance
- → **1** for prohibited practitioner/student
- → **6** for suitability/eligibility for registration

Criminal offence complaints

3 criminal offence complaints made
- → **2** about title protection
- → **1** about advertising breaches

5 were closed

Referred to an adjudication body

1 matter decided by a tribunal

No matters decided by a panel

2 appeals

Osteopaths

From the Chair

Issues this year

The COVID-19 pandemic temporarily changed the way we work as a Board. All Board and stakeholder meetings were held via Zoom, and face-to-face events, which had previously been well-attended in capital cities, have been suspended until travel and public events are safe. Conversely, it has been easier to attend regular Think Tank virtual meetings of osteopathy stakeholders from across Australia. Communication with registrants on social media and video continues to have very high open and click-through rates.

Regulatory response to COVID-19

During the year, the Board continued to contact registrants directly by newsletters and email with information about the impact of COVID-19 and the regulatory response for osteopaths, including some extensions of regulatory requirements and introducing hardship provisions for fees.

Standards and guidelines

The Board carried out a joint public consultation with other National Boards on the review of the shared *Code of conduct*; and was also involved in the release of the revised *Guidelines for advertising a regulated health service* with other Boards.

Accreditation

The Australian Osteopathic Accreditation Council (AOAC) consulted in three stages and presented the *Osteopathic accreditation standards* to the Board for approval. The major changes are: adopting a five-domain framework; including English language proficiency as a requirement for entry to an education program; and increasing emphasis on cultural safety that is integrated throughout the revised standards. The revised *Osteopathic accreditation standards (2021)* were approved by the Board in June. The AOAC also developed an essential evidence guide for accreditation.

The Australian Osteopathic Accreditation Council (AOAC) consulted in three stages and presented the Osteopathic accreditation standards to the Board for approval.

The AOAC reviewed the *Standard pathway assessment for registration in Australia* (SPA) and the changes were approved by the Board in April. The revised Standard pathway assessment contains newly formatted assessments and examinations that have greater alignment to contemporary assessment practices and are more accessible for candidates to undergo. Further information about these assessments is on the AOAC website.

Stakeholder engagement

Local

The Osteopathy Think Tank is organised by the Osteopathy Association, which holds meetings every two to three months with stakeholders regarding issues, updates, projects and information sharing. The Board and Ahpra have supplied registration growth and attrition data.

As Chair, I presented information on regulation and Board requirements for registration to final-year students in the osteopathy programs by online presentations.

International

I attended the annual Osteopathic International Alliance (OIA) Annual General Meeting, which was held virtually this year, and I continue as a member of the Public Relations Committee of the OIA.

We celebrated International Osteopathic Healthcare Week in early May after it was postponed last year.

Dr Nikole Grbin

Osteopathy Board members

- **Dr Nikole Grbin (practitioner), Chair**
- Dr Pamela Dennis (practitioner)
- Ms Judith Dikstein (community)
- Ms Julia Duffy (community)
- Mr Joshua Hatten (community)
- Dr Timothy McNamara (practitioner) – from 26 Sep
- Dr Paul Orrock PhD (practitioner)
- Dr Patricia Thomas (practitioner) – to 10 May
- Dr Andrew Yaksich (practitioner)

Dr Cathy Woodward PhD is the Executive Officer, Osteopathy.

For more information, see the appendices and www.osteopathyboard.gov.au.

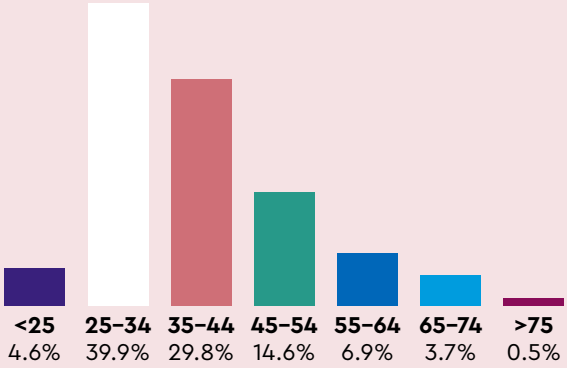
Snapshot

2,951 osteopaths
- → Up **7.2%** from 2019/20
- → **0.4%** of all registered health practitioners

0.8% identified as Aboriginal and/or Torres Strait Islander

54.6% female; **45.4%** male

Figure 48. Age

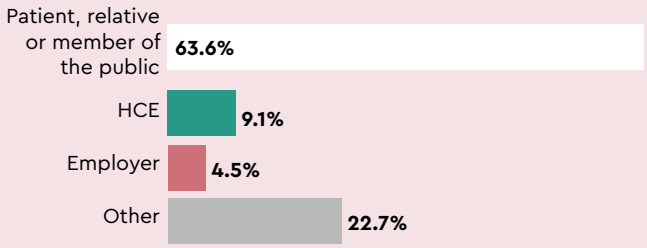


Regulating

Notifications

22 notifications lodged with Ahpra
- → **30** registered osteopaths Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.0%** of the profession

Figure 49. Sources of notifications



3 immediate actions taken

1 mandatory notification received

Figure 50. Most common types of complaints

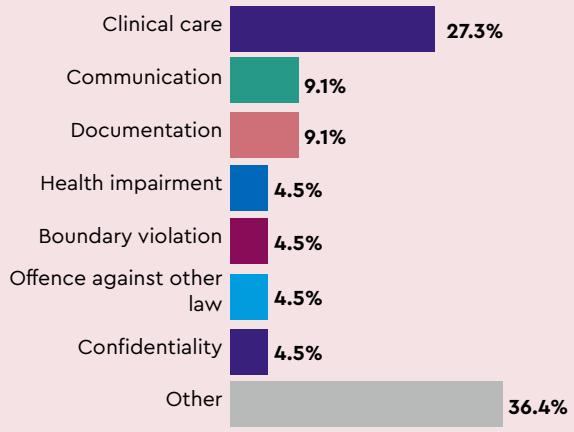
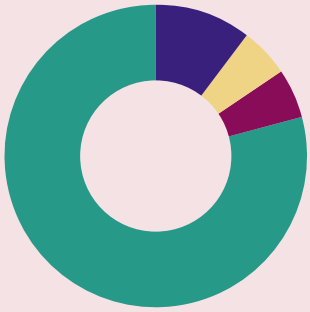


Figure 51. Notifications closed

19 notifications closed
- **10.5%** conditions imposed on registration or an undertaking accepted
- **5.3%** received a caution or reprimand
- **5.3%** referred to another body
- **78.9%** no further action



Monitoring

10 practitioners monitored for health, performance and/or conduct during the year

13 cases being monitored at 30 June:
- → **5** for conduct
- → **1** for health reasons
- → **1** for prohibited practitioner/student
- → **6** for suitability/eligibility for registration

Criminal offence complaints

4 criminal offence complaints made
- → **3** about title protection
- → **1** about advertising breaches

5 were closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

No appeals

Paramedics

From the Chair

Issues this year

The Paramedicine Board of Australia's work to further implement the regulation of the profession continued into the 2020/21 year. As Chair I am fortunate to have had all of the inaugural members reappointed for another term by the Ministerial Council. This stability is important to ensure the Board's ongoing work to oversee the completion of the grandparenting provision for entry into the profession and to finalise the implementation and consolidation of other key elements of paramedic regulation.

Regulatory response to COVID-19

The impact of the COVID-19 pandemic continued into this year and the ongoing ability of Board members to be flexible and adapt to remote ways of working without interruption to the work of the Board has been a credit to their professionalism and commitment to their regulatory responsibilities.

The Board continued to find regulatory approaches that could be modified, provided public safety was not compromised. Where the Board was satisfied that the clinical governance arrangements and supervised practice protocols of an organisation are likely to meet the Board's requirements and expectations, the Board agreed to pre-approve that organisation as an 'authorised body' for recency of practice purposes. This has the effect of reducing the burden of regulation on major employers, enabling workforce flexibility and streamlining case management.

New standards, code and guidelines

Two pieces of work critical to the implementation of the regulation of paramedics were completed and published this year. The *Professional capabilities for paramedicine practitioners* (the professional capabilities) and *Standards for accreditation of paramedicine education programs* (the accreditation standards) were both approved and came into effect on 1 June. The work done by the Paramedicine Accreditation Committee to develop, consult upon and submit the accreditation standards for approval was outstanding.

Two pieces of work critical to the implementation of the regulation of paramedics were completed and published. The Professional capabilities for paramedicine practitioners *and* Standards for accreditation of paramedicine education programs *were both approved.*

The professional capabilities identify the knowledge, skills and professional attributes needed to safely and competently practise as a paramedic in Australia, as well as complementing the accreditation standards that are used to support and guide the delivery of education and training programs for paramedics.

Other

On behalf of the Board, I thank everyone who has contributed to the regulation of paramedics during what was another difficult and challenging year for all of us. Board members, Ahpra, the profession, employers and government have all played a critical role in further developing the regulation of paramedicine as a health profession.

Professor Stephen Gough ASM

Paramedicine Board members

- **Professor Stephen Gough ASM (practitioner), Chair**
- Ms Jeanette Barker (community)
- Ms Clare Beech (practitioner)
- Mr Keith Driscoll ASM (practitioner)
- Associate Professor Ian Patrick ASM (practitioner)
- Ms Linda Renouf (community)
- Ms Tiina-Liisa Sexton (community)
- Mr Howard Wren ASM (practitioner)
- Ms Angela Wright (practitioner)

Mr Paul Fisher is the Executive Officer, Paramedicine.

For more information, see the appendices and www.paramedicineboard.gov.au.

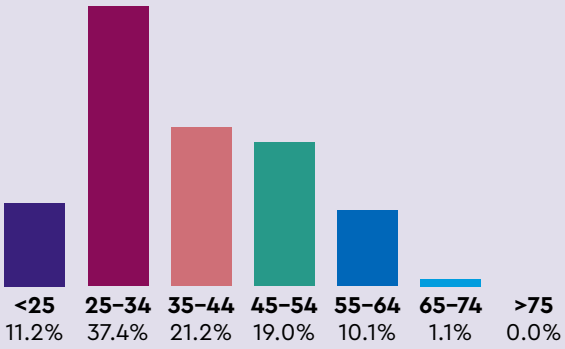
Snapshot

21,492 paramedics
- → Up **8.3%** from 2019/20
- → **2.6%** of all registered health practitioners

1.7% identified as Aboriginal and/or Torres Strait Islander

46.1% female; **53.9%** male

Figure 52. Age

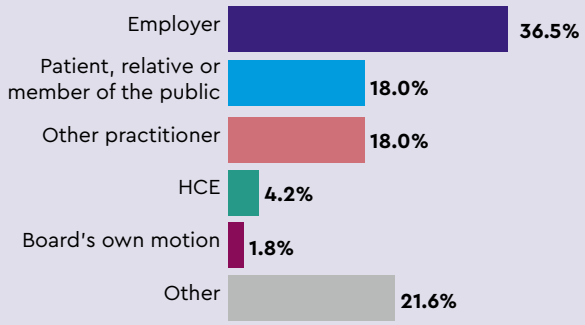


Regulating

Notifications

167 notifications lodged with Ahpra
- → **215** registered paramedics Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.0%** of the profession

Figure 53. Sources of notifications



23 immediate actions taken

50 mandatory notifications received
- → **26** about professional standards

Figure 54. Most common types of complaints

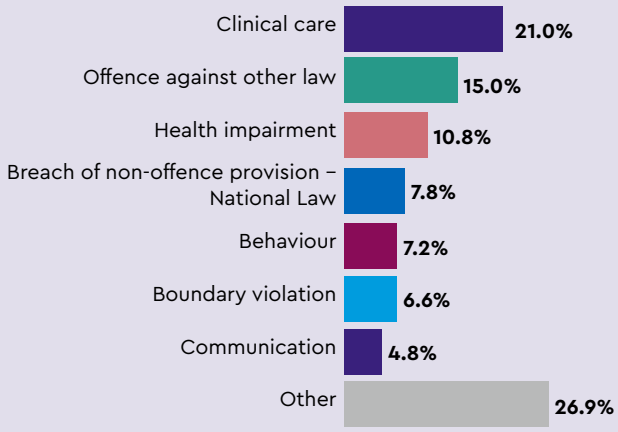
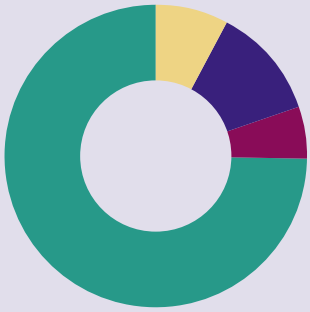


Figure 55. Notifications closed

126 notifications closed
- **7.9%** conditions imposed on registration or an undertaking accepted
- **11.9%** received a caution or reprimand
- **5.6%** retained by a health complaints entity
- **74.6%** no further action



Monitoring

72 practitioners monitored for health, performance and/or conduct during the year

240 cases being monitored at 30 June:
- → **4** for conduct
- → **18** for health reasons
- → **12** for prohibited practitioner/student
- → **206** for suitability/eligibility for registration

Criminal offence complaints

18 criminal offence complaints made
- → **16** about title protection
- → **2** about practice protection

21 were closed

Referred to an adjudication body

No matters decided by a tribunal

1 matter decided by a panel

1 appeal

Pharmacists

From the Chair

Regulatory response to COVID-19

In response to a request by the Australian Government, the Board enabled the continuing registration of pharmacists on the pandemic sub-register to provide additional support for the COVID-19 vaccination roll-out. To help states and territories in their preparation for delivering the COVID-19 vaccination strategy, the Board also conducted a survey of pharmacists who have completed immunisation training.

The Board confirmed funding to the Pharmacists' Support Service, a long-established service staffed by volunteer pharmacists who provide crisis telephone counselling ...

The Board confirmed ongoing measures to support pharmacists to meet their regulatory obligations during the COVID-19 pandemic, including:

- the reduction in the total number of supervised practice hours required for general registration and advice on modifications to the arrangements for supervision of interns
- the delivery of oral and written examinations using an online platform where required, given the need for social distancing.

Issues this year

Analysis of notifications involving oral methotrexate

The Pharmacy Board of Australia published an analysis of notifications involving oral methotrexate. In sharing these findings, the Board reminded pharmacists about the need for extra vigilance when supplying methotrexate given the types of errors in practice that have resulted in poor and, in some cases, catastrophic outcomes for the public.

The Board started stakeholder engagement to explore opportunities for collaborative work to support greater awareness of the risks that must be mitigated in practice when supplying methotrexate. The Board will continue its engagement on this issue during the next 12 months and share the outcomes with the profession, stakeholders and the public. The outcomes of the analysis will also inform the Board's upcoming review of its guidelines for pharmacists.

Intern assessment

The Board continued to modify the intern-assessment process, informed by the work of the Intern Year Blueprint Implementation Working Group, a collaboration between the Board and the Australian Pharmacy Council. Modifications were made to remove unnecessary duplication from the oral and written examinations, and examinations are being held according to a revised schedule. The working group has oversight of the delivery of a project to develop and trial workplace-based assessment tools for interns. The Board also conducted a survey of examiners as part of its intern-assessment quality improvement work program.

Contribution to the Pharmacists' Support Service

The Board confirmed funding ($30,000 annually for three years) to the Pharmacists' Support Service (PSS), a long-established service staffed by volunteer pharmacists who provide crisis telephone counselling and that offers valuable health support services to pharmacists and students across Australia. The funding will support PSS to raise awareness with pharmacists, interns, students and employers of pharmacists about the health issues that impact the profession and to develop information, educational materials and a database of health services available to pharmacists with, or at risk of, impairment. The decision of the Board to provide funding accords with provisions in the National Law to provide financial support to a health program for the profession.

Mr Brett Simmonds, Chair

Pharmacy Board members

- **Mr Brett Simmonds (practitioner), Chair**
- Mrs Elise Apolloni (practitioner)
- Ms Melissa Cadzow (community)
- Dr Alice Gilbert PhD (practitioner)
- Ms Joy Hewitt (practitioner)
- Mr Mark Kirschbaum (practitioner)
- Ms Hannah Mann (practitioner)
- Dr Suzanne Martin (veterinarian) (community)
- Dr Cameron Phillips PhD (practitioner)
- Dr Janet Preuss PhD (community – acting) – from 23 Feb
- Dr Rodney Wellard PhD (community) – to 17 Aug
- Mr Rodney Wellington (community)
- Mr Laurence (Ben) Wilkins (practitioner)

Mr Joe Brizzi is the Executive Officer, Pharmacy.

For more information, see the appendices and www.pharmacyboard.gov.au.

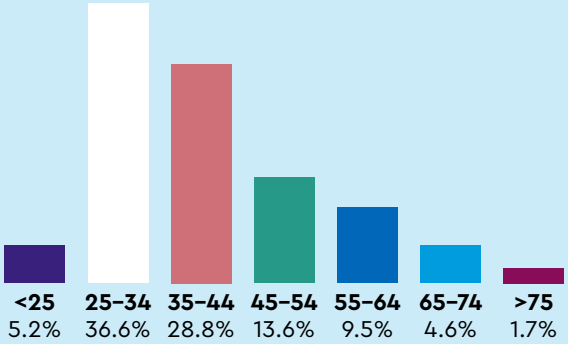
Snapshot

35,262 pharmacists
- → Up **2.2%** from 2019/20
- → **4.3%** of all registered health practitioners

0.3% identified as Aboriginal and/or Torres Strait Islander

63.0% female; **37.0%** male

Figure 56. Age

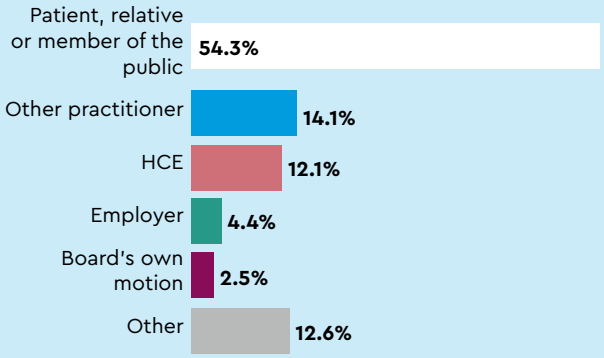


Regulating

Notifications

405 notifications lodged with Ahpra
- → **634** registered pharmacists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.8%** of the profession

Figure 57. Sources of notifications



27 immediate actions taken

42 mandatory notifications received
- → **21** about professional standards

Figure 58. Most common types of complaints

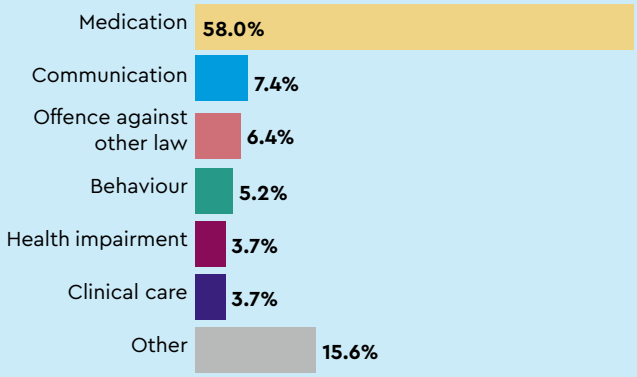
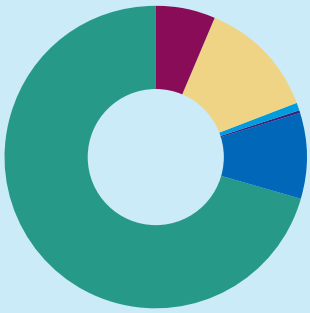


Figure 59. Notifications closed

476 notifications closed
- **6.5%** conditions imposed on registration or an undertaking accepted
- **12.8%** received a caution or reprimand
- **0.8%** registration suspended or cancelled
- **0.2%** fined
- **9.2%** referred to another body or retained by a health complaints entity
- **70.4%** no further action



Monitoring

253 practitioners monitored for health, performance and/or conduct during the year

145 cases being monitored at 30 June:
- → **17** for conduct
- → **17** for health reasons
- → **23** for performance
- → **29** for prohibited practitioner/student
- → **59** for suitability/eligibility for registration

Criminal offence complaints

16 criminal offence complaints made
- → **11** about title protection
- → **2** about practice protection
- → **3** about advertising breaches

16 were closed

Referred to an adjudication body

11 matters decided by a tribunal

1 matter decided by a panel

9 appeals

Physiotherapists

From the Chair

Issues this year

The Physiotherapy Board of Australia continued to build on last year's work, as COVID-19 interrupted progress of our strategic projects, and particularly their intended timeline. An extensive program of stakeholder engagement was a high priority due to the unpredictable nature of the pandemic and its impact on healthcare services. The Board met online each month for the entire year due to the pandemic.

The Board developed a background paper ... on whether to endorse prescribing for physiotherapists.

Regulatory response to COVID-19

The Board continued to respond to the needs of the profession, healthcare services and the public by modifying our regulatory approach to support the profession through the pandemic and contribute to the national response. A series of modifications were made to procedures such as introducing a financial hardship policy, a fully online registration process and a flexible approach to continuing professional development and recency of practice requirements.

Pandemic response sub-register

On 20 April, approximately 2,051 physiotherapists who were added to the pandemic sub-register in April 2020 were removed from the sub-register. All of those on the sub-register were given the opportunity to reinstate their registration; however, only a small proportion (approximately 6.3%) decided to retain their registration.

Policy updates

The Board participated in several multi-profession policy reviews, including a revised supervised practice framework and code of conduct, as well as the revised advertising guidelines. The Board has also supported several position statements such as the *Registered health practitioners and students and COVID-19 vaccination* and the joint statement with the Therapeutic Goods Administration *Promotion of COVID-19 vaccinations: further information for healthcare practitioners and other advertisers*.

Stakeholder engagement

Given the ongoing and fluctuating travel restrictions, the Board moved to online engagement. It held several webinars for practitioners, including one focused on new graduates and another on recency of practice, as well as engaging with state and territory jurisdictions.

The Board valued increased engagement and partnership with its stakeholders, including the Australian Physiotherapy Association, the Australian Physiotherapy Council, the NSW Physiotherapy Council and the Council of Physiotherapy Deans of Australia and New Zealand (CPDANZ). These partnerships have been critical to our pandemic response and remain pertinent to progressing the Board's strategic projects.

Strategic projects

The Board developed a background paper, building on the literature review and exploration report previously completed, on whether to endorse prescribing for physiotherapists. The next step will be to engage with stakeholders.

To improve its understanding of the characteristics of physiotherapy registrants and the workforce, the Board produced a workforce analysis report and snapshot of the physiotherapy profession in Australia. It will share this information with stakeholders.

The Board has been working with the New Zealand Physiotherapy Board on a first review of the bi-national practice thresholds, with a focus on cultural safety and digital competence. As the thresholds have only been in place for a short time, this will be a minor review with a more comprehensive review to come.

Ms Kim Gibson

Physiotherapy Board members

- **Ms Kim Gibson (practitioner), Chair**
- Ms Sally Adamson (practitioner)
- Mrs Janet Blake (community)
- Mr David Cross (practitioner)
- Mrs Lynette Green (community)
- Dr Paula Harding PhD (practitioner)
- Ms Cherie Hearn (practitioner)
- Mr Peter Kerr AM (community)
- Emeritus Professor Sheila Lennon (practitioner)
- Mr Noel McRoberts (practitioner – acting) – from 22 Feb
- Mr Lachlan Mortimer (practitioner) – to 10 Aug
- Ms Elizabeth Trickett (practitioner)
- Ms Katherine Waterford (community)

Ms Alison Abud is the Executive Officer, Physiotherapy.

For more information, see the appendices and www.physiotherapyboard.gov.au.

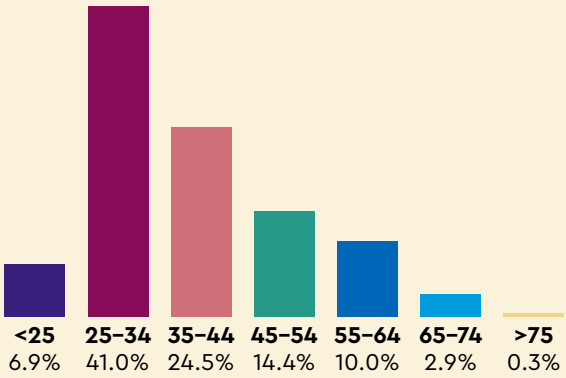
Snapshot

37,650 physiotherapists
- → Up **1.4%** from 2019/20
- → **4.6%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

65.1% female; **34.9%** male

Figure 60. Age

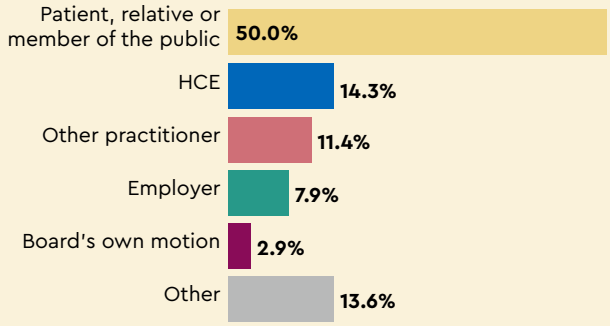


Regulating

Notifications

140 notifications lodged with Ahpra
- → **201** registered physiotherapists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.5%** of the profession

Figure 61. Sources of notifications



8 immediate actions taken

18 mandatory notifications received
- → **7** about professional standards

Figure 62. Most common types of complaints

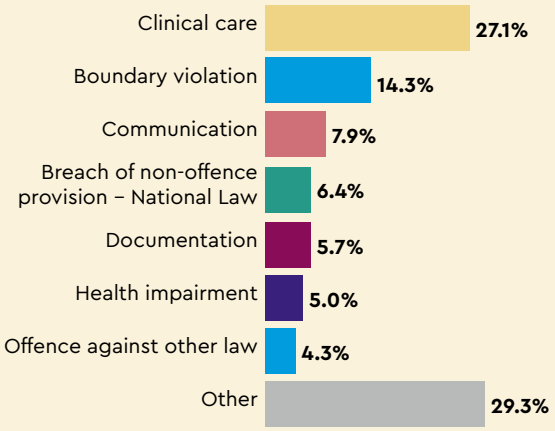
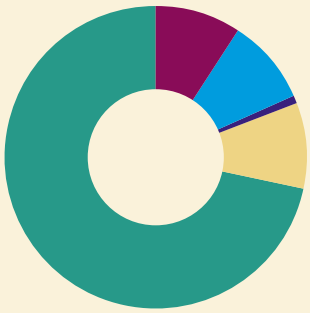


Figure 63. Notifications closed

130 notifications closed



- **9.2%** conditions imposed on registration or an undertaking accepted
- **9.2%** received a caution or reprimand
- **0.8%** registration cancelled
- **9.2%** referred to another body or retained by a health complaints entity
- **71.5%** no further action

Monitoring

48 practitioners monitored for health, performance and/or conduct during the year

61 cases being monitored at 30 June:
- → **11** for conduct
- → **4** for health reasons
- → **7** for performance
- → **7** for prohibited practitioner/student
- → **32** for suitability/eligibility for registration

Criminal offence complaints

25 criminal offence complaints made
- → **19** about title protection
- → **6** about advertising breaches

31 were closed

Referred to an adjudication body

2 matters decided by a tribunal

1 matter decided by a panel

No appeals

Podiatrists

From the Chair

Issues this year

The COVID-19 pandemic continued to have an impact on the podiatry profession. The Board recognised the professionalism of practitioners during the ever-changing public health requirements so the public could safely access essential podiatry care.

All meetings of the Board and its committees were held virtually.

Regulatory response to COVID-19

We temporarily modified some of our regulatory requirements to support practitioners during the pandemic while still ensuring public safety. Modifications included providing extensions for practitioners working towards endorsement for scheduled medicines, and some requirements for registration, such as:

- adopting a flexible approach to continuing professional development (CPD) and recency of practice (RoP), and not taking action if a practitioner was unable to meet the CPD and RoP standards
- offering a payment plan for registration fees for practitioners experiencing financial hardship.

We published a video for new graduates about the Board's role, registration standards, staying connected with the profession and lifelong, reflective learning.

The Board worked with Ahpra to provide information on COVID-19 including answering common questions and publishing guidance on telehealth use. National Boards and Ahpra published a joint statement to help practitioners and students understand what's expected of them in giving, receiving, advising on and sharing information about COVID-19 vaccination.

New and revised code and guidelines

Revised advertising guidelines and new *Guidelines for blood-borne viruses for registered health practitioners and students* took effect during the year. We consulted on a revised shared *Code of conduct* together with some other National Boards.

Accreditation

The Podiatry Accreditation Committee reported to the Board on the monitoring of podiatry programs and consulted on professional capabilities and accreditation standards for the podiatry profession.

Stakeholder engagement

The Board's program of stakeholder engagement includes regular meetings with the Australian Podiatry Association, the Podiatry Council of New South Wales, and the Podiatry Accreditation Committee.

We put on hold some of our planned face-to-face engagement activities and engaged virtually instead. Engagements included: discussions with podiatrists in Tasmania; a video message from the Chair on social media during Foot Health Week; and a discussion with a member of the Aboriginal and Torres Strait Islander Heath Practice Board who told us about practitioner roles and how our professions can work together to improve healthcare for Indigenous Australians.

In June, Ahpra and National Boards published a joint statement reminding practitioners that there is no place for sexism, sexual harassment or gendered violence in healthcare.

Engaging with students and graduates

Students have now begun receiving the Board's newsletter. We published a video for new graduates about the Board's role, registration standards, staying connected with the profession and lifelong, reflective learning.

Other news

The Board welcomed new community member Professor Andrew Taggart, who was appointed in September.

Associate Professor Cylie Williams

Podiatry Board members

- **Associate Professor Cylie Williams (practitioner), Chair**
- Dr Paul Bennett (practitioner)
- Mrs Maria Cosmidis (community) – to 17 Aug
- Dr Janice Davies OAM (community)
- Miss Julia Kurowski (practitioner)
- Dr Kristy Robson (practitioner)
- Ms Shellee Smith (community)
- Mrs Kathryn Storer (practitioner)
- Professor Andrew Taggart (community) – from 25 Sep
- Mr Andrew van Essen (practitioner)

Ms Jenny Collis is the Executive Officer, Podiatry.

For more information, see the appendices and www.podiatryboard.gov.au.

Snapshot

5,783 podiatrists[1]
- → Up **3.1%** from 2019/20
- → **0.7%** of all registered health practitioners

0.8% identified as Aboriginal and/or Torres Strait Islander

59.0% female; **41.0%** male

Figure 64. Age

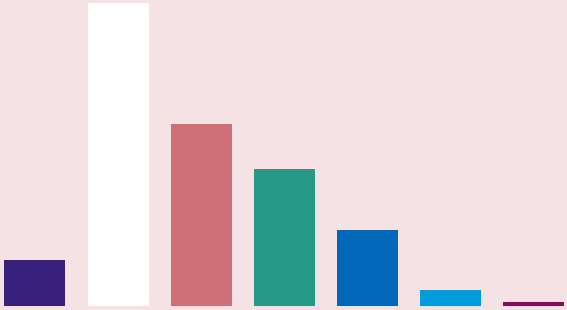


Figure 65. Registration status

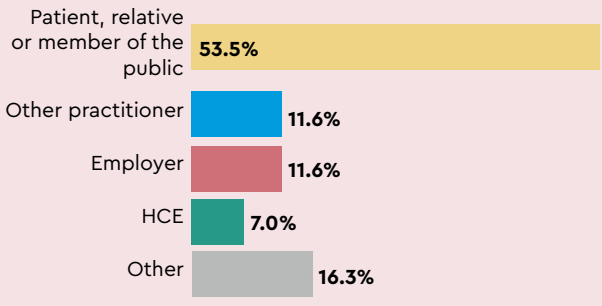
5,604	general
143	non-practising
36	general and specialist
5,783	**total**

Regulating

Notifications

43 notifications lodged with Ahpra
- → **63** registered podiatrists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.1%** of the profession

Figure 66. Sources of notifications



3 immediate actions taken

6 mandatory notifications received
- → **3** about professional standards

1 Includes podiatric surgeons

Figure 67. Most common types of complaints

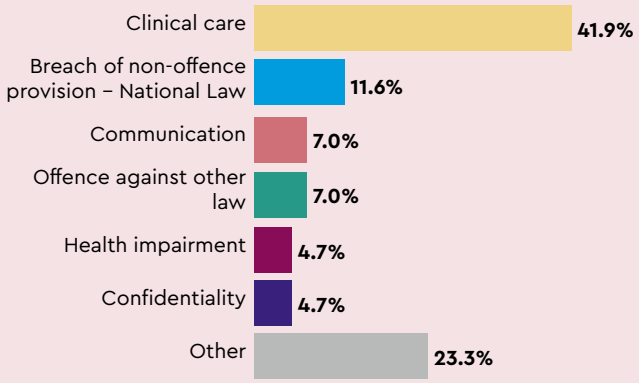
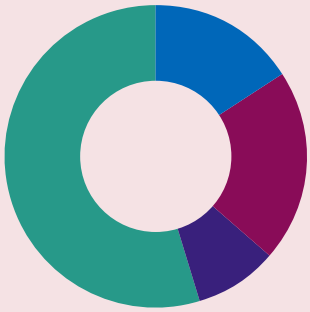


Figure 68. Notifications closed

44 notifications closed
- **15.9%** conditions imposed on registration or an undertaking accepted
- **20.5%** received a caution or reprimand
- **9.1%** referred to another body or retained by a health complaints entity
- **54.5%** no further action



Monitoring

25 practitioners monitored for health, performance and/or conduct during the year

21 cases being monitored at 30 June:
- → **1** for conduct
- → **3** for health reasons
- → **7** for performance
- → **1** for prohibited practitioner/student
- → **9** for suitability/eligibility for registration

Criminal offence complaints

No criminal offence complaints made

1 was closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

2 appeals

Psychologists

From the Chair

Key projects

Developing a code of conduct

This year we started developing a code of conduct to apply to all registered psychologists. Codes of conduct are used as regulatory instruments to protect the public. Our code will be based on the shared code that is used by most other healthcare professions.

Developing a code of conduct will be a priority for us over the next two years.

Developing a code of conduct will be a priority for us over the next two years. We have planned a rigorous development process that will involve engagement with code experts, key stakeholders, psychologists and the public. Our aim is to develop a contemporary, evidence-based code that reflects the standards expected of psychologists by the Australian community and peers.

The Board will no longer adopt the Australian Psychological Society's *Code of ethics* once we have implemented a code of conduct. Until then, complying with the *Code of ethics* will continue to be a requirement for registration as a psychologist.

Education and training reform

Our education and training reform work continued this year, with the aim of reviewing and clarifying the competencies for general registration and area of practice endorsement (AoPE) for psychologists in Australia. This is the first time that competencies have been thoroughly reviewed since the beginning of the National Scheme. We are reviewing the competencies for general registration first.

Over the last 12 months our work has included:

- Seeking views – we conducted a series of stakeholder engagement webinars to understand stakeholder views on our Green paper. A wide range of stakeholder groups was represented at the webinars, including key industry and employer groups, psychology professional bodies, national and international regulators, and government.
- Competency mapping – we appointed consultants with expertise in education, accreditation, higher education reforms and competent writing to carry out an objective and impartial review of our current competencies, and to map these against international comparisons and the Australian Psychology Accreditation Council (APAC) standards.
- Psychology-specific advice – we appointed a Psychology Expert Reference Group (PERG) to work with the consultants and provide advice on competencies for general registration. PERG members were selected for their expertise in training and supervising provisional psychologists, psychology regulation and psychology accreditation.

We will shortly be considering a draft of the revised general registration competencies before sending it out for consultation.

Regulatory response to COVID-19

We continued to modify some of our regulatory requirements for psychologists due to the continuing impact of the COVID-19 pandemic. This included continuing to deliver the national psychology exam by online proctoring (rather than sitting the exam in a testing centre) and permanently allowing psychologists to complete Board-approved supervisor training online.

A hardship policy was also put in place for psychologists and provisional psychologists who are experiencing genuine financial hardship due to COVID-19.

The temporary pandemic sub-register for psychologists was closed in April.

Ms Rachel Phillips

Psychology Board members

- **Ms Rachel Phillips (practitioner), Chair**
- Ms Mary Brennan (community)
- Ms Jade Gooding (practitioner) – from 22 Feb
- Ms Marion Hale (community)
- Ms Vanessa Hamilton (practitioner)
- Mr Peter Hooker (community)
- Dr Melissa Hughes (DPsych) (practitioner)
- Mr Christopher Joseph (community)
- Mr Timothy Ridgway (practitioner)
- Professor Jennifer Scott (practitioner)
- Dr Jennifer Thornton PhD (practitioner)
- Professor Kathryn von Treuer (practitioner)

Ms Angela Smith is the Executive Officer, Psychology.

For more information, see the appendices and www.psychologyboard.gov.au.

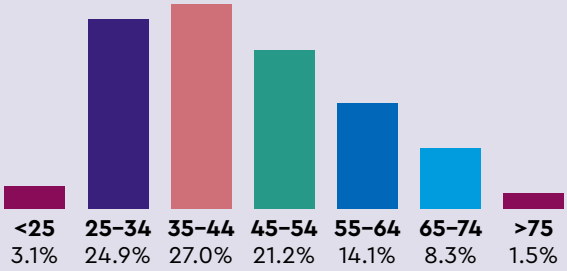
Snapshot

41,817 psychologists
- → Up **3.2%** from 2019/20
- → **5.1%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

80.4% female; **19.6%** male

Figure 69. Age

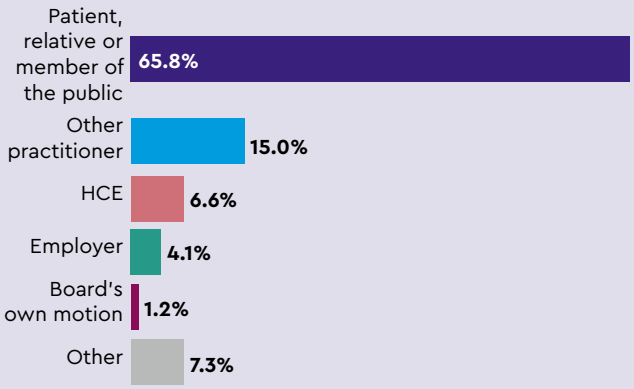


Regulating

Notifications

655 notifications lodged with Ahpra
- → **903** registered psychologists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **2.2%** of the profession

Figure 70. Sources of notifications



33 immediate actions taken

67 mandatory notifications received
- → **35** about professional standards

Figure 71. Most common types of complaints

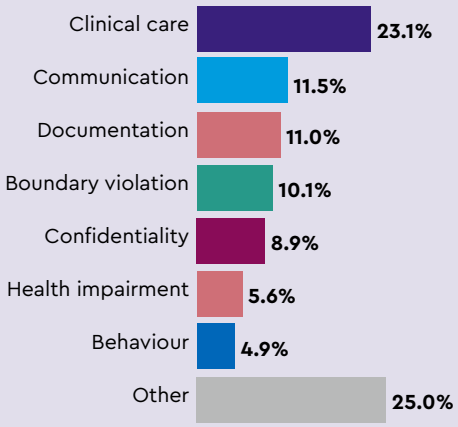
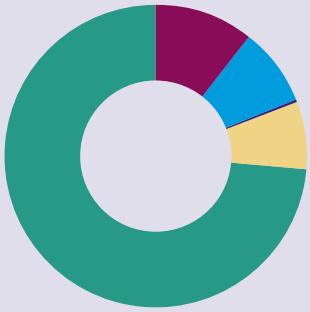


Figure 72. Notifications closed

715 notifications closed
- **10.8%** conditions imposed on registration or an undertaking accepted
- **8.3%** received a caution or reprimand
- **0.3%** registration suspended or cancelled
- **7.1%** referred to another body or retained by a health complaints entity
- **73.6%** no further action



Monitoring

221 practitioners monitored for health, performance and/or conduct during the year

235 cases being monitored at 30 June:
- → **66** for conduct
- → **18** for health reasons
- → **44** for performance
- → **20** for prohibited practitioner/student
- → **87** for suitability/eligibility for registration

Criminal offence complaints

119 criminal offence complaints made
- → **101** about title protection
- → **3** about practice protection
- → **14** about advertising breaches
- → **1** other offence

121 were closed

Referred to an adjudication body

6 matters decided by a tribunal

2 matters decided by a panel

8 appeals

Supporting the Boards

Appointments

National Board members are appointed by the Ministerial Council and state, territory and regional board members by the relevant Minister for Health in each jurisdiction.

The regulatory work of the National Scheme is not possible without the right people serving on boards and committees. Ahpra provided administrative support for 693 statutory appointments (see Table 1), which included: National Boards; National Board committees and panels (including advisory assessor panels); and state, territory and regional boards and committees.

Table 1. Statutory appointments

National Boards	52
National Board committees and panels	312
State, territory and regional boards	108
State, territory and regional committees	221
Total	**693**

The data cover all appointments made within the financial year.

We are working to increase the participation of Aboriginal and Torres Strait Islander Peoples through advertising and engagement strategies, and six appointments were made.

Payment to Board Chairs

Board members are entitled to remuneration, including travelling and subsistence allowances, within the framework determined by the Ministerial Council. In addition to sitting fees for scheduled Board and committee meetings, Chairs may also be remunerated for the additional work required.

Table 2. Payments to Board Chairs

Range	Number of Chairs[1]	2020/21 payments ($)[2]
$0–$20,000	3	26,006
$20,001–$40,000	3	70,117
$40,001–$60,000	6	285,478
$60,001–$80,000	2	133,431
$80,000 plus	4	358,602
Total	**18[2]**	**873,634**

1. Payments to Chairs, including the Agency Management Committee, under the approved remuneration framework.
2. Two new Chairs were appointed to replace those whose terms of appointment had concluded.

Supporting good governance

The Board Governance program has three areas of focus, aligned to the three-year regulatory 'life cycle' of members and Boards:

- orientation, induction and professional development, including member skills development support
- board effectiveness reviews
- documentation to support good governance.

Orientation and induction

All new National Board members are provided with an orientation to the National Scheme and to the Board(s) to which they have been appointed, usually before they attend their first meeting. Four sessions were held, orienting 21 new National Board members.

This is a half-day program aimed at giving members an overview of the National Scheme, its legislative and governance frameworks, how the partnership arrangements between the entities in the National Scheme work in practice and the role of regulatory boards in that environment. It is complemented by Board-specific orientation activities and briefings.

Professional development

To support Board effectiveness and strengthen the partnership with National Boards, Ahpra provides governance professional development for Board members aligned to the specific governance arrangements of the National Scheme. This is a key element in optimising Board performance and enhancing the effectiveness of individual members, the Board as a whole and the quality of engagement with partners across the scheme.

In collaboration with an external provider, Effective Governance, a customised two-day professional development program, *Governance and decision-making in the National Scheme*, has been developed and delivered to members.

The program was held five times virtually: 36 National Board members and seven Ahpra staff participated.

Board effectiveness reviews

Board evaluations and reviews are another key enabler of Board effectiveness. They help members in developing a shared understanding of both their individual roles and responsibilities and those of the Board, set expectations around Board performance and scope the potential for improvement.

The current review framework requires Boards to formally review their effectiveness on a triennial basis, interspersed with mini or informal reviews in other years. Five Boards conducted formal reviews.

Program development

In April, we started a procurement process to seek providers of governance consultancy and advisory services, including specialist services and professional development program delivery.

Accreditation is a way to assure that people seeking registration are suitably trained, qualified and competent to practise as health practitioners

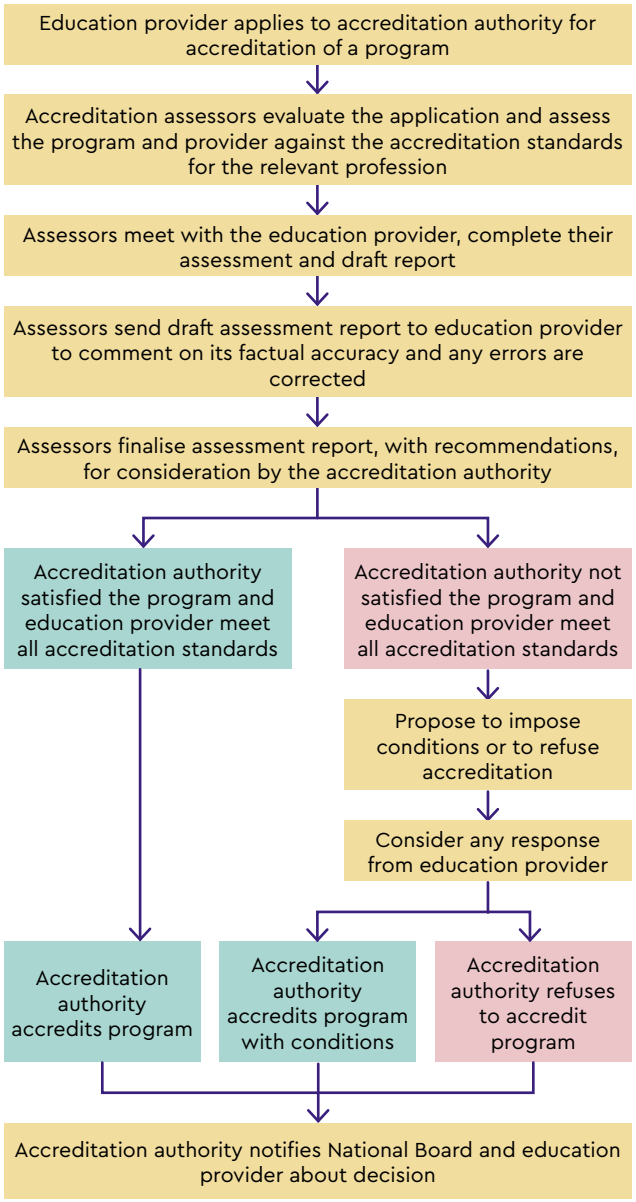
Accreditation

Ensuring the future health practitioner workforce is competent

National Boards and accreditation authorities have separate but complementary functions. For example, an accreditation authority accredits a program of study and the relevant National Board approves it as a basis for registration. Accreditation authorities can be an external council or a committee.

- Over **189,786** registered students are studying to be health practitioners in accredited programs.
- Over **860** programs of study are now accredited and approved.
- More than **130** education providers deliver accredited and approved programs of study.
- Approved programs of study can be searched on our website.

Figure 73. The accreditation process



A new, independent accreditation committee

In February, we received a Ministerial policy direction (see *Appendix 7*) requiring Ahpra to establish an independent accreditation committee as a new committee of the Agency Management Committee. The committee must have broad stakeholder membership and will provide independent and expert advice to National Scheme bodies on accreditation reform and other National Scheme accreditation matters. We began setting up the new committee in line with the Ministers' request, including consultation with relevant stakeholders and jurisdictions on the terms of reference and proposed membership.

Oversight

The Accreditation Advisory Committee, a subcommittee of the Agency Management Committee, provides a whole-of-scheme perspective on: accreditation through oversight of financial and reporting matters; accreditation governance, accountability and transparency issues; and accreditation agreements.

Our work with the committee focused on preparing for the expected policy direction from Health Ministers with details about the new independent accreditation committee (as foreshadowed in Ministers' response to the independent review of accreditation systems in the National Scheme, *Australia's health workforce: strengthening the education foundation*).

As the COVID-19 pandemic continued, we supported the committee to monitor the broader impact of pandemic restrictions that are likely to present significant challenges for the National Scheme, including changes to program delivery and risks that some students may not achieve the required capabilities before graduation.

The Agency Management Committee will discontinue the Accreditation Advisory Committee when the new independent accreditation committee is established. Oversight of relevant accreditation matters, including governance and performance reporting, will revert to the Agency Management Committee.

Developing standards

We completed reviewing and updating the procedures for developing accreditation standards in mid-2020 and published the revised version in August.

The procedures set out issues that:

- an accreditation authority should consider when developing or changing accreditation standards
- an accreditation authority should explicitly address when submitting accreditation standards to a National Board for approval
- a National Board should consider when deciding whether to approve accreditation standards developed by the accreditation authority
- a National Board should raise with the Ministerial Council, and when they should be raised.

Funding

Ten National Boards exercise accreditation functions through external councils. Five National Boards – Aboriginal and Torres Strait Islander Health Practice, Chinese Medicine, Medical Radiation Practice, Paramedicine and Podiatry – exercise accreditation functions through a committee established by the Board. The National Boards contributed over $10.8 million funding to these accreditation authorities.

Table 3. National Board funding contributions

Board	2020/21 $'000[1]	2019/20 $'000[1]
ATSIHPBA	136	149
CMBA	91	93
ChiroBA	226	192
DBA	454	447
MBA	3,829	3,648
MRPBA	125	196
NMBA	2,875[2]	2,832[2]
OTBA	19	0
OptomBA	333	323
OsteoBA	199[2]	186
ParaBA	291[2]	199[2]
PharmBA	660	595
PhysioBA	331	325
PodBA	236[2]	201[2]
PsyBA	1,038	1,013
Total	**10,843**	**10,399**

1. These are actual amounts. Requirements of the accounting standards may result in differences between these and the amounts stated in our financial statements.
2. These amounts include funding for the review of accreditation standards.

The work of the committees

Ahpra supported the five accreditation committees to:

- assess and accredit programs of study
- monitor approved programs of study
- develop and/or review accreditation standards for paramedicine and podiatry
- develop and implement consistent guidelines for accreditation of education and training programs in these professions.

Accrediting and monitoring programs

At 30 June, the accreditation committees have accredited these programs of study:

- 16 for Aboriginal and Torres Strait Islander Health Practice
- 9 for Chinese medicine
- 34 for medical radiation practice
- 15 for podiatry, with two accreditation assessments in progress into the next financial year.

The Paramedicine Accreditation Committee monitored 26 Board-approved programs and started to accredit these programs against newly developed paramedicine accreditation standards from 1 July 2021.

New and revised standards

We worked in collaboration with paramedicine and podiatry committees to draft accreditation standards that are consistent with the standards for 11 other professions, reflecting current and emerging trends in education and practice.

We also consulted widely on draft accreditation standards for podiatry and podiatric surgery, including endorsement for scheduled medicines, and this work has since been completed.

Policy and process

We supported the accreditation committees to:

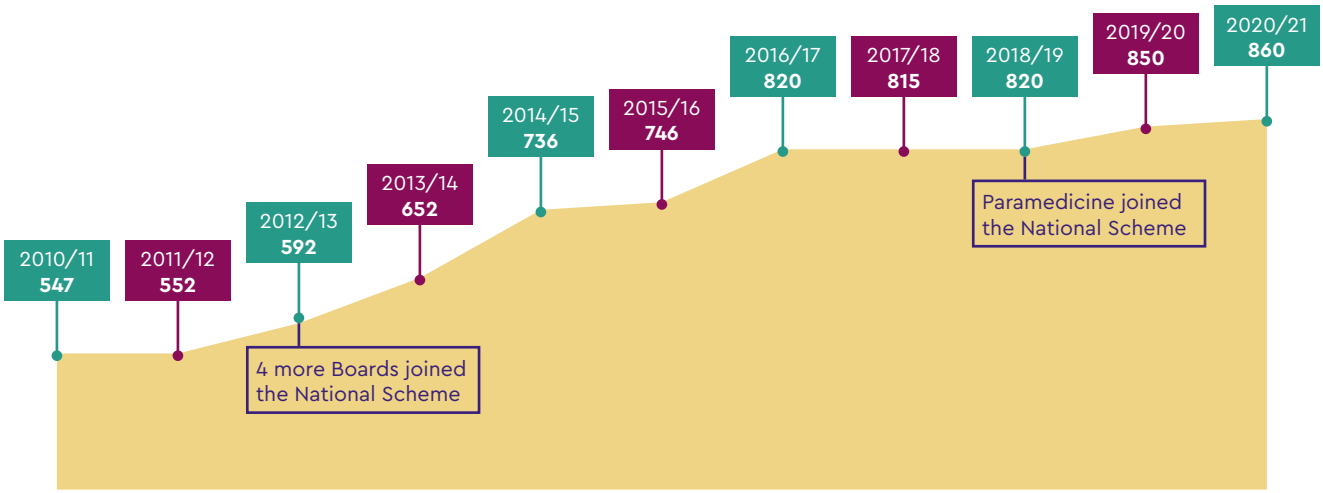
- develop and implement specific monitoring to assure the relevant National Boards that all students are achieving the capabilities required for safe and competent practice before graduation, despite significant changes to program delivery under the COVID-19 public health restrictions
- apply a flexible approach to monitoring education providers' compliance with accreditation standards, based on specific issues and risk profile – this flexible, risk-based model enabled COVID-responsive approaches to assessment and monitoring activities
- implement consistent cross-profession guidelines for accreditation, complemented by profession-specific processes (such as establishing assessment teams)
- collaborate to implement consistent cross-profession processes and tools to collect data from more than 45 education providers delivering over 90 approved programs across the five professions.

This work provides an opportunity for multi-profession approaches to accreditation.

Collaborative forum

The accreditation committees, with Ahpra, collaborated with the other 10 accreditation authorities through the Health Professions Accreditation Collaborative Forum (HPACF). This collaboration reflects the HPACF's multi-profession and multi-entity nature and its consideration of issues affecting all accreditation entities.

Figure 74. Number of accredited courses since the National Scheme began



Saving paramedicine students – so they can save us

A COVID story about responding quickly:

The Paramedicine Accreditation Committee had planned to begin its first accreditation assessment schedule in mid-2020. Then came COVID and its resulting disruption. The committee decided to delay the start to assessing programs and to cancel its routine annual monitoring.

But how could education providers ensure the committee that final-year students would be ready to graduate at the end of 2020 having attained the necessary professional capabilities required to be eligible for registration with the National Board?

Working with education providers, the committee started contingency planning and initiated special COVID monitoring.

Education providers moved the theoretical components online. For the practical components, they held extended summer schools to ensure students could have the necessary time on clinical placements, and slightly delayed some graduations to the end of December or January to enable students to qualify.

Education providers worked closely with jurisdictional ambulance services to adapt clinical placement blocks. Some placements were more intensive than usual, but students got the time allocation they needed to complete the placement requirements.

Dr Paul Simpson, the Chair of the Australasian Council of Paramedicine Deans, the national collaboration that brings together the 17 universities offering paramedicine programs, said: 'It was an extraordinary example of collaboration and cooperation between stakeholders and of being steadfast in our commitment to ensure the best outcomes both for our students and for the public in the newest regulated profession.'

Registration supports access to safe healthcare

Registration

In Australia, you have to be registered to use a protected title in any of the 16 regulated health professions

Registration snapshot

There are more than 825,000 registered health practitioners in Australia

- Including practitioners on the pandemic response sub-register, the number of registered health practitioners grew by **3.0%** this year, to **825,720**.
- Without the inclusion of the practitioners on the pandemic response sub-register, the number of health practitioners grew by **4.2%** this year to **801,750**.
- The pandemic response sub-register was extended for some professions for a further 12 months to help with the COVID-19 vaccination program.
- **97.6%** hold some form of practising registration.
- **84,706** practitioners hold specialist registration in an approved specialty.
- **24,036** practitioners hold endorsement to extend their scope of practice in a particular area because of an additional qualification.

You can check our national online register of practitioners to see if someone is registered and if there are any special requirements on their registration

Pandemic sub-register

The pandemic response sub-register was set up last year to fast track the return to the workforce of experienced and qualified health practitioners to help in the response to the COVID-19 pandemic. It was intended to remain in place for 12 months. In early April 2021, at the request of Health Ministers, National Boards agreed that medical practitioners, nurses, midwives, pharmacists and Aboriginal and Torres Strait Islander Health Practitioners would remain on the sub-register for up to another 12 months (to 5 April 2022) to help with the COVID-19 vaccination program.

The sub-register for psychologists, physiotherapists and diagnostic radiographers closed on 19 April 2021. All professions could apply for ongoing registration through a transition pathway before the sub-register closed. Practitioners who did not apply cannot practise.

There are 26,595 Aboriginal and Torres Strait Islander Health Practitioners, medical practitioners, midwives, nurses and pharmacists on the sub-register.

Figure 75. Registration numbers since the National Scheme began

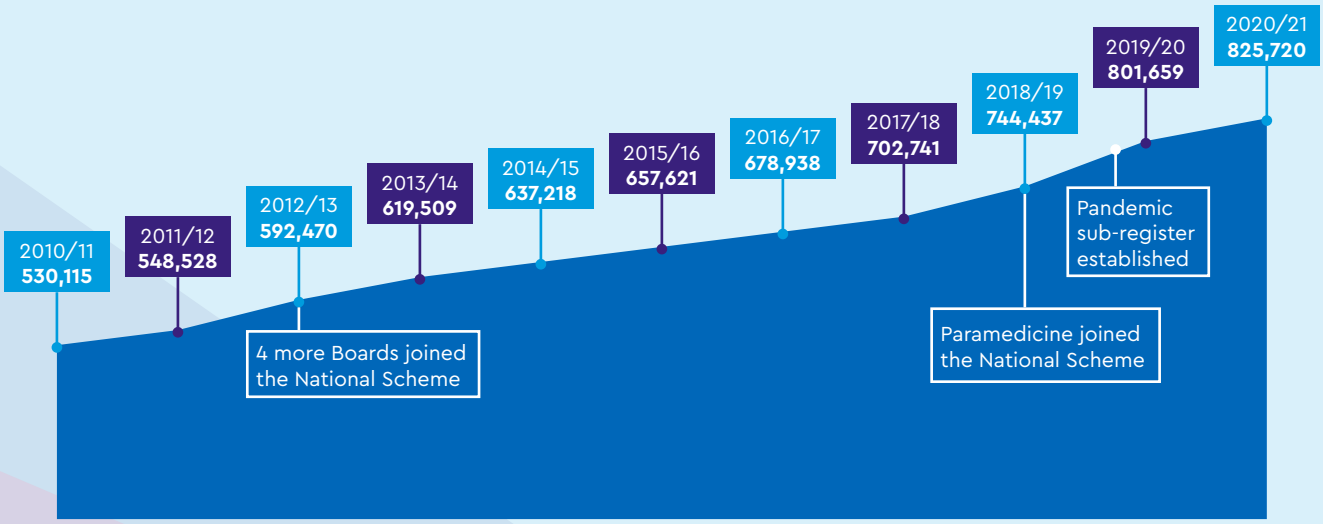


Table 4. Registered health practitioners (including pandemic sub-register), 30 June

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[1]	Total 2020/21[2]	Total 2019/20[2]	% Change 2019/20–2020/21
Aboriginal and Torres Strait Islander Health Practitioner	1	179	205	155	87	2	35	165		**829**	**812**	**2.1%**
Chinese medicine practitioner	70	1,959	14	894	198	45	1,300	260	123	**4,863**	**4,921**	**–1.2%**
Chiropractor	69	1,945	27	943	381	69	1,577	758	199	**5,968**	**5,777**	**3.3%**
Dental practitioner	453	7,420	157	5,123	2,085	399	5,900	2,850	597	**24,984**	**24,406**	**2.4%**
Medical practitioner	2,444	38,874	1,482	26,178	9,089	2,822	31,974	13,109	3,094	**129,066**	**125,641**	**2.7%**
Medical radiation practitioner	306	5,931	134	3,712	1,396	360	4,257	1,500	248	**17,844**	**18,243**	**–2.2%**
Midwife	218	1,677	104	1,540	819	69	1,650	518	190	**6,785**	**6,309**	**7.5%**
Nurse	7,246	115,353	4,763	88,544	36,041	10,480	113,366	41,830	11,635	**429,258**	**415,433**	**3.3%**
Nurse and midwife[3]	512	8,123	518	6,079	1,932	671	8,100	3,054	259	**29,248**	**29,736**	**–1.6%**
Occupational therapist	427	7,015	209	5,159	1,998	365	6,611	3,489	359	**25,632**	**23,997**	**6.8%**
Optometrist	110	2,064	33	1,264	399	115	1,671	477	155	**6,288**	**6,043**	**4.1%**
Osteopath	47	632	6	271	45	53	1,779	66	52	**2,951**	**2,753**	**7.2%**
Paramedic	336	5,525	200	5,526	1,403	607	6,181	1,399	315	**21,492**	**19,838**	**8.3%**
Pharmacist	714	10,509	285	7,034	2,473	891	9,047	3,764	545	**35,262**	**34,512**	**2.2%**
Physiotherapist	769	11,009	214	7,265	2,928	596	9,268	4,305	1,296	**37,650**	**37,113**	**1.4%**
Podiatrist[4]	76	1,631	30	999	534	119	1,818	512	64	**5,783**	**5,608**	**3.1%**
Psychologist	1,097	13,541	272	7,593	2,022	727	11,600	4,355	610	**41,817**	**40,517**	**3.2%**
Total 2020/21	**14,895**	**233,387**	**8,653**	**168,279**	**63,830**	**18,390**	**216,134**	**82,411**	**19,741**	**825,720**		**3.0%**
Total 2019/20	**14,209**	**227,530**	**8,445**	**161,813**	**62,047**	**17,540**	**210,730**	**79,568**	**19,777**		**801,659**	

1. No principal place of practice: includes practitioners with an overseas or unknown address.
2. Include practitioners registered on the temporary pandemic sub-register.
3. Registrants who hold dual registration as both a nurse and a midwife.
4. Throughout this report, the term 'podiatrist' refers to both podiatrists and podiatric surgeons unless otherwise specified.

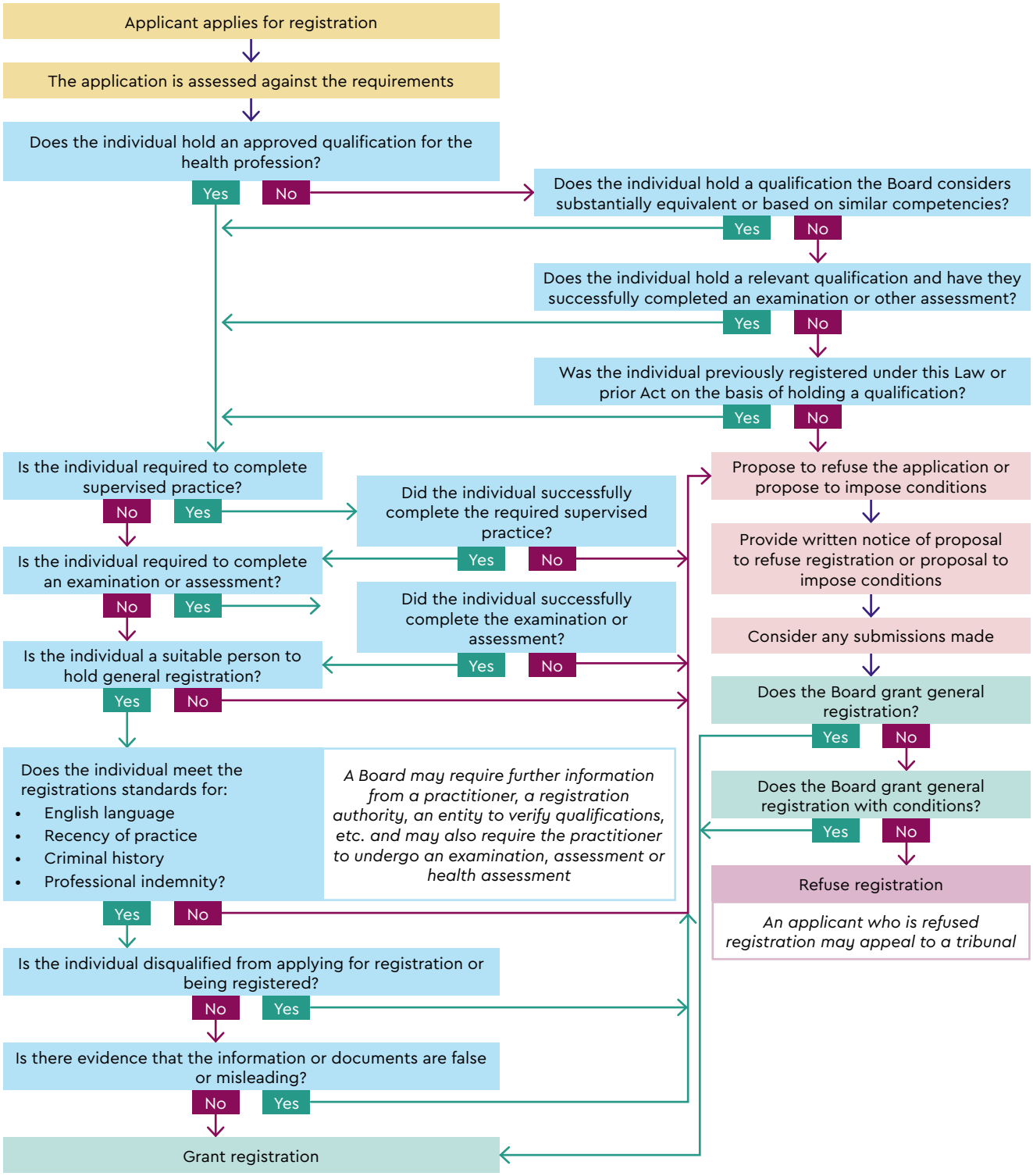
Table 4A. Registered health practitioners (excluding pandemic sub-register), 30 June

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[1]	Total 2020/21	Total 2019/20	% Change 2019/20–2020/21
Aboriginal and Torres Strait Islander Health Practitioner	1	174	202	152	86	2	34	156		**807**	**791**	**2.0%**
Chinese medicine practitioner	70	1,959	14	894	198	45	1,300	260	123	**4,863**	**4,921**	**–1.2%**
Chiropractor	69	1,945	27	943	381	69	1,577	758	199	**5,968**	**5,777**	**3.3%**
Dental practitioner	453	7,420	157	5,123	2,085	399	5,900	2,850	597	**24,984**	**24,406**	**2.4%**
Medical practitioner	2,383	37,949	1,457	25,530	8,843	2,747	31,244	12,685	3,077	**125,915**	**122,249**	**3.0%**
Medical radiation practitioner	306	5,931	134	3,711	1,396	360	4,257	1,500	248	**17,843**	**17,134**	**4.1%**
Midwife	215	1,632	99	1,515	794	66	1,601	494	188	**6,604**	**6,193**	**6.6%**
Nurse	6,997	110,898	4,621	85,176	34,390	10,064	109,266	40,018	11,617	**413,047**	**396,454**	**4.2%**
Nurse and midwife	460	7,306	479	5,521	1,685	613	7,496	2,805	255	**26,620**	**26,881**	**–1.0%**
Occupational therapist	427	7,015	209	5,159	1,998	365	6,611	3,489	359	**25,632**	**23,997**	**6.8%**
Optometrist	110	2,064	33	1,264	399	115	1,671	477	155	**6,288**	**6,043**	**4.1%**
Osteopath	47	632	6	271	45	53	1,779	66	52	**2,951**	**2,753**	**7.2%**
Paramedic	336	5,525	200	5,526	1,403	607	6,181	1,399	315	**21,492**	**19,838**	**8.3%**
Pharmacist	680	9,923	275	6,643	2,351	849	8,650	3,585	542	**33,498**	**32,559**	**2.9%**
Physiotherapist	769	11,009	214	7,263	2,926	596	9,266	4,304	1,296	**37,643**	**35,041**	**7.4%**
Podiatrist	76	1,631	30	999	534	119	1,818	512	64	**5,783**	**5,608**	**3.1%**
Psychologist	1,097	13,540	272	7,592	2,022	727	11,600	4,352	610	**41,812**	**38,785**	**7.8%**
Total 2020/21	**14,496**	**226,553**	**8,429**	**163,282**	**61,536**	**17,796**	**210,251**	**79,710**	**19,697**	**801,750**		**4.2%**
Total 2019/20	**13,649**	**218,111**	**8,151**	**155,283**	**59,200**	**16,805**	**202,416**	**76,059**	**19,756**		**769,430**	

1. No principal place of practice: includes practitioners with an overseas or unknown address.

How registration works

Figure 76. Granting general registration



Aboriginal and Torres Strait Islander Peoples are under-represented in our health workforce

This is something we are working with others to change

- Aboriginal and/or Torres Strait Islander participation in the regulated health professions was **1.1%**.
- This is well short of the **3.3%** Aboriginal and Torres Strait Islander representation in the general population.
- Increasing participation in the registered health workforce is a goal of the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy.
- **100%** of Aboriginal and Torres Strait Islander Health Practitioners identified as being Aboriginal and/or Torres Strait Islander. It is a requirement for registration in that profession.
- Paramedicine had the second highest representation with **1.7%** of their workforce identifying as Aboriginal and/or Torres Strait Islander.
- Midwifery (including dual-registered midwives and nurses) was next with **1.4%**, closely followed by nursing (including dual-registered) with **1.3%**.

In the graduate customer experience survey we asked how can we improve the process for Aboriginal and Torres Strait Islander applicants.

Survey participants who identified as Aboriginal and/or Torres Strait Islander (2.6%) suggested:

- an Aboriginal and/or Torres Strait Islander Liaison Officer as an alternative contact
- additional information and support for Aboriginal and/or Torres Strait Islander registrants entering the health workforce.

Table 5. Health practitioners who identified as Aboriginal and/or Torres Strait Islander, 2015 to 2020

Profession[1]	Registrants											
	2015	%	2016	%	2017	%	2018	%	2019	%	2020	%
Aboriginal and Torres Strait Islander Health Practitioner[2]	514	100.0%	549	100.0%	584	100.0%	647	100.0%	670	100.0%	760	100.0%
Chiropractor	17	0.3%	17	0.3%	25	0.5%	23	0.4%	23	0.4%	33	0.6%
Chinese medicine practitioner	19	0.4%	19	0.4%	15	0.3%	21	0.4%	21	0.4%	25	0.5%
Dental practitioner	73	0.3%	79	0.4%	98	0.4%	108	0.5%	121	0.5%	131	0.5%
Medical practitioner	302	0.3%	348	0.3%	399	0.4%	467	0.4%	519	0.4%	528	0.4%
Medical radiation practitioner	64	0.4%	60	0.4%	80	0.5%	95	0.6%	114	0.7%	111	0.6%
Nurse and midwife	3,428	1.0%	3,740	1.0%	4,136	1.1%	4,707	1.2%	5,094	1.3%	5,521	1.3%
Nurse (including dual registered)	3,374	0.9%	3,676	1.0%	4,053	1.1%	4,613	1.2%	4,982	1.2%	5,393	1.3%
Midwife (including dual registered)	304	0.9%	311	1.0%	336	1.0%	375	1.2%	417	1.3%	441	1.4%
Occupational therapist	76	0.4%	77	0.4%	89	0.4%	111	0.5%	137	0.6%	162	0.6%
Optometrist	16	0.3%	13	0.2%	11	0.2%	7	0.1%	12	0.2%	8	0.1%
Osteopath	16	0.8%	15	0.7%	17	0.7%	16	0.6%	18	0.7%	22	0.8%
Paramedic									287	1.6%	355	1.7%
Pharmacist	68	0.2%	73	0.2%	79	0.3%	80	0.3%	98	0.3%	93	0.3%
Physiotherapist	142	0.5%	157	0.5%	191	0.6%	213	0.7%	239	0.7%	245	0.7%
Podiatrist	30	0.7%	35	0.7%	30	0.6%	30	0.6%	38	0.7%	43	0.8%
Psychologist	167	0.5%	192	0.6%	199	0.6%	218	0.6%	246	0.7%	274	0.7%
Total of overall health workforce[3]	**4,932**	**0.8%**	**5,374**	**0.8%**	**5,953**	**0.9%**	**6,743**	**1.0%**	**7,637**	**1.0%**	**8,311**	**1.1%**

Source: National Health Workforce Data Set (NHWDS) medical practitioners, nursing and midwifery, allied health, 2015–20

1. Practitioners who identified themselves as being born in Australia and Aboriginal and/or Torres Strait Islander in a workforce survey conducted at renewal of registration.
2. The number in Table 5 is different from Table 4 due to when the data were extracted.
3. The workforce survey has very high response rates, making it a good source of information. However, accuracy is not guaranteed as it is voluntary. A small number will hold dual registration and may be counted twice.

Students are the health practitioners of the future

- **189,786** students were studying to be health practitioners through an approved program of study or clinical training program

Education providers supply student information so students can be registered

All National Boards, except the Psychology Board, register students. Psychology students receive provisional registration. The student register isn't public.

Table 6. Registered students

Students by profession[1]	Approved program of study[2] students by expected completion date	Clinical training[3] students by expected completion date	Total 2020/21[4]	Total 2019/20
Aboriginal and Torres Strait Islander Health Practice	529	56	**585**	**548**
Chinese medicine	1,528		**1,528**	**1,556**
Chiropractic	2,294	28	**2,294**	**2,147**
Dental	4,531		**4,531**	**4,416**
Medical	20,891	51	**20,942**	**22,415**
Medical radiation practice	4,849	343	**5,192**	**5,670**
Midwifery[5]	4,129		**4,129**	**4,135**
Nursing[5]	109,396	635	**110,031**	**111,746**
Occupational therapy	10,141		**10,141**	**9,843**
Optometry	1,747	9	**1,756**	**1,746**
Osteopathy	1,481		**1,481**	**1,885**
Paramedicine[5]	8,454		**8,454**	**9,026**
Pharmacy	7,298		**7,298**	**7,147**
Physiotherapy	9,883	261	**10,144**	**10,167**
Podiatry	1,280		**1,280**	**1,353**
Total 2020/21	**188,431**	**1,383**	**189,786[6]**	
Total 2019/20	**192,084**	**1,716**		**193,800[6]**

1. Students reported as enrolled in an approved program of study/clinical training program (accurate at 1 July 2021 and does not account for fluctuations throughout 2020/21). This may include ongoing students or students with a completion date falling within the period. These data reflect the information received from education providers, and as such have limitations if being used as a comprehensive, comparative or planning tool.
2. Refers to those students enrolled in a course approved by a National Board and that leads to a qualification for registration.
3. Defined as any form of clinical experience that does not form part of an approved program of study.
4. Due to ongoing improvements in validation and reporting, these data should not be objectively compared to previous years.
5. To avoid double-counting, 3,665 students who were studying an approved double degree involving more than one profession (nursing/midwifery and nursing/paramedicine) have only been assigned to a single profession (nursing [2,005]/midwifery [202] and nursing [1,458]/paramedicine [0]).
6. Data have been adjusted to remove duplicate students who meet the 100% match criteria, based on full name, date of birth, education provider, email address and program of study name.

Over 84,000 people applied to be registered this year

All applications

- Ahpra received **84,607** applications for registration
  - this is an increase of **3.9%** from last year.
- **91.7%** (77,566 applicants) sought practising registration.
- Applications for registration as a specialist in the medical profession increased by **116.7%** from 4,122 to **8,931** applications as a result of changes to the *Health Insurance Act 1973*.
- We finalised **84,232** applications
  - Of these, **2.3%** resulted in conditions being placed or a refusal of registration.
  - There was an **87.0%** reduction in the refusals of registration (353 this year compared to 2,713 last year) as only 229 nurses were refused registration compared to 2,579 nurses last year. This decrease was expected and likely due to the new registration application process for internationally qualified nurses, which enables an initial self-assessment before lodging an application.
- The time to decide the outcome of an application for registration was reduced:
  - median time of **2** days (**4** days in 2019/20)
  - average of **17** days (**19** days in 2019/20).

Figure 76 (page 52) shows how we decide an application for general registration.

Specialist registration of GPs

- We experienced a significant short-term increase in medical specialist applications from general practitioners (GPs) because of Commonwealth Government changes to the *Health Insurance Act 1973*.
- From 16 June 2021, Services Australia started using Ahpra's *Register of practitioners* to confirm GP specialist registration, required so their patients were eligible to retain access to Medicare rebates.
- We identified approximately 3,400 GPs as likely to be qualified for specialist registration because they were qualified for Fellowship of the Royal Australian College of General Practitioners (FRACGP) or Fellowship of the Australian College of Rural and Remote Medicine (FACRRM) but had never applied for specialist registration.
- This led to a surge in specialist applications. At 24 June, 99.3% of the affected GPs had applied for and were granted specialist GP registration. On average, applications were finalised in two days from receipt.

Arrivals of overseas graduates

The number of new registration applications received from overseas qualified applicants was affected by the Australian border closures. It continues to be difficult for applicants to travel to Australia, so the number of overseas applicants with in-principle approval who are waiting to travel to Australia to finalise proof of identity requirements continues to be higher than before the pandemic.

We received 2,531 applications from international medical graduates (IMGs), 22.6% fewer than the 3,271 applications received last year.

The number of requests from IMGs currently working in Australia, with limited or provisional registration, to change their employment circumstances has dropped by 11.9%. A request for a change in circumstances is typically made when an IMG with limited or provisional registration seeks a change to their approved employment and/or supervision arrangements. A streamlined process enables eligible IMGs with limited or provisional registration to be redeployed without a formal application to the Medical Board of Australia. This measure continues to facilitate IMGs being quickly available to work where the Australian health system needs them.

Some applicants sit an exam

Internationally qualified nurses and midwives

From March 2020, internationally qualified nurses and midwives (IQNMs) who wish to apply for registration in Australia are required to complete an online assessment of their qualifications. Those who hold qualification/s that are substantially equivalent or based on similar competencies to an Australian graduate (and who meet the mandatory registration standards) progress to an application for registration.

IQNMs who hold relevant but not equivalent qualification/s must successfully complete an outcomes-based assessment before being eligible to apply. These IQNMs complete two exams:

- a multiple-choice question examination (MCQ) (knowledge test)
- an objective structured clinical examination (OSCE) (behavioural test).

The MCQ examinations are:

- enrolled nurse (EN) – a paper-based exam coordinated by Ahpra that is yet to be delivered
- registered nurse (RN) – an online exam, the National Council of State Boards of Nursing (NCSBN) National Council Licensure Examination – Registered Nurse (NCLEX-RN)[1] conducted at Pearson VUE testing centres in more than 20 countries including Australia – 1,799 candidates sat the exam
- midwife – an online exam conducted at Aspeq managed facilities in Australia, New Zealand and internationally – 16 candidates sat the exam.

1 Candidates who have sat and passed the National Council Licensure Examination – Registered Nurse (NCLEX-RN) in the past 10 years are not required to re-sit the exam.

The OSCEs for IQNMs are coordinated by Ahpra at Adelaide Health Simulation. A total of 109 internationally qualified registered nurses participated in the RN OSCE offered in February, April and June. The EN OSCE and a midwife OSCE are yet to be delivered.

The delivery of all these exams has, to varying extents, been affected by restrictions related to the COVID-19 pandemic.

Pharmacy, psychology and medical radiation practice exams

Ahpra coordinated the following exams:

- 1,873 pharmacy interns were assessed in the oral examination (practice) in October, February and June. Victorian candidates sat the exam online in October 2020. NT candidates sat the exam online throughout 2020/21 as examiners have not been able to travel due to COVID-19.
- 67 oral exams were held for pharmacy practitioners holding limited or general registration with conditions on their registration requiring the completion of an examination in practice, or in law and ethics. These exams were offered monthly.
- 927 candidates sat the quarterly national psychology examination. These exams were offered by dual delivery, meaning candidates could choose to sit the exam in a test centre (where available) or by online supervision.
- 54 candidates sat the quarterly national medical radiation practice examination. The exams were offered by dual delivery, meaning candidates could choose to sit the exam in a test centre (where available) or by online supervision.

New graduate applications

- **41,548** applications were from new graduates, including nearly **23,300** nursing applications.
- We received **31,577** applications for registration (an **8.6%** increase from the previous year) during mid-September to March, the peak registration period for new graduates. On average the:
  - time taken to decide the outcome of a graduate application reduced to **9** days (down from 10 days) on receipt of a graduate list from education providers confirming qualification
  - time to finalise a graduate application from receipt was **52** days (up from 42 days last year). This increase was related to opening the application period earlier than last year. We can only complete applications on receipt of graduate lists from education providers, so we held applications for longer.

An early start to the new graduate campaign

The graduate campaign opened two weeks earlier (in mid-September) in response to advice from stakeholders that clinical placements for some students may be delayed due to COVID-19, which in turn could affect graduation dates and potentially employment start dates.

By opening the graduate campaign early, our aim was to:

- more evenly spread out the applications received in the peak registration period for new graduates qualifying at the end of the calendar year
- still meet our goal of registering graduates within two weeks of receiving their graduate results
- get health practitioners registered (and into the health workforce) earlier and in greater numbers than in previous years.

Our early preparations focused on recruiting and training new staff and supporting students with new resources, including an animated video to help them complete their applications correctly.

Targeted communication strategies also included:

- a direct email campaign to nursing, medicine and pharmacy students asking them to apply early
- a series of webinars for nursing and pharmacy students
- some frequently asked questions and answers published on the website.

The webinars were well attended with registrations for the nursing webinars reaching the 1,000-maximum capacity. The webinars were then published on our website.

We successfully conducted our second 'applicant experience' survey of graduates with 27,275 registrants invited to participate in the voluntary survey and we achieved an improved response rate of 22.4% (compared to 15.8% last year). Overall the feedback was positive, with almost 80% of respondents satisfied with how their application was managed.

Most respondents commented favourably on the timeliness of their assessment, felt they were generally well informed about their application status, had positive interactions with our Customer Service team and found the online form, process and website easy to understand.

Before starting a career as a registered health practitioner an applicant must provide evidence that they are eligible to be registered, and registration must be granted

One of our checks is of criminal history

- **69,571** results received from domestic and international criminal history checks of practitioners and/or applicants
  - this decrease of **10.4%** was likely due to reduced applications from internationally qualified practitioners linked to COVID-19, specialist registration applications from GPs, and other registration changes where a check is not required.
- **3.9%** indicated a disclosable court outcome
  - **three** cases where the check resulted in registration being granted with conditions
  - **two** cases where the check resulted in refusal to grant registration
  - **one** case where the check resulted in a refusal to renew registration.

Table 7. Criminal history checks and disclosable court outcomes

State/ territory	2020/21		2019/20	
	Number of criminal history checks[1]	Number of disclosable court outcomes	Number of criminal history checks[1]	Number of disclosable court outcomes
ACT	1,504	37	1,345	41
NSW	18,584	680	20,559	851
NT	695	44	836	43
QLD	13,221	521	13,736	632
SA	5,414	260	5,511	287
TAS[2]	1,424	300	1,344	330
VIC	17,369	461	19,526	493
WA	6,943	401	7,194	414
No PPP[3]	4,417	19	7,626	40
Total 20/21	**69,571**	**2,723**		
Total 19/20			**77,677**	**3,131**

1. Includes both domestic and international criminal history checks.
2. The National Law requires that all criminal history be released. In Tasmania, police include traffic offences such as speeding and seatbelt use in their definition of 'criminal history', while other states do not.
3. No principal place of practice: includes practitioners with an overseas or unknown address.

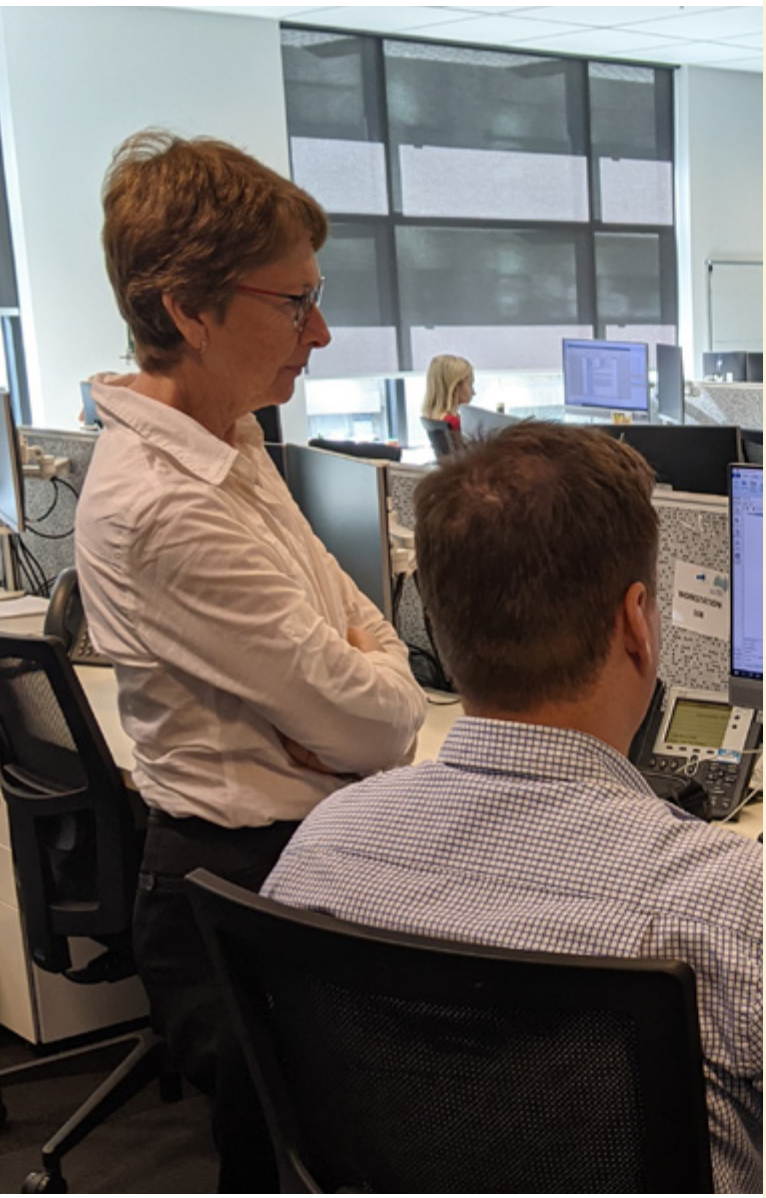
Only practitioners who are suitably trained and qualified to practise in a competent manner are registered

National Boards can place conditions on a practitioner's registration or refuse an application entirely.

Table 8. Applications finalised, by profession and outcome

Profession	Register	Register with conditions	Refuse application[1]	Withdrawn[2]	Total 2020/21	Total 2019/20
Aboriginal and Torres Strait Islander Health Practitioner	122			23	**145**	**238**
Chinese medicine practitioner	354	30	8	102	**494**	**609**
Chiropractor	401	6	3	18	**428**	**452**
Dental practitioner	1,542	31	15	82	**1,670**	**1,716**
Medical practitioner	20,699	267	37	773	**21,776**	**17,514**
Medical radiation practitioner	1,371	41	9	97	**1,518**	**1,621**
Midwife	1,781	20	7	213	**2,021**	**2,055**
Nurse	33,216	800	229	2,361	**36,606**	**38,272**
Occupational therapist	2,398	87	1	54	**2,540**	**2,577**
Optometrist	385	2	1	15	**403**	**403**
Osteopath	304	5		5	**314**	**330**
Paramedic	2,371	117	15	148	**2,651**	**3,482**
Pharmacist	3,266	49	4	106	**3,425**	**3,588**
Physiotherapist	3,246	28	10	156	**3,440**	**3,514**
Podiatrist	358	7	3	21	**389**	**464**
Psychologist	6,137	65	11	199	**6,412**	**5,685**
Total 2020/21	**77,951**	**1,555**	**353**	**4,373**	**84,232**	
Total 2019/20	**73,541**	**1,574**	**2,713**	**4,692**		**82,520**

1. If an applicant can't demonstrate that they meet the eligibility, suitability and/or qualification requirements their application will be refused.
2. When an applicant withdraws their application for registration before a final decision is made.



Caught out!

A registration officer's keen eye pays off:

An overseas-qualified dental practitioner applied for general registration with the Dental Board of Australia. They provided the required and independently certified documentation from the Australian Dental Council (ADC) stating that they had successfully completed the required written and clinical exam.

Something about the certificate didn't look right to the registration officer who assessed the application.

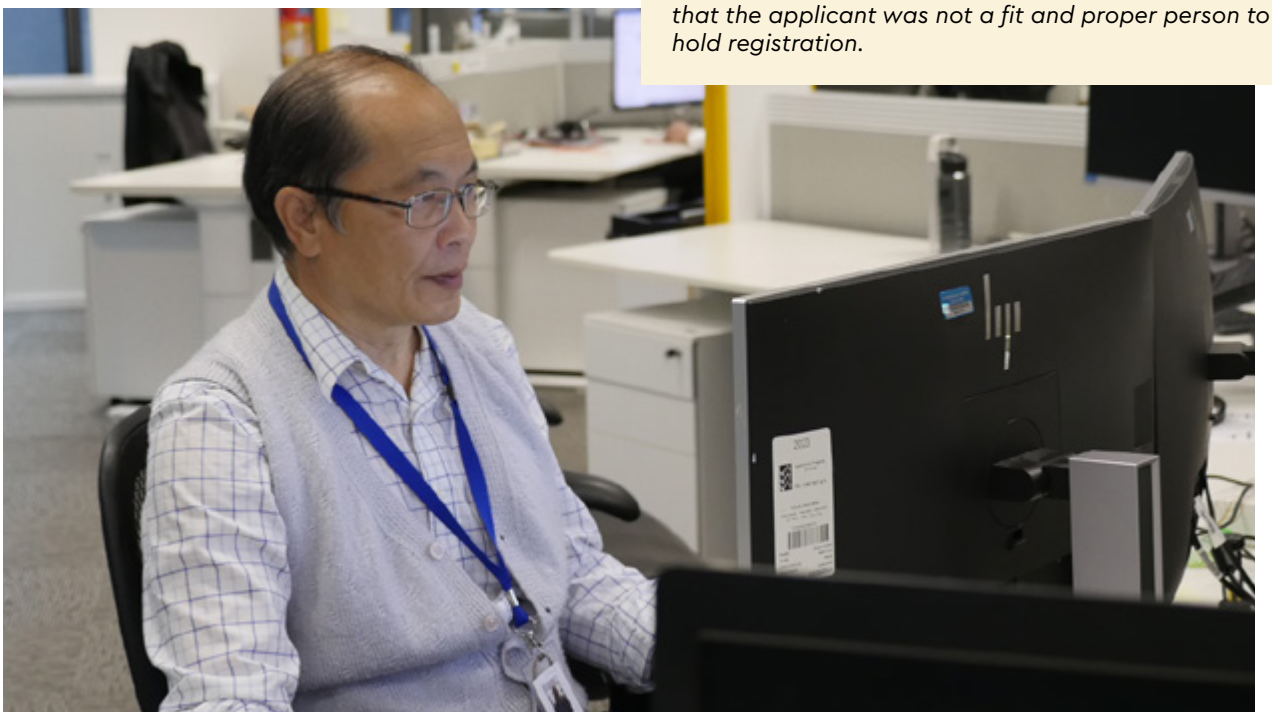
First, they checked ADC's portal, but couldn't find the applicant's name. Documentation was being submitted electronically due to COVID-19, so they couldn't view physical documentation.

Next, they asked the ADC whether their website was fully operational and up to date. It was.

They then elevated the matter within their team and a formal letter was prepared for the ADC. In response, the ADC categorically stated that they had not issued the documentation. Subsequent enquiries established that the applicant had previously sat their written exam but had failed the clinical component. A valid certificate had been obtained, copied and altered with intent to deceive.

The application for registration was refused and Ahpra referred the matter to the police. The applicant was charged on summons for making a false or misleading statement for authority/benefit and sentenced in the court to an 18-month Community Correction Order.

The Registration Committee considered it important that the refusal of registration was on the record, not just that the application was withdrawn. In its refusal, the committee referred to the deception and stated that the applicant was not a fit and proper person to hold registration.



Health practitioners apply to renew their registration yearly

Practitioners are required to make declarations and disclosures when applying to renew their registration

Renewals

- Ahpra renewed registration for **738,659** practitioners.[1]
- **99.6%** of all eligible practitioners renewed online.

Changes to renewals

- We updated the online renewal information and the renewal questions on the online form to help practitioners better understand what they need to do to renew their registration.
- For the first time, we asked practitioners to make a declaration about their compliance with advertising requirements.
- A new risk-assessment model is proving to be very successful in identifying risk early and in timely decision-making about declarations made by practitioners when renewing.
- For the first time, health practitioners in all professions did not receive a paper registration certificate at renewal. Instead all registered practitioners can print a registration certificate from their online services account after they have renewed.

A service for employers to check registration

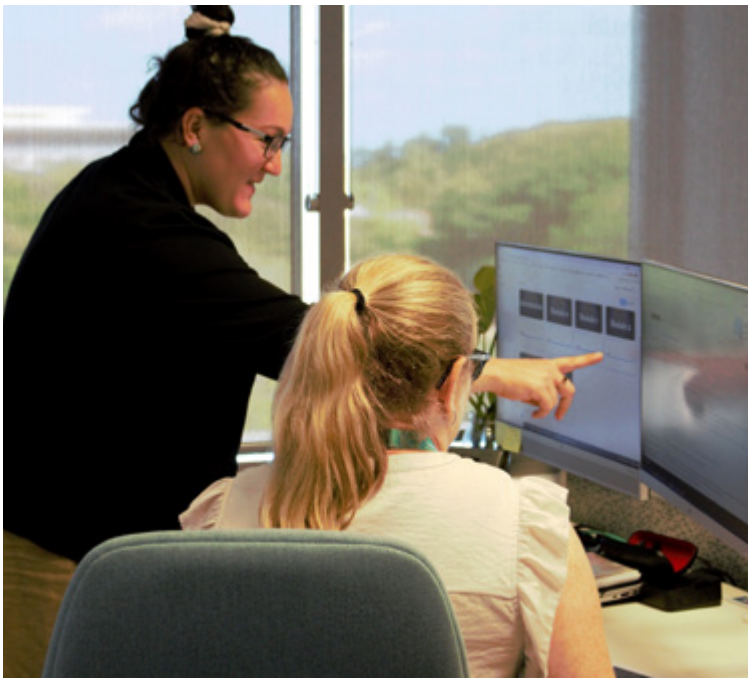
- 136 government departments, public and private hospitals, healthcare businesses, pharmaceutical companies, medical insurers, and nursing and aged care agencies subscribed to the Practitioner Information Exchange (PIE), a secure web-based system that enables bulk checking of registration status.

Financial hardship support

- In June, we introduced the *Policy – financial hardship for payment of registration fee for all professions*.
- People are considered to be experiencing financial hardship when they are unable to provide for themselves, their family or other dependants: food, accommodation, clothing, medical treatment, education, and/or other basic necessities.
- Applicants and practitioners can apply for financial hardship support before applying for registration or renewal of registration. This doesn't apply to recent graduates for Chinese medicine, medical, nursing or midwifery because a reduced application or registration fee already applies.
- The policy balances both the needs of people who are keen, but not able, to easily register or renew so they can be part of Australia's health workforce, and that the scheme is funded through practitioner fees.

Online upload service to continue

Ahpra offices have remained closed to the public due to ongoing public health restrictions. Applicants and registered health practitioners continue to submit applications and other forms online, along with supporting documents. This process has significantly reduced hardcopy submissions and enables practitioners to join the healthcare workforce sooner by reducing the time required to mail and process information, so we will continue with this approach.



1 This was incorrectly reported in last year's report as 693,751 practitioners, as we inadvertently missed including paramedics in the total. With paramedics, 713,402 practitioners renewed their registration in 2019/20.

Christmas is our busiest time of the year

Bernie Thomson, National Manager – Registration (Express) explains:

At the end of each year, applications for registration from new graduates flood in. It's a busy time for the registration team with over 30,000 applications to be assessed in as short a time as possible.

Applicants are anxious, some impatient. Employers are waiting. We rely on 130 educational institutions to provide evidence of qualifications. The Boards are wanting things to go smoothly for their new registrants. There are a lot of eyes on us. And lots of people wanting their application prioritised!

Each application is assessed and, while it's unusual for someone not to gain registration, we often need to follow up with applicants who don't always provide enough information, or the right sort.

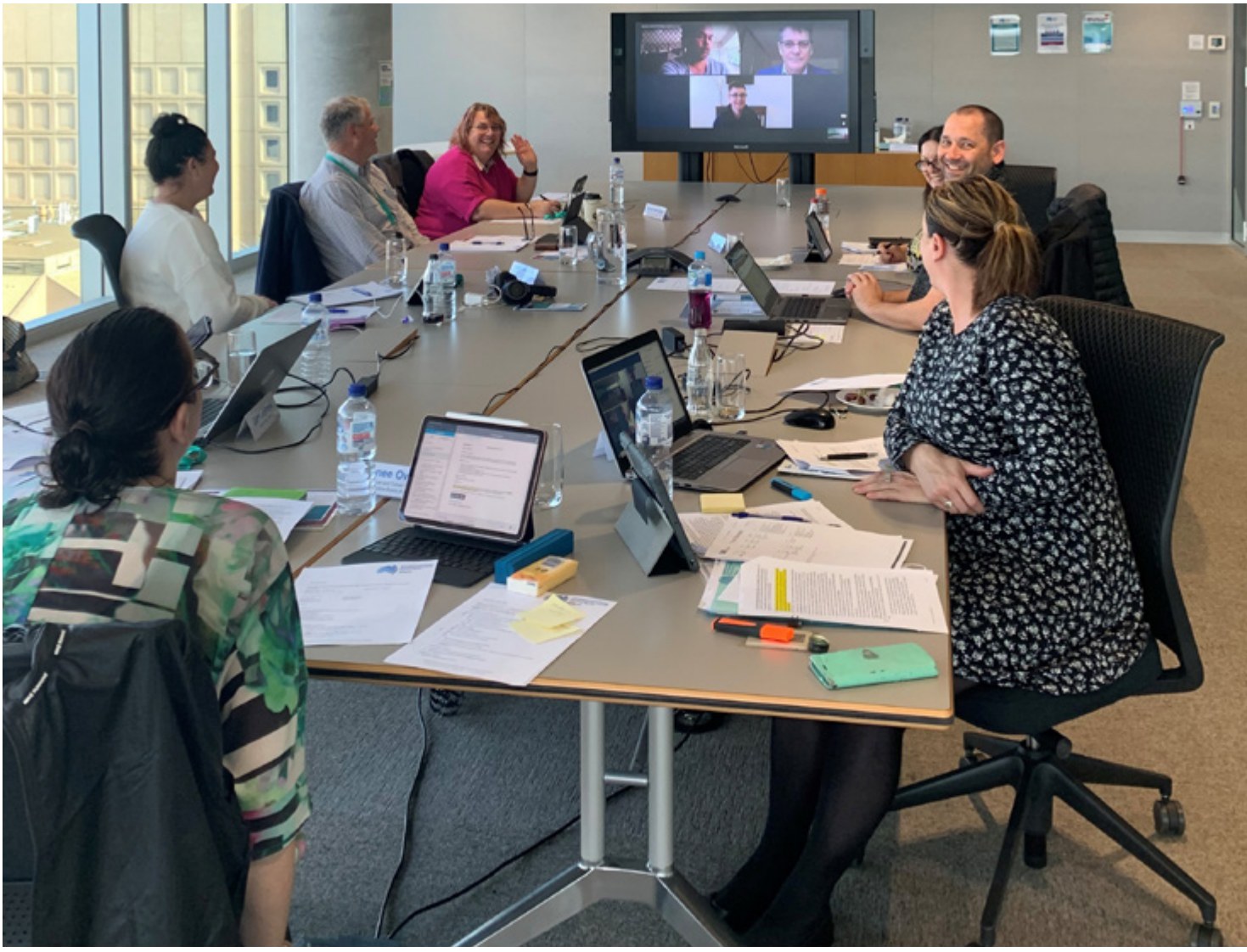
This happens a lot with evidence of identity. Either applicants don't provide all the evidence, or the evidence is expired (like an old passport), or they don't get their ID certified correctly.

We also obtain a national criminal history check. If an applicant has lived overseas as an adult, we do an international criminal history check. If an applicant has a criminal record, the Board may need to review it. Sometimes it's not relevant to the applicant's ability to practise; other times the Board may place conditions on an applicant's registration.

All professions have an English language evidence requirement, and we need to check we have been provided with sufficient and accurate evidence.

We employ extra staff and train them to focus on these applications. We closely monitor the number of incoming applications to ensure we have them assessed as quickly as possible.

In 2020, we received 7,441 graduate lists from education institutions providing student results that we then matched to graduate applications. It's a major coordination task and a sustained effort.



Ahpra audits practitioners to check that they comply with registration standards – the overwhelming majority do

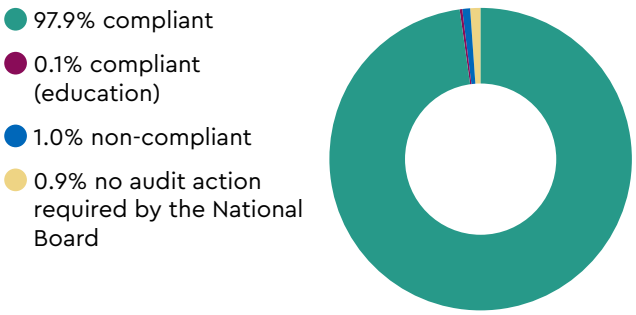
Audits

- The timing of audits was affected by COVID-19. We completed **1,055** audits.
- **97.9%** of practitioners were found to be in full compliance with the registration standards being audited.
- **0.1%** of practitioners did not quite meet the registration standard, but were able to provide evidence of achieving full compliance during the audit period.
- **0.9%** of practitioners required no audit action
  - **0.8%** changed their registration type to non-practising or failed to renew their registration; usually these were practitioners residing overseas, and those no longer practising but maintaining registration
  - **0.1%** were referred to a co-regulatory jurisdiction to manage.
- **1.0%** were found to be non-compliant with one or more standards.

The standards that may be audited are:

- continuing professional development
- recency of practice
- professional indemnity insurance arrangements
- criminal history.

Figure 77. Audit outcomes



Challenging a Board decision about registration

One applicant's successful outcome:

When Laura applied for registration as a nurse after being out of practice for just over 10 years, her case for re-entry into the profession, without some formal retraining, was considered borderline as she hadn't worked as a nurse for a long time. The Board refused to grant her re-entry with supervised practice. Instead they preferred she take a re-entry pathway that involved a six-month period of study and structured learning.

Where an applicant has worked outside the profession in a role where they may have exercised skill and judgement relevant to the profession, they are asked to demonstrate that by completing a mapping tool that compares that work to the relevant domains of practice. The Board also considers previous experience and postgraduate education. When a Board makes a proposal to refuse registration or impose conditions, the applicant is given an opportunity to provide further evidence in an effort to convince the Board to make a different decision in a show cause process.

Laura was very disappointed, and she sought to understand better what additional evidence could be presented to the Board. While she had substantial previous experience working as a theatre nurse, Laura's mapping tool was considered to lack sufficient evidence. Laura discussed her application with her case manager in the registration team. She was then able to demonstrate more fully that her recent employment working for a surgical supply company involved going into theatres and demonstrating how to fit prosthetic equipment. She also had a supportive prospective employer.

The Board discussed her case at some length, mindful of its responsibilities to protect the public and provide a safe and qualified workforce.

After considering Laura's show cause submission, Laura was pleased that the Board determined that supervised practice was the appropriate pathway back to general registration. And, in equally good news, her prospective employer is holding open her position as a nursing unit manager in a small day surgery until she completes her 450 hours of supervised practice.

Notifications provide a way for anyone to notify a board if they have concerns about a practitioner's or student's health, performance or conduct

Notifications

Notifications

What we do when someone raises a concern about a health practitioner

People share their concerns about practitioners with us. We call this 'making a notification' and refer to the person who raises the concern as a 'notifier'.

We receive more than 10,000 notifications a year.

Notifications are a source of information about practitioners registered in the scheme. They help us identify when a practitioner might not be practising safely or professionally.

They prompt us to reach out:

- to the person who told us about the problem
- to the practitioner who they are concerned about.

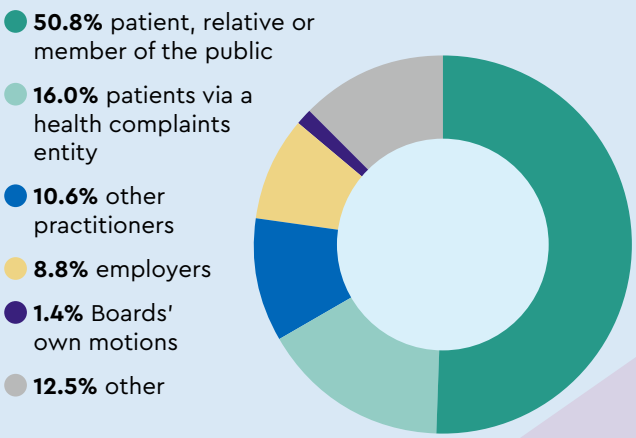
Notifications don't automatically mean that we will take regulatory action.

There is no 'threshold' that needs to be met by someone who wants to make a notification. We see a significant number of notifications that, while they are important for the person raising the concern, are of a relatively less serious nature in terms of the need for regulatory action.

We know that practitioners are often confused by this. Most practitioners assume that we can only accept serious cases and are often frustrated when we contact them to let them know we have received a notification.

We have made significant changes to the way we handle notifications to improve the way most practitioners and notifiers experience their interactions with us when we need to discuss a concern with them.

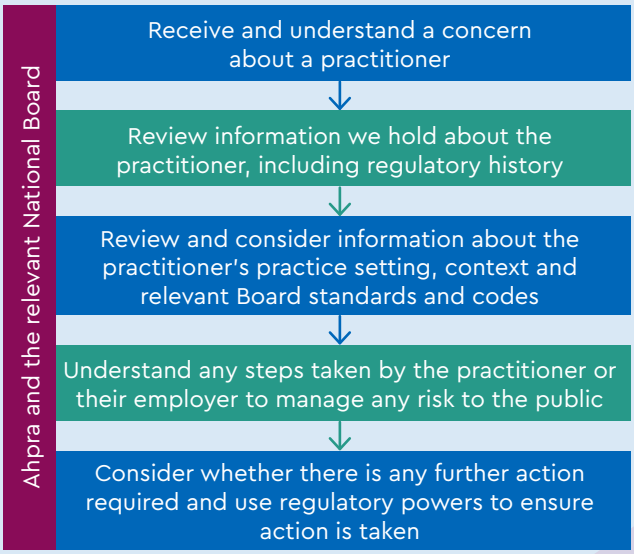
Figure 78. Who makes notifications?



Talk to us if you have a concern about the health, conduct or performance of a registered health practitioner

We are not a complaints resolution agency, so we can't help you get a refund or an apology. But we can take action to keep future patients safe.

Figure 79. How Ahpra and the National Boards manage complaints about health practitioners



Who makes notifications?

We receive most notifications **(50.8%)** from patients, their families and friends, and other members of the public; this is similar to last year (51.6%).

We receive some notifications **(19.4%)** from health practitioners and employers.

We received **1,862** confidential and anonymous notifications. Confidential notifications are when we know the identity of the notifier and are asked not to disclose it. Anonymous notifications are when we don't know the identity of the notifier.

What are notifications about?

We have changed the way we report the most common types of concern.

In previous years, we only reported one concern raised per notification, even though we may have been working on multiple concerns raised. This year for the first time, we can report **6,800** (67.0%) notifications received were about a single concern, **2,149** notifications (21.2%) were about two concerns, and **1,198** (11.8%) about three or more concerns.

Clinical care was the most common type of complaint received either as a single concern or one of multiple concerns in a notification.

Table 9. The number of concerns raised

Number of concerns raised	Number of notifications
1	6,800
2	2,149
3–4	1,031
5–7	143
8–14	24

Table 10. The five most common concerns

Complaint category[1]	Number of times the concern was raised
Clinical care	5,359
Communication	1,689
Medication	1,386
Health impairment	950
Documentation	937

1. Either as a single concern or one of multiple concerns received in a notification.

Over 10,000 notifications were made this year

- **10,147** notifications were received, which is
  - **0.9%** fewer than we received in 2019/20 (10,236)
  - **8.7%** more than in 2018/19 (9,338).
- **1.6%** of all registered health practitioners had notifications made about them, including the practitioners on the pandemic response sub-register.
- **1.7%** of registered health practitioners had notifications made about them, excluding the practitioners on the pandemic response sub-register. It was 1.7% in 2019/20 and 2018/19.

Explaining the data in our tables

While this is a national scheme, Ahpra does not manage all notifications made about health practitioners in Australia. We only manage a small number of notifications about NSW practitioners and only those referred to us in Queensland.

In this report, we mostly report on those notifications received and managed by Ahpra and the National Boards. When we have data to include about matters received and managed by the HPCA in NSW and by OHO in Queensland, they are either provided in separate columns or, if incorporated, acknowledged in the table title.

Figure 80. Notifications received by Ahpra since the National Scheme began

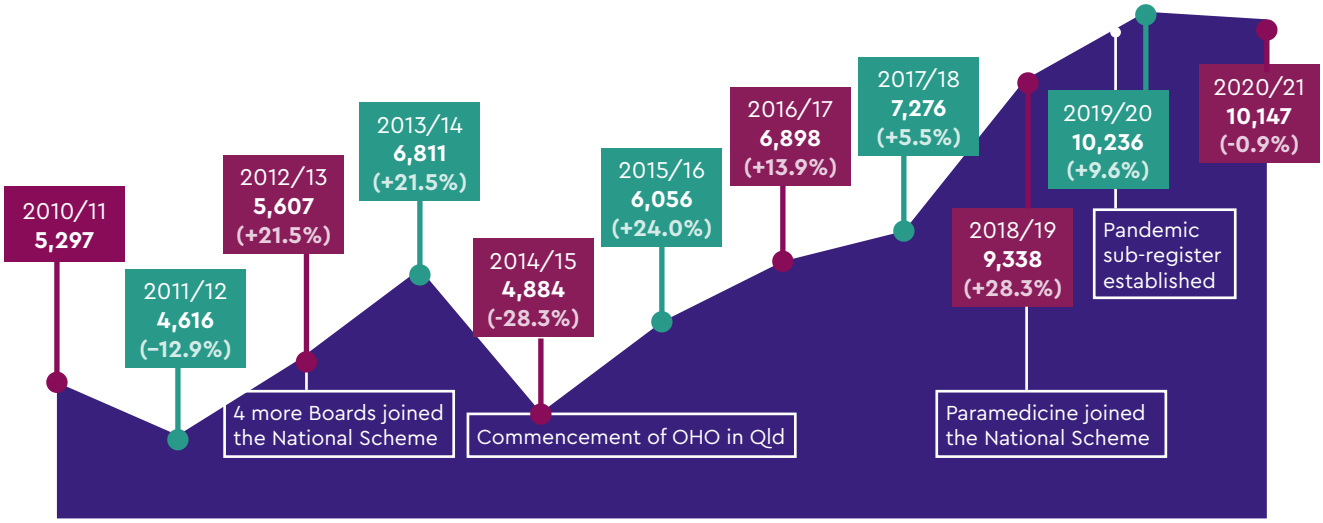


Figure 81. The notifications process

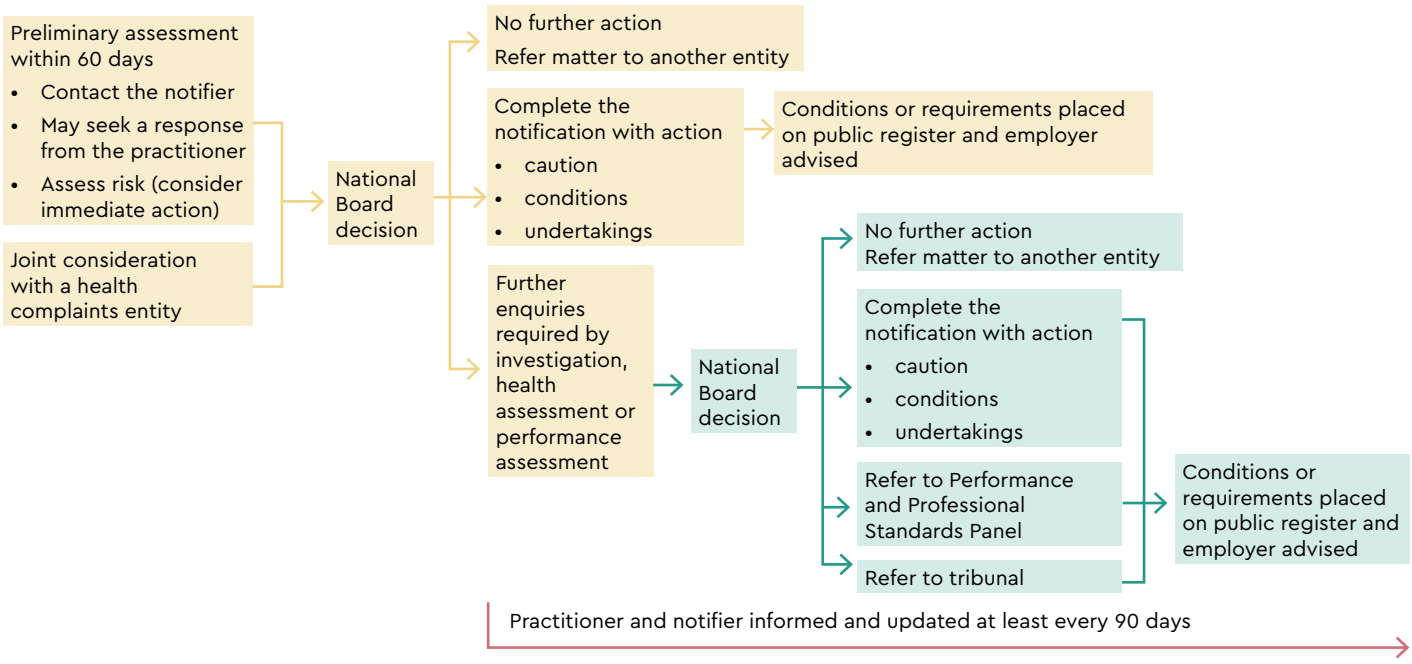


Table 11. Notifications received, by profession and state or territory

Profession	Ahpra									Ahpra subtotal 2020/21	HPCA[4]	OHO[5]	Total 2020/21	Total 2019/20[6]
	ACT	NSW[1]	NT	QLD[2]	SA	TAS	VIC	WA	No PPP[3]					
Aboriginal and Torres Strait Islander Health Practitioner			3	1				4	1	**9**	**1**		**10**	**10**
Chinese medicine practitioner	3	2		10			13	2	3	**33**	**23**	**8**	**64**	**75**
Chiropractor	4	1	1	26	7	1	31	24	4	**99**	**55**	**32**	**186**	**162**
Dental practitioner	23	2	12	217	57	12	283	75	29	**710**	**438**	**202**	**1,350**	**1,375**
Medical practitioner	164	70	63	1,422	552	141	2,203	624	277	**5,516**	**3,022**	**1,260**	**9,798**	**9,477**
Medical radiation practitioner		2		7	3	1	14	2	11	**40**	**14**	**1**	**55**	**47**
Midwife	5	2	1	25	12	4	28	21	13	**111**	**55**	**17**	**183**	**140**
Nurse	28	13	48	561	290	104	564	262	210	**2,080**	**819**	**384**	**3,283**	**2,822**
Occupational therapist			2	15	13	2	37	8	2	**79**	**45**	**11**	**135**	**97**
Optometrist				8	10		9	7	4	**38**	**11**	**6**	**55**	**67**
Osteopath	1			3			17		1	**22**	**9**	**4**	**35**	**37**
Paramedic	2	1	3	62	22	7	34	19	17	**167**	**74**	**49**	**290**	**192**
Pharmacist	11	6	2	70	30	12	132	50	92	**405**	**463**	**57**	**925**	**928**
Physiotherapist	2	3		31	21	3	55	20	5	**140**	**82**	**28**	**250**	**211**
Podiatrist	4	2		12	4	1	11	8	1	**43**	**24**	**12**	**79**	**82**
Psychologist	26	13	9	160	75	18	245	84	25	**655**	**356**	**137**	**1,148**	**1,136**
Total 2020/21	**273**	**117**	**144**	**2,630**	**1,096**	**306**	**3,676**	**1,210**	**695**	**10,147**	**5,491**	**2,208**	**17,846**	
Total 2019/20	**227**	**220**	**151**	**2,644**	**930**	**283**	**4,178**	**1,221**	**382**	**10,236**	**5,050**	**1,572**		**16,858**

1. Matters managed by Ahpra where the conduct occurred outside NSW.
2. Matters referred by the Office of the Health Ombudsman (OHO) to Ahpra and the National Boards, where the practitioner's principal place of practice is in Qld.
3. No principal place of practice: includes practitioners with an overseas or unknown address.
4. Matters received and managed by the Health Professional Councils Authority (HPCA) in NSW.
5. Matters received and managed by OHO in Qld.
6. Includes matters managed by the HPCA and OHO.

Table 12. Number of practitioners with notifications (includes HPCA and OHO)

Profession[1]	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]	Total 2020/21[5]	Total 2019/20[5]
Aboriginal and Torres Strait Islander Health Practitioner		1	3	1	1			3		**9**	**6**
Chinese medicine practitioner	3	17		12			15	2		**49**	**66**
Chiropractor	2	49	1	33	7	1	28	18	1	**140**	**137**
Dental practitioner	20	357	7	284	48	11	237	67	4	**1,035**	**1,010**
Medical practitioner	129	2,320	47	1,962	477	131	1,750	544	19	**7,379**	**7,254**
Medical radiation practitioner		12		11	2	1	11	2		**39**	**35**
Midwife[6]	5	43	2	23	11	3	27	20	1	**135**	**122**
Nurse[7]	30	664	53	639	256	95	505	237	4	**2,483**	**2,266**
Occupational therapist		41	2	25	11	2	34	9		**124**	**81**
Optometrist	1	6		11	10		11	5		**44**	**55**
Osteopath	1	9		4			16	0		**30**	**29**
Paramedic	2	59	3	74	22	6	30	19		**215**	**152**
Pharmacist	14	304		89	32	11	140	44		**634**	**649**
Physiotherapist	2	68		42	19	4	46	20		**201**	**176**
Podiatrist	2	21		17	5	1	10	7		**63**	**73**
Psychologist	20	289	8	226	69	14	211	66		**903**	**895**
Total 2020/21	**231**	**4,260**	**126**	**3,453**	**970**	**280**	**3,071**	**1,063**	**29**	**13,483**	
Total 2019/20	**199**	**3,958**	**127**	**3,522**	**857**	**250**	**3,028**	**1,034**	**31**		**13,006**

1. Registrants whose profession has been identified and whose principal place of practice (PPP) is an Australian state or territory. Registrants whose PPP is not in Australia are represented in the 'No PPP' section.
2. Includes matters managed by the HPCA, as well as notifications managed by Ahpra about a practitioner with a PPP in NSW.
3. Includes matters managed by OHO, as well as those referred to Ahpra by OHO about a practitioner with a PPP in Qld.
4. No principal place of practice: includes practitioners with an overseas or unknown address.
5. Includes practitioners with notifications managed by the HPCA and OHO.
6. Includes registrants with midwifery or with nursing and midwifery registration.
7. Includes registrants with nursing registration or with nursing and midwifery registration.

Table 13. Percentage of all registered health practitioners with notifications (including pandemic sub-register and HPCA and OHO)

Profession[1]	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]	Total 2020/21[5]	Total 2019/20[5]
Aboriginal and Torres Strait Islander Health Practitioner		0.6%	1.5%	0.6%	1.1%			1.8%		**1.1%**	**0.7%**
Chinese medicine practitioner	4.3%	0.9%		1.3%			1.2%	0.8%		**1.0%**	**1.3%**
Chiropractor	2.9%	2.5%	3.7%	3.5%	1.8%	1.4%	1.8%	2.4%	0.5%	**2.3%**	**2.4%**
Dental practitioner	4.4%	4.8%	4.5%	5.5%	2.3%	2.8%	4.0%	2.4%	0.7%	**4.1%**	**4.1%**
Medical practitioner	5.3%	6.0%	3.2%	7.5%	5.2%	4.6%	5.5%	4.1%	0.6%	**5.7%**	**5.8%**
Medical radiation practitioner		0.2%		0.3%	0.1%	0.3%	0.3%	0.1%		**0.2%**	**0.2%**
Midwife[6]	0.7%	0.4%	0.3%	0.3%	0.4%	0.4%	0.3%	0.6%	0.2%	**0.4%**	**0.3%**
Nurse[7]	0.4%	0.5%	1.0%	0.7%	0.7%	0.9%	0.4%	0.5%	0.0%	**0.5%**	**0.5%**
Occupational therapist		0.6%	1.0%	0.5%	0.6%	0.5%	0.5%	0.3%		**0.5%**	**0.3%**
Optometrist	0.9%	0.3%		0.9%	2.5%		0.7%	1.0%		**0.7%**	**0.9%**
Osteopath	2.1%	1.4%		1.5%			0.9%			**1.0%**	**1.1%**
Paramedic	0.6%	1.1%	1.5%	1.3%	1.6%	1.0%	0.5%	1.4%		**1.0%**	**0.8%**
Pharmacist	2.0%	2.9%		1.3%	1.3%	1.2%	1.5%	1.2%		**1.8%**	**1.9%**
Physiotherapist	0.3%	0.6%		0.6%	0.6%	0.7%	0.5%	0.5%		**0.5%**	**0.5%**
Podiatrist	2.6%	1.3%		1.7%	0.9%	0.8%	0.6%	1.4%		**1.1%**	**1.3%**
Psychologist	1.8%	2.1%	2.9%	3.0%	3.4%	1.9%	1.8%	1.5%		**2.2%**	**2.2%**
Total 2020/21	**1.6%**	**1.8%**	**1.5%**	**2.1%**	**1.5%**	**1.5%**	**1.4%**	**1.3%**	**0.1%**	**1.6%**	
Total 2019/20	**1.4%**	**1.7%**	**1.5%**	**2.2%**	**1.4%**	**1.4%**	**1.4%**	**1.3%**	**0.2%**		**1.6%**

1. Registrants whose profession has been identified and whose principal place of practice (PPP) is an Australian state or territory. Registrants whose PPP is not in Australia are represented in the 'No PPP' section.
2. Includes matters managed by the HPCA, as well as notifications managed by Ahpra about a practitioner with a PPP in NSW.
3. Includes matters managed by OHO, as well as those referred to Ahpra by OHO about a practitioner with a PPP in Qld.
4. No principal place of practice: includes practitioners with an overseas or unknown address.
5. Includes practitioners with notifications managed by the HPCA and OHO.
6. Includes registrants with midwifery or with nursing and midwifery registration.
7. Includes registrants with nursing registration or with nursing and midwifery registration.

Table 13A. Percentage of registered health practitioners with notifications (excluding pandemic sub-register, including HPCA and OHO)

Profession[1]	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]	Total 2020/21[5]	Total 2019/20[5]
Aboriginal and Torres Strait Islander Health Practitioner		0.6%	1.5%	0.7%	1.2%			1.9%		**1.1%**	**0.8%**
Chinese medicine practitioner	4.3%	0.9%		1.3%			1.2%	0.8%		**1.0%**	**1.3%**
Chiropractor	2.9%	2.5%	3.7%	3.5%	1.8%	1.4%	1.8%	2.4%	0.5%	**2.3%**	**2.4%**
Dental practitioner	4.4%	4.8%	4.5%	5.5%	2.3%	2.8%	4.0%	2.4%	0.7%	**4.1%**	**4.1%**
Medical practitioner	5.4%	6.1%	3.2%	7.7%	5.4%	4.8%	5.6%	4.3%	0.6%	**5.9%**	**5.9%**
Medical radiation practitioner		0.2%		0.3%	0.1%	0.3%	0.3%	0.1%		**0.2%**	**0.2%**
Midwife[6]	0.7%	0.5%	0.3%	0.3%	0.4%	0.4%	0.3%	0.6%	0.2%	**0.4%**	**0.4%**
Nurse[7]	0.4%	0.6%	1.0%	0.7%	0.7%	0.9%	0.4%	0.6%		**0.6%**	**0.5%**
Occupational therapist		0.6%	1.0%	0.5%	0.6%	0.5%	0.5%	0.3%		**0.5%**	**0.3%**
Optometrist	0.9%	0.3%		0.9%	2.5%		0.7%	1.0%		**0.7%**	**0.9%**
Osteopath	2.1%	1.4%		1.5%			0.9%			**1.0%**	**1.1%**
Paramedic	0.6%	1.1%	1.5%	1.3%	1.6%	1.0%	0.5%	1.4%		**1.0%**	**0.8%**
Pharmacist	2.1%	3.1%		1.3%	1.4%	1.3%	1.6%	1.2%		**1.9%**	**2.0%**
Physiotherapist	0.3%	0.6%		0.6%	0.6%	0.7%	0.5%	0.5%		**0.5%**	**0.5%**
Podiatrist	2.6%	1.3%		1.7%	0.9%	0.8%	0.6%	1.4%		**1.1%**	**1.3%**
Psychologist	1.8%	2.1%	2.9%	3.0%	3.4%	1.9%	1.8%	1.5%		**2.2%**	**2.3%**
Total 2020/21	**1.6%**	**1.9%**	**1.5%**	**2.1%**	**1.6%**	**1.6%**	**1.5%**	**1.3%**	**0.1%**	**1.7%**	
Total 2019/20	**1.5%**	**1.8%**	**1.6%**	**2.3%**	**1.4%**	**1.5%**	**1.5%**	**1.4%**	**0.2%**		**1.7%**

1. Registrants whose profession has been identified and whose principal place of practice (PPP) is an Australian state or territory. Registrants whose PPP is not in Australia are represented in the 'No PPP' section.
2. Includes matters managed by the HPCA, as well as notifications managed by Ahpra about a practitioner with a PPP in NSW.
3. Includes matters managed by OHO, as well as those referred to Ahpra by OHO about a practitioner with a PPP in Qld.
4. No principal place of practice: includes practitioners with an overseas or unknown address.
5. Includes practitioners with notifications managed by the HPCA and OHO.
6. Includes registrants with midwifery or with nursing and midwifery registration.
7. Includes registrants with nursing registration or with nursing and midwifery registration.

Improvements in managing notifications

Our risk-assessment approach includes consideration of risk controls

The information we consider when deciding how to approach a practitioner who is the subject of a notification continues to evolve. We look at a practitioner's overall regulatory history, practice context and setting information. For lower level conduct concerns and concerns about a practitioner's performance, we also consider individual and organisational risk controls.

Individual risk controls are put in place by practitioners. They can include:

- appropriately reflecting on the cause of an issue that led to a notification and taking steps to reduce the likelihood of it occurring again
- engaging in further education that would improve the practitioner's practice in the future
- working with a peer, mentor or supervisor to improve the way the practitioner practises.

Organisational risk controls are put in place by an employer or workplace. They can include supervision arrangements, provision of additional training, clinical governance systems and team-based care.

Health practitioner regulation literature and our own experience shows that an overwhelming proportion of health practitioners maintain safe, professional practice.

Health practice has inherent risks, and most health practitioners constantly screen for and take steps to mitigate those risks.

When things go wrong, most practitioners respond in ways that maintain safety and professionalism.

When concerns are raised with us, it is important that we take into account the way a practitioner responded. The need for us to intervene can be reduced when we identify that the practitioner is implementing appropriate risk controls to prevent a repeat of the incident or experience.

The risk of harm to patients can also be significantly influenced by the organisation where a practitioner practises. We seek to identify organisational risk controls through our enquiries with practitioners and the places at which they practise.

When there are strong individual and organisational risk controls in place, the need for us to take regulatory action about the performance of a health practitioner is reduced.

Engaging with notifiers

We are doing more than ever to make sure notifiers know their concerns are heard and contribute to safer practice.

When a notification is made, we aim to speak to notifiers quickly. We check we have understood the notifier's concerns properly. We seek to understand the context in which the notifier's concern arose.

If we don't think the notification is one that will need regulatory action, we try to identify other ways that the concern can be addressed.

We make records of every concern in case we receive more notifications that could indicate a pattern of behaviour that requires action by us, by an employer or by another regulator.

We provide notification outcomes in writing for all notifications. In addition, wherever it is possible, we also provide decisions and explanations over the phone. If we have relied on individual or organisational risk controls in our decisions, we tell the notifier what those risk controls are. This helps us explain how the notification process contributes to safer professional services provided by practitioners.

Engaging with practitioners to support safe, professional practice

Our preferred method of engagement with practitioners who are the subject of a notification has changed. We made investigations into less complex performance concerns about practitioners less adversarial – by scheduling early, in-depth discussions with them.

When we are assessing whether we need to intervene in a practitioner's practice, hearing firsthand reflections from a practitioner really helps.

Understanding and validating the steps practitioners take to ensure their practice continues to be safe and professional has become an important role for our frontline staff. We're working to ensure our team members have the skills and confidence to engage practitioners in reflective conversations focused on ways to ensure future practice protects the public.

Surveying notifiers and practitioners

We made significant changes to the survey questions for notifiers and practitioners to allow us to get feedback, identify issues and track improvements.

In addition to ensuring feedback was attributable to a specific matter (to identify our activities that were more often leading to poor experiences) we worked with the NSW Health Care Complaints Commission (HCCC) to benchmark experience data across our two organisations. We changed our survey questions to align with survey questions sent by the HCCC to enable us to compare results.

Benchmarking with another regulator helps to interpret results and set targets for improvement with a comparable organisation.

Confidentiality safeguards for notifiers

We continued to strengthen confidentiality safeguards for notifiers by acting on the recommendations of the independent review by the National Health Practitioner Ombudsman (NHPO) *Review of confidentiality safeguards for people making notifications about health practitioners*. We requested the review after the conviction of a medical practitioner for the attempted murder of a pharmacist who raised concerns about the practitioner's prescribing practices.

The review made 10 recommendations, and we have now implemented most of them. Of the two outstanding recommendations, one is waiting on a change to the National Law, and the other involves an IT system upgrade, which is scheduled for completion by mid-2022.

In a very small number of complaints we find the person who complained was wanting to do harm. Vexatious complaints are rare, but they can cause enormous damage.

Vexatious complaints

We consulted on and published a *Framework for identifying and dealing with vexatious notifications*. The framework supports our identification and management of potentially vexatious complaints.

This resource was developed based on recommendations outlined in the *Review of confidentiality safeguards for people making notifications about practitioners* conducted by the NHPO.

It builds on a research report published in 2018, *Reducing, identifying and managing vexatious complaints: Summary report of a literature review prepared for the Australian Health Practitioner Regulation Agency*. This research was the first international literature review of vexatious complaints in health practitioner regulation. The report found that the number of vexatious complaints dealt with in Australia and internationally is very small, representing less than 1.0%, but concluded that these complaints have a big effect on everyone involved.

Sharing information with employers

We engaged with major public and private health services who employ health practitioners to talk about our joint roles in protecting the public through ensuring practitioners' delivery of safe care.

This was the start of a broader campaign to ensure that our role as regulator in the broader patient safety network is better understood and the information-sharing provisions of the National Law are maximised.

Assessing the risk

Matthew Hardy, Notifications National Director, explains:

A psychologist's client made a notification about the way she had been treated following her recent relationship breakdown.

The concerns raised were about the practitioner's communication, whether it was appropriate for the practitioner to contact the notifier's former partner and that the practitioner had failed to tell her client that she had treated the client's former partner.

The practitioner has been registered since 2001 and has had no previous notifications. The clinical input team provided information about the clinical aspects of the notification and we sought to understand more about the practitioner, how she practises and what the risk for other clients was.

The practitioner subsequently provided her version of events, accepting that the notifier experienced distress and, although unintended, the practitioner had now reflected on this. The practitioner acknowledged that with hindsight her communication was inappropriate, and provided evidence of education she had undergone through the Australian Psychological Society.

The matter was considered by the Psychology Board of Australia and the Board decided that no further action was required. The Board was satisfied that the steps taken by the practitioner, including her insight, reflection, remorse, engagement with her supervisor about the matter and completion of education in ethics and communication, demonstrated a commitment to safe, professional practice.

We explained these outcomes to the notifier in a telephone conversation and followed up the explanation with written notice of the actions implemented by the practitioner and her supervisor.

We understand that even safe, professional practitioners will have things that go wrong – but will respond to those issues in safe and professional ways. The Board could be satisfied that the practitioner's own reflections and actions were enough to address any possible shortcomings in her practice.

Investigating a notification

Monica Lambley, National Manager, Notifications (Program Support) explains:

We considered three notifications about a general surgeon who was offering a high-risk surgical procedure in a remote location. When successful, the surgery could be lifesaving. However, it was not uncommon for the surgery to be stopped midway through if the surgeon assessed it was too dangerous.

The surgeon was the only practitioner performing this surgery in the remote location. If they stopped doing it, seriously ill patients would have to travel to a larger centre and undergo surgery without the support of family and friends.

Given the town's small population, the procedure was not performed often.

Two of the notifications related to events that occurred in 2016 and 2017.

In 2019, the surgeon's employer conducted an extensive review of the procedure to determine whether it should be performed in this location. They have since taken action to mitigate identified risks with the surgeon's performance, and the surgeon has also implemented appropriate individual risk controls including working with other surgeons to improve their skills and knowledge.

When the notifications were made, the hospitals where the procedures were performed did not have extensive support from intensive care and other surgeons.

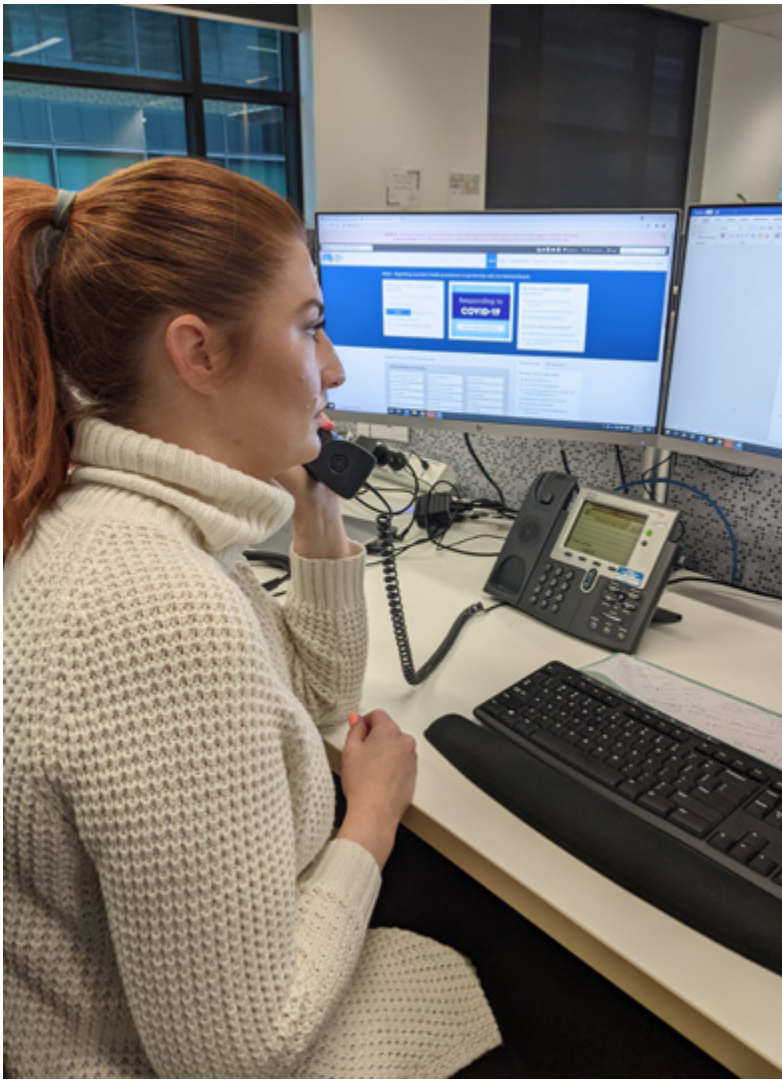
In our investigations we interviewed the employer to discuss organisational risk controls and we interviewed the practitioner to discuss individual risk controls.

Due to the extensive organisational and individual risk controls put in place, the Medical Board then determined that no further action needed to be taken. The Board also considered and gave positive feedback about this approach.

The information we received from the notifiers in these cases gave us a trigger to make enquiries and satisfy ourselves this practitioner was not putting patients at risk of harm. We investigated whether the practitioner posed an ongoing risk to the public – rather than just focusing on the incidents that had led to the notifications.

This approach is part of a strategy to transform the way we investigate practitioners who are subject to performance concerns.

It is consistent with Ahpra's primary purpose to protect the public by supporting safe and professional practitioners delivering healthcare.



We updated and republished the *Regulatory guide*, which is a comprehensive guide on how we manage notifications about the health, performance and conduct of practitioners under Part 8 of the National Law.

Notifications are made about students too

- **42** notifications were made to Ahpra about students; this is down from 44 last year.
- **11.6%** increase in the proportion of notifications resulting in conditions or undertakings affecting a student's registration compared to last year.

Table 14. Student notifications received

Profession	Ahpra									Ahpra subtotal 2020/21	HPCA[2]	OHO[3]	Total 2020/21	Total 2019/20[4]
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[1]					
Aboriginal and Torres Strait Islander Health Practitioner										0			0	1
Chinese medicine practitioner										0	1		1	0
Chiropractor									1	1			1	0
Dental practitioner									2	2	1		3	3
Medical practitioner									4	4	7	1	12	11
Medical radiation practitioner									3	3			3	4
Midwife									1	1			1	4
Nurse				4				2	18	24	26	1	51	49
Occupational therapist									1	1			1	6
Optometrist										0			0	0
Osteopath										0			0	1
Paramedic										0	2		2	1
Pharmacist							1		4	5	2		7	5
Physiotherapist									1	1			1	1
Podiatrist										0			0	0
Psychologist										0	1		1	0
Total 2020/21	0	0	0	4	0	0	1	2	35	42	40	2	84	
Total 2019/20	0	0	0	0	2	0	4	2	36	44	42			86

1. No principal place of practice: includes students with an overseas or unknown address.
2. Matters received and managed by the HPCA in NSW.
3. Matters received and managed by OHO in Qld.
4. Includes matters managed by Ahpra and HPCA.

Table 15. Outcomes of notifications about students by stage at closure

Stage at closure		Assessment	Health or performance assessment	Investigation	Panel hearing	Tribunal hearing	Total 2020/21	Total 2019/20
No further action	Ahpra	22	1	8			31	41
	HPCA[1]	7	2		3		12	15
Impose conditions	Ahpra		6	1			7	2
	HPCA				4		4	6
Accept undertaking	Ahpra						0	1
	HPCA						0	0
Caution	Ahpra						0	0
	HPCA						0	0
Cancel registration	Ahpra						0	0
	HPCA						0	0
No jurisdiction	Ahpra						0	0
	HPCA	1					1	10
Refer to other entity	Ahpra						0	0
	HPCA	1		2			3	0
Discontinue	Ahpra						0	0
	HPCA	25					25	13
Counselling	Ahpra						0	0
	HPCA						0	0
Surrender	Ahpra						0	0
	HPCA						0	0
Withdrawn	Ahpra						0	0
	HPCA						0	0
Total 2020/21		56	9	11	7	0	83	
Total 2019/20		57	14	12	5	0		88

1. Matters managed by the HPCA in NSW.

Where applicable, practitioners and employers must tell us if they think another practitioner's conduct, health impairment or performance places their patients at risk

They have mandatory reporting obligations.

Mandatory notifications made up **12.5%** of notifications received.

We received **1,266** mandatory notifications; **14.4%** more (159 notifications) than in 2019/20.

- **29.6%** were about medical practitioners
- **47.6%** were about nurses
- the number of mandatory notifications about impairment (**453**) is up from 322 in 2019/20
- immediate action arising from mandatory notifications was considered on **351** occasions and taken **271** times.

Table 16. Mandatory notifications received

Profession	Ahpra									Ahpra subtotal 2020/21	HPCA[4]	OHO[5]	Total 2020/21[6]	Total 2019/20[6]
	ACT	NSW[1]	NT	QLD[2]	SA	TAS	VIC	WA	No PPP[3]					
Aboriginal and Torres Strait Islander Health Practitioner			2					1	1	4	1		5	1
Chinese medicine practitioner							1			1	1		2	4
Chiropractor				2			1	2		5	4		9	9
Dental practitioner	3	1		4	5	1	13	7	4	38	4		42	51
Medical practitioner	15	10	5	65	54	16	133	69	8	375	128	19	522	450
Medical radiation practitioner		1		1	1	1	2		1	7	4		11	12
Midwife	1	1		9	2	1	11	5	1	31	14		45	36
Nurse	7	5	12	130	103	39	194	99	13	602	251	44	897	799
Occupational therapist			1	1	3		6	2		13	6		19	8
Optometrist				1	3			2		6	2		8	2
Osteopath							1			1		1	2	5
Paramedic		1	1	17	5	6	10	9	1	50	23	13	86	71
Pharmacist			1	2	4	6	15	11	3	42	25	1	68	71
Physiotherapist				2	5		4	6	1	18	8	3	29	25
Podiatrist						1	4	1		6	3		9	5
Psychologist	3	1	1	13	7	1	25	16		67	35		102	95
Total 2020/21	**29**	**20**	**23**	**247**	**192**	**72**	**420**	**230**	**33**	**1,266**	**509**	**81**	**1,856**	
Total 2019/20	**37**	**28**	**35**	**174**	**176**	**56**	**369**	**210**	**22**	**1,107**	**489**	**48**		**1,644**

1. Matters managed by Ahpra where the conduct occurred outside NSW.
2. Matters referred by OHO to Ahpra and the National Boards where the practitioner's principal place of practice is in Qld.
3. No principal place of practice: includes practitioners with an overseas or unknown address.
4. Mandatory notifications received and managed by the HPCA in NSW.
5. Matters received and managed by OHO in Qld.
6. Includes matters managed by the HPCA and OHO.

Table 17. Grounds for mandatory notification by profession

Profession	Standards		Impairment		Alcohol or drugs		Sexual misconduct		Total 2020/21		Total 2019/20	
	Ahpra	HPCA[1]	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA
Aboriginal and Torres Strait Islander Health Practitioner	3		1			1			4	1	1	0
Chinese medicine practitioner	1	1							1	1	4	0
Chiropractor	3	2	1	1	1			1	5	4	8	1
Dental practitioner	19	3	18	1	1				38	4	32	17
Medical practitioner	164	83	114	24	25	7	72	14	375	128	325	107
Medical radiation practitioner	2	3	4	1			1		7	4	6	6
Midwife	12	10	16	3	3	1			31	14	23	13
Nurse	284	169	241	42	53	25	24	15	602	251	533	245
Occupational therapist	7	5	2	1	2		2		13	6	4	4
Optometrist	2	2	2				2		6	2	2	0
Osteopath							1		1	0	2	2
Paramedic	26	12	10	4	9	3	5	4	50	23	41	27
Pharmacist	21	23	18	1	3	1			42	25	46	24
Physiotherapist	7	4	4	2			7	2	18	8	14	10
Podiatrist	3	1	2	1	1	1			6	3	2	3
Psychologist	35	25	20	5	1	2	11	3	67	35	64	30
Total 2020/21	**589**	**343**	**453**	**86**	**99**	**41**	**125**	**39**	**1,266**	**509**		
Total 2019/20	**633**	**317**	**322**	**131**	**92**	**3**	**60**	**38**			**1,107**	**489**

1. Matters managed by the HPCA in NSW.

The often serious nature of mandatory notifications is reflected in the outcomes.

- **31.3%** of completed mandatory notifications resulted in regulatory action being taken (compared to 14.2% for all notification categories).

Regulatory action taken about mandatory notifications is down from 35.8% in 2019/20.

Table 18. Outcomes of mandatory notifications closed, by profession

	Profession	Aboriginal and Torres Strait Islander Health Practitioner	Chinese medicine practitioner	Chiropractor	Dental practitioner	Medical practitioner	Medical radiation practitioner	Midwife	Nurse	Occupational therapist	Optometrist	Osteopath	Paramedic	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Total 2020/21	Total 2019/20
Discontinued/ proceedings withdrawn	**Ahpra**																	**0**	**0**
	HPCA			1	3	38	1	1	31	2	1			1	1		9	**89**	**114**
Changed to non-practising	**Ahpra**																	**0**	**0**
	HPCA					1			8									**9**	**5**
Other/no jurisdiction	**Ahpra**																	**0**	**0**
	HPCA[1]		1	1		8	1		15	2					4		2	**34**	**48**
Counselling	**Ahpra**																	**0**	**0**
	HPCA			1		1		1	13					1	1			**18**	**29**
No further action	**Ahpra**		2	3	24	177	4	17	363	9	1	1	24	33	9	4	47	**718**	**653**
	HPCA	1		1	4	24	4	9	83			1	10	3		2	9	**151**	**165**
Refer notification to another body	**Ahpra**					3			7								1	**11**	**16**
	HPCA				3	6			6				1	4	1		3	**24**	**29**
Health complaints entity to retain	**Ahpra**																	**0**	**2**
	HPCA																	**0**	**0**
Fine registrant	**Ahpra**					3												**3**	**1**
	HPCA																	**0**	**0**
Orders – no conditions	**Ahpra**																	**0**	**0**
	HPCA																	**0**	**0**
Caution or reprimand	**Ahpra**	1	2	1	2	16		1	33				10	6			5	**77**	**95**
	HPCA					1			3					3				**7**	**7**
Accept undertaking	**Ahpra**					10	1		18				1	1			1	**32**	**34**
	HPCA																	**0**	**0**
Impose conditions	**Ahpra**			3	5	47	1	5	119	1			3	4	1		4	**193**	**221**
	HPCA[2]		1		3	18		2	69				10	4	1	2	3	**113**	**109**
Accept surrender of registration	**Ahpra**																	**0**	**0**
	HPCA					2			1				1					**4**	**7**
Suspend registration	**Ahpra**	2				3			4					2				**11**	**6**
	HPCA					1			3									**4**	**8**
Cancel registration/ disqualify	**Ahpra**					5			10		1							**16**	**17**
	HPCA					5			9									**14**	**23**
Total 2020/21	**Ahpra**	**3**	**4**	**7**	**31**	**264**	**6**	**23**	**554**	**10**	**2**	**1**	**38**	**46**	**10**	**4**	**58**	**1,061**	
	HPCA	**1**	**2**	**4**	**13**	**105**	**6**	**13**	**241**	**4**	**1**	**1**	**22**	**16**	**8**	**4**	**26**	**467**	
Total 2019/20	**Ahpra**	**2**	**3**	**3**	**40**	**326**	**8**	**16**	**499**	**4**	**3**	**3**	**20**	**36**	**14**	**8**	**60**		**1,045**
	HPCA	**0**	**0**	**4**	**19**	**97**	**6**	**15**	**298**	**7**	**0**	**0**	**30**	**17**	**12**	**2**	**37**		**544**

1. Includes practitioners who failed to renew.
2. Includes conditions by consent.

National Boards can take immediate action when serious concerns are raised

- Immediate action was taken **597** times, **2.9%** (17) more times than in 2019/20.
- Immediate action was taken on **5.9%** of notifications received.
- This is a similar proportion of immediate action taken as a percentage of notifications received in previous years (5.7% in 2019/20 and 4.1% in 2018/19).

This interim action protects the public while more information is obtained.

Table 19. Immediate action taken

Type of immediate action taken	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16
Registration surrendered	**3.4%**	2.6%	2.9%	0.2%	0.3%	1.6%
Accept undertaking	**21.9%**	23.4%	29.9%	27.3%	21.6%	17.8%
Impose conditions	**31.2%**	34.7%	33.9%	42.0%	45.9%	60.9%
Suspended	**43.6%**	39.3%	33.3%	30.4%	32.2%	19.7%

Table 20. Immediate action cases

Profession	No action taken			Action taken[1]												Decision pending[2]			Total 2020/21			Total 2019/20		
				Suspend registration			Accept surrender of registration			Impose conditions			Accept undertaking												
	Ahpra	HPCA[3,4]	OHO[5]	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO
Aboriginal and Torres Strait Islander Health Practitioner	1				1														**1**	**1**	**0**	**0**	**0**	**0**
Chinese medicine practitioner	3	2		1	1			1		1	4	1				1		1	**6**	**8**	**2**	**2**	**11**	**0**
Chiropractor	8	1		8	2					4	2	1				2			**22**	**5**	**1**	**10**	**2**	**0**
Dental practitioner	8	7	1	7	9		1			9	3	1	8			3			**36**	**19**	**2**	**46**	**39**	**2**
Medical practitioner	126	33	6	81	25		9	11		69	103	7	36			50		1	**371**	**172**	**14**	**340**	**181**	**49**
Medical radiation practitioner	2			3				1		2			1						**8**	**1**	**0**	**4**	**0**	**0**
Midwife	3	3		4	1					1	2		5			1			**14**	**6**	**0**	**10**	**4**	**1**
Nurse	65	29	6	123	33	3	6	1		48	91	10	69			30		2	**341**	**154**	**21**	**296**	**156**	**28**
Occupational therapist	1			2						1	4								**4**	**4**	**0**	**2**	**3**	**0**
Optometrist	1			1															**2**	**0**	**0**	**1**	**0**	**0**
Osteopath	3	1					1			2									**6**	**1**	**0**	**2**	**1**	**1**
Paramedic	5	2	3	6	4		2			11	5	1	4			1		1	**29**	**11**	**5**	**21**	**12**	**6**
Pharmacist	4	10	3	14	27	1	1			8	54		4					1	**31**	**91**	**5**	**50**	**83**	**1**
Physiotherapist	3		2	2						5	6	1	1			1			**12**	**6**	**3**	**14**	**6**	**6**
Podiatrist	1			2						1	3								**4**	**3**	**0**	**1**	**2**	**1**
Psychologist	9	3	3	6	3			2		24	11	3	3			2		1	**44**	**19**	**7**	**38**	**17**	**5**
Total 2020/21	**243**	**91**	**24**	**260**	**106**	**4**	**20**	**16**		**186**	**288**	**25**	**131**	**0**		**91**	**0**	**7**	**931**	**501**	**60**			
Total 2019/20	**175**	**113**	**58**	**228**	**79**	**9**	**15**	**23**		**201**	**302**	**25**	**136**	**0**		**82**	**0**	**8**				**837**	**517**	**100**

1. Cases where immediate action has been initiated under Part 8, Division 7 of the National Law.
2. Where immediate action was initiated towards the end of the reporting year and a decision has not been finalised.
3. Matters managed by the HPCA in NSW.
4. Excludes matters that were considered for immediate action but did not proceed to a hearing; includes matters where the case did not proceed because the practitioner surrendered registration.
5. Matters received and managed by OHO in Qld.

There must be proper boundaries in a practitioner–patient relationship

The small number of practitioners who breach appropriate professional boundaries with patients cause immense harm.

We received 568 notifications involving a possible failure to maintain appropriate professional boundaries. These can range from comments made by a practitioner to a patient during a consultation, or even online, that are deemed inappropriate when considered against the relevant National Board's *Code of conduct*, to inappropriate sexual relationships or even unlawful sexual acts. This was:

- **22.4%** more than we received last year (464)
- **83.5%** were made about practitioners in three professions:
  - medical practitioners (53.2%)
  - nurses (19.5%)
  - psychologists (10.7%).

Boundary notifications received were:

- **5.5%** of all medical practitioner notifications
- **5.3%** of all nurse notifications
- **9.3%** of all psychologist notifications.

Immediate action was considered on 258 occasions and taken 161 times, with 34 matters yet to be decided at 30 June. Of the immediate action taken:

- **52.2%** was about medical practitioners
- **19.9%** was about nurses
- **10.6%** was about psychologists.

Boundary notifications had a higher proportion of suspensions through immediate action (**34.9%**) compared to all notifications (27.9%). National Boards:

- imposed conditions (16.7%)
- accepted an undertaking (7.0%)
- after consideration, decided not to take immediate action (24.4%).

The serious nature is reflected in the outcomes. Action was taken more often about boundary notifications:

- **10.3%** resulted in a caution or reprimand (compared to 5.0% for all notifications)
- **12.8%** resulted in conditions being imposed on a practitioner's registration (compared to 7.2% for all)
- **5.0%** resulted in a practitioner's registration being surrendered, suspended or cancelled (compared to 0.7% for all).

The higher risk profile of boundary matters is also reflected in the stage of closure:

- **53.5%** closed following an investigation (compared to 24.5% for all notifications)
- **34.5%** closed at assessment (compared to 72.5% for all notifications).
- **9.2%** closed after referral to a tribunal (compared to 1.2% for all notifications).

Table 21. Boundary notifications received

Profession	ACT	NSW[1]	NT	QLD[2]	SA	TAS	VIC	WA	No PPP[3]	Total 2020/21	Total 2019/20
Aboriginal and Torres Strait Islander Health Practitioner										**0**	**0**
Chinese medicine practitioner	2			1						**3**	**5**
Chiropractor				3			2	9	1	**15**	**11**
Dental practitioner				3	1		3			**7**	**4**
Medical practitioner	12	6	5	58	27	12	134	40	8	**302**	**209**
Medical radiation practitioner				1			6		1	**8**	**1**
Midwife		1		1					1	**3**	**2**
Nurse			2	22	25	5	37	11	9	**111**	**100**
Occupational therapist					3		3	1		**7**	**4**
Optometrist				1				2		**3**	**2**
Osteopath							2			**2**	**6**
Paramedic	1			5	1	3	5		3	**18**	**11**
Pharmacist				2			2			**4**	**6**
Physiotherapist	1			3	4		11	5		**24**	**19**
Podiatrist										**0**	**3**
Psychologist	9		2	19	4	1	20	5	1	**61**	**81**
Total 2020/21	**25**	**7**	**9**	**119**	**65**	**21**	**225**	**73**	**24**	**568**	
Total 2019/20	**14**	**5**	**6**	**93**	**58**	**20**	**193**	**64**	**11**		**464**

1. Matters managed by Ahpra where the conduct occurred outside NSW.
2. Matters referred by OHO to Ahpra and the National Boards, where the practitioner's principal place of practice is in Qld.
3. No principal place of practice: includes practitioners with an overseas or unknown address.

Some practitioners have several notifications made about them over time

We received 10,147 notifications about 7,858 practitioners: 4,839 practitioners (61.6%) hadn't had a notification made about them before and 3,019 (38.4%) had had a notification made about them in previous reporting years.

Table 22 looks at the notifications received about the practitioners in each profession and gives a percentage breakdown as to whether:

- it was the first time we had received a notification about the practitioner or
- the practitioner had been notified to us previously.

Of those medical practitioners who received a notification this year, 51.3% (2,172) had had a notification made about them in previous years. For dental practitioners who received a notification this year, 45.5% (251) had had a notification made about them in previous years.

Table 22. Practitioners with a notification received this year and whether we had received a notification about them before – by percentage

Profession	First-time notified[1]	Notified in a previous year	Total
Aboriginal and Torres Strait Islander Health Practitioner	85.7%	14.3%	**100%**
Chinese medicine practitioner	68.0%	32.0%	**100%**
Chiropractor	69.1%	30.9%	**100%**
Dental practitioner	54.5%	45.5%	**100%**
Medical practitioner	48.7%	51.3%	**100%**
Medical radiation practitioner	96.3%	3.7%	**100%**
Midwife	85.9%	14.1%	**100%**
Nurse	84.5%	15.5%	**100%**
Occupational therapist	88.6%	11.4%	**100%**
Optometrist	78.1%	21.9%	**100%**
Osteopath	90.0%	10.0%	**100%**
Paramedic	97.0%	3.0%	**100%**
Pharmacist	67.7%	32.3%	**100%**
Physiotherapist	86.4%	13.6%	**100%**
Podiatrist	73.0%	27.0%	**100%**
Psychologist	69.1%	30.9%	**100%**
Total	**61.6%**	**38.4%**	**100%**

1. Where a notification was received about the practitioner for the first time this year and subsequent notifications were also received about the practitioner this year, the practitioner is included as 'first-time notified'.

Of the 3,019 practitioners who had had a notification made about them in a previous reporting year, 71.9% (2,172) were medical practitioners, 8.5% (256) were nurses and 8.3% (251) were dental practitioners.

For 80% of the practitioners who were the subject of a regulatory action it was for the first time

Regulatory action was taken about 1,213 practitioners. The notification may have been received in a previous year and the action taken may have been about one or more notifications.

Most regulatory action (80.5%) was taken about a practitioner who had not had regulatory action taken about them before. A regulatory action was taken about 976 practitioners for the first time, and 237 practitioners (19.5%) had been subject to a regulatory action before.

In very serious cases, multiple notifications about a practitioner can be referred to a tribunal for it to make a decision about all open notifications about the practitioner at the same time.

We take every notification seriously – we assess them all

In 70% of cases, after our initial assessment, we had enough information to close the notification.

Following an assessment, 70.8% of notifications were closed and did not require an investigation:

- in **73.4%** of these cases the National Board decided that regulatory action was not required
- in **15.8%** of these cases, it was decided that a complaint raised with a health complaints entity (HCE) would be retained by it
- in **10.7%** of these cases, the National Board took regulatory action by: referring the notification to another body, cautioning the practitioner, imposing conditions on registration, or accepting an undertaking.

When a National Board decided after the initial assessment that regulatory action was not required, common reasons included:

- a reasonable standard had been met by the practitioner
- when we consider it in the context of everything we know about the practitioner and their practice, we have confidence that patients will be able to safely access services from the practitioner in the future
- when we consider the response to the concerns from the practitioner, including their reflections on what could be done better and any changes to practice they have implemented, there is no need for further action by the National Board
- when we consider the environment in which the concern arose, we have confidence that employers and other health service organisations who have important roles to play in patient safety have taken proper steps to ensure future patients are protected.

Does the Board always decide to investigate?

- No – a National Board decides to investigate practitioners only when there is a potential risk and insufficient information to make a properly informed decision.
- **27.4%** of notifications progressed from assessment to investigation because the National Board required more information before it could make an informed decision (26.2% in 2019/20 and 29.6% in 2018/19).
- **3,172** notifications about 2,447 practitioners were referred for investigation.

How long does it take to close notifications?

- We closed **10,121** notifications:
  - **8.9%** more than in 2019/20 (9,291)
  - the highest number since the National Scheme started
  - **14.2%** resulted in regulatory action about a practitioner
  - **14.7%** were referred to another body; or to a health complaints entity for consideration of early resolution, conciliation or other complaint resolution outcome
  - **71.1%** resulted in the National Board deciding that regulatory action was not required:
    - → while there is no threshold that needs to be met to make a notification, National Boards can elect to close a notification if it considers it unlikely to result in action – this happened in about 50% of these notifications
    - → in 9.0% of these cases, the practitioner had taken steps to address the concerns expressed in the notification, or steps that meant that any risk to future patients was being adequately addressed
    - → in 23.7% of these cases no action was required after an investigation
- **37.0%** of all notifications were closed in less than three months
- **72.0%** were closed in less than six months:
  - this is a slight improvement on last year (71.6% in 2019/20) and the year before that (68.2% in 2018/19)
- the average time taken to close matters in assessment increased to **105 days,** from 100 days
- **21.1%** of notifications were open for longer than 12 months, up from 15.4%
- **1.7%** increase in the average time taken to complete notifications, from 177 to 180 days
- **19.6%** increase in the average age of open notifications, from 209 to 250 days.

Figure 82. Average time to close notifications

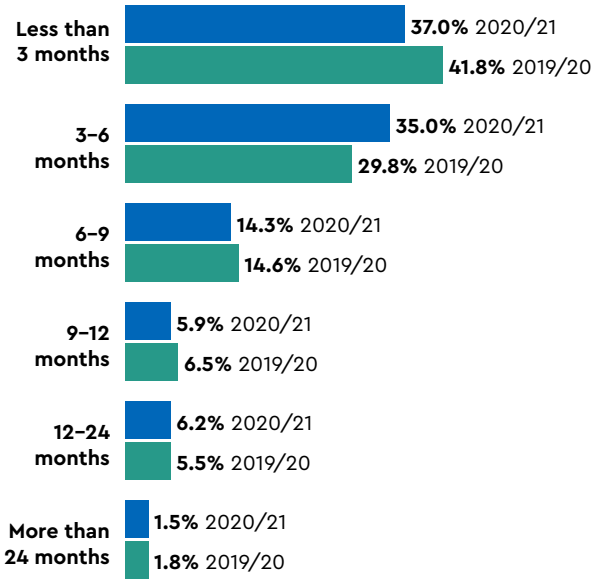


Table 23. Closed notification outcomes

Closed notification outcomes	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
No further action	66.5%	68.6%	72.0%	69.5%	69.5%	**71.1%**
Caution or reprimand	13.8%	14.2%	11.5%	7.4%	4.6%	**5.0%**
Impose conditions	11.1%	10.6%	9.7%	8.0%	7.3%	**7.2%**
Accept undertaking	3.5%	2.2%	2.2%	1.2%	1.1%	**1.3%**
Refer to an HCE or other entity	3.3%	3.2%	3.4%	12.9%	16.5%	**14.7%**
Registration surrendered, suspended or cancelled	1.9%	1.2%	1.0%	0.9%	0.9%	**0.7%**
Registrant fined			0.2%	0.1%	0.1%	**<0.1%**

Table 24. Timeframes for matters in assessment

Average time (in days) to:	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Close matters in assessment	82	84	82	70	100	**105**
Complete assessments and move to another stage	48	51	42	39	53	**46**

Table 25. Notifications closed, by stage at closure

Profession	Assessment		Investigation		Health or performance assessment		Panel hearing		Tribunal hearing		Subtotal 2020/21		Total 2020/21	Total 2019/20
	Ahpra	HPCA[1]	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA[4]	Ahpra	HPCA		
Aboriginal and Torres Strait Islander Health Practitioner			6			1			3		9	1	**10**	**11**
Chinese medicine practitioner	20	16	11	3		1		8	1		32	28	**60**	**75**
Chiropractor	42	56	34		3	1		1	1		80	58	**138**	**138**
Dental practitioner	562	382	187	12	4	19		36	4	4	757	453	**1,210**	**1,190**
Medical practitioner	4,204	2,267	1,132	19	54	199	7	108	48	64	5,445	2,657	**8,102**	**8,113**
Medical radiation practitioner	22	8	8		1	2					31	10	**41**	**49**
Midwife	69	50	39		5	1		3	3		116	54	**170**	**113**
Nurse	1,220	598	676	4	79	61	4	83	42	34	2,021	780	**2,801**	**2,435**
Occupational therapist	59	26	9		2	1		2			70	29	**99**	**83**
Optometrist	40	11	9						1		50	11	**61**	**60**
Osteopath	12	7	7								19	7	**26**	**23**
Paramedic	76	47	43		6	5	1	15			126	67	**193**	**121**
Pharmacist	348	280	110	11	6	14	1	15	11	17	476	337	**813**	**646**
Physiotherapist	103	65	23		1	5	1	3	2		130	73	**203**	**166**
Podiatrist	29	14	15			2		3			44	19	**63**	**83**
Psychologist	529	276	169		10	10	2	8	5		715	294	**1,009**	**918**
Total 2020/21	**7,335**	**4,103**	**2,478**	**49**	**171**	**322**	**16**	**285**	**121[2,3]**	**119**	**10,121**	**4,878**	**14,999**	
Total 2019/20	**6,842**	**4,200**	**2,014**	**71**	**264**	**330**	**25**	**218**	**146[5]**	**114**	**9,291**	**4,933**		**14,224**

1. Matters managed by the HPCA in NSW.
2. Excludes six matters that proceeded from compliance monitoring.
3. One matter closed at tribunal stage didn't progress to a tribunal. This was due to a data entry error.
4. Excludes appeals.
5. The number of cases closed at tribunal stage included five matters that did not progress to a tribunal. Two were due to data entry errors and in three matters a Board decided not to proceed to filing in the tribunal.

Table 26. Notifications closed, by outcome, Ahpra

Profession	No further action	Refer all or part of the notification to another body	HCE to retain[1]	Accept undertaking	Caution or reprimand	Fine registrant	Impose conditions	Accept surrender of registration	Suspend registration	Cancel registration	Total 2020/21[2]	Total 2019/20
Aboriginal and Torres Strait Islander Health Practitioner	1				5				3		**9**	**9**
Chinese medicine practitioner	26		1		2		2		1		**32**	**38**
Chiropractor	43	1	6	1	10		18			1	**80**	**84**
Dental practitioner	490	33	124	6	23		80			1	**757**	**730**
Medical practitioner	3,868	216	799	61	202	3	272	1	10	13	**5,445**	**5,498**
Medical radiation practitioner	20	2	1	2	3		3				**31**	**30**
Midwife	88	3	4	2	1		15		1	2	**116**	**56**
Nurse	1,473	52	118	31	98	1	220		9	19	**2,021**	**1,624**
Occupational therapist	60	1	4		2		3				**70**	**45**
Optometrist	37	2	4		3		3			1	**50**	**36**
Osteopath	15	1			1		2				**19**	**15**
Paramedic	94		7	1	15		9				**126**	**65**
Pharmacist	335	21	23	9	61	1	22		3	1	**476**	**336**
Physiotherapist	93	3	9	1	12		11			1	**130**	**101**
Podiatrist	24	2	2	1	9		6				**44**	**44**
Psychologist	526	17	34	13	59		64		1	1	**715**	**580**
Total 2020/21	**7,193**	**354**	**1,136**	**128**	**506**	**5**	**730**	**1**	**28**	**40**	**10,121**	
Total 2019/20	**6,460**	**177**	**1,353**	**99**	**430**	**8**	**682**	**4**	**37**	**41**		**9,291**

1. Health complaints entity.
2. A matter may result in more than one outcome. Only the most serious outcome from each closed notification has been noted.

Table 27. Notifications closed by outcome, HPCA

Profession	Aboriginal and Torres Strait Islander Health Practitioner	Chinese medicine practitioner	Chiropractor	Dental practitioner	Medical practitioner	Medical radiation practitioner	Midwife	Nurse	Occupational therapist	Optometrist	Osteopath	Paramedic	Pharmacist	Physiotherapist	Podiatrist	Psychologist	Total 2020/21	Total 2019/20
No further action[1]	1	9	4	171	315	5	19	211	4	3	5	22	65	9	4	63	**910**	**925**
No jurisdiction[2]		3	3	3	36	2		31	2	2		6	4	6	2	12	**112**	**126**
Discontinued		5	29	188	1,897	3	31	335	21	5	2	17	139	42	10	177	**2,901**	**2,908**
Withdrawn		1	2	21	91			4	1			3	21	2		17	**163**	**115**
Make a new complaint																	**0**	**0**
Refer all or part of the notification to another body			7	21	93		1	6				1	23	6		13	**171**	**334**
Caution				8	3			1									**12**	**14**
Reprimand				1	1			5					8			1	**16**	**37**
Orders – no conditions																	**0**	**1**
Finding – no orders								1									**1**	**2**
Counselling/ interview		2	12	12	5		1	42		1		3	46	7		1	**132**	**103**
Resolution/ conciliation by HCCC																2	**2**	**3**
Fine																	**0**	**0**
Refund/ payment/ withhold fee/ re-treat																	**0**	**0**
Conditions by consent		5	1	4	66		1	92					13		1	2	**185**	**107**
Order – impose conditions; would be conditions if registered		1		19	93		1	6	1			14	11	1	2	4	**153**	**178**
Accept surrender		2		4	15			2				1	1			3	**28**	**31**
Accept registration type change to non-practising				6	3			13									**22**	**16**
Suspend					23			7									**30**	**26**
Cancelled registration/ disqualified from registering				4	37			27					14				**82**	**59**
Total 2020/21	**1**	**28**	**58**	**462**	**2,678**	**10**	**54**	**783**	**29**	**11**	**7**	**67**	**345**	**73**	**19**	**295**	**4,920**	
Total 2019/20	**2**	**37**	**55**	**470**	**2,642**	**19**	**57**	**819**	**38**	**24**	**8**	**56**	**315**	**65**	**39**	**339**		**4,985**

Source: Data supplied by the HPCA. NSW legislation provides for a range of different outcomes for complaints in NSW. Some map to outcomes available; others are specific to the NSW jurisdiction. Each notification may have more than one outcome; all outcomes have been included.

1. Includes: Resolved before assessment, Apology, Advice, Council letter, Comments by Health Care Complaints Commission (HCCC), Deceased, Interview.
2. Includes practitioners who failed to renew.

Table 28. Open notifications by length of time at each stage, 30 June

Current stage of open notification	Less than 3 months	3–6 months	6–9 months	9–12 months	12–24 months	More than 24 months	Total 2020/21	Total 2019/20
Assessment	1,418	526	75	18	2		**2,039**	**2,342**
Health or performance assessment	104	71	38	26	37	10	**286**	**210**
Investigation	759	455	378	335	604	287	**2,818**	**2,579**
Panel hearing	1						**1**	**12**
Subtotal 2020/21	**2,282**	**1,052**	**491**	**379**	**643**	**297**	**5,144**	
Subtotal 2019/20	**2,187**	**1,387**	**565**	**325**	**509**	**170**		**5,143**
Tribunal hearing[1]	41	38	28	40	122	102	**371**	**348**[2]
Total 2020/21[2]	**2,323**	**1,090**	**519**	**419**	**765**	**399**	**5,515**	
Total 2019/20[3]	**2,249**	**1,420**	**615**	**363**	**611**	**233**		**5,491**

1. Tribunal proceedings are conducted in accordance with timetables set by the responsible tribunal in each jurisdiction.
2. There were also three compliance breaches before the tribunal at 30 June 2021.
3. There were also ten compliance breaches before the tribunal at 30 June 2020.

Table 29. Open notifications by profession and state or territory, 30 June

Profession	Ahpra									Ahpra subtotal 2020/21	HPCA[2]	Total 2020/21	Total 2019/20
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[1]				
Aboriginal and Torres Strait Islander Health Practitioner			2	1	1			1		**5**	**1**	**6**	**6**
Chinese medicine practitioner	3			6			13	1	1	**24**	**21**	**45**	**49**
Chiropractor	2	2	1	23	8	1	30	23	3	**93**	**22**	**115**	**99**
Dental practitioner	10		8	124	33	10	127	54	6	**372**	**292**	**664**	**725**
Medical practitioner	97	45	29	706	272	79	1,132	415	66	**2,841**	**1,493**	**4,334**	**3,964**
Medical radiation practitioner	1	1		5	4	1	9		5	**26**	**6**	**32**	**20**
Midwife	2	2		15	6	2	14	13	5	**59**	**15**	**74**	**80**
Nurse	25	8	36	314	162	55	375	137	58	**1,170**	**388**	**1,558**	**1,459**
Occupational therapist				7	6	2	16	7		**38**	**24**	**62**	**38**
Optometrist				4	3		3	2	1	**13**	**3**	**16**	**28**
Osteopath	1			3			15			**19**	**13**	**32**	**27**
Paramedic	4	1	3	41	13	5	19	10	4	**100**	**39**	**139**	**93**
Pharmacist	7	1	1	45	18	11	86	41	21	**231**	**461**	**692**	**658**
Physiotherapist	1	2	1	17	16	3	38	16	2	**96**	**43**	**139**	**121**
Podiatrist	1			6	1	1	11	5		**25**	**12**	**37**	**33**
Psychologist	19	9	7	92	34	12	163	63	4	**403**	**154**	**557**	**559**
Total 2020/21[3]	**173**	**71**	**88**	**1,409**	**577**	**182**	**2,051**	**788**	**176**	**5,515**	**2,987**	**8,502**	
Total 2019/20[4]	**166**	**93**	**90**	**1,458**	**579**	**150**	**2,006**	**833**	**116**	**5,491**	**2,468**		**7,959**

1. No principal place of practice: includes practitioners with an overseas or unknown address.
2. Matters managed by the HPCA in NSW.
3. There were also three compliance breaches before the tribunal at 30 June 2021.
4. There were also ten compliance breaches before the tribunal at 30 June 2020.

What practitioners and notifiers tell us

We received **1,948** responses to our post-notifications surveys, 59.3% were from practitioners.

Practitioners tend to think we are on the side of the patient.

It's not uncommon for practitioners to feel judged when we tell them someone has made a notification. We're making changes to the language we use to explain notifications based on surveys of practitioners who have been through a notification process.

One practitioner told us that seeing a patient's allegation repeated in our initial letter made them feel that we accepted what the patient had told us as fact.

'[Complainants] can say untruthful things with personal bias and insult me professionally. I would have liked to challenge that person and ask them to justify their comments.'

We attempt to contact every practitioner who is the subject of a notification by phone. That way we have the opportunity to explain what a notification is – and what it isn't.

Practitioners are responding to this change positively. Practitioner satisfaction with the notification process overall increased to 59% in comparison to 53% last year.

'The matter was resolved quickly and not in a punitive way. I think Ahpra handled the whole matter in a kind and expeditious manner. It was nothing like I imagined it to be.

Notifiers tend to think we side with the practitioner.

Many notifications end without us taking regulatory action about the practitioner. Notifiers felt that this was because we represented practitioners and protected them from the complaint.

'I am disappointed that there was no consequence nor penalty for [the practitioner] whatsoever.'

Our risk assessment and controls approach helps us share information with notifiers about actions that a practitioner or their employer has taken to prevent a similar incident arising again.

Notifiers are letting us know, in our post-notification outcome surveys, that knowing about these actions can make a difference.

'The notification officer took details by phone. I got regular communications by email about progress and felt officers made adjustments to help me understand, which was appreciated. It was helpful to know that [the practitioner] made sure no one else would go through what I did.'

'Knowing that the practitioner as well as their employer was taking what I reported seriously showed the system was working.'

Practitioners are acknowledging the benefits of this approach as well!

'The outcome was fair and reasonable and Ahpra recognised the large effort I put into my response and into my self-improvement.'

It can be confronting and feel overwhelming to be the subject of a notification.

Practitioners often tell us that they thought notifications were only about very serious concerns.

'When I received the notification, even though I was told there was no case against me, I felt very anxious until I could contact someone the next day. I had never received even an informal complaint against me in 30 years. I was worried what the complainant's issue was that was so bad it went to Ahpra.'

Practitioners tell us that hearing from us directly helps. They also have helpful advice about seeking support from peers, professional associations and indemnity providers early.

'The lady who conducted the initial contact explained how it would work and she helped ease my shock and anxiety.'

'It is a fair process and just hang in there. It gives [practitioners] an opportunity to reflect on their practices and improve … take it as constructive criticism though it is very stressful to wait for the outcome.'

'The process can take an extremely long period. Seek the assistance of your PI provider early.'

Sometimes we refer serious matters to the police.

It's important to understand that we are a regulator of professional standards. When a practitioner's conduct has the potential to amount to criminal conduct, having the police investigate and then charge and prosecute is important. It is the role of the criminal justice process to investigate and, where relevant, punish individuals for criminal behaviour.

We explain the role of regulation to notifiers.

Sometimes notifiers expect that a practitioner will suffer a punishment when something has gone wrong.

'Nothing was resolved … I see no transparency or accountability in this case. [The practitioner] is still able to practise and wasn't punished in any way for what they did wrong.'

It's important to know what our role is, and what it isn't. We're here to make sure that risk to future patients is minimised. We use concerns notifiers tell us about as a trigger to check whether things need to be done to ensure that.

'The eventual outcome was everything that I had hoped for – education, not punishment (though initially I was very angry with the person under investigation).'

Practitioners can be relieved when they hear that we won't take any further action but they can find the process very stressful.

'I found my experience stressful and bewildering. I had been contacted by phone initially and informed about the notification. I heard nothing more for months until [I] received a notification stating no further action.'

'Ahpra was objective in their review and tried to balance the issues raised. Although I may not have agreed with the whole of the outcome, Ahpra was reasonable and endeavoured to be fair as much as possible to all parties concerned.'

Legal action

Independent tribunals and panels decide the most serious allegations

- **374** matters (371 notifications, 3 compliance breaches) were the subject of ongoing tribunal proceedings at 30 June, compared with 358 matters last year.
- **126** tribunal matters were finalised:
  - **121** matters were decided by a tribunal, **96.7%** resulting in disciplinary action; National Boards continue to appropriately identify the thresholds for referring a matter to a tribunal to protect the public
  - **5** matters were withdrawn or did not proceed to a tribunal because: the practitioner was deceased (4 matters), and a separate tribunal matter was withdrawn in Western Australia when it became clear that co-regulatory authorities in New South Wales had addressed the same conduct in separate proceedings (1 matter).
- **19** matters were decided by panels with more than **80%** resulting in regulatory action.

Tribunal decisions

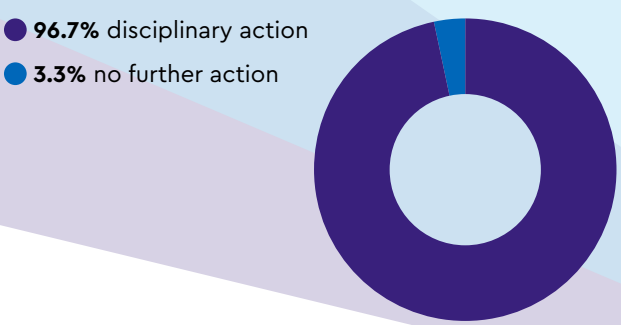
National Boards refer serious matters to tribunals in each state and territory. Only a tribunal can cancel a practitioner's registration, disqualify a person from applying for registration for a time or prohibit a person from using a specified title or providing a specified health service.

We include links to published adverse tribunal (disciplinary) decisions and court outcomes for a practitioner on the online *Register of practitioners*, if the name of the practitioner has not been suppressed by the court or tribunal.

When a court or tribunal cancels a practitioner's registration or disqualifies them from applying for registration, or using a specified title, or providing a specified health service, this is recorded in the online *Register of cancelled practitioners*.

When a tribunal reprimands, suspends or places conditions on the registration of a practitioner, this is recorded on the online *Register of practitioners*.

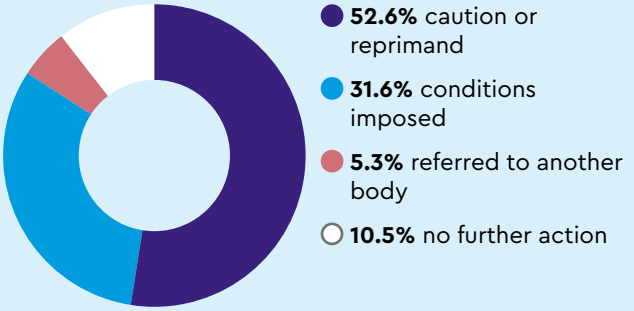
Figure 83. Matters decided by tribunals



Panel decisions

A National Board establishes health or professional standards panels to decide matters when appropriate. Panels must include members from the relevant health profession and community members. All health panels must include a medical practitioner.

Figure 84. Matters decided by panels



Some serious allegations are referred to tribunals

Matters included findings of professional misconduct involving:

- family violence offending and other serious criminal offending
- sexual boundary breaches and other general boundary breaches such as inappropriate relationships with patients
- misappropriating or prescribing of 'peptides' or other drugs that are at risk of misuse/abuse, for non-therapeutic purposes
- failure to comply with conditions imposed on registration by a Board or a panel
- continuing to practise when registration has lapsed or not been renewed
- inappropriate commentary on social media
- providing treatments for which the practitioner was not qualified.

Significant periods of disqualification were imposed in appropriate matters, including in matters involving:

- misappropriation of drugs by a registered nurse (three years)
- a former dental practitioner who maintained false, misleading and inaccurate records and recorded procedures or tests that had not been performed and who made fraudulent claims to a health insurer for those procedures (five years).

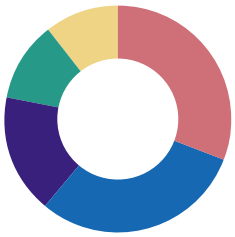
To create opportunities for professional learning we publish court and tribunal summaries

We published **103** summaries of decisions. Some decisions are not published for privacy reasons or due to suppression orders applied by the tribunal or court.

Decisions can be appealed

- **106** appeals were lodged nationally about decisions made by National Boards.
- The number of appeals lodged this year was the same as in 2019/20.
- The majority of appeals were from professions that have a higher number of regulatory decisions such as medical practitioners (57) and nurses (16).
- **95** appeals were finalised.
- **84** appeals were not yet decided at 30 June.

Figure 85. Appeals managed



- **31.1%** decision to suspend a person's registration
- **30.2%** decision to impose or change a condition on a person's registration or endorsement
- **17.0%** decision to refuse registration, refuse renewal of registration, or refuse an endorsement on registration
- **11.3%** appeals against other decisions
- **10.4%** decision to refuse to change or remove a condition imposed on a person's registration, or an undertaking given by the practitioner, or the endorsement of a person's registration

Figure 86. Appeals finalised

- **15.8%** original decision confirmed
- **49.5%** withdrawn by the appellant and did not proceed, meaning the original decision remained in place
- **16.8%** original decision substituted with a new decision (12 matters) or the original decision amended (4 matters)
- **17.9%** dismissed on administrative grounds

Table 30. Appeals lodged, by profession and jurisdiction

Profession	Ahpra								Ahpra subtotal 2020/21	HPCA[1]	Total 2020/21	Total 2019/20
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA				
Aboriginal and Torres Strait Islander Health Practitioner									**0**		**0**	**0**
Chinese medicine practitioner									**0**	1	**1**	**1**
Chiropractor								1	**1**		**1**	**1**
Dental practitioner				1	1	1	5	1	**9**	4	**13**	**5**
Medical practitioner	1	3		17	5	1	26	4	**57**	18	**75**	**67**
Medical radiation practitioner				1					**1**		**1**	**0**
Midwife									**0**		**0**	**0**
Nurse		2	1	4	1		7		**15**	4	**19**	**27**
Nurse and midwife					1				**1**		**1**	**4**
Occupational therapist									**0**		**0**	**0**
Optometrist					2				**2**		**2**	**0**
Osteopath									**0**		**0**	**0**
Paramedic				1					**1**		**1**	**4**
Pharmacist				3	1		2	3	**9**	14	**23**	**12**
Physiotherapist									**0**	1	**1**	**1**
Podiatrist							2		**2**		**2**	**0**
Psychologist	1	1	1	2	1		1	1	**8**		**8**	**12**
Total 2020/21	**2**	**6**	**2**	**29**	**12**	**2**	**43**	**10**	**106**	**42**	**148**	
Total 2019/20	**5**	**7**	**1**	**21**	**16**	**3**	**38**	**15**	**106**	**28**		**134**

1. In NSW Ahpra manages appeals of registration decisions and the HPCA manages appeals of notification matters.

Table 31. Nature of decision appealed where the appeal was finalised through consent order or contested hearing or was withdrawn

Nature of decision appealed	Original decision confirmed		Original decision amended		Original decision substituted for a new decision		Withdrawn		Dismissed – administrative		Total 2020/21		Total 2019/20	
	Ahpra[1]	HPCA[2]	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA
Appeal against a tribunal decision	1				3	1			2		6	1	4	1
Decision to impose conditions on a person's registration under section 178	4		3		5		15	1	7		34	1	22	0
Decision to impose or change a condition on a person's registration or the endorsement of the person's registration		1	1	1		1	3	12	1		5	15	12	10
Decision to refuse to change or remove a condition imposed on the person's registration or the endorsement of the person's registration	1	2					4	3	1	2	6	7	2	1
Decision to refuse to endorse a person's registration											0	0	1	0
Decision to refuse to register a person	2						8	1	3		13	1	6	1
Decision to refuse to renew a person's registration							2				2	0	1	0
Decision to reprimand a person											0	0	0	0
Decision to suspend a person's registration	6	2			4	4	15	8	2		27	14	23	10
Other	1								1	1	2	1	1	0
Not an appellable decision											0	0	0	0
Judicial review											0	0	1	0
Total 2020/21	**15**	**5**	**4**	**1**	**12**	**6**	**47**	**25**	**17**	**3**	**95**	**40**		
Total 2019/20	**10**	**1**	**8**	**3**	**11**	**4**	**33**	**9**	**11**	**6**			**73**	**23**

1. Ahpra manages appeals of registration decisions in NSW.
2. Notification matters managed by the HPCA in NSW.

Any person or company can be fined if found guilty of a criminal offence, and people can be jailed

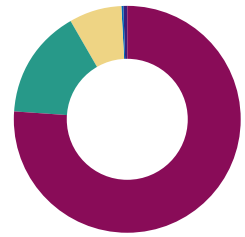
We investigate and, where appropriate, prosecute allegations of criminal offences.

- **451** criminal offence complaints were received
  - **76.1%** related to alleged unlawful use of title and unlawful claims to registration.
- **462** criminal offence complaints were considered and closed, some from the last year.
- **215** open criminal offence complaints were still under review at 30 June.
- **70** new complaints about advertising were considered and managed where advertising was assessed as unlawful – most related to the advertising of corporate entities or unregistered persons.
  - **87** complaints were closed, some from last year.

Types of criminal offence

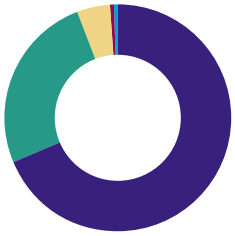
- Unlawful use of protected titles
- Unlawful claims that a person is registered
- Performing a restricted act
- Unlawful advertising.

Figure 87. Offence complaints received



- **76.1%** title protection offences
- **15.5%** advertising offences by corporate entities or unregistered persons
- **7.5%** practice protection offences
- **0.4%** directing or inciting unprofessional conduct/ professional misconduct
- **0.4%** other offences

Figure 88. Offence complaints open, 30 June



- **68.8%** title protections offences
- **25.6%** advertising breaches by corporate entities or unregistered persons
- **4.7%** practice protection offences
- **0.5%** directing or inciting unprofessional conduct/ professional misconduct
- **0.5%** failing to cooperate with investigators and inspectors

Table 32. Criminal offence complaints received and closed, by type of offence and profession[1]

Profession	Title protections (ss. 113–120)		Practice protections (ss. 121–123)		Advertising breach (s. 133)		Directing or inciting unprofessional conduct/professional misconduct (s. 136)		Other offence		Total 2020/21		Total 2019/20	
	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed
Aboriginal and Torres Strait Islander Health Practitioner	0	1	0	0	1	1	0	0	0	0	1	2	1	2
Chinese medicine practitioner	8	11	0	1	1	2	0	0	0	0	9	14	16	15
Chiropractor	10	8	4	1	4	6	0	0	0	0	18	15	15	20
Dental practitioner	14	15	2	1	6	16	0	0	0	0	22	32	80	68
Medical practitioner	69	73	11	3	22	26	1	1	1	2	104	105	162	176
Medical radiation practitioner	2	5	0	0	1	1	0	0	0	0	3	6	3	0
Midwife	6	5	0	0	0	0	0	0	0	1	6	6	9	8
Nurse	70	55	9	3	9	12	1	2	0	0	89	72	82	81
Occupational therapist	12	9	1	0	1	1	0	0	0	0	14	10	7	8
Optometrist	2	3	0	0	1	2	0	0	0	0	3	5	6	4
Osteopath	3	4	0	0	1	1	0	0	0	0	4	5	7	13
Paramedic	16	20	2	1	0	0	0	0	0	0	18	21	26	24
Pharmacist	11	13	2	0	3	3	0	0	0	0	16	16	13	8
Physiotherapist	19	25	0	0	6	6	0	0	0	0	25	31	35	33
Podiatrist	0	0	0	0	0	1	0	0	0	0	0	1	5	4
Psychologist	101	109	3	1	14	9	0	0	1	2	119	121	132	130
Unknown	0	0	0	0	0	0	0	0	0	0	0	0	6	8
Total 2020/21	**343**	**356**	**34**	**11**	**70**	**87**	**2**	**3**	**2**	**5**	**451**	**462**		
Total 2019/20	**412**	**420**	**13**	**13**	**172**	**150**	**7**	**4**	**1**	**15**			**605**	**602**

1. All offences under the National Law, not only offences about advertising, title and practice protection.

We prosecute people who pretend to be registered health practitioners when they are not

Figure 89. Prosecution outcomes

all prosecutions finalised resulted in a finding of guilt against the defendant on one or more charges, with penalties imposed ranging from a good behaviour bond to fines of up to $30,000

Significant prosecutions this year demonstrate the importance of criminal offence provisions for the protection of the public.

- **16** proceedings completed in the courts for offences across five jurisdictions (including 2 appeals)
- **1** matter pending appeal at 30 June.

Outcomes show that Ahpra continues to identify appropriate thresholds for referring offence complaints for prosecution.

- **7** prosecutions and **1** appeal ongoing at 30 June.

Table 33. Completed prosecutions

Defendant	Date of decision	Jurisdiction	Relevant Board	Type of offence	Outcome
Russell John Menzies	9 July 2020	NSW	Nursing and Midwifery	Holding out as being a registered health practitioner	Convicted and fined $3,000 and ordered to pay $4,400 in costs to Ahpra.
Melissa Madex	3 September 2020	SA	Nursing and Midwifery	Holding out as being a registered health practitioner	Convicted and fined $3,500 and ordered to pay prosecution costs of $1,210 and a compulsory victims of crime levy of $640.
Name withheld	25 September 2020	Qld	Medical	Appeal against findings of guilt	Appeal dismissed. The original sentence of a fine of $15,000 with no conviction recorded[1] and the order for the offender to pay Ahpra's costs of $10,000 remains in place.
Praveen Kumar	18 December 2020	Vic	Medical	Holding out as being a registered health practitioner	Fined $20,000 and ordered to pay $27,121 in legal costs to Ahpra. No conviction was recorded.
Ieuan Lakay	17 December 2020	WA	Physiotherapy	Holding out as being a registered health practitioner	Convicted and sentenced to a 12-month community-based order with supervision and 200 hours of community service and ordered to pay $10,000 in legal costs to Ahpra.
Michael Dempsey	22 December 2020	Vic	Physiotherapy and Occupational Therapy	Holding out other persons as being registered health practitioners	Convicted and fined $2,500 for each offence, making a total fine of $10,000, and ordered to pay Ahpra's entire legal costs of the prosecution, $50,685.
Name withheld	3 February 2021	Qld	Medical	Holding out other person as being registered health practitioner	Convicted on one charge, 13 charges dismissed, fined $6,000 with no conviction recorded. Appeal against conviction pending.
Brian Hickman	4 February 2021	NSW	Psychology	Holding out as being a registered health practitioner	Convicted and fined $20,000 and ordered to pay Ahpra's legal costs of $39,176.
Brian Hickman	10 February 2021	Vic	Psychology	Holding out as being a registered health practitioner	Convicted and sentenced to an 18-month community correction order and ordered to pay Ahpra's legal costs of $30,000.

1 See *Glossary*

Defendant	Date of decision	Jurisdiction	Relevant Board	Type of offence	Outcome
Sara Matthews	11 February 2021	NSW	Dental	Appeal against conviction and sentence imposed in 2019 for performing restricted dental acts	Appeal dismissed.
Tanya Bechara	22 February 2021	Vic	Nursing and Midwifery	Holding out as being a registered health practitioner	Fined $5,000, no conviction recorded.
Name withheld	22 March 2021	SA	Medical	Holding out as being a registered health practitioner	Two-year, $5,000 good behaviour bond, no conviction recorded, ordered to pay Ahpra's legal costs of $1,210 and a compulsory victims of crime levy of $240.
Name withheld	15 April 2021	WA	Dental	Holding out as being a registered health practitioner, performing restricted dental acts	$10,000 fine and ordered to pay $2,500 in costs to Ahpra. A spent conviction order[2] was also made.
Albert Young	21 April 2021	NSW	Pharmacy	Holding out as being a registered health practitioner	Convicted and sentenced to a total fine of $38,000 ($2,000 per charge), ordered to pay $2,500 in legal costs to Ahpra and $3,230 in court costs.
Jeremy Chan	20 May 2021	NSW	Optometry	Holding out as being a registered health practitioner and unlawful prescription of optical appliances	Convicted and fined $7,700 and ordered to pay Ahpra's legal costs of $4,813.
Aliaa Mohammad Elmetwally Ismaeli Sherif	22 June 2021	Vic	Medical	Holding out as being a registered health practitioner	Convicted and fined $15,000 and ordered to pay Ahpra's costs (yet to be assessed)

Hard work and collaboration catch an unregistered person

Katherine Mackenzie, the National Manager of Ahpra's Criminal Office Unit reports:

In the face of fraud, harm and repeat offending, Ahpra maintained a strong approach in a serious matter involving a person holding themselves out to be a medical practitioner. It took over three years from the start of the investigation to reach a successful conclusion. COVID-19 was only one of the inherent challenges involved in finally prosecuting this case.

In 2018, Ahpra obtained a warrant to search a cosmetic clinic following a tip-off that Schedule 4 (prescription only) cosmetic injectables were on the premises. The clinic was run by a person who held themselves out as a medical practitioner, despite never being registered with the Medical Board of Australia and not being authorised to possess or administer these drugs.

When charges were laid in 2019, they related to a range of activities including injecting patients with dermal fillers and botox, providing medical advice, providing unapproved antibiotics (from overseas) and producing a fraudulent registration certificate when trying to expand their business.

The unregistered person went on to treat others, despite warnings from Ahpra, their premises being searched and charges being laid. One patient, who believed she was being treated by a medical practitioner, made a complaint after suffering adverse reactions from the cosmetic treatment.

In the course of the investigation, Ahpra liaised with the Victorian Department of Health and Human Services (now known as the Department of Health), the Health Care Complaints Commission in NSW, the Therapeutic Goods Administration, the Health Complaints Commissioner in Victoria and the Australian Border Force.

In June 2021, the person was convicted of 10 charges by the Magistrates' Court of Victoria, fined, and ordered to pay Ahpra's costs. The magistrate commented that the offending was wilful and planned, and a persistent course of conduct.

Many people worked hard to bring about this outcome, all of whom were motivated to secure public health and safety in the face of persistent offending. We hope this case serves as a deterrent to others, and a reminder to the public that they can always check the registration of their health practitioners on our website for themselves at any time.

2 See *Glossary*

Compliance

Monitoring restrictions

Monitoring streams

Health	Performance
Conduct	Suitability/eligibility
Prohibited practitioner/student	

We monitor restrictions and requirements that have been placed on practitioners to check that they are complying.

- **4,650 cases** related to **4,648 registered practitioners** who were being actively monitored at 30 June
  - **1,467 cases (31.6%)** were about conduct, health or performance
  - **2,734 cases (58.8%),** the majority, were about suitability/eligibility for registration
  - **449 cases (9.7%)** related to prohibited practitioners/students.
- **3,516 practitioners** were monitored by Ahpra to ensure health, performance and/or conduct requirements were being met during the year.

Table 34. Active monitoring cases at 30 June, by profession and stream

Profession	Conduct			Health			Performance			Prohibited practitioner/ student	Suitability/ eligibility[1]	Total 2020/21			Total 2019/20		
	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	Ahpra	Ahpra[2]	HPCA	OHO[3]	Ahpra[2]	HPCA	OHO[3]
Aboriginal and Torres Strait Islander Health Practitioner		1		1						2		**3**	**1**	**0**	4	1	0
Chinese medicine practitioner	5	10	3	1	1		2	7	1	5	773	**786**	**18**	**4**	818	14	3
Chiropractor	9	7	1	4	2		9			8	11	**41**	**9**	**1**	39	5	0
Dental practitioner	14	19	2	17	16		86	30	1	9	39	**165**	**65**	**3**	137	74	4
Medical practitioner	139	192	23	175	127		268	168	6	103	524	**1,209**	**487**	**29**	1,118	413	35
Medical radiation practitioner	3			8	1		2			6	44	**63**	**1**	**0**	41	3	0
Midwife	3	2		4	4		10	3		4	28	**49**	**9**	**0**	31	8	1
Nurse	114	100	20	232	163		100	85	3	240	833	**1,519**	**348**	**23**	1,404	327	21
Occupational therapist	3	3		5	2		1			1	77	**87**	**5**	**0**	79	3	0
Optometrist	2				1		4			1	6	**13**	**1**	**0**	9	1	0
Osteopath	5	3	1	1						1	6	**13**	**3**	**1**	8	4	1
Paramedic	4	7	2	18	15					12	206	**240**	**22**	**2**	168	14	2
Pharmacist	17	98	1	17	17		23	33		29	59	**145**	**148**	**1**	125	134	0
Physiotherapist	11	8	4	4	3		7			7	32	**61**	**11**	**4**	56	7	4
Podiatrist	1			3	6		7	1		1	9	**21**	**7**	**0**	17	4	0
Psychologist	66	12	5	18	17		44	12		20	87	**235**	**41**	**5**	161	40	2
Total 2020/21	**396**	**462**	**62**	**508**	**375**	**0**	**563**	**339**	**11**	**449**	**2,734**	**4,650**	**1,176**	**73**			
Total 2019/20	**284**	**422**	**64**	**494**	**367**	**0**	**535**	**263**	**9**	**382**	**2,520**				**4,215**	**1,052**	**73**

1. Ahpra monitors compliance cases in the 'suitability/eligibility' stream in every jurisdiction.
2. Ahpra reports by monitoring of established cases, rather than by the number of registrants being monitored. A registrant may have a set of restrictions (conditions or undertakings) in more than one stream. The 4,650 Ahpra monitoring cases relate to 4,648 registrants. The HPCA reports on the number of registrants being monitored.
3. In Qld, Ahpra monitors all cases except where the restrictions are imposed by OHO as immediate registration actions. OHO counts each of these actions separately, and not by practitioner being monitored. In a small number of instances, one practitioner may be monitored about more than one immediate registration action. A single immediate registration action may be about more than one stream. Cases have been categorised according to the stream that comprises the bulk of the immediate registration action. This excludes interim prohibition orders against registered practitioners who are currently being monitored.

Table 35. Active monitoring cases at 30 June, by state or territory

Stream	Ahpra									Ahpra subtotal 2020/21[3]	HPCA[4]	OHO[5]	Total 2020/21	Total 2019/20
	ACT	NSW[1]	NT	QLD	SA	TAS	VIC	WA	No PPP[2]					
Conduct	13	1	12	77	69	12	148	63	1	**396**	**462**	**62**	**920**	**769**
Health	13	4	11	188	57	21	134	72	8	**508**	**375**		**883**	**862**
Performance	12	10	12	178	81	19	169	82		**563**	**339**	**11**	**913**	**807**
Prohibited practitioner/student	6	1	9	90	76	18	185	53	11	**449**			**449**	**382**
Suitability/eligibility[6]	49	1,043	21	463	179	42	570	286	81	**2,734**			**2,734**	**2,520**
Total 2020/21	**93**	**1,059**	**65**	**996**	**462**	**112**	**1,206**	**556**	**101**	**4,650**	**1,176**	**73**	**5,899**	
Total 2019/20	**96**	**1,010**	**48**	**843**	**434**	**91**	**996**	**452**	**245**	**4,215**	**1,052**	**73**		**5,340**

1. Includes cases to be transferred from Ahpra to the HPCA for conduct, health and performance streams.
2. No principal place of practice: includes practitioners with an overseas or unknown address.
3. Ahpra reports by monitoring established cases, rather than by the number of registrants being monitored. A registrant may have a set of restrictions (conditions or undertakings) in more than one stream. The 4,650 Ahpra monitoring cases relate to 4,648 registrants. The HPCA reports on the number of registrants being monitored.
4. The HPCA monitors practitioners in relation to health, performance and conduct in NSW.
5. In Qld, Ahpra monitors all cases except where the restrictions are imposed by OHO as immediate registration actions. OHO counts each of these actions separately, and not by practitioner being monitored. In a small number of instances, one practitioner may be monitored about more than one immediate registration action. A single immediate registration action may be about more than one stream. Cases have been categorised according to the stream that comprises the bulk of the immediate registration action. This excludes interim prohibition orders against registered practitioners who are currently being monitored.
6. Ahpra monitors compliance cases in the 'suitability/eligibility' stream in every jurisdiction.

What aeroplane safety and health regulation have in common

Jason McHeyzer joined Ahpra in 2020 as our National Director, Compliance

I bring my regulatory and leadership experience from aviation safety to my role at Ahpra.

Both industries have a relatively high consequential risk. And the public threshold for failure is very low. On the flip side, health practitioners and pilots are highly trusted.

Both regulators face similar binds. If we shut down everyone who ever made a mistake or was subject to a complaint then we would shut down aviation or our health system would slow down so much that patients would miss out on care, so the overall outcome would be less safe.

Keeping the system going has a real value. We have to find that delicate balance. When something goes wrong, Ahpra and the Boards can put additional risk controls in place. We also consider the other systems, organisations and regulatory agencies that seek to control risks. Sometimes we require a practitioner to do something different to keep practising: undergo education, limit or modify their practice, be screened regularly for drugs or be supervised.

Compliance is where we make sure those controls are working. For example, we can look at billing and prescribing data to confirm practitioners aren't seeing patients that they aren't permitted to.

The vast majority of practitioners want to comply with their restrictions, and we aim to support them and get them back to normal practice.

Unfortunately, a minority seek to avoid restrictions, and to hide their non-compliance. They are motivated to work their way around the system. This means that we sometimes require detailed records that may seem 'over the top' to compliant practitioners.

Compliance activities and initiatives

Additional guidance to practitioners

Some of the restrictions placed on practitioners require them to provide a report reflecting on the original issue that led to the condition or undertaking and how they would approach the same situation differently following the education or mentoring they were required to complete. We have published additional guidance, including an example approach, to help in practitioner reflection to help minimise unnecessary additional work by the practitioner.

Compliments

One of our most onerous conditions is Urine Drug Screening, used to ensure that practitioners with historical health impairments are not taking restricted substances. Practitioners are required to present to a pathology collection centre on random days, up to 12 times per month, and provide a urine sample with someone watching. It is always great to receive positive feedback from practitioners, and even more pleasing when someone subject to onerous requirements has something nice to say about our staff:

> *The case officer has connected with me on many occasions with regular updates, just to 'check in' and is there when difficult news has to be delivered. She has made herself accessible and available to my prospective employers, assisted with the mountain of forms and given support wherever it's required. So, I basically want to express not only my gratitude and appreciation to the case officer for her dedication as a compliance officer, but I want it brought to the attention of her superior to alert them to what an amazing and outstanding job she is doing.*

Reviewing our performance

Two performance and quality assurance reviews were carried out:

- Recording regulatory action arising from a monitoring case – we evaluated how staff were recording information on key decisions made about monitored cases. The review found that the policy and procedure was not as clear as it could be and that staff were required to record some information that was unnecessary. Policies have been updated and additional staff training completed.
- Use of delegations and authorisations – we evaluated the use of delegations and authorisations that permit specified Ahpra staff to make certain decisions on behalf of the National Boards. The review identified that the majority of decisions made were consistent with procedures and identified opportunities to improve reporting to National Boards. The report also identified efficiencies and faster decision-making when delegations and authorisations were used.

Restrictions most often placed on practitioners

The top 10 restriction categories by volume being monitored by Ahpra at 30 June equate to 6,702 restrictions. Although 4,650 cases were being actively monitored, each case may have more than one restriction category requiring compliance by the practitioner.

- **69.8%** (4,679) of restrictions in the top 10 restriction categories were imposed as a result of the routine process of a health practitioner obtaining or renewing registration with a National Board.
- **30.2%** (2,023) of the restrictions in the top 10 restriction categories were imposed as a result of a finding made by a National Board, panel or tribunal about a practitioner's health, performance or conduct.

Table 36. Top 10 restriction categories, 30 June

Restriction category	Total
Restriction on practice and employment	**1,958**
Requirement for supervision	**1,461**
Undertake assessment	**817**
Undertake education	**553**
Attend treating practitioner	**444**
Restriction on scope of practice	**443**
Prohibition on practice	**331**
Restriction on workplace location	**264**
Requirement to practise under indirect and remote supervision	**231**
Restriction on work type	**200**

Investigating complaints about advertising

We received **386** advertising complaints. Of these:

- **70** were complaints about corporate entities or unregistered persons, or assessed as serious-risk complaints (see page 87)
- **316** were lower risk complaints about registered health practitioners and assessed under the *Advertising compliance and enforcement strategy:*
  - **157** were assessed as potential breaches (412 in 2019/20); the reduction of about **60%** is unusual and may be related to the COVID-19 pandemic
  - **152** cases had no breach identified
  - **7** are awaiting initial assessment.

When we identify that advertising by registered health practitioners is not compliant with the *Guidelines for advertising a regulated health service*, we initially provide practitioners with an opportunity to correct their advertising and only take further regulatory action when this is unsuccessful. There were no instances of continued non-compliant advertising that required regulatory action.

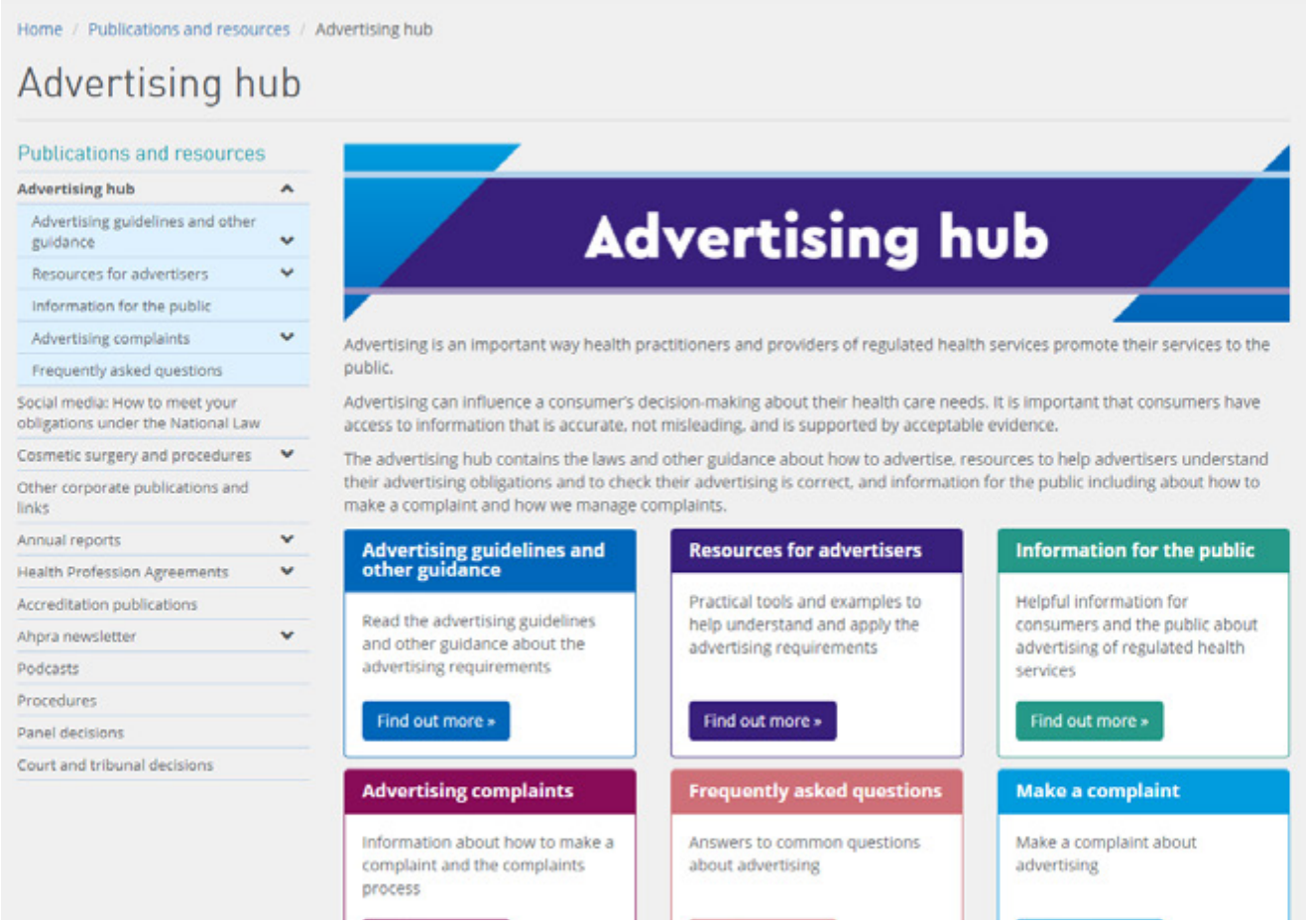
Proactive advertising strategy

We have historically relied on complaints to identify advertising that doesn't meet our guidelines. We are now supplementing this approach with a proactive audit of advertising from a sample of practitioners in every profession. This approach is helping us understand the rates of advertising and common issues in each profession. We will be using this information to make further improvements to the dedicated advertising pages on our website and will engage with each profession through Board newsletters and professional associations. The overall objective is to identify issues and make it easy for practitioners to comply.

Sometimes practitioners don't realise what they are not allowed to claim when they advertise. We provide information to help them.

Advertising

We reviewed the *Guidelines for advertising a regulated health service* and evaluated the *Advertising compliance and enforcement strategy for the National Scheme*. The revised guidelines and updated strategy took effect on 14 December. To support understanding and compliance with the advertising requirements, we redeveloped existing web resources to create an *Advertising hub* on our website.



Insights to help practitioners better manage risk

Through our work, we have data and insights into some of the challenges and opportunities for registered health practitioners and, more broadly, for the healthcare system in Australia.

We want to use this knowledge and experience to support practitioners to practise professionally and so they can identify and manage risk in their practice. Our aim in sharing these insights is to promote a culture of reflection and continuous improvement for practitioners that protects the public and contributes to the safety and quality of healthcare.

We are exploring opportunities to share more detailed insights directly with health practitioners, such as through profession-specific newsletters and case studies. We will also look for ways to share relevant insights with consumers and our health system partners.

Our data show there are risks to the public and for practitioners in the following areas.

Health and wellbeing

- **Staying healthy and well** maintains a practitioner's ability to provide safe, professional healthcare.
- There has been an **increase in self-reported notifications from practitioners experiencing mental health issues** over the last two years, and an increase in reports about practitioners misusing drugs and alcohol.
- Consistent with international experience, these are potential indicators of **increased stress from working as a health practitioner during the pandemic**. For example, from frontline exposure or through impact on practitioner businesses affected by shutdowns.

To manage this risk

Practitioners are encouraged to look after their own health and support their health practitioner colleagues. Practitioners who have concerns about their own or a colleague's health are encouraged to seek support. For many practitioners (dentists, doctors, pharmacists, nurses and midwives), free and confidential support services are available from their profession's dedicated practitioner health service.

Respectful practice

- **Practitioners must always treat patients, consumers, students, employees and colleagues with respect**. This includes communicating professionally and respectfully with and about others.
- **Being respectful and culturally safe** towards patients and colleagues supports a positive patient experience and can reduce the likelihood of a notification.
- **Discrimination in healthcare, such as sexual harassment, racism or bullying, is a barrier to better health outcomes**. This includes care provided to Aboriginal and Torres Strait Islander Peoples, which must be culturally safe.

To manage this risk

Practitioners can invite feedback from patients and colleagues. They can reflect on any feedback received and consider the expectations set out in their code of conduct or equivalent. Practitioners can learn or refresh themselves on what is involved in culturally safe healthcare and reflect on whether they are providing culturally safe healthcare and what changes they could make to overcome any unintentional shortcomings (remembering that only Aboriginal and Torres Strait Islander Peoples can define whether care is culturally safe).

Complaints handling

- **Feedback and complaints play an important role** in the safety and quality of healthcare.
- Practitioners with a sound patient complaint system are more likely to resolve a complaint successfully and less likely to have action taken on their registration.
- Many notifications involve concerns such as communication or billing that don't meet our regulatory threshold and can often be resolved at the local health provider level. Practitioners who **try to manage patient complaints before they become a notification** had the notification closed at an early, assessment stage in 96% of cases.
- **Notifiers often tell us the outcome they were looking for is an apology or an explanation**, which are not areas that we can help with. Resolving complaints at the local level is usually the best and most timely outcome for consumers, and also has benefits for practitioners.

To manage this risk

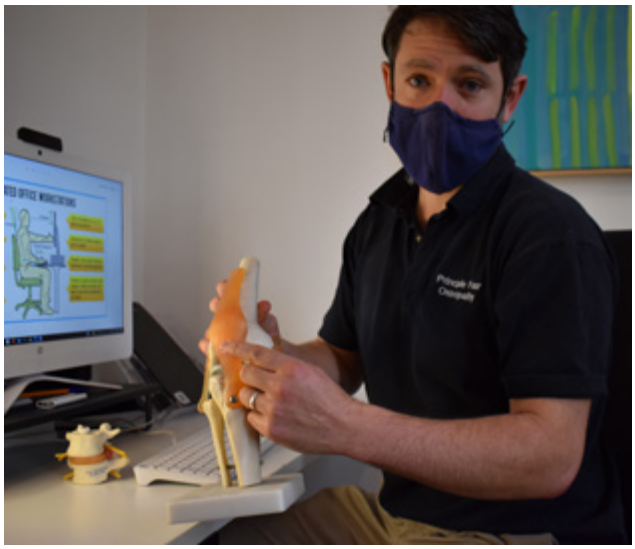
Practitioners and employers can reflect on their process for managing complaints, improve it where necessary, and check whether they are clearly communicating with patients about how they can provide feedback, including making complaints. When dealing with a person who has made a complaint, practitioners can use this as an opportunity to reflect on how they could have managed the interaction differently.

Managing health records

- **Maintaining clear and accurate patient health records** is essential for the continuing good care of patients.
- When a notification is made, the **relevant patient health records are often a key piece of further information** National Boards will seek from a practitioner.
- Many practitioners who have been through the notifications process report that they would recommend 'good record keeping' to other practitioners, as a way to help in responding to a complaint.

To manage this risk

Practitioners could reflect on their processes for maintaining health records, ensuring that they are sufficient to support the care being provided. There are resources that practitioners can access to help them, including guidance resources and electronic record-keeping programs.



Communication

- **Effective and respectful communication** is critical to providing safe healthcare.
- Communication continues to be a strong theme in notifications.
- Patients who are dissatisfied with the communication of their healthcare provider are more likely to complain to both their provider and us.

To manage this risk

Practitioners can reflect on their communication with patients and colleagues, and identify and quickly address communication breakdowns in their practice. This can support better relationships and more engaged patients who have a deeper understanding of their care.

Informed consent

- **Informed consent is a critical part** of the practitioner–patient relationship.
- **Managing informed consent well can prevent misunderstandings**. What a practitioner might consider as adequate communication to gain informed consent can be different from the client's or patient's expectations, particularly where the examination or procedure to be done involves physical contact with a patient.
- There continues to be a gap between contemporary consumer expectations of informed consent and the approach to consent taken by many health practitioners.
- **A physical examination that is poorly conducted or not supported by clear communication and consent can be distressing, alienating and harmful for patients**. Such an exam may be considered assault and result in serious consequences, including police investigations and prosecutions.

To manage this risk

Practitioners can reflect on their approach to informed consent – and the expectations set out in their code of conduct or equivalent, and consider whether their communication or documentation of consent can be strengthened. Remember that informed consent is individual and different people may need more information and time to consider it than others. Practitioners should use simple language to explain what is involved in the physical examination, and check that the patient has understood. What has worked in the past with one person may not be effective or appropriate for another. In some circumstances, recording that a patient has consented to the specific, physical contact that will occur during the examination can be helpful evidence of informed consent.

Research and evaluation to improve regulation

Our research and evaluation work improves our regulatory effectiveness and helps us become an evidence-informed regulator.

Projects

Research projects focused on were:

- finishing a cross-profession study of health practitioners with repeat notifications
- evaluating the first phase of the pandemic response sub-register
- a study of whether notification rates vary by the pathways practitioners use to meet English language skills registration standards
- developing snapshots of trend data for National Scheme professions, with snapshots to be published soon
- literature and rapid evidence reviews on:
  - continuing professional development and recency of practice requirements to inform registration standard reviews
  - professionalism, to support further work on protective factors of professional practice and reflection
  - global health workforce regulatory responses to COVID-19
- initial research on possible ways augmented intelligence could provide additional information to help human judgement in our regulatory processes:
  - developing a proof of concept approach using augmented intelligence to help in identifying lower and higher risk notifications to help human judgement in the triage process
  - a collaboration with Royal Holloway University of London, the Nursing and Midwifery Council (UK) and the Texas Board of Nursing on artificial intelligence research to support regulatory decision-making in complaints about nurses in the US, UK and Australia
- initial work analysing notifications related to racism and Aboriginal and Torres Strait Islander Peoples
- an initial exploration of the prevalence of notifications in recently graduated health practitioners
- supporting our regulatory functions in developing evaluations.

Research framework

We reviewed and revised the current research framework to better align research and evaluation projects to the overall National Scheme objectives and strategy.

Research ethics

To implement the National Scheme research ethics position statement, we now have a formal arrangement with Queensland Health's Prince Charles Hospital to use their National Health and Medical Research Council-registered human research ethics committee (HREC).

Publications and presentations

The National Scheme's Combined Meeting's program incorporated research and evaluation, discussing the potential use of augmented intelligence in regulation.

We participated in the Digital Health Cooperative Research Centre's Telehealth Datathon. In this competition, participants use real data to answer real questions, solve health management challenges and produce data visualisations and models that can be applied to support business processes and decision-making. Ahpra was the only regulator participating and we won the retrospective analysis section.

We produce publications for peer-reviewed health journals, to share knowledge. Publications were:

- Gee C, Tonkin A, Gaby S, Urh V, Anderson S, Hardy H & Fletcher M (2021). 'Responding to sexual boundary notifications: the evolving regulatory approach in Australia', *Journal of Medical Regulation*, 107(2), 25–31.
- Leslie K, Moore J, Robertson C, Bilton D, Hirschkorn K, Langelier MH, & Bourgeault IL (2021). 'Regulating health professional scopes of practice: comparing institutional arrangements and approaches in the US, Canada, Australia and the UK', *Human Resources for Health*, 19(1), 1–12.
- Fletcher M, Anderson S, Townley H & Simmonds B (2020) 'Reflections from Australia: how regulators have responded to the pandemic', *Healthcare Professionals Crossing Borders*, Winter edition issue 49, 15.

Access to data for research

While the comprehensive national regulation data that Ahpra collects have registration, workforce planning, demographic, commercial and research value, the National Law and the *Privacy Act 1988* (Cth) impose strict limits on their use. Our data access and research policy focuses on helping researchers and other parties to better understand the process for considering requests for data and research.

Ahpra's website outlines the data already available and how to access them, the processes for accessing data not publicly available, and the policies and legislation that govern what can and cannot be released.

Table 37. Data access requests

Data access requests by type	Number
Request to contact or survey practitioners	4
Copies or extracts of the *Register of practitioners*	24
Quantitative statistics (regulatory data)	51
Research data	4
Other (general information)	20
Total	**103**

Collaborating on shared policy issues

National Boards and Ahpra regularly collaborate on shared policy issues, when the issue involved affects professions similarly. This collaboration facilitates effective, collaborative care, supports good inter-professional practice and helps to simplify the regulatory landscape. It makes it easier for the public, practitioners and employers to know what to expect of registered health practitioners.

We have continued to explore and expand how our work as a health practitioner regulator can support registered health practitioners to provide safe and effective care in their professional practice.

Responses to the pandemic

Registered health practitioners continued to play a vital role in treating and containing COVID-19 and supporting the national vaccination program. We continued to develop, review and refine policy advice to National Boards to support timely, proactive regulatory responses to the COVID-19 pandemic.

As part of our efforts to support health practitioners, we developed temporary policy positions to support:

- a temporary modification to the National Boards' English language skills standard test pathway
- flexible recency of practice requirements for professions whose renewal period ended 30 November 2020.

We also reviewed and updated our telehealth guidance for practitioners to support the provision of safe virtual care, and are working with National Boards to monitor the need for further guidance.

Supporting professional practice

We issued several position statements to provide further advice and guidance on National Boards' expectations of registered health practitioners in response to emerging issues, including:

- COVID-19 and appropriate use of social media
- COVID-19 vaccination, including guidance about being vaccinated, administering vaccines and giving advice and information about vaccination
- a joint statement with the Therapeutic Goods Administration on promoting COVID-19 vaccination and complying with the advertising requirements of the National Law
- sexism, sexual harassment and gendered violence in healthcare.

Policy support and coordination

Ahpra develops policy resources and tools to support regulatory policy development and provides policy advice to National Boards. Together with the National Boards, we provided input to external policy consultations and reviews for:

- National Prescribing Service MedicineWise's review of the Prescribing Competencies Framework
- National Skills Commission's Skills Priority List Stakeholder Survey
- Victorian Department of Health and Human Services' consultation on options to respond to the independent review of Chiropractic Spinal Manipulation of Children Under 12 Years
- Australian Commission on Safety and Quality in Health Care's proposed National Safety and Quality Primary Healthcare Standards
- Australian Commission on Safety and Quality in Health Care's draft resource, Credentialing and Defining Scope of Clinical Practice
- House of Representatives' terms of reference for a Select Committee on Mental Health and Suicide Prevention
- Safer Care Victoria's consultation on a proposed statutory duty of candour and protections for clinical incident reviews.

Work progressed

So that National Boards' regulatory requirements remain contemporary and relevant, we continued our work:

- finalising a review of the supervised practice guidelines used by some National Boards to establish a Supervised Practice Framework to allow for a responsive and risk-based approach to supervised practice across the National Scheme (with some profession-specific exclusions)
- on the joint review of the *Code of conduct* shared by 12 National Boards, most in an identical form with some minor variations for several National Boards; an eight-week public consultation on the shared code started in May
- coordinating reviews for some National Boards' English language skills, continuing professional development and recency of practice registration standards.

Strategy

The new National Scheme Strategy 2020–25 launched in July 2020

Our strategy describes the vision, purpose, values and strategic themes that guide our work as we continue to evolve and meet the needs of our stakeholders. As always, public protection remains our foremost priority.

Martin Fletcher
Chief Executive Officer

A strong evidence base and cross-professional consistency will contribute to a regulatory framework that works effectively in the public interest.

Brett Simmonds
Chair, Pharmacy Board of Australia
Co-convenor, Forum of National Registration and Accreditation Scheme Chairs

Arranging our strategy into themes helps us to communicate how we will achieve our vision

Regulatory effectiveness

To protect the public, we must maintain a strong focus on having efficient and effective core regulatory functions. This includes being responsive to the rapidly evolving nature and scope of health practitioner practice and ensuring that our financial planning and management approaches achieve long-term financial sustainability.

Initiatives

- **Implementing a risk-assessment and control framework** to manage investigations at the team, delegate and practitioner level. The operation reset initiative in notifications, was implemented from October to May, and has strengthened our risk-based regulatory practices.
- **Providing greater transparency and visibility to stakeholders on costs**, informing National Boards on financial decision-making and financial strategies, and helping in the determination of costs in our co-regulatory environments in our cost-allocation project.
- **Building a contemporary and user-friendly technological interface** for our regulatory operations in the transformation project.

Evidence and innovation

We use our data to understand critical issues in health practitioner regulation and the healthcare environment and make sure our standards, codes and guidelines continue to be supported by strong evidence. We are developing and improving our systems and processes to identify risk and make sure we have a strong, reliable and consistent framework for data, analysis, evaluation and reporting.

Initiatives

- **Building a modern data platform** from which other initiatives and programs can leverage data and services in the data and integration program.
- **Improving and promoting the search function of the online public register** and improving the quality of the published information on registered health practitioners in the public register enhancement project. This will also provide us with better data and analytics to inform our future direction.

Trust and confidence

We are focused on building the trust and confidence that the public, health practitioners, organisational partners and other stakeholders have in the National Scheme.

Initiatives

- **Providing Moong-moong-gak cultural safety training** as part of our commitment to improve Aboriginal and Torres Strait Islander Peoples' health equity and increase the trust and confidence of the community in our ability to provide culturally safe regulatory practices. All Ahpra staff, Board and committee members in Tasmania, ACT, Queensland, Northern Territory and South Australia have now completed the training. Our people in the remaining states will finish the training by the end of 2021.

Capability and culture

We are focused on creating a workplace that is: psychologically and physically safe for all; enhances the capability, learning and development of our people; and embeds a culture that motivates our people to actively participate and achieve positive outcomes in all that we do.

Initiatives

- **Scoping a 'culture roadmap'** that defines our aspirational culture and key drivers to enable delivery of the National Scheme Strategy.
- **Implementing a Leadership Development Framework** and supporting programs to continuously improve our management and leadership capabilities.
- **Implementing a new flexible working policy and other initiatives** across our workspaces to better enable our flexible ways of working, and continue supporting our staff to better balance their work and personal commitments.
- **Exploring options to expand our current wellbeing,** offering to create psychologically safe workplaces and ensure easily accessible programs and support services are in place.
- **Continuing to implement actions from the *Ahpra Aboriginal and Torres Strait Islander employment strategy 2020–2025*** to create a culturally safe work environment that encourages increased Aboriginal and Torres Strait Islander workforce participation rates and long-term retention, and that reflects the communities in which we operate and serve.

Communicating and engaging

We are committed to providing accessible, timely and appropriate information

- The Ahpra website was viewed over **29 million** times.[1] The most frequently visited section was 'Registration' with almost 16 million unique page views, then 'About Ahpra' with 770,000 unique views. The *Register of practitioners* was the most popular page with 5.3 million unique views, followed by the home page with 3.8 million unique views.
- Our social media posts were seen over **3 million** times and received 109,135 interactions (likes, shares and comments). We had 35,528 Facebook likes, 10,559 Twitter followers, 89,839 LinkedIn followers and 1,939 Instagram followers.
- More than **2.5 million** searches were made of the *Register of practitioners*.[2]
- Every business day, **935** calls were answered and **222** web enquiries responded to by our national Customer Service team. People who need an interpreter or are more comfortable speaking in their own language can contact us through the Translating and Interpreting Service (TIS) and those with hearing or speech impairments through National Relay Service.
- We published **633** news items, including 51 media releases.
- We responded to **316** media enquiries.
- We published **54** National Board newsletters, with a median open rate of 63.7%, and three issues of the *Ahpra Report* for stakeholders.
- We published **23** episodes of our *Taking care* podcast on topics including kindness in healthcare, how the pandemic is changing healthcare systems and practitioner and patients' experiences, advocating for kids, mental healthcare, sexual misconduct, aged care, and advertising. The podcasts had over 21,000 listens, with an average of 58 per day. The most popular episode was 'Brett Sutton and Jeannette Young in the spotlight' with over 2,800 listens.

Success in the media

Communications Adviser (media relations) Gemma Williams reports on a media story.

The chief health officers from Victoria and Queensland, Professor Brett Sutton and Dr Jeanette Young PSM, spoke candidly on our Taking care *podcast about the professional challenges they faced and the responsibility they felt making those big decisions at the height of the pandemic.*

Preparing for the episode's release meant working closely with the media. We had to consider which journalists and outlets would be most interested. We also considered the timing, to ensure good coverage, as well as who we might suggest for spokespeople if asked.

On the day it went live, I unlocked my phone at 5.30am hoping the story had been picked up. A quick search found the ABC story and news.com.au coverage. By 6am I was getting texts about the story on ABC breakfast radio. By 8am Professor Sutton had tweeted about it. By 10am the story was on all the major newspaper homepages. At the end of that day, the story had more than 200 overwhelmingly positive media mentions and huge social media interest. Our eight social media posts were shared widely. Over 19,000 people saw them on Twitter, 6,000 in LinkedIn, 1,600 on Facebook and 1,200 on Instagram.

It's always a relief when hard work pays off. Working in the media space, there's never any guarantees despite all your good work and planning. The success of this episode was a reminder to me of the power of good stories and great storytelling. Being vulnerable is a strength and a powerful way to connect, especially with those we've never met.

Being part of the campaign was an honour and one of my proudest work moments at Ahpra.

1 Web statistics include staff working remotely as well as external visitors.
2 Practitioners also search the register to check the status of their registration.

We seek feedback on an ongoing basis

What do practitioners and the community think about us?

We surveyed a random sample of health practitioners and community members for a third year. More than 10,200 practitioners and 2,000 people from the broader community responded. The high levels of general public confidence and trust in Ahpra to keep the public safe that were first benchmarked in 2018 were sustained (over 70%). A total of 73% of the broader community said they trust a National Board and 68% were confident the Board (of which they were aware) was doing everything it could to keep the public safe. Practitioners who expressed trust in Ahpra increased to 58%, and to 63% for trust in National Boards. Perhaps due to community focus on the COVID-19 pandemic for much of 2020, overall knowledge of Ahpra among the broader community dropped to 43% but remained constant among practitioners at 78%.

Consulting with advisory groups

Professions Reference Group

'The Professions Reference Group (PRG) provides an excellent forum for the exchange of information and ideas between Ahpra and practitioners via the professional associations. This has been all the more critical during the pandemic, which has highlighted the importance of the collaborative and consultative approach under which the PRG is conducted.'

Mr Nello Marino, Chair, PRG
CEO, Australian Podiatry Association

With a membership representing the professional associations for each of the regulated professions, the PRG met seven times. It discussed consultations, gave feedback to projects and was updated on operational changes across Ahpra. Feedback on policy consultations included a framework for identifying and dealing with vexatious notifications, an update on implementation of policy directions issued by the Health Council, the shared revised *Code of conduct* preliminary consultation, user testing of advertising compliance and enforcement strategy documents, and revised regulatory principles for the National Scheme.

Ahpra updated PRG members on the *National Scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025, National Scheme strategy 2020–2025* and work to improve management of notifications. PRG members shared Ahpra information on their organisations' websites, with their members and stakeholders and social media networks. Information shared included *Taking care* podcasts, a public statement on *No place for sexism, sexual harassment or violence in healthcare*, guidance on COVID-19 vaccinations, the pandemic response sub-register extension and a call for applications to the National Boards. The PRG publishes a communiqué after each of its meetings.

Community Reference Group

The Community Reference Group (CRG) worked with the Agency Management Committee to strengthen the connection between the two groups. This included revising CRG's terms of reference to put a greater emphasis on its role in amplifying the voice of the community within the National Scheme.

The CRG provided advice and feedback on a range of consultations, including the shared *Code of conduct*, the tranche 2 amendments to the National Law, the National Boards' work to support professional practice, Ahpra's data strategy and the review of the English language skills registration standards.

Members represented the community and consumer view on the various working groups including the Forum of National Registration and Accreditation Chairs and the Accreditation Liaison Group, and nominated a representative for the new independent Accreditation Committee. The CRG publishes a communiqué after each of its meetings.

Solving callers' queries

Customer Experience Manager Melita Fusco explains:

Ahpra's Customer Service team is busy all year around, taking over 1,000 calls many days. The nature and volume of the calls can fluctuate, with the new graduate season and nursing and midwifery renewal period being particularly busy.

Every call is important, and callers want an answer straightaway. Some callers do hang up if they can't wait for their call to be answered. We offer a callback service now, so callers can hang up and receive a call back while maintaining their position in the queue.

We hear stories every day of applicants feeling stressed about getting registered in time for a potential job or anxious about getting their documents and applications correct. We often need to reassure them that we will be in touch if we need any further information.

Every day we get a small number of calls that are very serious, such as where the caller has made a notification or been the subject of one. Even if the outcome of a notification is to take no further action after an investigation, it can be a stressful experience for the practitioner. Practitioners often feel a notification can affect their reputation if others find out. Notifiers often feel they haven't been heard.

Our priority is to support the caller. We have a robust escalation process that helps us handle calls, and, if needed, to transfer a distraught caller to someone who is familiar with their case or to Lifeline or to 000 when a caller is suicidal and/or at risk of immediate harm. After doing our best to help the caller, we also need to support the customer service officer, floor support and team leaders. We have a strong employee assistance program, and encourage staff to use it.

We are a committed crew. We care and go to as much effort as we can to resolve a caller's query.

Trust is fundamentally important to being an effective regulator

Our goals for effective engagement

Build interest in and understanding of regulation by the community and practitioners

To build trust in the scheme

Elicit and understand community and practitioner expectations

So that we can address expectations

Our policies and programs are based on best available evidence and reflect the relevant expertise of our key stakeholders

So that we can be effective

Promote informed practices to regulate more effectively and efficiently

For safer healthcare

Improved collaboration and coordination with partners in patient safety

For patient safety

Provide more positive experiences of our processes

So that people are not discouraged from engaging with us

Towards a culturally safe and racism-free health system

One year in, important progress has been achieved in implementing the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy.

Aboriginal and Torres Strait Islander Health Strategy Group

The Aboriginal and Torres Strait Islander Health Strategy Group provided strategic advice during the implementation of the *National Scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025*.

Embedding cultural safety into codes, standards and guidelines

The Wordsmithing working group, a small group of strategy group members, has reviewed and provided feedback to embed cultural safety into profession codes of conduct, accreditation standards and profession guidelines. The group has embedded cultural safety in 15 of the 16 regulated health professions.

Aboriginal and Torres Strait Islander Employment Strategy

In late 2020, the inaugural *Ahpra Aboriginal and Torres Strait Islander employment strategy 2020–2025* was released. Alongside this strategy, Ahpra welcomed an identified role to lead the implementation of the strategy. The strategy focuses on creating a culturally safe work environment that increases our Aboriginal and Torres Strait Islander workforce and reflects the communities in which we operate and serve.

Reconciliation Action Plan

In April, Ahpra launched its second Reconciliation Action Plan (RAP) – this time at Innovate level. Our RAP sits under the *National Scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025* and is led by Ahpra's National RAP Working Group as well as local RAP working groups in every state and territory office. The RAP is a framework of practical actions that drives our contribution to reconciliation and guides us toward respectful relationships and meaningful opportunities with Aboriginal and Torres Strait Islander Peoples.

Our vision for reconciliation is a healthcare system in which Aboriginal and Torres Strait Islander Peoples receive care that is culturally safe and meets their needs. Our vision is for a healthcare system that is also culturally safe for Aboriginal and Torres Strait Islander health practitioners, in any profession, in any setting.

Moong-moong-gak cultural safety training

PwC Indigenous Consulting (PIC) started delivering the Moong-moong-gak cultural safety training program in February to 1,400 Ahpra staff, Board and committee members. PIC is providing the program with online and face-to-face components, true to the intentions of the procurement and integrity of the National Aboriginal Community Controlled Health Organisation (NACCHO) cultural respect framework, all while adapting to real-time lockdowns and jurisdictional safety measures. By 30 June, 1,159 people had enrolled in the training and 556 participants from ACT, Northern Territory, Queensland, South Australia and Tasmania had completed it.

The Moong-moong-gak cultural safety training provides participants with knowledge, skills and capabilities to critically reflect on themselves as individuals, and how to identify and respond to racism. Ahpra staff, Board and committee members are required to complete the program and critically reflect on work and Board practices to embed culturally safe practices into the everyday workplace and Board business. The feedback from participants is very positive.

'It was a revelation. The Moong-moong-gak training was new to me and I was genuinely educated by the content. It is without doubt the most transformative education I have done in many years.'

'I found the Moong-moong-gak cultural safety training particularly resonated with me as a person of colour. The training provided me with insight into the hidden histories and stories of Aboriginal and Torres Strait Islander Peoples, a subject I didn't have the opportunity of learning about in school. I found the content beneficial and necessary.'

'The clear message for me was that Australian history was never taught in Australian schools, with the focus being on colonial history. That hidden history is so important in understanding the strengths of our First Nations peoples and the struggles that they continue to experience.'

Artwork (this page and opposite) by Leon Design

Working with governments

Ahpra maintains a strong working relationship with Commonwealth, state and territory health departments, primarily through its Jurisdictional Advisory Committee.

National Law amendments

Ahpra and the National Boards welcomed the opportunity to provide feedback on a targeted consultation draft amendment Bill. The Bill proposes reforms to the National Law that have been agreed by Health Ministers to update the guiding principles and objectives of the National Scheme to strengthen public protections, improve governance arrangements and registration processes, and to increase the regulatory responses that are available to respond to risks to the public.

Government inquiries

National Boards and Ahpra have contributed to a number of inquiries. Of particular note are:

Royal Commission into Aged Care Quality and Safety

The Australian Government's response to the final report of the Royal Commission was published on 11 May. Ahpra and the National Boards will continue to work with the Australian Government as it progresses a new regulatory scheme – National care and support worker regulation. We expect there will be interactions between our schemes and appreciate the opportunity for early engagement with the Australian Government.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

National Boards and Ahpra welcomed the invitation from the Commissioners to contribute to a public hearing that examined the education and training of health professionals in relation to the healthcare and treatment of people with cognitive disability.

Senate inquiry into the administration of registration and notifications by Ahpra and related entities

In May, Ahpra and the National Boards made a joint submission to the inquiry about our administration of the National Scheme to protect the public. We work hard to be transparent about the operations and performance of the National Scheme and do not shy away from public scrutiny. Our submission highlighted improvements that have been made and emphasised our continuous improvement agenda to further strengthen public protections and ensure the scheme is efficient, effective and fair.

Contributing internationally

World Health Organization

Ahpra has continued its work as a recognised World Health Organization (WHO) Collaborating Centre for Health Workforce Regulation. The centre works in partnership to strengthen the capacity and skills of regulators in the Western Pacific Region of WHO.

The Western Pacific Regional Network of Health Workforce Regulators, with members from approximately 20 countries, held three regional network webinars on health workforce regulation topics.

In February, Ahpra's CEO accepted an invitation to join the global WHO Technical Expert Group (TEG) on Health Practitioner Regulation. The TEG is an advisory body that is developing guidance on the design, reform and implementation of good practice health practitioner regulation in member states of WHO.

In June, the Western Pacific Region of WHO hosted a virtual meeting, chaired by Ahpra, to consult with member states on the draft regional framework for strengthening traditional medicine systems.

CLEAR

Ahpra staff have shared in the Council for Licensure, Enforcement and Regulation (CLEAR) webinars, discussion groups and podcasts. In September, Ms Kym Ayscough, Ahpra's Executive Director for Regulatory Operations, completed her term as President of CLEAR.

IAMRA

Ahpra's CEO served as a member of the Management Committee of the International Association of Medical Regulatory Authorities (IAMRA).

REAG

The International Regulatory Expert Advisory Group (REAG), chaired by Ahpra's CEO, aims to provide and share multi-disciplinary knowledge and expert advice to support the development of strategies and approaches to challenging contemporary regulatory issues.

This year, meetings have centred on developing responses to challenging strategic issues, including the continuing impact of COVID-19, supporting practitioner health and wellbeing, and addressing changing community expectations around diversity, equity and inclusion. Its most recent meeting focused on the role of regulators in addressing the important social issue of racism, including what it means for our own operations and what it means for our regulation of the professions. Outcomes for implementing our scheme and Aboriginal and Torres Strait Islander health strategies include:

- the importance of active involvement in decision-making by the peoples who are affected by racism
- an acknowledgement that regulation can be a tool to challenge healthcare injustice; however, regulation needs to understand its place in tackling these issues on personal, moral, organisational and legislative levels
- the potential to identify and harness people of goodwill who are already working in the system and who want to challenge and to do things differently.

Combined meeting to share and improve

Disruption prompting discussion and transformative change

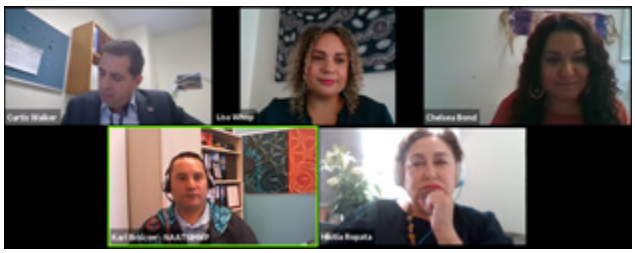
The annual All Boards Combined Meeting of the National Scheme was held virtually in March with the theme of *Emerging stronger and better together*.

The broad context for the meeting was to acknowledge the many ways in which 2020 was a year that was not only unexpected, but also brought to the fore issues that many within the health system had been grappling with for years. When will our next pandemic be and how will we respond when it occurs? How can we work together to quickly and safely respond to the immediate public health crisis, protect our frontline health workers, and ensure the broader sustainability of our health system in both the immediate and longer term?

The year also brought into plain view questions of systemic racism, equity and trust – in access to healthcare and vaccines – and also fundamental questions about the nature of our health system, and our roles, as health practitioners and regulators, in ensuring safe, accessible and equitable health outcomes and care for all.

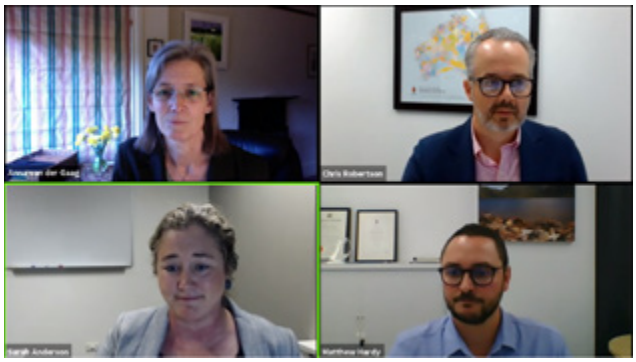
Opening session: Who are we here for?

Black Lives Matter: How should regulators respond?



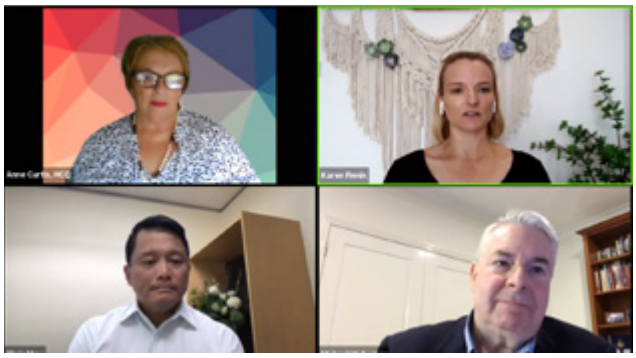
Neglect: The need for major change in aged care

Can AI transform notifications?



What does it mean to be a truly accessible regulator?

Telehealth: Is the onsite visit to your health practitioner so 2019?



Leading, directing and managing

Agency Management Committee

The Agency Management Committee, Ahpra's governing body, meets up to 11 times per year. The Committee publishes a communiqué of meetings that summarises issues discussed and decisions made.

It has established four committees:

- **Finance, Audit and Risk Management Committee** is responsible to the Agency Management Committee for the oversight of risk and to provide advice on the effectiveness of the corporate assurance framework and risk management, financial strategy, sustainability and internal audit functions. The Committee also provides oversight of the external audit process.
- **Regulatory Performance Committee** is responsible for making recommendations to the Agency Management Committee to: strengthen the performance culture across the National Scheme; provide oversight and scrutiny of regulatory performance measures and data; and provide assurance that any organisational performance-related issues, including the consistency of data and statistics, are being well managed.
- **People and Remuneration Committee** was established to help the Agency Management Committee to effectively discharge its functions by providing governance oversight of strategy and performance in relation to people, capability and culture within the National Scheme.
- **Accreditation Advisory Committee** was established by the Agency Management Committee to provide oversight and leadership on accreditation governance, accountability and transparency issues, and a whole-of-scheme perspective on Ahpra's management of contracts for the performance of the accreditation functions.

National Executive

The National Executive is Ahpra's national leadership group. Its members were:

- Mr Martin Fletcher
  Chief Executive Officer
- Ms Kym Ayscough
  Executive Director, Regulatory Operations
- Ms Elizabeth Davenport
  Chief Finance Officer, Finance and Risk
- Mr Mark Edwards
  Executive Director, People and Culture
- Mr Chris Robertson
  Executive Director, Strategy and Policy
- Mr Clarence Yap
  Chief Information Officer, Information Technology.

Directorates

Ahpra has five directorates:

Regulatory Operations carries out Ahpra's core regulatory functions – registration, notifications and compliance – and includes the national legal practice. It continues to mature in the application of risk-based assessment of regulatory matters, so we can focus our regulatory efforts and resources on matters of high risk and high complexity and resolve other matters more quickly wherever possible.

Strategy and Policy's purpose is to protect the public through effective and responsive strategy, policy, engagement and regulatory governance. It provides high-quality national services that are multi-profession in their focus. It works in partnership with National Boards and collaboratively with accreditation authorities and partners to fulfil our regulatory functions.

People and Culture is accountable for whole-of-organisation people initiatives that drive employee engagement and include services such as learning and organisational capability, health, safety and wellbeing, recruitment, payroll and property and facilities.

Finance and Risk comprises business professionals responsible for efficient and effective financial strategy and management, procurement, risk management and assurance and audit programs.

Information Technology partners with all internal and external stakeholders in providing the required technology and services to support health practitioner regulation in Australia.

How Ahpra is structured

Chief Executive Officer

Executive Director Regulatory Operations
- National Director Notifications
- National Director Registration
- National Director Compliance
- General Counsel
- National Complaints Manager
- National Manager Business Transformation
- National Business Coordinator Regulatory Operations

Executive Director Strategy and Policy
- National Director Policy and Accreditation
- National Director Strategy
- National Director Regulatory Governance
- National Director Engagement and Government Relations
- National Director Business Transformation
- Executive Officer Medical
- Executive Officer Nursing and Midwifery
- National Business Coordinator Strategy and Policy

Executive Director People and Culture
- National Director Employee Services
- National Director Organisational Capability
- Senior People and Culture Business Partners

Chief Financial Officer
- Deputy Chief Financial Officer
- National Director Organisational Risk and Resilience

Chief Information Officer
- National Director IT Strategy and Architecture
- National Director IT Service Development
- National Director IT Service Management and Operations
- National Director IT Management

Table 38. Staff, 30 June

Directorate	Full-time equivalent staff
Regulatory Operations	711
Strategy and Policy	198
Information Technology	105
Finance and Risk	42
People and Culture	42
Office of the CEO	2
Total	**1,100**

State and territory managers

Our state and territory managers are our senior leaders in each jurisdiction, and are based at each of our offices:

- Australian Capital Territory: Mr Anthony McEachran
- New South Wales: Ms Jane Eldridge
- Northern Territory: Ms Helen Egan
- Queensland: Ms Heather Edwards
- South Australia: Ms Sheryle Pike
- Tasmania: Mr David Clements
- Victoria: Dr Clarissa Martin PhD
- Western Australia: Mrs Karen Banks.

Financial management

Ahpra and the National Boards work in partnership to deliver financial performance. The financial statements section of this report describes the performance in more detail, including the net result and equity position for each National Board.

Financial overview

Key results for the past five years are summarised in Table 39.

Both total income and expenses from transactions have steadily increased since 2016/17. The fluctuation in the net result for each period reflects growing business operations to support the scheme and phasing of investment in technology programs. The overall net result of $17.3 million in 2020/21 is an increase from $6.7 million in 2019/20.

Fluctuations in net cash flows reflect the timing and any changes in registration renewals, employee and vendor payments and operating results.

Table 39. Financial results, 2017–21

Five-year financial summary	2021 ($ million)	2020 ($ million)	2019 ($ million)	2018 ($ million)	2017 ($ million)
Income from government grants	**4.6**	1.7		1.6	
Income from operating activities	**230.6**	218.8	203.2	183.2	173.2
Total income from transactions	**235.2**	220.4	203.2	184.8	173.2
Total expenses from transactions	**217.8**	213.8	209.0	196.6	179.2
Net result for the period	**17.3**	6.7	(5.8)	(11.8)	(6.0)
Net cash flow from operating activities	**37.7**	24.4	20.0	2.7	3.9
Income collected on behalf of government agencies	**39.3**	37.1	34.3	31.3	30.9
Total assets	**284.7**	266.4	208.1	196.4	192.1
Total liabilities	**197.9**	196.9	145.3	113.4	104.3

Financial performance

The National Scheme income for the full financial year to 30 June was $235.2 million, an increase of $14.8 million from 2019/20. The growth was due to an increase in registration income and government grants. Fees are set for each National Board to meet the full costs of regulation for each profession. Five National Boards froze their registration renewal fees, eight Boards increased their fees by 2.5% or 3.0%, and two Boards reduced them.

The scheme income sources for 2020/21 and the prior year are summarised below.

Table 40. Income

Income	2020/21 ($ million)	2019/20 ($ million)
Registration and application fee income	**222.4**	210.5
Interest income	**2.6**	4.0
Grant income	**4.6**	1.7
Accreditation	**0.3**	0.5
Certificate of registration status	**0.2**	0.3
Legal fee recovery and fines	**1.7**	0.7
Examinations	**1.7**	1.2
Practitioner Information Exchange	**1.1**	0.9
Application for registrar program	**0.3**	0.3
Other	**0.3**	0.4
Total	**235.2**	**220.4**

Grant funding from the Commonwealth Department of Health provided $4.6 million in support to Ahpra and National Boards to increase the number of health practitioners registered and available to work in the health system in response to COVID-19.

Total expenses from transactions were $217.8 million, an increase of $4.0 million from 2019/20. The higher net result realised this year was due to increased income and reductions in expenditure from the impact of COVID-19 on business as usual and project delivery, offset by enterprise agreement wage increases, additional resource and technology costs of business continuity and the response to increase Australia's health workforce capacity.

Financial position

The balance sheet remains healthy at 30 June 2021, with the largest contributor to this being both cash and term deposits held that includes $109.5 million registration fees paid in advance. Overall net assets (equity) increased by $17.3 million to $86.9 million.

The financial statements provide disclosure of income and expenditure by each National Board for the year and the equity balances held at year end. The amounts held are assessed against equity targets, based on independently developed actuarial models.

Equity serves several important purposes, including:

- mitigating against unexpected loss not covered by the National Scheme's comprehensive insurance
- funding capital and strategic projects that support the effective and efficient operation of Boards and the Scheme
- offsetting the impact to the financial position due to variance in the operating result.

The equity balance at June 2021 includes funding for strategic projects that were deferred by 12 to 24 months due to restrictions or other consequences of COVID-19. These projects have been committed to by Boards and the Scheme to support effective and efficient operation.

Assets

Current assets increased by $53.5 million to $137.0 million in 2021, largely offset by the $27.5 million reduction in long-term investments and the $8.7 million consumption of right-of-use property lease assets. As term deposit rates decline, a change to investment policy is being considered and we made more short-term investments to ensure funds can be readily accessed at maturity for transition to new types of investments, which will be beneficial to realise early improvement to return on assets.

Capital expenditure

Capital expenditure was below anticipated levels with several approved projects being delayed. IT capital projects were delayed as the team prioritised requirements for work from home, implementation of the second stage of the IT restructure and adjustment to the lead-in phase of our transformation program.

Liabilities

The significant increase in employee benefits provisions arises from business growth, maturity in years of service, wage inflation and economic revaluation of long service leave and lower than accrued levels of annual leave taken due to pandemic restrictions.

The year ahead

We expect the overall financial performance in 2021/22 to be a smaller operating surplus, then to stabilise over the coming years consistent with our five-year financial plan.

Risk management

Ahpra's *Corporate assurance framework* aims to provide sufficient, continuous and reliable assurance on the management of major risks to continuously improve regulatory services to the Australian community. Ahpra, in partnership with National Boards, seeks to manage risks in ways that allow us to meet the objectives of the National Scheme Strategy.

During 2020/21, the National Scheme managed its risks within the following risk themes:

- Regulatory performance
- Business transformation, continuity and resilience
- Improving the health of Aboriginal and Torres Strait Islander Peoples and protecting all vulnerable communities
- Financial sustainability
- Public confidence/trust
- Data governance
- People and culture
- Health practitioner workforce sustainability.

Risks are managed in accordance with the Australian and New Zealand Standard (AS/NZS ISO 31000:2018) and the risk management processes are an element of Ahpra's *Corporate assurance framework*. The corporate assurance and risk management processes are integrated with the strategic and business planning processes and come from many sources within the organisation.

Insurance policies are in place to adequately mitigate the risk of financial losses arising from an (insured) event.

Corporate legal compliance

In addition to regular reporting to Finance, Audit and Risk Management Committee (FARMC), we have undertaken the following tasks to improve governance and compliance:

- a review of Ahpra's *Procedure to respond to a breach of privacy* in consultation with the National Health Practitioner Ombudsman (NHPO) to ensure it reflects best practice and encourages open reporting of privacy breaches by staff
- a review and re-draft of Ahpra's *Privacy policy* to implement recommendations made by the NHPO in its *Review of confidentiality safeguards for people making notifications about health practitioners* December 2019 report
- amendment of Ahpra's *Fraud and corruption control framework* to include clear reference to ethical issues and community expectations, and to clarify the interaction between the framework and Ahpra's *Public interest disclosure policy*
- starting the roll-out of an Ahpra-wide legislative compliance program using existing technology to automate reporting.

Ahpra's *Public interest disclosure policy* is for the use of Ahpra staff as well as members of the public. Nine referrals were received by Ahpra's whistleblower hotline provider, Deloitte. After an assessment, none of these referrals were found to meet the criteria of public interest disclosures. No matters were referred to the Independent Broad-based Anti-corruption Commission IBAC (Vic) or Independent Commissioner Against Corruption ICAC (NT).

Administrative complaints

When – and why – people complain about us

Ahpra aims to listen to the concerns that people raise, respond to complaints promptly, empathetically and fairly, and to learn from the issues raised.

Administrative complaints relate to concerns about the service delivery, policies, procedures and decisions of Ahpra, National Boards and Committees, and the Agency Management Committee.

Straightforward complaints (stage 1) are handled by the Ahpra area that receives them, and complex complaints (stage 2) are managed by a National Complaints team. Stage 3 complaints are investigated or reviewed externally by the National Health Practitioner Ombudsman (NHPO).

We have improved the information we collect about complaints. This year's increase in the number of complaints received is attributed to:

- implementing online submission of complaints in July 2020, which has made it easier for people to make a complaint
- reporting stage 1 complaints that are submitted online; previously these were not included.

Table 41 outlines who raised complaints. Most complaints – 536 – were received from health practitioners. People who had made a notification about a health practitioner made 149 complaints. Ahpra also received 48 complaints made as a result of public campaigns encouraging people to raise an issue with Ahpra. We received public campaign complaints about statements made by Ahpra and the National Boards in support of the COVID-19 vaccination program and about regulatory action taken about specific health practitioners.

Table 41. Source of administrative complaints

Who made the complaint?	Number
Employer	14
Health practitioner (applicant)	373
Health practitioner (notification)	89
Health practitioner (other)	64
Member of Parliament	1
Member of the public	74
Notifier	149
Public campaign	48
Total	**812**

Issues raised

Table 42 shows the issues raised. A complaint may include more than one issue.

Table 42. Administrative complaints by issue

Issues raised	Number
Dissatisfaction with regulatory outcome	253
Delay	241
Communication	188
Process/policy	187
Fees	44
COVID-19	35
Privacy breach	15
Other	70

Table 43 shows the number of complaints (812) we received by profession, with information about the 892 issues raised. A complaint may include more than one issue.

Table 43. Stage 1 and 2 administrative complaints by profession

Profession	Complaints received	Stage 1	Stage 2	Registration	Notifications	Customer service team interactions	Compliance	IT/website issues	Other
Aboriginal and Torres Strait Islander Health Practice	2		2						2
Chinese medicine	6	2	4	6					
Chiropractic	6	2	4	4	4				1
Dental practice	32	8	24	17	13		3	2	1
Medical practice	323	123	200	99	221	6	9	5	24
Medical radiation practice	9	3	6	10	2	1	1		
Nursing and midwifery	232	103	129	177	38	9	6	4	15
Occupational therapy	7	3	4	5	0	1			1
Optometry	4		4	1	3				
Osteopathy	1		1	1	1				
Paramedicine	20	4	16	15	3		1	1	
Pharmacy	19	10	9	18			2	1	
Physiotherapy	15	7	8	12	3	1	1		
Podiatry	4	2	2	2	1		3		
Psychology	132	40	92	78	43	7	4	3	
Total	**812**	**307**	**505**	**445**	**332**	**25**	**30**	**16**	**44**

Registration complaints – top 4 issues

In the 445 complaints received about registration, perceived delay in our management of applications was raised 174 times, policies or processes 118 times, communication 87 times, and the outcome 65 times.

Notification complaints – top 4 issues

In the 332 complaints received about notifications, dissatisfaction with the outcome was raised 218 times, communication 56 times, policies or processes 49 times, and the time taken to finalise a notification 48 times.

Resolving complaints

We responded to 798 complaints. When we receive a complaint, we carefully review the information provided and how people would like their complaint resolved. We then conduct a review of the information we hold and endeavour to respond in a way that meaningfully addresses the concerns raised.

Table 44 outlines the actions we took to resolve complaints this year. A complaint may include more than one issue.

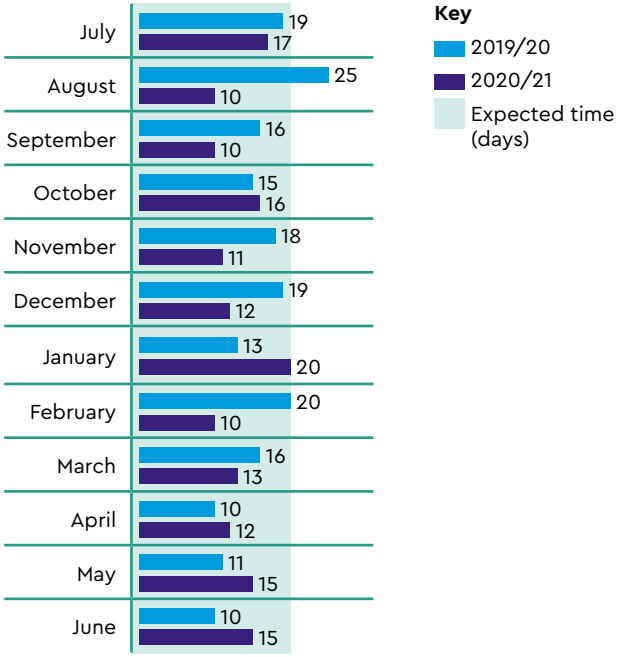
Table 44. Action taken on the issues raised

Action taken to resolve issues	Number
Provided further explanation to complainant	517
Offered apology	256
Provided an update on progress of regulatory matter	160
Corrected an error	16
Arranged for a regulatory matter to be reconsidered	6
Offered a refund	9
Undertook to review a process or policy	81
Other	121

Performance

We aim to respond to complaints within 20 business days. Figure 90 shows that our average time to respond was consistently below the expected timeframes.

Figure 90. Time to finalise complaints (days)



Engaging with the NHPO

The NHPO receives complaints and helps people who think they may have been treated unfairly in administrative processes by the national agencies in the National Scheme. We engage collaboratively with the NHPO to resolve complaints and value its contribution.

Under our early resolution transfer process with the NHPO, 143 complaints were handed to us to resolve directly.

We responded to 81 enquiries received from the NHPO seeking preliminary information about a complaint. We also provided documents and other information in response to 96 notices of investigation from the NHPO.

A complaint can be reported more than once if a person complains to both Ahpra and the NHPO.

Listening to complaints

Amanda Watson, National Complaints Manager, explains:

The work of our National Complaints team is busy and diverse. We manage complex concerns that relate to all areas of our regulatory work.

Sometimes it is difficult to resolve complaints to everybody's satisfaction if people are hoping for an outcome that we can't provide, like overturning a decision to take no further action regarding a notification. We always do our best to provide people with a response to their complaint that better explains the way we work to protect the public and how their matter was handled.

In this last year we learnt that a document on our website had a link that wasn't working. We heard again that sometimes our notifications process can feel cold and impersonal and that small efforts to personalise our communication with people goes a long way to address this. After reviewing themes from a cohort of complaints from registered health practitioners about renewals we learnt that sometimes people forget to renew their registration and then fall off the register, unintentionally causing disruption for themselves and their patients when they cannot practise.

We address issues to ensure that in the future people have a better experience with us. It was easy to fix the broken document link on our website once we knew about it. We trialled sending an SMS to registered health practitioners who had not yet renewed a few days before their renewal ended to see if this reduced the number of 'fast track' applications for registration received shortly after the renewal ended.

We recognised that there are improvements we could make to how we communicate with people during the notifications process. We work with our notifications team to embed a more personal communication style to ensure that we communicate with people in a way that makes our notifications process as accessible and transparent as possible.

Freedom of information requests

Ahpra received:

- **204** valid applications for access to documents under the *Freedom of Information Act 1982* (FOI Act)
- **13** applications for internal review of an FOI decision.

The National Health Practitioner Privacy Commissioner (NHPPC) notified Ahpra that:

- **9** applications for external review of an Ahpra FOI decision had been made
- **7** external reviews had been closed because they were withdrawn.

The NHPPC provided notice that Ahpra's FOI decision had been affirmed in three matters. In another two matters, the NHPPC notified Ahpra that a decision about not releasing documents was being upheld, but that the reasons for withholding access had been varied. Ahpra was advised that five applicants had withdrawn their applications for external review.

During the year, 248 FOI applications were finalised. Outcomes are shown in Table 45. At 30 June, 42 FOI matters were open and had not been finalised.

Table 45. Finalised FOI applications

Application outcome	Number
Granted in full	23
Granted in part	117
Access refused	51
Withdrawn	35
Internal review	13
External review	9

Table 46 describes the nature of the documents sought by FOI applicants.

Table 46. Documents sought by FOI applicants

Document type	Number of FOI applications
Notifications/complaints	207
Registration applications and decisions	24
Monitoring and compliance of registration restrictions	9
Criminal offences	2
Coroner's matter	1
Statistics and general data	2
Request to correct a record	1

Evidentiary certificates

Ahpra issued 155 evidentiary certificates, most in response to requests from our co-regulatory partners, health complaints entities and police, to help them to perform their functions in the community.

Production of documents

We responded to 105 subpoenas and orders to produce documents issued by courts, tribunals and law enforcement bodies about proceedings in which neither Ahpra nor a National Board was a party.

'Good humaning'

Annabelle, Senior Freedom of Information Officer, says:

Ahpra is a complex organisation. Our team decides whether Ahpra's documents can be released externally. Our National Information Release Unit (NIRU) receives hundreds of formal requests for access to documents each year. It's clear that a lot of the people asking for these documents are going through tough times – for example, they may have lost a loved one, or something has happened to them personally and they are trying to find answers to explain their situation.

One of the great things about NIRU is the humanistic approach the team takes to dealing with people. My predecessor coined the phrase 'good humaning'. Good humaning involves making decisions in a way that weighs up other people's needs. I interpret this as looking behind an individual's behaviour and asking what I can do to help. The process of releasing documents under the Freedom of Information Act *means I must work within a statutory framework. However, applying the principle of 'good humaning' means I take the time to talk to people, listen to their story, be respectful of their experience, treat them with dignity, and have the hard conversations upfront. It can be difficult and time-consuming to do, particularly when trying to get work done and deadlines are looming, but good humaning means that I ask myself what can I do to help and how would I like to be treated in this situation.*

Australian Health Practitioner Regulation Agency

Financial statements for the year ended 30 June 2021

Declaration by Chair of the Agency Management Committee, Chief Executive Officer and Chief Financial Officer

The attached financial statements for the Australian Health Practitioner Regulation Agency have been prepared in accordance with Part 3 of Schedule 3 to the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory, Australian Accounting Standards and Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the *Statement of comprehensive income*, *Statement of financial position*, *Statement of changes in equity*, *Statement of cash flow*, and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2021 and financial position of the Australian Health Practitioner Regulation Agency at 30 June 2021.

At the time of signing, we are not aware of any circumstance that would render any particulars included in the financial statements to be misleading or inaccurate.

We are authorised by the Agency Management Committee to issue the attached financial statements on this day.

Gill Callister PSM

Chair, Agency Management Committee

26 August 2021

Martin Fletcher

Chief Executive Officer

26 August 2021

Elizabeth Davenport FCPA

Chief Financial Officer

26 August 2021

Independent Auditor's Report

Victorian Auditor-General's Office

To the Agency Management Committee of the Australian Health Practitioner Regulation Agency

Opinion

I have audited the financial report of the Australian Health Practitioner Regulation Agency (the agency) which comprises the:

- statement of financial position as at 30 June 2021
- statement of comprehensive income for the year then ended
- statement of changes in equity for the year then ended
- statement of cash flows for the year then ended
- notes to the financial statements, including significant accounting policies
- declaration by chair of the agency management committee, chief executive officer and chief financial officer.

In my opinion the financial report presents fairly, in all material respects, the financial position of the agency as at 30 June 2021 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 3 of the *Health Practitioner Regulation National Law Act* and applicable Australian Accounting Standards.

Basis for Opinion

I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report.

My independence is established by the *Constitution Act 1975.* My staff and I are independent of the agency in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Agency Management Committee's responsibilities for the financial report

The Agency Management Committee of the agency is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Health Practitioner Regulation National Law Act*, and for such internal control as the Agency Management Committee determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the Agency Management Committee is responsible for assessing the agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

Level 31 / 35 Collins Street, Melbourne Vic 3000
T 03 8601 7000 enquiries@audit.vic.gov.au www.audit.vic.gov.au

Auditor's responsibilities for the audit of the financial report

As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit 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 agency's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Agency Management Committee
- conclude on the appropriateness of the Agency Management Committee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the agency to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Agency Management Committee regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

MELBOURNE
15 September 2021

Travis Derricott
as delegate for the Auditor-General of Victoria

Australian Health Practitioner Regulation Agency

Statement of comprehensive income for the year ended 30 June 2021

Continuing operations	Note	2021 $'000	2020 $'000
Revenue and income from transactions			
Registration and application fee	*A1*	222,369	210,464
Interest income	*A2*	2,589	3,977
Grant income	*A3*	4,581	1,679
Other income	*A4*	5,638	4,311
Total revenue and income from transactions		**235,177**	**220,431**
Expenses from transactions			
Employee costs	*B1.1*	140,707	130,552
Board and committee sitting fees		5,881	6,188
Legal and notification costs		12,854	12,487
Accreditation expenses		9,893	9,535
Other operating expenses	*B2*	34,862	41,981
Depreciation and amortisation	*C4*	12,804	12,092
Finance costs – leases	*E1*	837	941
Total expenses from transactions		**217,838**	**213,776**
Net result for the year		**17,339**	**6,655**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency

Statement of financial position as at 30 June 2021

	Note	2021 $'000	2020 $'000
Current assets			
Cash and cash equivalents	*E2*	10,661	15,812
Receivables	*D1*	2,990	2,379
Investments	*C1*	120,500	63,000
Prepayments	*D3*	2,871	2,313
Total current assets		**137,022**	**83,504**
Non-current assets			
Long-term investments	*C1*	89,000	116,500
Property, plant and equipment	*C2*	49,347	58,090
Intangible assets	*C3*	9,396	8,312
Total non-current assets		**147,743**	**182,902**
Total assets		**284,765**	**266,406**
Current liabilities			
Payables and accruals	*D2*	10,808	7,873
Income in advance	*A1*	109,538	107,062
Employee benefits	*B1*	24,267	21,439
Lease liability	*E1*	7,576	7,191
Other provisions	*D4*	194	921
Total current liabilities		**152,383**	**144,486**
Non-current liabilities			
Employee benefits	*B1*	4,115	3,855
Lease liability	*E1*	40,654	47,728
Make good provision	*D4*	754	817
Total non-current liabilities		**45,523**	**52,400**
Total liabilities		**197,906**	**196,886**
Net assets		**86,859**	**69,520**
Equity			
Contributed capital	*G7*	43,895	43,895
Accumulated surplus	*G7*	42,964	25,625
Total equity		**86,859**	**69,520**
Commitments	*E3*		
Contingent assets and liabilities	*F3*		

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 2021

	Note	Contributed capital $'000	Accumulated surplus $'000	Total equity $'000
Balance at 1 July 2019		**43,895**	**18,970**	**62,865**
Net result for the year			6,655	6,655
Balance at 30 June 2020		**43,895**	**25,625**	**69,520**
Net result for the year			17,339	17,339
Balance at 30 June 2021	*G7*	**43,895**	**42,964**	**86,859**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency

Statement of cash flows for the year ended 30 June 2021

	Note	2021 $'000	2020 $'000
Cash flows from operating activities			
Payments to suppliers, employees and others		(204,258)	(212,346)
Receipts relating to registrant fees		229,426	216,725
Receipts from government grant	*A3*	0	6,260
Net Goods and Services Tax (GST) received from the Australian Taxation Office (ATO)		5,755	6,344
Other receipts		5,529	4,547
Interest received		2,089	3,771
Interest paid		(837)	(941)
Net cash flows from operating activities	*E2*	**37,704**	**24,360**
Cash flows from investing activities			
Payments for plant and equipment, intangibles and work-in-progress		(5,907)	(7,265)
Purchase of investments		(108,000)	(87,500)
Proceeds of investments		78,000	82,000
Receipts for property, plant and equipment disposal	*C4(2)*	44	0
Net cash flows used in investing activities		**(35,863)**	**(12,765)**
Cash flows from financing activities			
Repayment of principal portion of lease liabilities		(6,993)	(5,953)
Net cash flows used in financing activities		**(6,993)**	**(5,953)**
Net increase/(decrease) in cash and cash equivalents		**(5,152)**	**5,642**
Cash and cash equivalents at the beginning of the year		15,812	10,170
Total cash and cash equivalents at end of the year	*E2*	**10,661**	**15,812**

All amounts are inclusive of GST.

This statement should be read in conjunction with the accompanying notes.

About this report

Reporting entity

Ahpra is a statutory body governed by the National Law, which came into effect in most states and territories on 1 July 2010 and in Western Australia on 18 October 2010. This law means that registered health professions are regulated by nationally consistent legislation.

Ahpra supports the National Boards in the administration of the National Scheme across Australia. National Boards are responsible for regulating their respective health professions. The primary role of the National 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 of the Agency Management Committee is Ms Gill Callister PSM. The Chief Executive Officer is Mr Martin Fletcher.

The financial statements include activities of Ahpra and National Boards.

Ahpra's corporate address is 111 Bourke Street, Melbourne, Victoria, 3000.

Basis of accounting preparation and measurement

The financial statements have been prepared on a going-concern basis.

These financial statements are in Australian dollars and the historical cost convention is used unless a different measurement basis is specifically disclosed in the note associated with the item measured on a different basis.

The accrual basis of accounting has been applied in preparing these financial statements, except for the cash flow information, whereby assets, liabilities, equity, income or expenses are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

Judgements, estimates and assumptions are required to be made about financial information being presented. The significant judgements made in the preparation of these financial statements are disclosed in the notes where amounts affected by those judgements are disclosed. Estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The estimates and underlying assumptions used in preparing these financial statements are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision.

Judgements and assumptions made by management in the application of Australian Accounting Standards (AAS) that have significant effects on the financial statements and estimates relate to:

- the applicable accounting standard in determining revenue and income recognition (refer to *Note A1*)
- assumptions for employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to *Note B1*)
- the fair value of intangible assets (refer to *Note C3*)
- the fair value measurement of financial assets and liabilities (refer to *Note F1*)
- the determination, in accordance with AASB 16 *Leases*, of the lease term, the estimation of the discount rate when not implicit in the lease and whether an arrangement in is substance short term or low value (refer to *Note E1*).

All amounts in the financial statements have been rounded to the nearest thousand dollars unless otherwise stated.

All regulatory fees are exempt from GST legislation. Revenue, 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 or payable to the Australian Taxation Office (ATO) is included in the *Statement of financial position*. The GST component of a receipt or payment is recognised on a gross basis in the *Statement of cash flows* in accordance with AASB 107 *Statement of Cash Flows*.

Income 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.*

Statement of compliance

These financial statements are referred to as general purpose financial statements which have been prepared in accordance with AAS and Interpretations and other mandatory requirements.

The financial statements have also been prepared in accordance with the relevant requirements of the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory.

For the purpose of preparing the financial statements, Ahpra is a not-for-profit entity.

Accounting policies selected and applied in preparing the financial statements for the year ended 30 June 2021 ensure 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 appropriately reported.

These financial statements were authorised to be issued by the Agency Management Committee on 26 August 2021.

Note A: Funding the delivery of our services

Introduction

Ahpra supports the National Boards in the administration of the National Scheme across Australia. National Boards are responsible for regulating their respective health professions. The primary role of the National Boards is to protect the public and set standards and policies that all registered health practitioners must meet.

Ahpra is predominantly funded by registration-related fees to deliver services in partnership with the National Boards.

Income is recognised to the extent that it is probable that the economic benefits will flow to Ahpra and it can be reliably measured. Income over which Ahpra does not have control is disclosed as administered income (see *Note G8*).

Structure

A1. Registration and application fee

A2. Interest income

A3. Grant income

A4. Other income

Note A1: Registration and application fee

Ahpra has assessed AASB 15 *Revenue from Contracts with Customers* as the applicable standard and determined registration revenue as a non-IP licence providing the right to practise.

Applying the low-value licences and short-term licences (with a term of 12 months or less) exemptions under AASB 15 to the recognition of registration and application fee, Ahpra will continue to recognise registration fees over the term of the registration and recognise application fees upfront.

Registrations are payable periodically in advance. Only those registration fees that are attributable to the current financial year are recognised as revenue.

When a person pays an application fee, the fee is recognised in the financial year in which it is received.

	2021 $'000	2020 $'000
Registration fees	206,989	195,509
Application fees	15,380	14,955
Total registration and application fee revenue	**222,369**	**210,464**

Registration fees that relate to future periods are recorded as income in advance within the *Statement of financial position*.

Income in advance	Note	2021 $'000	2020 $'000
Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA)		51	49
Chinese Medicine Board of Australia (CMBA)		714	850
Chiropractic Board of Australia (ChiroBA)		1,055	1,095
Dental Board of Australia (DBA)		5,109	4,839
Medical Board of Australia (MBA)		20,200	19,123
Medical Radiation Practice Board of Australia (MRPBA)		1,188	1,125
Nursing and Midwifery Board of Australia (NMBA)		62,197	57,568
Occupational Therapy Board of Australia (OTBA)		1,097	999
Optometry Board of Australia (OptomBA)		716	661
Osteopathy Board of Australia (OsteoBA)		414	371
Paramedicine Board of Australia (ParaBA)		2,233	2,049
Pharmacy Board of Australia (PharmBA)		4,668	4,448
Physiotherapy Board of Australia (PhysioBA)		1,860	1,721
Podiatry Board of Australia (PodBA)		790	763
Psychology Board of Australia (PsyBA)		7,246	6,820
Government grant	*A3*	0	4,581
Total income in advance		**109,538**	**107,062**

Note A2: Interest income

Interest income is accrued by reference to the principal of a financial asset at the effective interest rate when earned.

	2021 $'000	2020 $'000
Interest on term deposits	2,589	3,977
Total interest income	**2,589**	**3,977**

Note A3: Grant income

Income from grants that are enforceable and with sufficiently specific performance obligations are accounted for under AASB 15 *Revenue from Contracts with Customers*, with revenue recognised as these performance obligations are met.

During 2019/20, a $6.26 million grant consideration was received from the Commonwealth Government in supporting Ahpra to increase the pool of appropriately trained health practitioners registered and available to work in COVID-19-related roles, or to backfill where needed. Other work, related to communicating with practitioners on changes to standards of practice as determined by the National Cabinet, is also supported through this grant.

The grant encompasses activities with measurable performance indicators.

Grant income in advance includes grant consideration received by Ahpra in 2019/20 (*Note A1*). Grant income is recognised when the relevant services are provided and service obligations are met.

In 2020/21, Ahpra has recognised the remaining $4.581 million grant received as income. All work covered by the grant was delivered by 7 April 2021.

Grant income in advance	2021 $'000	2020 $'000
Opening balance	**4,581**	**0**
Add: Grant	0	6,260
Less: Income recognised from performance obligations satisfied	(4,581)	(1,679)
Total payments received for performance obligations yet to be completed	**0**	**4,581**
Represented by		
Current liabilities	0	4,581
	0	**4,581**

Note A4: Other income

Other income includes income that is not registration fees or interest. Key items of other income include certificates of registration status requested by registrants, legal fee recoveries and fees related to the examinations.

	2021 $'000	2020 $'000
Accreditation	295	490
Certificate of registration status	216	302
Legal fee recoveries and fines	1,692	744
Examinations	1,704	1,195
Practitioner Information Exchange (PIE)	1,123	888
Application for registrar program	294	283
Other	314	409
Total other income	**5,638**	**4,311**

Note B: The cost of delivering services

Introduction

This section provides an account of the expenses incurred by Ahpra in delivering services.

Judgement required

Judgements have been applied in the calculations of employee benefits provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates.

Structure

B1. Employee benefits

B1.1 Employee costs

B1.2 Employee benefits in the *Statement of financial position*

B1.3 Superannuation contributions

B2. Other operating expenses

Expenses from transactions are recognised in the *Statement of comprehensive income* when they are incurred.

Expenses from transactions	Note	2021 $'000	2020 $'000
Employee costs	*B1.1*	140,707	130,552
Board and committee sitting fees		5,881	6,188
Legal and notification costs		12,854	12,487
Accreditation expenses		9,893	9,535
Other operating expenses	*B2*	34,862	41,981

Board and committee sitting fees

Board and committee sitting fee costs include national, state and regional board expenditure relating to meetings held by the National Boards and their committees.

Legal and notification costs

Legal costs include external costs relating to managing the notification (complaint) process by Ahpra. These costs include legal fees paid to external firms and costs of civil tribunals. They do not include the costs associated with Ahpra staff in the assessment and investigation of notifications, or the cost of legal staff employed by Ahpra.

Accreditation expenses

Accreditation expenses relate to payments to external accreditation bodies to exercise accreditation functions, as defined in section 42 of the National Law. Staff costs and committee sitting fees when these functions are carried out by accreditation committees are not included.

Five boards have assigned accreditation functions under section 42 of the National Law to accreditation committees administered by Ahpra.

Accrediting activities relating to registration of health practitioners under section 52 of the National Law are disclosed separately as funding for intern training accreditation authorities under other operating expenses.

Note B1: Employee benefits

Employee costs relate to all Ahpra employment costs, including wages and salaries, fringe benefits tax, leave entitlements and on-costs, termination payments, WorkCover premiums, superannuation and contractor-cost.

Note B1.1 Employee costs

	Note	2021 $'000	2020 $'000
Salaries and related on-costs		111,628	103,159
Leave entitlements		12,280	11,671
Superannuation expenses	*B1.3*	11,258	10,496
Termination benefits		250	673
Contractors		4,044	4,064
Staff development and amenities		1,247	489
Total employee benefit expenses		**140,707**	**130,552**

Note B1.2 Employee benefits in the *Statement of financial position*

Provision is made for benefits accruing to employees in respect of annual leave and long service leave for services rendered to the reporting date and recorded as an expense during the period the services are delivered.

Current employee benefits provisions	2021 $'000	2020 $'000
Annual leave		
Unconditional and expected to be settled within 12 months	8,028	7,420
Unconditional and expected to be settled after 12 months	2,825	2,048
Long service leave		
Unconditional and expected to be settled within 12 months	1,696	1,710
Unconditional and expected to be settled after 12 months	8,555	7,475
Provision for on-costs		
Unconditional and expected to be settled within 12 months	1,468	1,352
Unconditional and expected to settle after 12 months	1,695	1,434
Total current provisions for employee benefits and on-costs	**24,267**	**21,439**
Non-current employee benefits provisions	**2021 $'000**	**2020 $'000**
Conditional long service leave entitlements expected to be settled after 12 months	3,322	3,358
On-costs	793	497
Total non-current provisions for employee benefits and on-costs	**4,115**	**3,855**
Total provisions for employee benefits and on-costs	**28,382**	**25,294**

Reconciliation of movement in provisions and on-costs

	Annual leave $'000	Long service leave $'000	On-costs $'000	Total $'000
Carrying amount at the beginning of the year	**9,520**	**12,445**	**3,329**	**25,294**
Additional provisions recognised	9,154	3,121	627	**12,902**
Reductions arising from payments	(7,822)	(1,369)	0	**(9,191)**
Reductions resulting from settlement without cost	0	(293)	0	**(293)**
Effect of changes in the discount rate	33	(331)	0	**(298)**
Carrying amount at the end of the year	**10,853**	**13,573**	**3,956**	**28,382**

(a) Annual leave

Liabilities for annual leave are recognised in the provision for employee benefits as current liabilities, because Ahpra does not have an unconditional right to defer settlements of these liabilities.

The liabilities for salaries are recognised in the *Statement of financial position* at remuneration rates which are current at the reporting date.

When the annual leave is expected to wholly settle within 12 months of the reporting date, it is measured at its nominal value. Those liabilities not expected to be wholly settled within 12 months of the reporting date are 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.

(b) Sick leave

No provision has been made for sick leave as all sick leave is non-vesting. An expense is recognised in the *Statement of comprehensive income* as it is taken.

(c) Long service leave

The long service leave entitlement is recognised from an employee's start date and becomes payable according to the employment arrangements in place. The classification of long service leave for employees who have met the conditions of service to take long service leave is recognised as a current liability, while the classification for those employees still to meet the conditions of service is recognised as a non-current liability.

Part of the current liability is measured at nominal value when it is expected to wholly settle within 12 months of the reporting date. When liabilities are not expected to wholly settle within 12 months of the reporting date, it is measured at the present value of the 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 the Reserve Bank of Australia's 10-year rate for semi-annual coupon bonds.

(d) Employee benefits on-costs

Employee benefits on-costs such as payroll tax, WorkCover insurance premium and superannuation entitlements are not employee benefits. They are recognised as liabilities when the employee benefits to which they relate are recognised.

(e) 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 it is 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.

Note B1.3 Superannuation contributions

The amount expensed in respect of superannuation represents Ahpra contributions for members of both defined benefit and defined contribution superannuation plans that are paid or payable during the reporting period.

Employees of Ahpra are entitled to receive superannuation benefits and Ahpra contributes to both defined benefit and defined contribution plans. The defined benefit plans provide benefits based on years of service and final average salary.

Ahpra does not recognise any defined benefit liability in respect of the plans because it has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due.

Superannuation contributions paid or payable for the reporting period are included as part of employee costs in Ahpra's *Statement of comprehensive income*.

The reported contributions reflect gross superannuation payments to each of the funds, inclusive of superannuation guarantee contributions.

The name, details and amounts expensed in relation to the major employee superannuation funds and contributions made by Ahpra are as follows:

	Paid contribution for the year		Contribution outstanding at year end	
Fund	2021 $'000	2020 $'000	2021 $'000	2020 $'000
Defined benefit plans:				
Southern State Superannuation Scheme	221	211	1	0
Qsuper	110	132	0	0
Other (5 funds)	109	165	7	0
Defined contribution plans:				
Australian Super	4,016	3,688	0	0
First State accumulation	521	468	0	0
HESTA	437	387	0	0
VicSuper	385	377	0	0
QSuper accumulation	472	403	0	0
UniSuper	441	428	0	0
Sunsuper	483	424	0	0
Other (about 200 funds)	3,994	3,785	66	13
Total	**11,189**	**10,468**	**74**	**13**

Note B2. Other operating expenses

	Note	2021 $'000	2020 $'000
Systems and communications		9,941	11,461
Travel and accommodation		1,033	5,547
Property expenses		2,569	2,708
Strategic and project consultant costs		2,323	2,467
Office of the Health Ombudsman (OHO, in Queensland)	*G8*	4,532	5,684
National Health Practitioner Ombudsman and Privacy Commissioner Office		2,570	2,200
Health programs		3,808	3,380
External contract services		504	484
Bank charges and merchant fees		1,129	1,213
Insurance		908	907
Criminal history checks		1,199	1,283
Printing, postage and publications		1,006	1,730
Funding for intern training accreditation authorities (section 52)		925	907
Internal audit fees		310	311
Other		2,105	1,699
Total other operating expenses		**34,862**	**41,981**

Systems and communication

Systems and communication costs relate to the technology systems of Ahpra.

Travel and accommodation

Travel and accommodation relates to flights, taxis and hotel costs incurred by Ahpra, National Boards and their committees for travel attending scheduled board and committee meetings.

Property expenses

Property expenses include maintenance of leased properties, variable lease payments such as rates and outgoings and offsite storage costs.

In accordance with the AASB 16 *Leases*, lease payments for office rental previously classified under property expenses are accounted as depreciation of right-of-use assets and interest on leases (*Note E1.2*). Variable lease payments, such as rates and outgoings, which do not depend on an index or a rate and which are not in substance fixed, are recognised in the period in which they are incurred as property expenses.

Strategic and project costs

Strategic and project costs relate to project costs incurred in the year for both National Boards and Ahpra projects. These expenses are assessed as not meeting the definition of asset under AASB 138 *Intangible Assets*.

Health programs

Health programs are national schemes financially supported by Boards and operated at arm's length. A health program provides telephone and online services offering health support to practitioners, contributing to better health and wellbeing for practitioners, and safer care for the public.

Note C: Key assets available

Introduction

Ahpra controls property, plant and equipment that are used in fulfilling our objectives and conducting our activities. Along with financial assets, they represent a key resource used in the delivery of services.

Judgement required

The assets included in this section are carried at cost, less accumulated depreciation and impairment.

Judgement has been applied in assessing the useful lives of plant and equipment. Assessment of intangible assets resulted in a change to their useful lives in 2019/20.

Structure

C1. Investments

C2. Property, plant and equipment (PPE)

C3. Intangible assets

C4. Depreciation, amortisation and impairment

Note C1: Investments

Investments include term deposits that Ahpra has the positive intent and ability to hold to maturity at fixed or repricing interest rates. Ahpra manages its investments in accordance with the investment policy. Investments are classified as current with original maturity dates of three to 12 months, whilst term deposits with original dates in excess of 12 months are classified as non-current.

	2021 $'000	2020 $'000
Current		
Bank term deposits maturing less than 90 days	27,500	28,000
Bank term deposits maturing more than 90 days but less than 1 year	93,000	35,000
Total current investments	**120,500**	**63,000**
Non-current		
Bank term deposits maturing greater than 1 year	89,000	116,500
Total non-current investments	**89,000**	**116,500**
Total investments	**209,500**	**179,500**

Note C2: Property, plant and equipment (PPE)

	Right-of-use property $'000	Leasehold improvements $'000	Furniture and fittings $'000	Computer equipment $'000	Office equipment $'000	Total property, plant and equipment $'000
At cost						
Balance at 30 June 2019[1]	56,473	14,967	1,472	6,946	439	**80,297**
Additions	343	85	43	1,322	108	**1,901**
Disposals/write-offs	0	(810)	0	0	0	**(810)**
Balance at 30 June 2020	**56,816**	**14,242**	**1,515**	**8,268**	**547**	**81,388**
Additions	433	821	28	679	57	**2,018**
Disposals/write-offs	(388)	(12)	0	(252)	(3)	**(655)**
Balance at 30 June 2021	**56,861**	**15,051**	**1,543**	**8,695**	**601**	**82,751**
Accumulated depreciation						
Balance at 30 June 2019	0	(7,604)	(466)	(4,406)	(231)	**(12,707)**
Depreciation charge during the year	(7,826)	(1,110)	(177)	(1,778)	(50)	**(10,941)**
Disposals/write-offs	0	350	0	0	0	**350**
Balance at 30 June 2020	**(7,826)**	**(8,364)**	**(643)**	**(6,184)**	**(281)**	**(23,298)**
Depreciation charge during the year	(7,756)	(1,099)	(179)	(1,561)	(59)	**(10,654)**
Disposals/write-offs	342	6	0	198	2	**548**
Balance at 30 June 2021	**(15,240)**	**(9,457)**	**(822)**	**(7,547)**	**(338)**	**(33,404)**
Net book value						
At 30 June 2020	**48,990**	**5,878**	**872**	**2,084**	**266**	**58,090**
At 30 June 2021	**41,621**	**5,594**	**721**	**1,148**	**263**	**49,347**

1. This balance of right-of-use property represents the recognition of right-of-use assets recorded on balance sheet on 1 July 2019 on initial application of AASB 16.

Items of plant, equipment and leasehold improvements, are measured at cost less accumulated depreciation and impairment.

Note C2.1 Right-of-use assets

For any contracts entered into or changed, Ahpra considers whether a contract is, or contains, a lease. A contract is, or contains, a lease if the contract conveys the right to control the use of an identified asset for a period of time in exchange for consideration. To apply this definition Ahpra assesses whether the contract meets three key criteria which are:

- The contract involves the use of an identified asset.
- Ahpra has the right to obtain substantially all of the economic benefits from use of the asset throughout the period of use.
- Ahpra has the right to direct the use of the asset.

As a lessee, Ahpra recognises a right-of-use asset and a lease liability at the lease commencement date. The right-of-use asset is initially measured at cost which comprises the initial amount of the lease liability adjusted for:

- *less* any lease payments made at or before the commencement date adjusted for any lease incentives received
- *plus* any initial direct costs incurred
- *plus* any estimate of costs to dismantle and remove the underlying assets or to restore the underlying asset or the site the asset is located on
- *less* any lease incentive received.

Note C3: Intangible assets

Purchased intangible assets are initially recognised at cost. When the recognition criteria in AASB 138 *Intangible Assets* are met, internally generated intangible assets are recognised and measured at cost less accumulated amortisation and accumulated impairment.

An internally generated intangible asset arising from development (or from the development phase of an internal project) is recognised if, and only if, all of the following are demonstrated:

1. the technical feasibility of completing the intangible asset so that it will be available for use or sale
2. an intention to complete the intangible asset and use it
3. the ability to use the intangible asset
4. the intangible asset will generate probable future economic benefits
5. the availability of adequate technical, financial and other resources to complete the development and to use the intangible asset
6. the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Expenditure on research activities is recognised as an expense in the period in which it is incurred.

Intangible assets not yet available for use are tested annually for impairment and whenever there is an indication that the asset may be impaired.

	Computer software $'000	Work in progress $'000	Total $'000
At cost			
Balance at 30 June 2019	15,450	1,474	**16,924**
Additions	0	5,706	**5,706**
Disposals/write-offs	0	(105)	**(105)**
Transfer to additions	4,945	(5,238)	**(293)**
Balance at 30 June 2020	**20,395**	**1,837**	**22,232**
Additions	0	4,322	**4,322**
Disposals/write-offs	0	(274)	**(274)**
Completed projects	1,988	(2,802)	**(814)**
Balance at 30 June 2021	**22,383**	**3,083**	**25,466**
Accumulated amortisation			
Balance at 30 June 2019	(12,769)	0	**(12,769)**
Amortisation charge during the year	(1,151)	0	**(1,151)**
Balance at 30 June 2020	**(13,920)**	**0**	**(13,920)**
Amortisation charge during the year	(2,150)	0	**(2,150)**
Balance at 30 June 2021	**(16,070)**	**0**	**(16,070)**
Net book value			
At 30 June 2020	**6,475**	**1,837**	**8,312**
At 30 June 2021	**6,313**	**3,083**	**9,396**

Note C4: Depreciation, amortisation and impairment

Plant and equipment are measured at cost less accumulated depreciation and impairment. These assets are depreciated at rates based on their expected useful lives, using the straight-line method, which is reviewed annually.

Intangible assets are amortised annually at a rate of between 20% and 40% depending on their useful life. Work in progress is not depreciated until it reaches service delivery capacity.

The annual depreciation rates and estimated assets' useful lives used for major assets in each class for current and prior years are included in the table below:

	2021		2020	
Furniture and fittings	13%	7 years	13%	7 years
Computer equipment	20–40%	2.5–5 years	20–40%	2.5–5 years
Office equipment	15%	7 years	15%	7 years
Intangibles	20–40%	5 years	20–40%	5 years

Leasehold improvements are depreciated over the shorter of the remaining term of the lease or their estimated useful lives.

The right-of-use asset is depreciated using the straight-line method from the commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease term, ranging from 2 to 12 years. The estimated useful lives of right-of-use assets are determined on the same basis as those of property, plant and equipment. In addition, the right-of-use asset is periodically reduced by impairment losses, if any, and adjusted for certain measurements of the lease liability.

Note C4.1: Depreciation and amortisation charged for the reporting period

	2021 $'000	2020 $'000
Depreciation		
Leasehold improvements	1,099	1,110
Furniture and fittings	179	177
Computer equipment	1,561	1,778
Office equipment	59	50
Right-of-use assets	7,756	7,826
Amortisation		
Computer software	2,150	1,151
Total depreciation and amortisation	**12,804**	**12,092**

Note C4.2: Impairment

All non-financial assets are assessed annually for indications of impairment. If there is an indication of impairment, the asset concerned is tested as to whether its carrying amount exceeds its possible recoverable amount. The difference is written off as an expense (Other operating expenses – other) except to the extent that the write-down can be debited to an asset revaluation surplus account applicable to that same class of asset.

The net gain or loss arising from the sale of non-financial assets is included as revenue (Other income) or expenses (Other operating expenses – other) 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.

Ahpra has concluded that the recoverable amount of property, plant and equipment which are regularly revalued is expected to be materially consistent with the current fair value. As such, there were no indications of property, plant and equipment being impaired at balance date.

Written-down value of non-financial assets written off	2021 $'000	2020 $'000
Right-of-use assets	46	0
Computer equipment	54	0
Office equipment	1	0
Leasehold improvement	6	460
Total written-down value of non-financial assets written off	**107**	**460**
Net gain/(loss) on disposal of non-financial assets	**2021 $'000**	**2020 $'000**
Proceeds from disposals of non-financial assets		
Computer equipment	44	0
Total proceeds from disposal	**44**	**0**
Less: written down value of assets sold		
Right-of-use assets	(46)	0
Computer equipment	(54)	0
Office equipment	(1)	0
Leasehold improvement	(6)	0
Net gain/(loss) on disposal	**(63)**	**0**

Note D: Other assets and liabilities

Introduction

This section sets out other financial and non-financial assets arising from Ahpra's operations. It also includes information on Ahpra's financial liability towards external suppliers.

Judgement required

Judgement has been exercised in estimating the provision for expected credit losses. Significant judgement and estimates have been applied to determine the present value of Ahpra's obligation to restore leased assets to their original condition at the end of a lease term.

Structure

D1: Receivables

D2: Payables and accruals

D3: Other non-financial assets

D4: Other provisions

Note D1: Receivables

	Note	2021 $'000	2020 $'000
Contractual			
Trade receivables		2,580	1,943
Credit loss allowance	*E2*	(1,854)	(1,375)
Accrued income		1,589	1,334
Statutory			
GST receivable		675	477
Total receivables		**2,990**	**2,379**

Movement in the loss allowance for contractual receivables	2021 $'000	2020 $'000
Balance at beginning of year	1,375	1,401
Increase in allowance recognised in net result for the year	610	0
Reversal of provision of receivables written off during the year	(131)	(26)
Balance at end of year	**1,854**	**1,375**

Contractual receivables are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. Ahpra holds the contractual receivables with the objective of collecting the contractual cash flows and subsequently they are measured at amortised cost using the effective interest method, less any impairment.

Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. Ahpra applies AASB 9 *Financial Instruments* for initial measurement of the statutory receivables and, as a result, they are initially recognised at fair value plus any directly attributable transaction cost.

Details about Ahpra's impairment policies, its exposure to credit risk, and the calculation of the credit loss allowance are set out in *Note F1.2*.

Note D2: Payables and accruals

	2021 $'000	2020 $'000
Contractual		
Trade creditors	2,310	757
Accrued expenses	8,030	6,686
Statutory		
Payroll tax and other payables	468	430
Total payables and accruals	**10,808**	**7,873**
Represented by:		
Current payables	10,646	7,711
Non-current payables	162	162
	10,808	**7,873**

Contractual payables are classified as financial instruments and measured at amortised cost. Accounts payable represent liabilities for goods and services provided to Ahpra prior to the end of the financial year that are unpaid.

Statutory payables are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts.

Payables for suppliers and services have an average credit period of 30 days. No interest is charged on the trade creditors.

Terms and conditions of amounts payable to the government and agencies vary according to the particular agreements.

Note D3: Other non-financial assets

Other non-financial assets include prepayments, which represent payments made in advance of receipt of goods or services or expenditure made in one accounting period that covers a term extending beyond that period. It is then recognised as expenditure in the period to which the service relates.

Note D4: Other provisions

	2021 $'000	2020 $'000
Current provisions		
Other contractual provisions	0	921
Make-good provisions	194	0
Total current provisions	**194**	**921**
Non-current provisions		
Make-good provisions	754	817
Total non-current provisions	**754**	**817**
Total other provisions	**948**	**1,738**

Provisions are recognised when Ahpra has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably. The amount recognised as a provision is the best estimate of the consideration required to settle the present obligation at the reporting date, taking into account the risks and uncertainties surrounding the obligation.

Where a provision is measured using the cash flows estimated to settle the present obligation, its carrying amount is the present value of those cash flows, using a discount rate that reflects the time value of money and risks specific to the provision.

Make-good provisions are recognised when Ahpra has contractual obligations to remove leasehold improvements from leased properties and restore the leased premises to their original condition at the end of the lease term. During the calculation of make-good provisions, assumptions and estimations have been applied to work out the average make-good cost per square metre when on-going maintenance and updating is committed to, and/or the local market conditions in re-negotiating an incentive at lease expiration for each office is considered.

The make-good provision is recognised in accordance with the lease agreement over the offices' leases.

Restructure and other contractual provisions have been fully utilised in 2020/21.

Reconciliation of movements in provisions

	Make good $'000	Restructure $'000	Other contractual $'000	Total $'000
Opening balance at 30 June 2020	**817**	**363**	**558**	**1,738**
Additional provisions recognised	131	0	0	**131**
Reductions arising from payments	0	(326)	(558)	**(884)**
Reductions due to transfer out	0	(37)	0	**(37)**
Closing balance at 30 June 2021	**948**	**0**	**0**	**948**
Current	194	0	0	**194**
Non-current	754	0	0	**754**
Total	**948**	**0**	**0**	**948**

Note E: Financing our operations

Introduction

This section provides information on the sources of finance utilised by Ahpra during its operations and other information related to financing activities of Ahpra.

Judgement required

Ahpra applies judgement to determine if a contract is or contains a lease and whether the lease meets the short-term or low-value asset lease exemption. Ahpra estimates the discount rate applied to future lease payments and assesses the lease term when there is an option to extend or terminate leases.

Structure

E1. Leases

E2. Cash flow information and balances

E3. Commitments

Note E1: Leases

A lease is defined as a contract, or part of a contract, that conveys the right for Ahpra to use an asset for a period of time in exchange for payment.

To apply this definition, Ahpra ensures the contract meets the following criteria:

- The contract contains an identified asset, which is either explicitly identified in the contract or implicitly specified by being identified at the time the asset is made available to Ahpra and for which the supplier does not have substantive substitution rights.
- Ahpra has the right to obtain substantially all of the economic benefits from use of the identified asset throughout the period of use, considering its rights within the defined scope of the contract, and Ahpra has the right to direct the use of the identified asset throughout the period of use.
- Ahpra has the right to take decisions in respect of 'how and for what purpose' the asset is used throughout the period of use.

Ahpra's lease arrangements consist mainly of various properties for office operations in each state and territory. The lease contracts are typically made for fixed periods of 3 to 10 years with an option to renew the lease after that date.

All leases are recognised on the balance sheet, with the exception of low-value leases (less than $10,000) and short-term leases of less than 12 months. The payments in relation to these are recognised as an expense on a straight-line basis over the lease term.

Note E1.1 Right-of-use assets

Right-of-use assets are presented in *Note C2.1*.

Note E1.2 Other presentation of leases in financial statements

The following amounts are recognised in the *Statement of comprehensive income* relating to leases:

	2021 $'000	2020 $'000
Interest expense on lease liabilities	837	941
Variable lease payments, not included in the measurement of lease liabilities	1,577	1,619
Total amount recognised in the *Statement of comprehensive income*	**2,414**	**2,560**

The following amounts are recognised in the *Statement of cash flows* relating to leases:

	2021 $'000	2020 $'000
Interest paid	837	941
Repayment of principal portion of lease liabilities	6,993	5,953
Total cash outflow for leases	**7,830**	**6,894**

The following amounts are recognised as lease liabilities in the *Statement of financial position* at 30 June:

Lease liabilities	2021 $'000	2020 $'000
Current	7,576	7,191
Non-current	40,654	47,728
Total lease liabilities recognised in the *Statement of financial position*	**48,230**	**54,919**

Note E1.3 Recognition and measurement of leases as a lessee

The lease liability is initially measured at the present value of the lease payments unpaid at the commencement date, discounted using Ahpra's incremental borrowing rate.

Lease payments included in the measurement of the lease liabilities comprise fixed payments less any lease incentive receivable plus payments arising from lease extension options that are reasonably certain to be exercised. Variable lease payments are not included in the measurement of the lease liability or the carrying amount of right-of-use asset.

In determining the lease term, management considers all facts and circumstances that create an economic incentive to exercise an extension option. South Australia and Tasmania office leases contain 5-year extension options which have been included in the lease term and lease liability because the lease is reasonably certain to be extended.

The assessment is reviewed if a significant event or a significant change in circumstances occurs which affects this assessment and is within the control of the lessee.

Lease liabilities reported on the balance sheet at 30 June 2021 include lease liabilities $4.187 million from lease fit-out incentives and $44.042 million from lease accounting implementation, both to be amortised over the lease terms.

Subsequent to initial measurement, the liability will be reduced for payments made and increased for interest. It is remeasured to reflect any reassessment or modification to lease contract that changes fixed periodic payment. When the lease liability is remeasured, a corresponding adjustment is made to the carrying amount of the right-of-use asset, or is recorded in profit or loss if the carrying amount of the right-of-use asset is already reduced to zero.

Minimum future lease payments (undiscounted)

Repayments in relation to leases are payable as follows:	2021 $'000	2020 $'000
Less than one year	7,477	7,278
One to five years	29,998	32,363
More than five years	9,654	14,652
Total undiscounted lease liabilities as at 30 June	**47,129**	**54,293**

Note E2: Cash flow information and balances

Cash and cash equivalents include cash on hand and cash at bank, deposits held at call, and other short-term liquid deposits with an original maturity of three months or less, which are readily convertible to known amounts of cash with an insignificant risk of changes in value.

	2021 $'000	2020 $'000
Cash and cash equivalents, at bank	10,661	15,812
Total cash and cash equivalents	**10,661**	**15,812**

Reconciliation of net result for the period to cash flow from operating activities

	2021 $'000	2020 $'000
Net result for the year	**17,339**	**6,655**
Adjustments for:		
Depreciation and amortisation	12,804	12,092
Loss on disposal of assets	63	0
Other provisions	0	558
Provision for doubtful debts	(131)	(26)
Changes in assets and liabilities		
(Increase)/Decrease in receivables	(225)	532
(Increase) in prepayments	(558)	(524)
(Increase) in accrued income	(254)	(473)
Increase in income in advance	2,476	10,840
Increase/(Decrease) in payables and accruals	4,023	(7,594)
Increase in employee benefits	3,088	3,051
(Decrease) in other provisions	(921)	(751)
Net cash flows from operating activities	**37,704**	**24,360**

Note E3: Commitments

Commitments for future expenditure include operating commitments arising from non-cancellable contractual or statutory obligations. These commitments are recorded below at their nominal value and inclusive of GST. The future expenditures cease to be disclosed as commitments once the related liabilities are recognised in the *Statement of financial position*.

Ahpra does not have capital commitments.

Commitments in relation to non-cancellable contractual obligations are disclosed as:

Nominal amounts	Not later than 1 year $'000	1–5 years $'000	5+ years $'000	Total $'000
Non-cancellable:				
2021				
Other commitments payable (inclusive of GST)	1,828	1,980	0	**3,808**
Less: GST recoverable	(166)	(180)	0	**(346)**
Total commitments (exclusive of GST)	**1,662**	**1,800**	**0**	**3,462**
2020				
Other commitments payable (inclusive of GST)	2,353	3,808	0	**6,161**
Less: GST recoverable	(214)	(346)	0	**(560)**
Total commitments (exclusive of GST)	**2,139**	**3,462**	**0**	**5,601**

(a) The present value of the minimum lease payments for leased properties are recognised on the *Statement of financial position*.

(b) The year-on-year reduction in the nominal amounts of the other commitments reflects the payments made.

(c) The total commitments will not equal the sum of the minimum lease payments and other commitments because they are at present value, whereas total commitments are at nominal value.

Note F: Risks, contingencies and valuation

Introduction

Ahpra is exposed to risk from its activities and outside factors. In addition, it is often necessary to make judgements and estimates associated with recognition and measurement of items in the financial statements. This section sets out financial-instrument-specific information, including exposures to financial risks, as well as those items that are contingent in nature or require a higher level of judgement to be applied, which for Ahpra related mainly to fair value determination.

Structure

F1. Financial instruments

F2. Financial risk management

F3. Contingent assets and liabilities

Note F1: Financial instruments

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Certain financial assets and financial liabilities arise under statute rather than contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 *Financial Instruments: Presentation*.

Note F1.1: Categories of contractual financial instruments

Categories of contractual financial instruments under AASB 9 include:

Financial assets at amortised cost

Financial assets in this category are held by Ahpra to collect the contractual cash flows, and the assets' contractual terms give rise to cash flows that are solely payments of principal and interest. These assets are initially recognised at fair value plus any directly attributable transaction costs and subsequently measured at amortised costs using the effective interest method less any impairment.

Ahpra recognises the following financial assets at amortised cost:

- cash and cash equivalents
- term deposit investments
- contractual receivables
- accrued investment income.

Ahpra does not hold financial assets within the two other categories i.e. financial assets at fair value through other comprehensive income such as unlisted equity instruments and financial assets at fair value through net result such as listed equity securities.

Financial liabilities at amortised cost

Financial instrument liabilities are recognised on the date they originate. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these liabilities are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in the *Statement of comprehensive income* over the period of the interest-bearing liability, using the effective interest rate method.

A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

Ahpra recognises the following as financial liabilities at amortised cost:

- contractual payables
- lease liabilities.

Note F1.2: Impairment of financial assets

Ahpra records the allowance for expected credit loss for the relevant financial instruments applying AASB 9's Expected Credit Loss (ECL) approach. Subject to AASB 9, impairment assessment includes Ahpra's contractual receivables. Cash and cash equivalents are also subject to the impairment requirements of AASB 9, but the identified impairment loss was immaterial.

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

Ahpra applies AASB 9 simplified approach for contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. The loss allowance is measured in the same period as an asset is recognised. Ahpra has grouped contractual receivables on shared credit risk characteristics and days past due and selected the expected credit loss rate based on the agency's past history, existing market conditions, as well as forward-looking estimates at the end of the financial year.

Note F2: Financial risk management

The main purpose in holding financial instruments is to prudentially manage Ahpra's financial risks within the financial risk management policy parameters. Ahpra's main financial risks include credit risk, liquidity risk and interest rate risk. Ahpra has no exposure to foreign exchange rate risk and equity price risk.

(a) 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, is the carrying amount, net of any provisions for impairment of those assets, as disclosed in the *Statement of financial position* and notes to the financial statements. Credit risk associated with Ahpra's contractual financial assets is minimal because Ahpra mainly obtains contractual financial assets that are term deposits and cash at bank. As with the policy for investment, Ahpra's policy is to deal only with banks with high credit ratings. As a result, 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.

Ahpra monitors the credit risk by actively assessing the rating quality and liquidity of counterparties. Except as otherwise detailed in the table opposite, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Ahpra's maximum exposure to credit risk.

There has been no material change to Ahpra's credit risk profile in 2020/21.

Credit quality of contractual financial assets[(a)]

2021	Financial institutions (AA- credit rating)[1] $'000	Other $'000	Total $'000
Financial assets with loss allowance measured at 12 month expected credit loss:			
Cash and cash equivalents	10,661	0	**10,661**
Investments	209,500	0	**209,500**
Accrued income	1,589	0	**1,589**
Financial assets with loss allowance measured at lifetime expected credit loss:			
Contractual receivables applying the simplified approach for impairment	0	726	**726**
Total financial assets	**221,750**	**726**	**222,476**

2020	Financial institutions (AA- credit rating)[1] $'000	Other $'000	Total $'000
Financial assets with loss allowance measured at 12 month expected credit loss:			
Cash and cash equivalents	15,812	0	**15,812**
Investments	179,500	0	**179,500**
Accrued income	1,334	0	**1,334**
Financial assets with loss allowance measured at lifetime expected credit loss:			
Contractual receivables applying the simplified approach for impairment	0	568	**568**
Total financial assets	**196,646**	**568**	**197,214**

(a) The total amount disclosed here excludes statutory amounts (e.g. GST input tax credit recoverable).

Ahpra determines the loss allowance at end of the financial year as follows:

30 June 2021	Current $'000	Less than 1 month $'000	1–3 months $'000	3–12 months $'000	More than 1 year $'000	Total $'000
Expected loss rate	0%	18%	20–58%	11–63%	17–97%	
Contractual receivables	123	167	232	569	1,489	**2,580**
Loss allowance	**0**	**(30)**	**(84)**	**(349)**	**(1,391)**	**(1,854)**

30 June 2020	Current $'000	Less than 1 month $'000	1–3 months $'000	3–12 months $'000	More than 1 year $'000	Total $'000
Expected loss rate	5%	20%	17–36%	41%	94%	
Contractual receivables	115	340	94	84	1,310	**1,943**
Loss allowance	**(5)**	**(69)**	**(31)**	**(34)**	**(1,236)**	**(1,375)**

Reconciliation of the movement in the loss allowance for contractual receivables can be found in *Note D1*.

Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

Ahpra's statutory receivable relates to GST input tax receivables. It is considered to have low credit risk. No loss allowance recognised at 30 June 2021 under AASB 9 *Financial Instruments*.

1 Standard & Poor's rate AA-. Moody's Investors Service rate Aa3. Fitch ratings A+.

(b) Liquidity risk exposure

Liquidity risk is the risk that an entity will encounter difficulty in meeting obligations associated with financial liabilities as they fall due. Ahpra manages liquidity risk by monitoring cash flows' forecast and ensuring that adequate liquid funds are available to meet current obligations.

Ahpra's exposure to liquidity risk is deemed insignificant based on prior period's data and current assessment of risk. Cash for unexpected events is generally sourced from liquidation of available-to-recall term deposits.

These tables disclose the maturity analysis of Ahpra's financial liabilities. The maximum exposure to liquidity risk is the total carrying amount of the financial liabilities as shown below.

	Maturity dates					
2021 Payables[a]	Carrying amount $'000	Less than 1 month $'000	1–3 months $'000	3 months–1 year $'000	1–5 years $'000	More than 5 years $'000
Trade creditors	2,310	2,045	94	9	0	162
Accrued expenses	8,030	8,030	0	0	0	0
Lease liabilities[b]	47,129	0	0	7,477	29,998	9,654
Total	**57,469**	**10,075**	**94**	**7,486**	**29,998**	**9,816**

	Maturity dates					
2020 Payables[a]	Carrying amount $'000	Less than 1 month $'000	1–3 months $'000	3 months–1 year $'000	1–5 years $'000	More than 5 years $'000
Trade creditors	757	575	2	18	0	162
Accrued expenses	6,686	6,686	0	0	0	0
Lease liabilities[b]	54,293	0	0	7,278	32,363	14,652
Total	**61,736**	**7,261**	**2**	**7,296**	**32,363**	**14,814**

(a) The total amount disclosed here excludes statutory amounts (e.g. payroll tax payable).

(b) Contractual amounts disclosed in the maturity analysis are the contractual undiscounted cash flows. For lease liabilities, it is gross lease obligation before deducting finance charge.

(c) Market risk exposure

Currency risk

Ahpra had no exposure to currency risk at 30 June 2021 or at 30 June 2020.

Equity price risk

Ahpra had no exposure to equity price risk at 30 June 2021 or at 30 June 2020.

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.[1]

1. Standard & Poor's rate AA-. Moody's Investors Service rate Aa3. Fitch ratings A+.

Interest rate exposure of financial instruments

2021	Weighted average interest rate	Non- interest bearing $'000	Floating interest rate $'000	Fixed interest rate $'000	Total $'000
Financial assets					
Cash and cash equivalents	0.05%	573	10,088	0	**10,661**
Investments	1.37%	0	36,500	173,000	**209,500**
Receivables	0.00%	2,580	0	0	**2,580**
Accrued income	0.00%	1,589	0	0	**1,589**
Total financial assets		**4,742**	**46,588**	**173,000**	**224,330**
Financial liabilities					
Payables [(a)]	0.00%	2,310	0	0	**2,310**
Accrued expenses	0.00%	8,030	0	0	**8,030**
Lease liabilities [(b)]	1.28–2.09%	0	0	44,041	**44,041**
Total financial liabilities		**10,340**	**0**	**44,041**	**54,381**

2020	Weighted average interest rate	Non- interest bearing $'000	Floating interest rate $'000	Fixed interest rate $'000	Total $'000
Financial assets					
Cash and cash equivalents	0.31%	0	0	15,812	**15,812**
Investments	2.15%	0	75,500	104,000	**179,500**
Receivables	0.00%	1,943	0	0	**1,943**
Accrued income	0.00%	1,334	0	0	**1,334**
Total financial assets		**3,277**	**75,500**	**119,812**	**198,589**
Financial liabilities					
Payables[(a)]	0.00%	757	0	0	**757**
Accrued expenses	0.00%	6,686	0	0	**6,686**
Lease liabilities[(b)]	1.28–2.09%	0	0	50,402	**50,402**
Total financial liabilities		**7,443**	**0**	**50,402**	**57,845**

(a) The total amount disclosed here excludes statutory amounts (e.g. payroll tax payable).

(b) Lease liabilities subject to interest rate risk excludes lease fit-out incentive $4.187m.

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 +0.25% and −0.05% (2020: +0.25% and −0.25%) in market interest rates (AUD) from year-end rates of 1.37% and 0.05% due to current historical low interest rate and central bank's intention to keep interest rates low to stimulate the economy.

This table discloses the impact on net operating result and equity for each category of financial instrument held by Ahpra at year end. Investments which have fixed rate of return over the next 12 months are assessed as not subject to the market interest rates shift. Investments which will mature during the next 12 months or invested in floating rate of return are assessed accordingly for the impact on net operation result and equity.

2021 financial assets	Carrying amount $'000	At +0.25% $'000 Surplus	At +0.25% $'000 Equity	At −0.05% $'000 Surplus	At −0.05% $'000 Equity
Cash and cash equivalents	10,661	27	27	(5)	(5)
Investments	209,500	189	189	(37)	(37)
		216	**216**	**(42)**	**(42)**

2020 financial assets	Carrying amount $'000	At +0.25% $'000 Surplus	At +0.25% $'000 Equity	At −0.25% $'000 Surplus	At −0.25% $'000 Equity
Cash and cash equivalents	15,812	40	40	(40)	(40)
Investments	179,500	240	240	(240)	(240)
		280	**280**	**(280)**	**(280)**

Other market risk

Ahpra had no exposure to other market risk at 30 June 2021 or at 30 June 2020.

Note F2.1: Fair value determination

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

- Level 1 – the fair value of financial instruments with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices.
- Level 2 – the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly.
- Level 3 – the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

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 settled in full.

This table shows that the fair values of the contractual financial assets and liabilities are the same as the carrying amounts.

Comparison between carrying amount and fair value

	Note	Carrying amount 2021 $'000	Fair value 2021 $'000	Carrying amount 2020 $'000	Fair value 2020 $'000
Contractual financial assets					
Cash and cash equivalents		10,661	10,661	15,812	15,812
Investments		209,500	209,500	179,500	179,500
Receivables	*D1*	726	726	568	568
Accrued income		1,589	1,589	1,334	1,334
Total contractual financial assets		**222,476**	**222,476**	**197,214**	**197,214**
Contractual financial liabilities					
Payables	*D2*	2,310	2,310	757	757
Accrued expenses		8,030	8,030	6,686	6,686
Lease liabilities		44,041	44,041	50,402	50,402
Total contractual financial liabilities		**54,381**	**54,381**	**57,845**	**57,845**

Note F3: Contingent assets and liabilities

Contingent assets	2021 $'000	2020 $'000
Legal proceedings and disputes	0	0

No claim for damages was lodged during the year.

Contingent liabilities	2021 $'000	2020 $'000
Legal proceedings and disputes	0	0

Contingent assets and contingent liabilities are not recognised in the *Statement of financial position*, 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.

Contingent assets and liabilities are possible assets and obligations that arise from past events, whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of Ahpra.

Contingent liabilities could also be present obligations arising from past events but are not recognised, when it is not probable that an outflow of resource embodying economic benefits will be required to settle the obligations, or the amount of the obligations cannot be measured with sufficient reliability.

Claims for damages were lodged during the year. Liabilities have been disclaimed and the actions have been defended. Insurers are involved in defending these matters. The extent to which an outflow of funds is required in excess of insurance is dependent on the case outcomes being less favourable than currently expected.

Note G: Other disclosures

Introduction

This section includes additional material disclosures required by accounting standards or otherwise, for the understanding of this financial report.

Structure

G1. Related party disclosures

G2. Remuneration of executives

G3. Remuneration of external auditor for the audit of the financial statements

G4. Australian Accounting Standards issued that are not yet effective

G5. Changes in accounting policy

G6. Events occurring after the balance sheet date

G7. Equity by board

G8. Co-regulatory jurisdictions

Note G1: Related party disclosures

Key management personnel (KMP) of Ahpra include the responsible Minister in each jurisdiction that forms part of the Ministerial Council under the National Law, members of the Agency Management Committee, Chief Executive Officer and members of the National Executive team.

(a) Ministerial Council

The Ministerial Council comprises Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health. The following Ministers were members of the Ministerial Council (formally known as the Australian Health Workforce Ministerial Council) during the year 1 July 2020 to 30 June 2021, unless otherwise noted.

Name	Portfolio	Jurisdiction
Ms Rachel Stephen-Smith MLA	Minister for Health Minister for Children, Youth and Families Minister for Aboriginal and Torres Strait Islander Affairs	Australian Capital Territory
The Hon Greg Hunt MP	Minister for Health (to December 2020) Minister Assisting the Prime Minister for the Public Service and Cabinet (to December 2020) Minister for Health and Aged Care (from December 2020)	Commonwealth
The Hon Bradley Hazzard MP	Minister for Health Minister for Medical Research	New South Wales
The Hon Natasha Fyles MLA	Attorney-General and Minister for Justice Minister for Health Minister for Arafura Games Minister for Disabilities	Northern Territory
The Hon Dr Steven Miles MP (to November 2020)	Deputy Premier Minister for Health and Minister for Ambulance Services	Queensland
The Hon Yvette D'Ath MP (from November 2020)	Minister for Health and Ambulance Services	Queensland
The Hon Stephen Wade MLC	Minister for Health and Wellbeing	South Australia
The Hon Sarah Courtney MP (to May 2021)	Minister for Health Minister for Strategic Growth Minister for Women Minister for Small Business, Hospitality and Events	Tasmania
The Hon Jeremy Rockliff, MP (from May 2021)	Deputy Premier and Minister for Health Minister for Mental Health and Wellbeing Minister for Community Services and Development Minister for Advanced Manufacturing and Defence Industries	Tasmania
The Hon Jenny Mikakos MP (to September 2020)	Minister for Health Minister for Ambulance Services	Victoria
The Hon Martin Foley MP (from September 2020)	Minister for Health Minister for Ambulance Services	Victoria
The Hon Roger Cook MLA	Deputy Premier Minister for Health; Medical Research; State Development, Jobs and Trade; Science	Western Australia

Amounts relating to responsible ministers' remuneration are reported in the financial statements of the relevant minister's jurisdiction.

(b) Agency Management Committee members

	Period
Ms Gill Callister PSM, Chair	01/07/2020–30/06/2021
Dr Peggy Brown AO	01/07/2020–30/06/2021
Adjunct Professor Karen Crawshaw PSM	01/07/2020–30/06/2021
Ms Philippa Smith AM	01/07/2020–31/10/2020
Ms Jenny Taing OAM	01/07/2020–30/06/2021
Ms Barbara Yeoh AM	01/07/2020–30/06/2021
Dr Susan Young	01/07/2020–30/06/2021
Professor Arie Freiberg AM, FASSA, FAAL	30/09/2020–30/06/2021
Mr Lynton Norris	01/10/2020–30/06/2021
Mr Jeffrey Moffet	30/09/2020–30/06/2021

(c) Chief Executive Officer and National Executive team

- Chief Executive Officer, Martin Fletcher
- Executive Director, Regulatory Operations, Kym Ayscough
- Executive Director, Strategy and Policy, Chris Robertson
- Executive Director, People and Culture, Mark Edwards
- Chief Information Officer, Clarence Yap
- Chief Financial Officer, Elizabeth Davenport

(d) Remuneration of KMP

Other than the responsible ministers, the remuneration for KMP is disclosed as follows:

	2021 $	2020 $
Short-term employee benefits	2,099,367	1,887,681
Long-term employee benefits	52,811	21,211
Post-employment benefits	152,475	136,326
Termination benefits	0	76,856
Total	**2,304,653**	**2,122,074**

Outside of normal citizen type transactions with Ahpra, there were no related party transactions that involved KMP, their close family members and their personal business interests. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

There were no transactions involving the Ministerial Council during 2020/21.

Note G2: Remuneration of executives

Remuneration of Chief Executive Officer and Executive Directors

The Chief Executive Officer (CEO) is Mr Martin Fletcher who held the position throughout the period 1 July 2020 to 30 June 2021.

The aggregate compensation made to the CEO and National Executive team is set out below:

	2021 $	2020 $
Short-term employee benefits	1,991,107	1,790,370
Long-term employee benefits	52,811	21,211
Post-employment benefits	142,589	127,121
Termination benefits	0	76,856
Total	**2,186,507**	**2,015,558**
Total number of executives	6	7
Total annualised employee equivalents	6	5.4

Note G3: Remuneration of external auditor for the audit of the financial statements

	2021 $'000	2020 $'000
Victorian Auditor-General's Office	160	169
	160	**169**

Note G4: Australian Accounting Standards issued that are not yet effective

This table outlines the accounting pronouncements that have been issued but are not effective for 2020/21, which may result in potential impact for future reporting periods. 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 or after	Impact on Ahpra financial statements
AASB 2020-1 *Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-Current*	This standard amends AASB 101 to clarify requirements for the presentation of liabilities in the *Statement of financial position* as current or non-current. A liability is classified as non-current if an entity has the right at the end of the reporting period to defer settlement of the liability for at least 12 months after the reporting period. The meaning of settlement of a liability is also clarified.	1 January 2022. However, ED 301 has been issued with the intention to defer application to 1 January 2023.	The standard is not expected to have a significant impact on Ahpra.

Note G5: Changes in accounting policy

There were no changes in accounting policies in preparing the financial statements.

Note G6: Events occurring after the balance sheet date

Assets, liabilities, income or expenses arise from past transactions or other past events.

Where the transactions result from an agreement between Ahpra and other parties, the transactions are only recognised when the agreement is irrevocable at or before the end of the reporting period.

For events that occur between the end of the reporting period and the date when the financial statements are authorised for issue, where those events provide information about conditions that existed at the reporting date, adjustments are made to amounts recognised in the financial statements.

Note disclosure is made about events between the end of the reporting period and the date the financial statements are authorised for issue where the events relate to conditions that arose after the end of the reporting period, and which are considered to be of material interest.

While the COVID-19 pandemic has created unprecedented economic uncertainty, it is not expected that economic events and conditions will be materially different from those observed by Ahpra at the reporting date.

No subsequent events are identified for disclosure in this report.

Note G7: Equity by board

Note G7.1: Summary of income and expenses by board

The Ahpra annual financial statements are a report of the Agency Fund under the National Law and include transactions of all 15 National Boards administered by Ahpra.

Under the National Law, the National Boards are unable to enter into transactions themselves, with Ahpra administering all revenue and expense transactions on behalf of each National Board, as set out in each Health Profession Agreement.

The total amount transacted is reflected in the *Statement of comprehensive income* and accompanying notes. The aggregated total revenue and total expenses transacted and attributed to each National Board are shown in the table below.

National Board	2021 Revenue $'000	2021 Expenses $'000	2021 Net result $'000	2020 Revenue $'000	2020 Expenses $'000	2020 Net result $'000
ATSIHPBA	607	607	0	543	543	0
CMBA	2,031	1,615	416	2,312	1,871	441
ChiroBA	2,940	1,740	1,200	2,813	1,784	1,029
DBA	12,556	12,487	69	12,077	11,968	109
MBA	82,597	81,041	1,556	78,119	80,578	(2,459)
MRPBA	3,285	3,546	(261)	3,219	3,550	(331)
NMBA	76,404	69,148	7,256	71,972	67,979	3,993
OTBA	2,879	3,126	(247)	2,716	3,549	(833)
OptomBA	1,950	1,711	239	1,677	1,790	(113)
OsteoBA	1,082	887	195	1,003	907	96
ParaBA	5,751	3,645	2,106	5,505	3,550	1,955
PharmBA	12,627	11,331	1,296	12,037	11,528	509
PhysioBA	4,887	4,903	(16)	4,573	4,797	(224)
PodBA	2,028	1,681	347	2,045	1,843	202
PsyBA	18,648	15,465	3,183	17,856	15,575	2,281
Other	4,905	4,905	0	1,964	1,964	0
Total	**235,177**	**217,838**	**17,339**	**220,431**	**213,776**	**6,655**

Note G7.2: Summary of equity by board

Consistent with the requirements of AASB 1004 *Contributions*, contributions by owners (that is, contributed capital) are treated as equity transactions and, therefore, do not form part of the income and expenses of Ahpra.

Additions to net assets designated as contributions by all former boards at transition to Ahpra are recognised as contributed capital.

Summary of contributed capital, equity and accumulated surplus/(deficit) by board ($'000)

National Board	Contributed capital	Accumulated surplus/(deficit) to 30 June 2020	Equity at 30 June 2020	2020/21 net result	2020/21 net result funded from equity	Accumulated surplus/(deficit) to 30 June 2021	Equity at 30 June 2021
ATSIHPBA	276	(276)	**0**	0	0	(276)	**0**
CMBA	1,293	5,112	**6,405**	416	0	5,528	**6,821**
ChiroBA	1,164	3,986	**5,150**	1,200	0	5,186	**6,350**
DBA	3,120	1,363	**4,483**	69	0	1,432	**4,552**
MBA	12,257	1,010	**13,267**	1,557	0	2,567	**14,824**
MRPBA	2,218	1,314	**3,532**	0	(261)	1,053	**3,271**
NMBA	12,816	(4,894)	**7,922**	7,256	0	2,362	**15,178**
OTBA	3,574	1,335	**4,909**	0	(247)	1,088	**4,662**
OptomBA	1,061	606	**1,667**	239	0	845	**1,906**
OsteoBA	996	358	**1,354**	194	0	552	**1,548**
ParaBA	0	5,098	**5,098**	2,106	0	7,204	**7,204**
PharmBA	2,716	(106)	**2,610**	1,296	0	1,190	**3,906**
PhysioBA	2,728	473	**3,201**	0	(16)	457	**3,185**
PodBA	420	2,898	**3,318**	347	0	3,245	**3,665**
PsyBA	2,194	4,410	**6,604**	3,183	0	7,593	**9,787**
Other	(2,938)	2,938	**0**	0	0	2,938	**0**
Total	**43,895**	**25,625**	**69,520**	**17,863**	**(524)**	**42,964**	**86,859**

	2021 $'000	2020 $'000
Contributed capital		
Balance at the beginning of the financial year	43,895	43,895
Capital contributions from former boards	0	0
Balance at end of the financial year	**43,895**	**43,895**
Accumulated surplus		
Balance at the beginning of the financial year	25,625	18,970
Net result for the year	17,339	6,655
Balance at end of the financial year	**42,964**	**25,625**

Note G8: Co-regulatory jurisdictions

The Health Practitioner Regulation National Law (NSW) No. 86a and the *Queensland Health Ombudsman Act 2013* allow for co-regulation of registered health practitioners at the discretion of the respective member jurisdictions. Both New South Wales (NSW) and Queensland (Qld) have determined that co-regulation applies.

NSW Health Professional Councils Authority (HPCA)

In NSW, the Health Minister informs Ahpra and the National Boards of the amount to be collected per registrant on behalf of the NSW Health Professional Councils Authority (HPCA), for the purpose of handling notifications related to NSW-based practitioners. Ahpra collects these amounts and passes them on to the various Health Profession Councils, via the HPCA. As this amount is set per registrant and collected by Ahpra and remitted to the HPCA within seven days after the end of the month, it is treated as an administered item in these financial statements. These amounts are not recorded within the *Statement of comprehensive income* and *Statement of cash flows*.

Transactions relating to this activity are reported as administered (non-controlled) items in this table.

Summary of HPCA fee collected and payable

National Board	2021 $'000	2020 $'000
ATSIHPBA	8	8
CMBA	381	357
ChiroBA	449	424
DBA	4,132	3,917
MBA	16,432	15,392
MRPBA	212	292
NMBA	10,617	9,953
OTBA	262	248
OptomBA	256	247
OsteoBA	217	206
ParaBA	718	645
PharmBA	3,164	3,054
PhysioBA	517	483
PodBA	275	266
PsyBA	1,713	1,638
Total	**39,353**	**37,130**

Office of the Health Ombudsman (OHO) Queensland

In Queensland, the Health Minister informs Ahpra and the National Boards of the amount to be paid to the Office of the Health Ombudsman (OHO). This payment is included in the *Statement of comprehensive income* as an expense. In 2020/21, Ahpra was required to pay $4.24 million (2019/20: $4.14 million) to OHO under these arrangements.

A further $0.93 million (2019/20: $1.94 million) accrual has been made for additional Queensland Civil and Administrative Tribunal (QCAT) cases occurring during this financial year, which is over and above the costs included in the Minister's determination of $4.24 million. Along with the final 2019/20 reconciliation adjustment $0.64 million credit processed in 2020/21, total reported expenses in 2020/21 is $4.53 million. The breakdown of the payment and accrual is shown in this table.

National Board	Minister's determination for 2021 $'000	QCAT accrual for 2021 $'000	Reconciliation adjustment for 2020 $'000	2021 $'000	2020 $'000
ATSIHPBA	1	(1)	(1)	**(1)**	**3**
CMBA	35	35	(39)	**31**	**41**
ChiroBA	6	(4)	(19)	**(17)**	**20**
DBA	163	1	(34)	**130**	**320**
MBA	2,457	(49)	(323)	**2,085**	**2,703**
MRPBA	19	1	17	**36**	**1**
NMBA	939	846	(177)	**1,608**	**1,637**
OTBA	10	(6)	0	**4**	**9**
OptomBA	6	0	0	**6**	**8**
OsteoBA	38	29	0	**67**	**64**
ParaBA	67	22	0	**89**	**10**
PharmBA	159	(4)	(37)	**118**	**332**
PhysioBA	134	39	2	**175**	**120**
PodBA	41	(30)	6	**17**	**112**
PsyBA	169	47	(32)	**184**	**304**
Total	**4,244**	**926**	**(637)**	**4,532**	**5,684**

Appendices

Appendix 1: Structure of the National Boards

National Board	National committees	Regional boards	State and territory boards	State and territory/ regional committees
ATSIHPBA	Immediate Action Committee[1] Registration and Notifications Committee	N/A	N/A	N/A
CMBA	Examination Committee (from 1 Oct) Immediate Action Committee[1] Policy, Planning and Communications Committee Registration and Notifications Committee	N/A	N/A	N/A
ChiroBA	Immediate Action Committee[1] Registration, Notifications and Compliance Committee	N/A	N/A	N/A
DBA	Notifications Committee: Assessment Registration and Compliance Committee (from 1 Feb) Notification and Compliance Committee (from 1 Feb) Immediate Action Committee (from 1 Sep)	N/A	N/A	Immediate Action Committee (to 1 Feb) (excluding NSW) Registration Committee (to 1 Feb) (NSW only) Registration and Notifications Committee (to 1 Feb) (excluding NSW)
MBA	Finance Committee Notifications Committee: Assessment Sexual Boundaries Notifications Committee Standing Notifications Committee: Assessment	N/A	All states and territories	Immediate Action Committee (excluding NSW) Notifications Committees (excluding NSW) Registration Committees
MRPBA	Immediate Action Committee[1] National Examination Committee Registration and Notifications Committee Supervised Practice Committee Policy Committee	N/A	N/A	N/A
NMBA	Accreditation Committee (Assessment of Overseas Qualified Nurses and Midwives) Finance, Governance and Communications Committee Notifications Committee Midwifery Assessment Notifications Committee Nursing Assessment Program Approval Committee Registration and Notifications Committee State and Territory Chairs' Committee	N/A	All states and territories	Immediate Action Committee (excluding NSW) When required: Notifications Committee (excluding NSW) Registration Committee
OTBA	Immediate Action Committee[1] Registration and Notifications Committee	N/A	N/A	N/A
OptomBA	Finance and Risk Committee Immediate Action Committee[1] Policy and Education Committee Registration and Notifications Committee Scheduled Medicines Advisory Committee	N/A	N/A	N/A
OsteoBA	Immediate Action Committee[1] Registration and Notifications Committee	N/A	N/A	N/A
ParaBA	Immediate Action Committee[1] Registration, Notifications and Compliance Committee Notifications Committee: Assessment	N/A	N/A	N/A
PharmBA	Finance, Risk and Governance Committee Immediate Action Committee Notifications Committee Notifications Committee: Assessment Policies, Codes and Guidelines Committee Registration and Examinations Committee	N/A	N/A	N/A
PhysioBA	Immediate Action Committee[1] Registration and Notifications Committee	N/A	N/A	N/A
PodBA	Immediate Action Committee[1] Registration and Notifications Committee Strategic Planning and Policy Committee	N/A	N/A	N/A
PsyBA	Immediate Action Committee Notification Committee: Assessment	ACT, Tas and Vic NT, SA and WA	NSW Qld	N/A

1 As part of the Multi-Profession Immediate Action Committee. See page 152.

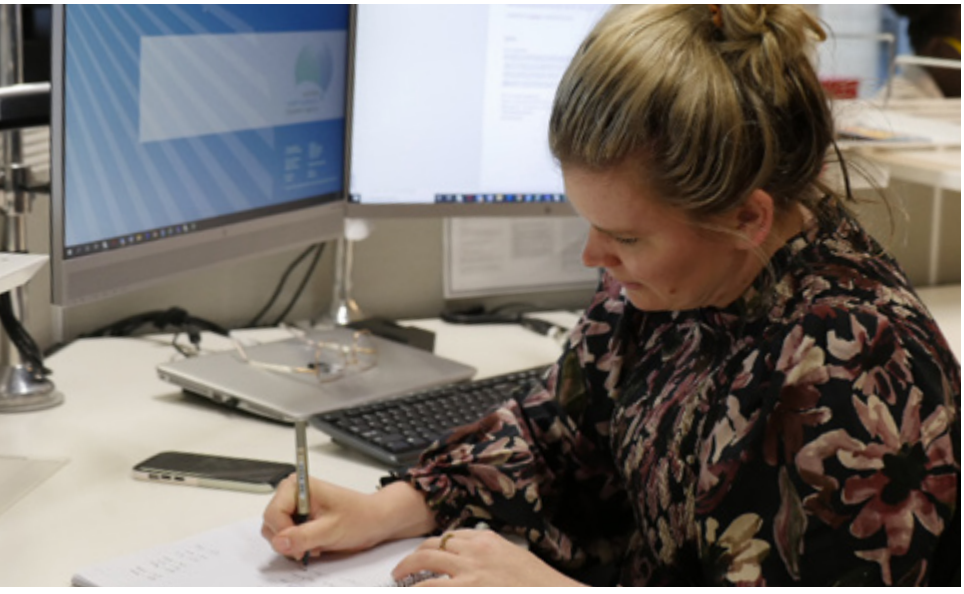
Appendix 2: Meetings of Boards and committees

This table details the number of National Board, national committee, state/territory board and committee meetings held. Each Board has different committee structures to support their day-to-day regulatory decision-making and policy work, largely determined by both the volume and the risk profile of the tasks.

The purpose of the committees varies, and includes decision-making about individual practitioners (e.g., registration, notifications, immediate action and compliance matters); finance and policy-oriented committees look at standards, codes and guidelines for the profession.

All of the meetings listed as either state/territory board or state/territory committee, along with the majority of national committee meetings, were engaged in regulatory decision-making affecting individual practitioners. Numbers include out-of-session and immediate action committee meetings where those occurred.

National Board	National Board meetings	National committee meetings	Total national meetings	State/ territory board meetings	State/territory committee meetings	Total state/ territory meetings	Total
ATSIHPBA	10	8	18			0	**18**
CMBA	13	27	40			0	**40**
ChiroBA	17	32	49			0	**49**
DBA	12	97	109		42	42	**151**
MBA	15	357	372	128	390	518	**890**
MRPBA	12	24	36			0	**36**
NMBA	17	45	62	108	327	435	**497**
OTBA	11	30	41			0	**41**
OptomBA	14	22	36			0	**36**
OsteoBA	11	18	29			0	**29**
ParaBA	18	85	103			0	**103**
PharmBA	14	130	144			0	**144**
PhysioBA	12	55	67			0	**67**
PodBA	13	28	41			0	**41**
PsyBA	11	101	112	59		59	**171**
Total	**200**	**1,059**	**1,259**	**295**	**759**	**1,054**	**2,313**



Appendix 3: State, territory and regional board, committee, panel and group members

The members of state, territory and regional boards, committees, panels, and working, reference and advisory groups make an enormous and valued contribution.

Members appointed for the entire or part of 2020/21 are listed, so some committees appear to have a larger membership than they actually do at any given time. Part-year term dates are only shown for Chairs.

All boards have practitioner and community members. One third of all National Board positions are filled by community members: 52 of 156 positions. On state, territory and regional boards, 34.3% of positions are filled by community members: 68 of 198 positions.

Aboriginal and Torres Strait Islander Health Practice Board of Australia: National committee members

Registration and Notifications Committee

Ms Renee Owen (practitioner), Chair

Members are the National Board

Chinese Medicine Board of Australia: National committee and reference group members

Examination Committee (from 1 Oct)

Professor Brian Jolly (community), Chair

Dr Liming (Henry) Liang (practitioner)

Professor Chi Eung Danforn Lim (practitioner), Deputy Chair

Miss Yu-Ting Sun (practitioner)

Mr Brett Vaughan (community)

Policy, Planning and Communication Committee

Ms Sophy Athan (community), Chair, from 23 Mar

Dr David Graham PhD (community), Chair, to 8 Feb

Ms Christine Berle (practitioner)

Dr Liang Zhong Chen PhD (practitioner)

Mr Luke Hubbard (practitioner)

Mr Roderick Martin (practitioner), Deputy Chair

Ms Glenys Savage (practitioner)

Ms Dina Tsiopelas (practitioner)

Registration and Notifications Committee

Mr David Brereton (community), Chair

Ms Stephanie Campbell (community), Deputy Chair

Dr Di Wen Lai (practitioner)

Dr Li Mei-Kin Rees PhD (practitioner)

Ms Jacinta Ryan (practitioner)

Dr Johannah Shergis PhD (practitioner)

Ms Bing Tian (practitioner)

Chinese Medicine Reference Group

Individual practitioner members

Dr Kevin Ryan

Ms Honglin (Linda) Yang

Dr Shengxi (George) Zhang

Community representatives

Ms Patricia (Tricia) Greenway

Dr Cheryl McRae PhD, Assistant Secretary, Complementary & Over the Counter Medicines Branch, Therapeutic Goods Administration

Professional association representatives

Ms Donna Chew, Federation of Chinese Medicine & Acupuncture Societies of Australia (FCMA)

Ms Kaitlin Edin, Australian Natural Therapists Association (ANTA)

Ms Waveny Holland, Australian Acupuncture and Chinese Medicine Association (AACMA)

Dr Max Ma, Chinese Medicine Industry Council of Australia (CMIC)

Education institution representatives

Dr Greg Cope

Associate Professor Xiaoshu Zhu

Graduate representative

Ms Laura Sutton

Chiropractic Board of Australia: National committee members

Registration, Notifications and Compliance Committee

Dr Michael Badham (practitioner), Chair, from 6 Jul

Mr Frank Ederle (community)

Ms Anne Burgess (community)

Dr Abbey Chilcott (practitioner), Deputy Chair

Dr Wayne Minter AM (practitioner)

Dr Arcady Turczynowicz (practitioner)

Ms Alison von Bibra (community)

Dr Ailsa Wood (practitioner)

Dental Board of Australia: State, territory and national committee members

ACT Registration and Notifications Committee (to 1 Feb)

Dr Peter Wong (practitioner), Chair

Professor Craig Zimitat (community)

Dr Kerrie O'Rourke (practitioner)

NSW Registration Committee (to 1 Feb)

Professor Iven Klineberg (practitioner), Chair

Dr Alexander Holden (practitioner)

Mr Michael Miceli (community)

Dr Philippa Sawyer (practitioner)

NT Registration and Notification Committee (to 1 Feb)

Dr Erna Melton (practitioner), Chair

Mrs Megan Lawton (community)

Dr Quentin Rahaus (practitioner)

Dr Michael Rees (practitioner)

Qld Registration and Notifications Committee and Immediate Action Committee (to 1 Feb)

Dr Robert McCray (practitioner), Chair

Mrs Brydget Barker-Hudson (community)

Professor Robert Love (practitioner)

Dr Bruce Newman (practitioner)

Mr Stuart Unwin (community)

SA Registration and Notifications Committee (to 1 Feb)

Dr Cosimo Maiolo (practitioner), Chair

Ms Michelle Kuss (practitioner)

Dr Sophia Matiasz PhD (community)

Dr Heidi Munchenberg (practitioner)

Ms Joanna Richardson (community)

Dr Michael Rees (practitioner)

Tas Registration and Notifications Committee (to 1 Feb)

Dr Ioan Jones (practitioner), Chair

Mr Leigh Gorringe (practitioner)

Mr Nikolas Peacock (practitioner)

Professor Craig Zimitat (community)

Vic Registration and Notifications Committee and Immediate Action Committee (to 1 Feb)

Dr Werner Bischof (practitioner), Chair

Dr Janice Davies PhD (community)

Professor Lesleyanne Hawthorne (community)

Dr Ioan Jones (practitioner)

Dr Rachel Martin (practitioner)

WA Registration and Notifications Committee (to 1 Feb)

Dr Simon Shanahan (practitioner), Chair

Dr Erna Melton (practitioner)

Ms Yvonne Parnell (community)

Dr Bernadette Pilkington (practitioner)

Professor Craig Zimitat (community)

Immediate Action Committee (from 1 Sep)

Dr Werner Bischof (practitioner), Chair

Dr Ioan Jones (practitioner), Chair

Dr Kerrie O'Rourke (practitioner), Chair

Professor Craig Zimitat (community), Chair

Mrs Brydget Barker-Hudson (community)

Mr Leigh Gorringe (practitioner)

Professor Lesleyanne Hawthorne (community)

Dr Sophia Matiasz PhD (community)

Mr Nikolas Peacock (practitioner)

Dr Quentin Rahaus (practitioner)

Notifications Committee: Assessment

Mrs Brydget Barker-Hudson (community)

Dr Werner Bischof (practitioner)

Dr Ioan Jones (practitioner)

Mrs Megan Lawton (community)

Professor Robert Love (practitioner)

Dr Sophia Matiasz PhD (community)

Dr Erna Melton (practitioner)

Mr Michael Miceli (community)

Mr Nikolas Peacock (practitioner)

Dr Simon Shanahan (practitioner)

Professor Craig Zimitat (community)

Notification and Compliance Committee (from 1 Feb)

Dr Ioan Jones (practitioner), Chair

Professor Robert Love (practitioner), Chair

Dr Rachel Martin (practitioner), Chair

Dr Simon Shanahan (practitioner), Chair

Mrs Brydget Barker-Hudson (community)

Dr Werner Bischof (practitioner), Deputy Chair

Mr Leigh Gorringe (practitioner)

Professor Lesleyanne Hawthorne (community)

Dr Robert McCray (practitioner)

Dr Cosimo Maiolo (practitioner), Deputy Chair

Dr Erna Melton (practitioner)

Dr Kerrie O'Rourke (practitioner), Deputy Chair

Mr Nikolas Peacock (practitioner)

Dr Bernadette Pilkington (practitioner)

Dr Michael Rees (practitioner)

Mr Stuart Unwin (community)

Dr Peter Wong (practitioner), Deputy Chair

Professor Craig Zimitat (community)

Registration and Compliance Committee (from 1 Feb)

Dr Werner Bischof (practitioner), Chair

Mr Leigh Gorringe (practitioner)

Professor Iven Klineberg (practitioner), Deputy Chair

Dr Sophia Matiasz PhD (community)

Dr Erna Melton (practitioner)

Dr Philippa Sawyer (practitioner)

Mr Stuart Unwin (community)

Dr Peter Wong (practitioner), Deputy Chair

Medical Board of Australia: State and territory board, national committee and group members

Australian Capital Territory

Professor Peter Warfe (practitioner), Chair, from 1 Jun

Dr Kerrie Bradbury (practitioner), Chair, to 31 May

Mrs Gulnara Abbasova (community)

Dr Emma Adams (practitioner)

Dr Iain Dunlop (practitioner)

Ms Catherine (Kate) Gauthier (community)

Associate Professor Boon Lim (practitioner)

Mr Robert Little (community)

Associate Professor Rodney Petersen (practitioner)

Mr Aasish Ponna (community)

Dr Louise Stone (practitioner)

Dr Jill Van Acker (practitioner)

New South Wales

Dr Sergio Diez Alvarez (practitioner), Chair, from 24 Aug

Associate Professor Stephen Adelstein (practitioner), Chair, to 23 Aug

Dr Costa Boyages (practitioner)

Dr Jennifer Davidson (practitioner)

Dr Maria (Tessa) Ho (practitioner)

Dr Amanda Mead PhD (community)

Professor Abdullah Omari (practitioner)

Ms Jebby Phillips (community)

Professor Allan Spigelman (practitioner)

Ms Amanda Wilson (community)

Northern Territory

Dr Hemanshu Patel (practitioner), Chair

Mrs Lea Aitken (community)

Mrs Julia Christensen (community)

Dr Tamsin Cockayne (practitioner)

Dr Henry Duncan (practitioner)

Ms Annette Flaherty (community)

Dr Sarah Giles (practitioner)

Dr Paul Helliwell (practitioner)

Dr Verushka Krigovsky (practitioner)

Associate Professor Dianne Stephens (practitioner)

Queensland

Dr Philip Richardson (practitioner), Chair

Dr Cameron Bardsley (practitioner)

Dr Anelisa Dazzi Chequer De Souza (practitioner)

Dr Patrick Clancy (practitioner)

Mr Timothy Cole (community)

Dr Caron Forde (practitioner)

Ms Christine Gee (community)

Dr Genevieve Goulding (community)

Dr Gordon McGurk PhD (community)

Professor Eleanor Milligan (community)

Ms Megan O'Shannessy (community)

Dr Morgan Windsor (practitioner)

South Australia

Dr Mary White (practitioner), Chair

Professor Andrew (Simon) Carney (practitioner)

Dr Daniele (Daniel) Cehic (practitioner)

Dr Carolyn Edmonds (practitioner)

Dr Catherine Gibb (practitioner)

Ms Kate Ireland (community)

Ms Louise Miller-Frost (community)

Dr Bruce Mugford (practitioner)

Dr Lynne Rainey (practitioner)

Ms Katherine Sullivan (community)

Mr Thomas Symonds (community)

Dr Melanie Turner (practitioner)

Tasmania

Dr Kristen Fitzgerald (practitioner), Chair

Mrs Kristen Adams (community)

Dr Colin Chilvers (practitioner)

Mr Fergus Leicester (community)

Dr Katja Lindemann (practitioner)

Ms Louise Mason (community)

Dr Gavin Mackie (practitioner)

Professor Peter McMinn (practitioner)

Dr Colin Merridew (practitioner)

Dr Brooke Sheldon (practitioner)

Associate Professor Stuart Walker (practitioner)

Mrs Joan Wylie (community)

Victoria

Dr Debra O'Brien (practitioner), Chair

Mrs Jennifer Barr (community)

Dr Christine Bessell (practitioner)

Professor George Braitberg (practitioner)

Dr John Carnie PSM (practitioner)

Ms Jane (Meredith) Carter (community)

Dr Anthony Cross (practitioner)

Dr Nicola Cunningham (practitioner)

Ms Jacqueline Gibson (community)

Dr Susan Gould PhD (community)

Ms Louise Johnson (community)

Associate Professor Vinay Lakra (practitioner)

Associate Professor Jenepher (Jenny) Martin (practitioner)

Associate Professor Solomon Menahem (practitioner)

Dr Pamela Montgomery PhD (community)

Dr Ines Rio (practitioner)

Dr Abhishek (Abhi) Verma (practitioner)

Dr Ruth Vine (practitioner)

Dr Miriam Weisz OAM (DBA) (community)

Western Australia

Professor Mark Edwards (practitioner), Chair, from 18 Apr

Professor Constantine (Con) Michael AO (practitioner), Chair, to 17 Apr

Dr Richelle Douglas (practitioner)

Dr Alan Duncan (practitioner)

Dr Pathma Edge (practitioner)

Dr George Eskander (practitioner)

Dr Michael Levitt (practitioner)

Dr Clare Matthews (practitioner)

Ms Sonia McKeiver (community)

Ms Meneesha Michalka (community)

Mr Liam Roche (community)

Non-Board members appointed to national committees

ACT

Ms Vicki Brown (community)

Qld

Dr Charles Kilburn (practitioner)

Mr Geoff Rowe (community)

Dr Samuel Stevens (practitioner)

Dr Susan Young (Doctor of Education) (community)

SA

Mr Paul Laris (community)

Tas

Ms Leigh Mackey (community)

Medical Training Survey Advisory Group

Associate Professor Stephen Adelstein (practitioner), Chair

Dr Mohamed Abdeen (practitioner)

Dr Monica Chen (practitioner)

Dr Dean Choong (practitioner)

Dr Jeanette Conley (practitioner)

Ms Helen Craig (community)

Dr Marco Giuseppin (practitioner)

Dr James Edwards (practitioner)

Mr Warwick Hough (community)

Dr Kym Jenkins (practitioner)

Mr Oliver Jones (community)

Dr Joanne Katsoris (practitioner)

Ms Sophie Keen (practitioner)

Professor Robyn Langham (practitioner)

Mr John McGurk (community)

Dr David Mountain (practitioner)

Dr Susan O'Dwyer (practitioner)

Dr Annette Pantle (practitioner)

Dr Andrew Singer (practitioner)

Professor Richard Tarala (practitioner)

Professor Susan Wearne (practitioner)

Dr Christopher (Chris) Wilson (practitioner)

Ms Fearn (Michelle) Wright (community)

Ms Jessica Yang (community)

Dr John Zorbas (practitioner)

Mr Daniel Zou (practitioner)

Medical Training Survey Steering Committee

Associate Professor Stephen Adelstein (practitioner), Chair

Dr Joanne Katsoris (practitioner)

Dr Linda MacPherson (practitioner)

Dr Bavahuna Manoharan (practitioner)

Dr Susan O'Dwyer (practitioner)

Ms Theanne Walters (community)

Ms Kirsty White (community)

Ms Fearn (Michelle) Wright (community)

National Specialist International Medical Graduate Committee

Dr Susan O'Dwyer (practitioner), Chair

Ms Sophy Athan (community)

Dr Sergio Diez Alvarez (practitioner)

Ms Kym Ayscough (community)

Associate Professor Terry Brown (practitioner)

Professor Gavin Frost (practitioner)

Dr Patrick Giddings (practitioner)

Ms Lynne Gillam (community)

Dr Paul Helliwell (practitioner)

Dr Jon Hodge (practitioner)

Dr Joanne Katsoris (practitioner)

Ms Megan Lewis (community)

Dr Andrew Mulcahy (practitioner)

Dr Bruce Mugford (practitioner)

Dr Hemanshu Patel (practitioner)

Mr Philip Pigou (community)

Dr Diane Neill (practitioner)

Adjunct Associate Professor Andrew Singer AM (practitioner)

Dr Janaka Tennakoon (practitioner)

Professional Performance Framework Implementation Working Group

Dr Anne Tonkin (practitioner), Chair

Mr Mark Bodycoat (community)

Associate Professor David Hillis (practitioner)

Professor Katherine (Kate) Leslie (practitioner)

Professor Constantine (Con) Michael AO (practitioner)

Dr Joanne Katsoris (practitioner)

Sexual Boundaries Notifications Committee

Ms Christine Gee (community), Chair

Professor Peter Warfe (practitioner), Deputy Chair

Mr Mark Bodycoat (community)

Mrs Julia Christensen (community)

Dr Anthony Cross (practitioner)

Dr Sergio Diez Alvarez (practitioner)

Dr Alan Duncan (practitioner)

Dr Kristen Fitzgerald (practitioner)

Dr Janelle Hamilton (practitioner)

Dr Maria (Tessa) Ho (practitioner)

Dr Verushka Krigovsky (practitioner)

Mr Fergus Leicester (community)

Associate Professor Hannah McGlade (community)

Ms Meneesha Michalka (community)

Dr Debra O'Brien (practitioner)

Dr Susan O'Dwyer (practitioner)

Dr Kim Rooney OAM (practitioner)

Ms Katherine Sullivan (community)

Dr Anne Tonkin (practitioner)

Dr Abhishek (Abhi) Verma (practitioner)

Dr Miriam Weisz OAM (DBA) (community)

Mrs Joan Wylie (community)

Medical Radiation Practice Board of Australia: National committee and group members

Finance Working Group

Ms Cara Miller (practitioner), Chair

Mr Richard Bialkowski (community)

Dr Susan Gould PhD (community)

Mr Mark Marcenko (practitioner)

Mr Travis Pearson (practitioner)

Mr Roger Weckert (practitioner)

National Examination Committee

Dr Susan Gould PhD (community), Chair

Mr Anthony Buxton (practitioner)

Mr James Green (practitioner)

Mr Travis Pearson (practitioner)

Mr Roger Weckert (practitioner)

Dr Caroline Wright PhD (practitioner)

Policy Committee

Ms Joan Burns (community), Chair, from 1 Jun

Mr Christopher Hicks (practitioner), Chair, to 8 Feb

Ms Donisha Duff (community)

Mr James Green (practitioner)

Dr Susan Gould PhD (community)

Ms Renea Hart (community)

Mr Mark Marcenko (practitioner)

Mr Travis Pearson (practitioner)

Ms Tracy Vitucci (practitioner)

Mr Roger Weckert (practitioner)

Dr Caroline Wright PhD (practitioner)

Registration and Notifications Committee

Mr Brendan McKernan (practitioner), Chair, from 1 Jun

Mr Mark Marcenko (practitioner) Chair, to 31 May

Mr Richard Bialkowski (community)

Mr Anthony Buxton (practitioner)

Mr James Green (practitioner)

Dr Susan Gould PhD (community)

Ms Renea Hart (community)

Ms Cara Miller (practitioner)

Mr Roger Weckert (practitioner)

Supervised Practice Committee

Ms Caroline Wright (practitioner), Chair, from 1 Jun

Mr Brendan McKernan (practitioner), Chair, to 31 May

Mr Gerard Amirtham (practitioner)

Mr Richard Bialkowski (community)

Mrs Nainaben Dhana (practitioner)

Mrs Kelly Elsner (practitioner)

Ms Fiona Franklin (practitioner)

Mr Simon Lejcak (practitioner)

Ms Cara Miller (practitioner)

Miss Lauren Moon (practitioner)

Mr John Tessier (practitioner)

Mr Glenn Trainor (practitioner)

Mr Roger Weckert (practitioner)

Nursing and Midwifery Board of Australia: State and territory board and national committee members

State and Territory Chairs' Committee

Adjunct Professor Veronica Casey AM, Chair, from 2 Oct

Associate Professor Lynette Cusack, Chair, to 2 Oct

Mrs Sharon Bingham (practitioner) (Tas)

Ms Angela Bull (practitioner) (NT)

Ms Felicity Dalzell (practitioner) (ACT)

Ms Michelle Garner (practitioner) (Qld)

Associate Professor Bethne Hart (Nursing and Midwifery Council of NSW)

Mrs Eithne Irving (practitioner) (NSW)

Ms Marie Louise MacDonald (practitioner) (WA)

Ms Paula Medway (practitioner) (SA)

Ms Amanda Singleton (practitioner) (Vic)

Australian Capital Territory

Ms Felicity Dalzell (practitioner), Chair

Mrs Gulnara Abbasova (community)

Mrs Alison Archer (community)

Ms Marjorie Atchan (practitioner)

Ms Janet (Emma) Baldock (practitioner)

Dr Katrina Cubit PhD (practitioner)

Ms Catherine (Kate) Gauthier (community)

Ms Eileen Jerga AM (community)

Mr Rory Maguire (practitioner)

Ms Kelley Stewart (practitioner)

Professor Karen Strickland (practitioner)

New South Wales

Mrs Eithne Irving (practitioner), Chair

Ms Kathryn (Kate) Adams (practitioner)

Ms Alison Barnes (practitioner)

Ms Katherine Becker (practitioner)

Mr Bruce Brown (community)

Mr Roderick (Rod) Cooke (community)

Mrs Maria Cosmidis (community)

Ms Adrienne Farago (community)

Dr Joanne Gray PhD (practitioner)

Mrs Susan (Sue) Greig (practitioner)

Ms Melissa Maimann (practitioner)

Mrs Annette (Anne) Moehead (practitioner)

Northern Territory

Ms Angela Bull (practitioner), Chair

Mrs Leanne Chapman (practitioner)

Mrs Emma Childs (practitioner)

Ms Heather King (community)

Ms Aislinn McIntyre (community)

Mrs Priscilla Moore (practitioner)

Dr Brian Phillips PhD (practitioner)

Ms Alison Phillis (community)

Dr Joanne Seiler (Doctorate Business Administration) (practitioner)

Mrs Helen (Nell) Stonham (community)

Mr Jonathan Wright (practitioner)

Queensland

Ms Michelle Garner (practitioner), Chair, from 23 Dec

Professor Patsy Yates (practitioner), Chair, to 30 Dec

Ms Jacinta Ashton (practitioner)

Ms Suzanne (Sue) Cadigan (practitioner)

Mrs Karen (Kaz) Dolci (community)

Ms Tracey Duke (practitioner)

Dr Amanda Henderson PhD (practitioner)

Mr Stanley Macionis (community)

Ms Catherine Mickel (community)

Ms Helen Towler (practitioner)

South Australia

Ms Paula Medway (practitioner), Chair, from 26 Jan

Associate Professor Linda Starr (practitioner), Chair, to 23 Nov

Mr Mark Bodycoat (community)

Mrs Zinta Docherty (community)

Ms Elisa Gardiner (practitioner)

Mrs Gillian Homan (practitioner)

Mrs Margaret McCallum (community)

Dr Philippa Rasmussen PhD (practitioner)

Mr Thomas Symonds (community)

Mrs Lisa Turner (practitioner)

Ms Kellie Whelan (practitioner)

Tasmania

Ms Carol Baines (practitioner), Presiding Member, to 30 Dec

Mrs Sharon Bingham (practitioner), Chair, from 1 Jan

Mrs Briony (Bebe) Brown (practitioner)

Professor Rosalind Bull (practitioner)

Ms Hazel Bucher (practitioner)

Mrs Lucy Byrne (community)

Mr Stephen Carey (community)

Miss Aleara Crichton-Gill (practitioner)

Ms Christine Schokman (community)

Mrs Lynette Staff (practitioner)

Ms Belinda Webster (community)

Victoria

Ms Amanda Singleton (practitioner), Chair

Dr Leslie Cannold PhD (community)

Professor Maxine Duke (practitioner)

Mr Matthew Grace (practitioner)

Associate Professor David Hills (community)

Ms Helen Karagiozakis (community)

Mrs Joanne Mapes (practitioner)

Ms Thilaka Sathananthavel (community)

Adjunct Professor Paula Stephenson (practitioner)

Mrs Brenda Waites (practitioner)

Dr Miriam Weisz OAM (DBA) (community)

Western Australia

Ms Marie Louise MacDonald (practitioner), Chair

Dr Sara Bayes PhD (practitioner)

Ms Justine Burg (practitioner)

Dr Margaret Crowley PhD (community)

Ms Michelle Dillon (practitioner)

Adjunct Associate Professor Karen Gullick (practitioner)

Mrs Linda Hadfield (community)

Dr Yvonne Hauck PhD (practitioner)

Mr John (Kim) Laurence (community)

Ms Margaret Lundy (community)

Mrs Kristian Malic (practitioner)

Miss Kathryn Pedler (practitioner)

Mr Michael Piu (community)

Accreditation Committee (Assessment of Overseas Qualified Nurses and Midwives)

Professor Denise Fassett (practitioner), Chair

Mr Ian Frank AM (community)

Ms Marie Heartfield (practitioner)

Dr Daniel Malone PhD (community)

Professor Catherine Nagle (practitioner)

Ms Fiona Stoker (practitioner)

Mr Brett Vaughan (community)

Finance, Governance and Communications Committee

Ms Melodie Heland (practitioner), Chair, from 1 Jan

Mrs Allyson Warrington (community), Chair, to 31 Dec

Mr David Carpenter (practitioner)

Dr Jessica (Jessa) Rogers PhD (community)

Ms Catherine Schofield (practitioner)

Notifications Committee Midwifery

Ms Paula Medway (practitioner), Chair, from 26 Jan

Mrs Gulnara Abbasova (community)

Dr Sara Bayes PhD (practitioner)

Mr Stephen Carey (community)

Dr Amanda Henderson PhD (practitioner)

Mr Stanley Macionis (community)

Ms Amanda Singleton (practitioner)

Notifications Committee Nursing Assessment

Dr Sara Bayes (practitioner)

Ms Felicity Dalzell (practitioner)

Ms Michelle Garner (practitioner)

Ms Paula Medway (practitioner)

Ms Amanda Singleton (practitioner)

Associate Professor Linda Starr (practitioner)

Ms Paula Stephenson (practitioner)

Mrs Brenda Waites (practitioner)

Program Approval Committee

Associate Professor Linda Starr (practitioner), Chair, from 1 Jan

Adjunct Professor Veronica Casey AM (practitioner), Chair, to 31 Dec

Dr Christopher Helms PhD (practitioner)

Mr Max Howard (community)

Mrs Jennifer Wood (practitioner)

Registration and Notifications Committee

Ms Annette Symes (practitioner), Chair

Mr David Carpenter (practitioner)

Ms Maria Ciffolilli (community)

Dr Christopher Helms PhD (practitioner)

Ms Catherine Schofield (practitioner)

Associate Professor Linda Starr (practitioner)

Mrs Jennifer Wood (practitioner)

RN OSCE Examination Committee of the Nursing and Midwifery Accreditation Committee (from 12 Oct)

Dr Jane Frost (Doctorate Nurse Practitioner) (practitioner), Chair

Ms Leah Bradley (practitioner)

Dr Ylona Chun Tie PhD (practitioner)

Dr Paul (John) Glew (EdD) (practitioner)

Dr Alexander (Curtis) Lee PhD (practitioner)

Mr Mark Rosenthal (practitioner)

Non-Board members appointed to committees

Vic Registration Committee and Notifications Committee

Mrs Jennifer Gilmartin (practitioner)

Ms Karen Sawyer (practitioner)

Occupational Therapy Board of Australia: National committee members

Registration and Notifications Committee

Ms Roxane Marcelle-Shaw (community), Chair

Mr Darryl Annett (community)

Ms Julie Brayshaw (practitioner)

Mr James Carmichael (practitioner)

Ms Sally Cunningham (practitioner)

Mrs Rachael Kay (practitioner)

Dr Catherine McBryde PhD (practitioner)

Mr Areti Metuamate (community)

Miss Jennifer Morris (community)

Dr Claire Pearce PhD (practitioner)

Mrs Terina Saunders (practitioner)

Dr Justin Scanlan PhD (practitioner), Deputy Chair

Ms Rebecca Singh (practitioner)

Mrs Angela Thynne (practitioner)

Optometry Board of Australia: National committee members

Finance and Risk Committee

Mr Anthony Evans (community), Chair

Mr Stuart Aamodt (practitioner)

Associate Professor Ann Webber (practitioner)

Policy and Education Committee

Associate Professor Ann Webber (practitioner), Chair

Dr Carla Abbott (practitioner)

Associate Professor Daryl Guest (practitioner)

Ms Adrienne Farago (community)

Associate Professor Rosemary Knight (community)

Registration and Notifications Committee

Mr Ian Bluntish (practitioner), Chair

Mrs Nancy Atkinson (practitioner)

Ms Adrienne Farago (community)

Mrs Judith Hannan (practitioner)

Mr Kenneth Ingram (practitioner)

Mr Neville Turner (practitioner)

Scheduled Medicines Advisory Committee

Associate Professor Daryl Guest (practitioner), Chair

Dr Carla Abbott (practitioner)

Professor Alex Gentle (practitioner)

Mr Benjamin Hamlyn (practitioner)

Dr Graham Lakkis (practitioner)

Professor Danny Liew (practitioner)

Ms Angela Stathopoulos (practitioner)

Associate Professor Robert (Andrew) Symons (practitioner)

Associate Professor James Ziogas (community)

Osteopathy Board of Australia: National committee members

Registration and Notifications Committee

Dr Nikole Grbin (practitioner), Chair

Members are the National Board.

Paramedicine Board of Australia: National committee members

Notifications Committee: Assessment

Mr Keith Driscoll ASM

Associate Professor Ian Patrick ASM

Ms Angela Wright

Mr Howard Wren ASM

Registration, Notifications and Compliance Committee

Ms Linda Renouf (community), Chair

Members are the National Board.

Pharmacy Board of Australia: National committee members

Finance, Risk and Governance Committee

Mr Laurence (Ben) Wilkins (practitioner), Chair

Dr Alice Gilbert PhD (practitioner)

Ms Joy Hewitt (practitioner)

Mr Mark Kirschbaum (practitioner)

Ms Hannah Mann (practitioner)

Dr Suzanne Martin (veterinarian) (community)

Mr Brett Simmonds (practitioner)

Mr Rodney Wellington (community)

Immediate Action Committee

All members of the Pharmacy Board of Australia are eligible for appointment to the Immediate Action Committee.

Notifications Committee

Mr Mark Kirschbaum (practitioner), Chair

Ms Melissa Cadzow (community)

Dr Alice Gilbert PhD (practitioner)

Ms Hannah Mann (practitioner), Deputy Chair

Dr Suzanne Martin (veterinarian) (community)

Dr Cameron Phillips PhD (practitioner)

Mr Brett Simmonds (practitioner)

Mr Rodney Wellington (community)

Mr Laurence (Ben) Wilkins (practitioner)

Notifications Committee: Assessment (from 1 Jul)

Mr Mark Kirschbaum (practitioner), Alternate Chair

Mr Laurence (Ben) Wilkins (practitioner), Alternate Chair

Ms Melissa Cadzow (community)

Dr Suzanne Martin (veterinarian) (community)

Mr Brett Simmonds (practitioner)

Policies, Codes and Guidelines Committee

Mr Brett Simmonds (practitioner), Chair

Mrs Elise Apolloni (practitioner)

Ms Melissa Cadzow (community)

Dr Alice Gilbert PhD (practitioner)

Ms Joy Hewitt (practitioner)

Dr Suzanne Martin (veterinarian) (community)

Dr Cameron Phillips PhD (practitioner)

Mr Laurence (Ben) Wilkins (practitioner)

Registration and Examinations Committee

Ms Joy Hewitt (practitioner), Chair

Mrs Elise Apolloni (practitioner)

Dr Alice Gilbert PhD (practitioner)

Mr Mark Kirschbaum (practitioner)

Ms Hannah Mann (practitioner)

Dr Suzanne Martin (veterinarian) (community)

Dr Cameron Phillips PhD (practitioner)

Dr Janet Preuss PhD (community – acting)

Mr Brett Simmonds (practitioner)

Dr Rodney Wellard PhD (community)

Mr Rodney Wellington (community)

Physiotherapy Board of Australia: National committee members

Registration and Notifications Committee

Ms Fiona McKinnon (practitioner), Chair

Ms Sally Adamson (practitioner)

Ms Maureen Capp OAM (community)

Mr David Cross (practitioner)

Mr Mark Hindson (practitioner)

Mr Peter Kerr AM (community)

Mr Lachlan Mortimer (practitioner)

Ms Elizabeth Soderholm (practitioner)

Podiatry Board of Australia: National committee members

Registration and Notifications Committee

Dr Janice Davies PhD (community), Chair

Dr Paul Bennett PhD (practitioner)

Miss Julia Kurowski (practitioner)

Dr Kristy Robson PhD (practitioner), Deputy Chair

Mr Anthony Short (practitioner)

Ms Shellee Smith (community)

Strategic Planning and Policy Committee

Mrs Kathryn (Kate) Storer (practitioner), Chair

Professor Andrew Taggart (community)

Mr Andrew van Essen (practitioner)

Dr Cylie Williams PhD (practitioner)

Psychology Board of Australia: Regional board and national committee members

ACT/Tas/Vic Regional Board

Dr Joel Godfredson (practitioner), Presiding Member, from 29 May

Dr Melissa Casey (practitioner), Chair, to 18 Dec

Associate Professor Rubina Alpitsis (practitioner)

Dr Ann Boonzaier (practitioner)

Mr Robin Brown (community)

Mr Carl Buik (community)

Dr Simon Crisp (practitioner)

Ms Vicki de Prazer (practitioner)

Dr Sally Kalek (practitioner)

Dr Elke Kellis (practitioner)

Dr Rosamond Lethbridge (practitioner)

Ms Lisa Wardlaw-Kelly (community)

Dr Miriam Weisz OAM (DBA) (community)

New South Wales Regional Board

Associate Professor Christopher Wilcox (practitioner), Chair, from 24 Aug

Associate Professor Michael Kiernan (practitioner), Chair, to 23 Aug

Mr Yat Sang (Sang) Cheung (practitioner)

Mr Roderick (Rod) Cooke (community)

Mrs Margo Gill (community)

Mr Timothy Hewitt (practitioner)

Mr Robert Lagaida (community)

Ms Maralean (Maz) McCalman (community)

Ms Pauline O'Connor (community)

Ms Alison O'Neill (practitioner)

Professor Nickolai Titov (practitioner)

Ms Lila Vrklevski (practitioner)

Dr Ann Wignall (practitioner)

NT/SA/WA Regional Board

Mr Neil McLean (practitioner), Chair, from 29 Jun

Ms Cathy Beaton (community)

Ms Carolyn Bright (practitioner)

Ms Jacqueline Fidler (practitioner)

Mrs Megan Lawton (community)

Mr Colby Pearce (practitioner)

Ms Elizabeth Pritchard (practitioner)

Ms Claire Simmons (practitioner)

Mr Theodore Sharp (community)

Queensland Regional Board

Dr Fiona Black (practitioner), Chair, from 23 Dec

Ms Kathryn Bekavac (practitioner)

Mr Robert Blin (community)

Ms Julia Duffy (community)

Ms Karen Dunshea (practitioner)

Associate Professor Gene Moyle (practitioner)

Ms Ylishavai Ngateejah (practitioner)

Ms Linda Renouf (community)

Mr David Rodwell (practitioner)

Immediate Action Committee

Ms Mary Brennan (community), Chair

Dr Fiona Black (practitioner)

Ms Carolyn Bright (practitioner)

Dr Melissa Casey (practitioner)

Ms Julia Duffy (community)

Dr Joel Godfredson (practitioner)

Dr Sally Kalek (practitioner)

Dr Elke Kellis (practitioner)

Associate Professor Michael Kiernan (practitioner)

Mr Neil McLean (practitioner)

Professor Jennifer Scott (practitioner)

Mr Theodore Sharp (community)

Ms Claire Simmons (practitioner)

Dr Miriam Weisz OAM (DBA) (community)

Associate Professor Christopher Wilcox (practitioner)

Notifications Committee: Assessment

Dr Haydn Till (practitioner), Chair

Dr Fiona Black (practitioner)

Ms Carolyn Bright (practitioner)

Ms Angela Marie Davis (practitioner)

Mr John Gardiner (practitioner)

Mr Neil McLean (practitioner)

Dr Shirley Morrissey (practitioner)

Ms Claire Simmons (practitioner)

Associate Professor Christopher Wilcox (practitioner)

Dr Sarah Wrigley (practitioner)

Multi-Profession Immediate Action Committee

Mr Bruce Brown (ATSIHPBA) (community), Chair, to 7 May

Dr Janice Davies PhD (PodBA) (community), Alternate Chair

Ms Linda Renouf (ParaBA) (community), Alternate Chair

Ms Sally Adamson (PhysioBA) (practitioner)

Dr Michael Badham (ChiroBA) (practitioner)

Dr Paul Bennett PhD (PodBA) (practitioner)

Mr Ian Bluntish (OptomBA) (practitioner)

Mr James Carmichael (OTBA) (practitioner)

Dr Abbey Chilcott (ChiroBA) (practitioner)

Mr David Cross (PhysioBA) (practitioner)

Ms Sally Cunningham (OTBA) (practitioner)

Dr Pamela Dennis (OsteoBA) (practitioner)

Mr Keith Driscoll (ParaBA) (practitioner)

Dr Nikole Grbin (OsteoBA) (practitioner)

Mr James Green (MRPBA) (practitioner)

Mrs Judith Hannan (OptomBA)

Ms Celia Harnas (ATSIHPBA) (practitioner)

Mr Christopher Hicks (MRPBA) (practitioner)

Miss Julia Kurowski (PodBA) (practitioner)

Dr Di Wen Lai (CMBA) (practitioner)

Mr Mark Marcenko (MRPBA) (practitioner)

Mr Brendan McKernan (MRPBA) (practitioner)

Dr Timothy McNamara (OsteoBA) (practitioner)

Ms Cara Miller (MRPBA) (practitioner)

Dr Wayne Minter AM (ChiroBA) (practitioner)

Mr Lachlan Mortimer (PhysioBA) (practitioner)

Dr Paul Orrock PhD (OsteoBA) (practitioner)

Ms Renee Owen (ATSIHPBA) (practitioner)

Associate Professor Ian Patrick (ParaBA) (practitioner)

Dr Johannah Shergis PhD (CMBA) (practitioner)

Mrs Angela Thynne (OTBA) (practitioner)

Ms Bing Tian (CMBA) (practitioner)

Mr Arcady Turczynowicz (ChiroBA) (practitioner)

Associate Professor Ann Webber (OptomBA) (practitioner)

Dr Cylie Williams PhD (PodBA) (practitioner)

Mr Kenton Winsley (ATSIHPBA) (practitioner)

Dr Ailsa Wood (ChiroBA) (practitioner)

Ms Angela Wright (ParaBA) (practitioner)

Mr Andrew Yaksich (OsteoBA) (practitioner)

Accreditation Committees

Aboriginal and Torres Strait Islander Health Practice Board of Australia Accreditation Committee

Professor Elaine Duffy (community), Chair

Mrs Elizabeth Shuttle (community)

Mrs Norma Solomon (practitioner)

Ms Sharon Wallace (practitioner)

Chinese Medicine Board of Australia Accreditation Committee

Dr Meeuwis Boelen PhD (community), Chair

Mrs Suzi Mansu (practitioner)

Mr David Schievenin (practitioner)

Dr Wei Hong (Angela) Yang (practitioner), Deputy Chair

Associate Professor Christopher Zaslawski (practitioner)

Medical Radiation Practice Board of Australia Accreditation Committee

Professor Brian Jolly (community), Chair

Mrs Allison Dry (practitioner)

Dr Daphne James PhD (practitioner)

Dr Sarah Lewis PhD (practitioner), Deputy Chair

Dr Louise McCall PhD (community)

Ms Natalie Pollard (practitioner)

Mrs Jane Shepherdson (practitioner)

Paramedicine Board of Australia Accreditation Committee

Professor Eileen Willis (community), Chair

Mr Anthony Hucker (practitioner)

Mr Richard Larsen (practitioner)

Dr William Lord PhD (practitioner), Deputy Chair

Mr Alan Morrison (practitioner), Deputy Chair

Mr Martin Nichols (practitioner)

Dr Helen Webb PhD (practitioner)

Podiatry Board of Australia Accreditation Committee

Dr Meeuwis Boelen PhD (community), Chair

Ms Alison Bell (community)

Dr Vivienne Chuter PhD (practitioner)

Mr Mark Gilheany (practitioner), Deputy Chair

Dr Sara Jones AM PhD (practitioner)

Dr Lloyd Reed PhD (practitioner)

Appendix 4: Attendance at Agency Management Committee and its subcommittee meetings

This table shows how many meetings of the Agency Management Committee and its subcommittees each member attended, compared with the total number of meetings those members were eligible to attend. Members who left or joined during 2020/21 were eligible to attend a smaller number of meetings. Not all Agency Management Committee members are members of each subcommittee. Non-Agency Management Committee members, including National Board Chairs and members and some external experts, have also been appointed to its subcommittees and these members are listed at the end of each committee list.

Name	Number of meetings attended/ eligible to attend
Agency Management Committee	
Ms Gill Callister PSM, Chair	11/11
Dr Peggy Brown AO	11/11
Adjunct Professor Karen Crawshaw PSM	11/11
Emeritus Professor Arie Freiberg AM	8/8
Mr Jeff Moffet	7/8
Mr Lynton Norris	7/8
Ms Philippa Smith AM	3/3
Ms Jenny Taing OAM	11/11
Ms Barbara Yeoh AM	11/11
Dr Susan Young	11/11
Mr Brett Simmonds	10/11
Accreditation Advisory Committee	
Ms Gill Callister PSM, Chair	3/3
Adjunct Professor Karen Crawshaw PSM	2/3
Dr Susan Young	2/3
Adjunct Professor Veronica Casey AM	2/2
Associate Professor Lynette Cusack	1/1
Emeritus Professor Christine Ewan	3/3
Dr Susan Gould	2/3
Mr Brett Simmonds	1/3
Finance, Audit and Risk Management Committee	
Ms Barbara Yeoh AM, Chair	6/6
Mr Lynton Norris	3/3
Ms Jenny Taing	6/6
Mr David Balcombe	6/6
Mr Anthony Evans	6/6
Ms Kim Jones	6/6
Ms Allyson Warrington	5/6
Pandemic Preparedness Oversight Group	
Ms Gill Callister PSM, Chair	5/7
Dr Peggy Brown AO	6/7
Dr Susan Young	7/7
Adjunct Professor Veronica Casey AM	2/3
Associate Professor Lynette Cusack	2/4
Ms Kim Gibson	6/7
Mr Brett Simmonds	7/7
Dr Murray Thomas	7/7
Dr Anne Tonkin	6/7

Name	Number of meetings attended/ eligible to attend
Regulatory Performance Committee	
Dr Peggy Brown AO, Chair	6/6
Adjunct Professor Karen Crawshaw PSM	6/6
Emeritus Professor Arie Freiberg AM	4/4
Ms Philippa Smith AM	2/2
Dr Susan Young	5/6
Ms Jeanette Barker	3/5
Mr Ian Bluntish	5/6
Adjunct Professor Veronica Casey AM	3/4
Associate Professor Lynette Cusack	2/2
Ms Rachel Phillips	5/6
Ms Tiina Liisa Sexton	3/3
Mr Brett Simmonds	6/6
Dr Murray Thomas	6/6
Dr Anne Tonkin	5/6
People and Remuneration Committee	
Ms Gill Callister PSM, Chair	4/4
Adjunct Professor Karen Crawshaw PSM	4/4
Ms Jenny Taing OAM	4/4
Ms Susie George	1/1
Dr Wayne Minter	4/4
Dr Murray Thomas	4/4

Appendix 5: National Board consultations

National Board	Name of consultation	Start date	End date
All National Boards	Public consultation on revised *Regulatory principles for the National Scheme*	23 March 2021	18 May 2021
ATSIHPBA, CMBA, ChiroBA, DBA, MRPBA, OTBA, OptomBA, OsteoBA, ParaBA, PharmBA, PhysioBA, PodBA	Shared *Code of conduct*	11 May 2021	6 July 2021
MBA	Draft revised registration standard: *Endorsement of registration for acupuncture for registered medical practitioners*	8 February 2021	5 April 2021
MRPBA	Revised *National medical radiation practice exam guidelines*	28 April 2021	25 June 2021
NMBA	Public consultation on the proposed changes to the *Nurse practitioner standards for practice*	13 July 2020	31 August 2020
NMBA	Public consultation on the proposed revised *Registration standard: Recency of practice*	13 July 2020	31 August 2020

Appendix 6: Registration standards, codes and guidelines

Registration standards are approved by the Ministerial Council after submission by the relevant National Board.

Codes or guidelines are developed and approved by the relevant National Boards.

Before approval there must be public consultation.

See the Board reports for updates about professional standards, capabilities, and accreditation standards.

National Board	Registration standard, code or guideline	Approved and/or came into effect in 1 July 2020 to 30 June 2021	Approved by	Date of approval	Status: effective from
All Boards	*Guidelines for advertising a regulated health service*	Came into effect	All National Boards	April 2020	14 December 2020
DBA, MBA, NMBA, ParaBA, PodBA	*Guidelines: Registered health practitioners and students in relation to blood-borne viruses*	Came into effect	All National Boards	26 February 2020	6 July 2020
DBA	*Revised scope of practice guidelines*	Came into effect	Dental Board of Australia	22 November 2019	1 July 2020
DBA	*Revised scope of practice registration standard*	Came into effect	Ministerial Council	5 November 2019	1 July 2020
MBA	*Good medical practice: A code of conduct for doctors in Australia*	Came into effect	Medical Board of Australia	27 May 2020	1 October 2020
MBA	*Standards: Specialist medical college assessment of specialist international medical graduates*	Came into effect	Medical Board of Australia	24 June 2020	1 January 2021
OptomBA	*Continuing professional development registration standard (Optometry)*[1]	Came into effect	Ministerial Council	30 June 2019	1 December 2020

1 Revised as part of a multi-profession review but implemented at a later date by the OptomBA.

Appendix 7: Policy direction

Health Council

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Rundle Mall
South Australia 5000

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www.coaghealthcouncil.gov.au

Ms Gill Callister PSM, Chair, Agency Management Committee
Ms Renee Owen, Chair, Aboriginal and Torres Strait Islander Health Practice Board of Australia
Distinguished Professor Charlie C. Xue, Chair, Chinese Medicine Board of Australia
Dr Wayne Minter AM, Chair, Chiropractic Board of Australia
Dr Murray Thomas, Chair, Dental Board of Australia
Dr Anne Tonkin, Chair, Medical Board of Australia
Mr Mark Marcenko, Chair, Medical Radiation Board of Australia
Adjunct Professor Veronica Casey AM, Chair, Nursing and Midwifery Board of Australia
Ms Julie Brayshaw, Chair, Occupational Therapy Board of Australia
Mr Ian Bluntish, Chair, Optometry Board of Australia
Dr Nikole Grbin, Chair, Osteopathy Board of Australia
Associate Professor Stephen Gough ASM, Chair, Paramedicine Board of Australia
Mr Brett Simmonds, Chair, Pharmacy Board of Australia
Ms Kim Gibson, Chair, Physiotherapy Board of Australia
Dr Cylie Williams, Podiatry Board of Australia
Ms Rachel Phillips, Chair, Psychology Board of Australia

Dear colleagues

Ministerial Council Policy Direction 2020-1 – Independent Accreditation Committee advice

I am writing to provide a policy direction is given under section 11 of the Health Practitioner Regulation National Law, as in force in each state and territory.

On 9 December 2020, the Ministerial Council resolved to issue this policy direction to support its response to the Independent Review of Accreditation Systems Final Report.

The Ministerial Council published its response to the Accreditation Systems Review on 12 February 2020 as outlined in a communique and *Consultation report on implementation of recommendations from Australia's Health Workforce: strengthening the education foundation.*

Consistent with Health Ministers' response, Ahpra will convene an independent accreditation committee with broad stakeholder membership to provide independent and expert advice on accreditation reform and other National Scheme accreditation matters as determined in its terms of reference. The committee will be established by the Ahpra Agency Management Committee (or its equivalent under the National Law) with an independent chair (external to Ahpra) and broad membership appointed from accreditation stakeholders.

The committee's advice will be addressed within existing Scheme mechanisms relating to accreditation such as Ahpra's and National Boards' development of Accreditation Authority contracts/terms of reference and associated reporting against key performance indicators, revised funding principles and production of procedures for the development of accreditation standards.

The intent of the policy direction is that all National Scheme entities (Ahpra, National Boards and their Accreditation Authorities) are accountable for having regard to the independent accreditation committee's advice when exercising their functions under the National Law. Other external entities performing accreditation roles as part of the National Scheme, including specialist colleges and postgraduate medical councils, should also have regard for the committee's advice, where relevant.

The policy direction is as follows:

1. Ahpra and the National Boards are to:
    a. take into account the independent accreditation committee's advice when exercising their functions under the National Law;
    b. document the outcome of that consideration in meeting minutes, communiques or other relevant formats; and
    c. require Accreditation Authorities to take into account the independent accreditation committee's advice when exercising their functions for the purpose of the National Law and also document the outcome of their consideration of advice.
2. Ahpra Jurisdictional Advisory Committee (or its equivalent) members may request copies of the above records or other evidence of compliance with this policy direction.

Yours sincerely

Natasha

Hon Natasha Fyles MLA
Chair
Health Council

– 4 FEB 2021

Cc: Martin Fletcher, CEO, Ahpra: martin.fletcher@ahpra.gov.au

Common abbreviations

National Board abbreviations

ATSIHPBA
Aboriginal and Torres Strait Islander Health Practice Board of Australia

CMBA
Chinese Medicine Board of Australia

ChiroBA
Chiropractic Board of Australia

DBA
Dental Board of Australia

MBA
Medical Board of Australia

MRPBA
Medical Radiation Practice Board of Australia

NMBA
Nursing and Midwifery Board of Australia

OTBA
Occupational Therapy Board of Australia

OptomBA
Optometry Board of Australia

OsteoBA
Osteopathy Board of Australia

ParaBA
Paramedicine Board of Australia

PharmBA
Pharmacy Board of Australia

PhysioBA
Physiotherapy Board of Australia

PodBA
Podiatry Board of Australia

PsyBA
Psychology Board of Australia

Acronyms

Ahpra
Australian Health Practitioner Regulation Agency
Established by section 23(1) of the National Law
www.ahpra.gov.au

CRG
Community Reference Group
ahpra.gov.au/About-Ahpra/Our-engagement-activities/Advisory-groups/Community-Reference-Group

HCCC
Health Care Complaints Commission
Manages complaints about health service providers in NSW
www.hccc.nsw.gov.au

HCE
Health complaints entity
An entity that is established by or under an Act of a participating jurisdiction, and whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system
ahpra.gov.au/notifications/further-information/health-complaints-organisations

HCEF
Health Chief Executives Forum
Formerly the Australian Health Ministers' Advisory Council (AHMAC), is the advisory and support body to the Health Council
www.coaghealthcouncil.gov.au/Health-Chief-Executives-Forum/Introduction

HPCA
Health Professional Councils Authority
Manages complaints and concerns about practitioners in NSW
www.hpca.nsw.gov.au

NHPO
National Health Practitioner Ombudsman
www.nhpo.gov.au

NRAS
National Registration and Accreditation Scheme
(referred to as the National Scheme)
www.ahpra.gov.au/About-Ahpra/What-We-Do/FAQ

OHO
Office of the Health Ombudsman
Manages complaints and concerns about practitioners in Queensland
www.oho.qld.gov.au

PRG
Professions Reference Group
ahpra.gov.au/About-Ahpra/Our-engagement-activities/Advisory-groups/Professions-Reference-Group

Glossary

Accreditation

Accreditation ensures the education and training leading to registration as a health practitioner meets approved standards and prepares graduates to practise a health profession safely and competently. The accreditation authority may be a committee established by a National Board, or a separate organisation.

Adjudication body

A health panel, a performance and professional standards panel, a responsible tribunal, a Court or an entity in a co-regulatory jurisdiction that is declared to be an adjudication body.

Appeals

A person may appeal to a tribunal against a decision by a National Board, a health panel or a performance and professional standards panel as set out in section 199 of the National Law. Decisions may also be judicially reviewed if there is a perceived flaw in the administrative decision-making process, as opposed to a concern about the merits of the individual decision itself.

Board's own motion

A National Board may decide on its own motion to investigate a practitioner or require a practitioner to attend a health assessment or performance assessment. For example, a National Board may decide to investigate on its own motion after a practitioner or student informs the National Board of certain events under section 130 of the National Law, or to ensure a practitioner or student is complying with a condition or undertaking.

Breach of non-offence provision under the National Law

Ahpra receives notifications alleging that a practitioner has breached a relevant registration standard or endorsement, breached a condition on registration or an undertaking accepted by a National Board, or provided care beyond scope of practice. These matters are dealt with under Part 8 (where the Board has the option to take regulatory action) because they are not offences under the National Law.

Caution

A formal caution may be issued by a National Board or an adjudication body. A caution is intended to act as a deterrent so that the practitioner does not repeat the conduct. A caution is not usually recorded on the *Register of practitioners*. However, a National Board can require a caution to be recorded on the *Register of practitioners*.

Condition

A National Board or an adjudication body can impose a condition on the registration of a practitioner or student, or on an endorsement of registration. A condition aims to restrict a practitioner's practice in some way, to protect the public.

Current conditions that restrict a practitioner's practice of the profession are published on the *Register of practitioners*. When a National Board or adjudication body decides the conditions are no longer required to ensure safe practice, they are removed and no longer published.

Examples of conditions include requiring a practitioner to:

- complete specified further education or training within a specified period
- complete a specified period of supervised practice
- do, or refrain from doing, something in connection with the practitioner's practice
- manage their practice in a specified way
- report to a specified person at specified times about the practitioner's practice, or
- not employ, engage or recommend a specified person, or class of persons.

There may also be conditions related to a practitioner's health (such as psychiatric care or drug screening).

The details of health conditions are not usually published on the *Register of practitioners*. Also see the definition of *Undertaking*.

Criminal offences under the National Law

Criminal offences under the National Law by a person (including registered health practitioners and unregistered individuals) and/or corporate entities predominantly relate to breaching prohibition orders, inappropriate use of protected titles, unlawful claims as to registration, performing restricted acts, and advertising of regulated health services.

Disciplinary action

Disciplinary action is regulatory action taken by a performance and professional standards panel or a responsible tribunal after it decides that:

- a practitioner has engaged in unprofessional conduct, unsatisfactory professional performance or professional misconduct
- a practitioner's registration was improperly obtained.

Division

Part of a health profession. A practitioner can be registered in more than one division within a profession. Not all professions have divisions.

For more information, please refer to the list published online at www.ahpra.gov.au/registration/registers-of-practitioners/professions-and-divisions.

Education provider

A university, tertiary education institution, specialist medical or other health-profession college that provides a program of study.

Endorsement

An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the National Board.

There is a number of different types of endorsement available under the National Law, including:

- scheduled medicines
- nurse practitioner
- acupuncture
- approved area of practice.

In psychology, these are divided into 'subtypes' that describe additional qualifications and expertise. An endorsement can include more than one 'subtype'.

Health complaints entity (HCE)

National Boards are provided copies of all concerns about a registered health practitioner that are made to an HCE. On receipt of a notification a National Board can decide to talk to the HCE about the complaint and refer it to the HCE if they are the appropriate entity to deal with a concern.

The HCEs in each state and territory are listed on page 6.

Decisions, made on receipt of concerns, are not defined as regulatory action and are counted and reported on separately in the report.

Health impairment

Physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects, or is likely to detrimentally affect, a registered health practitioner's capacity to safely practise the profession or a student's capacity to do clinical training.

Immediate action

Immediate action (also referred to as interim action) can be taken as an interim step to restrict a practitioner's registration while a complaint is investigated. Immediate actions include:

- the suspension of, or imposition of a condition on, a registered health practitioner's or student's registration
- accepting an undertaking from a registered health practitioner or student
- accepting the surrender of a registered health practitioner's or student's registration.

Mandatory notifications

Notification that an entity is required to make to Ahpra under Division 2 of Part 8 of the National Law. It is mandatory that colleagues, employers or education providers of a registered practitioner or student submit a notification about them if they have behaved in a way that constitutes notifiable conduct. Refer to each Board's website for *Guidelines for mandatory notifications*.

Ministerial Council

Ministerial Council, as defined in the National Law, is 'the COAG [Council of Australian Governments] Health Council or a successor of the Council by whatever name called, constituted by Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health'.

National Board

Appointed by the Ministerial Council to regulate the profession in the public interest and meet the responsibilities set down in the National Law. Comprising practitioner members and community members, National Boards and/or state boards and/or committees are delegated the functions/powers of the National Board.

National Law

The Act, adopted in each state and territory, setting out the provisions of the Health Practitioner Regulation National Law. The National Law has been adopted by the parliament of each state or territory through adopting legislation. The National Law is generally consistent in all states and territories. NSW did not adopt Part 8 of the National Law.

National Restrictions Library (NRL)

The National Restrictions Library documents common restrictions (conditions or undertakings) used across the regulatory functions of the National Boards to support:

- consistency in recommendations from Ahpra to the National Boards and delegates
- consistency in the restrictions appearing on the national public register of health practitioners
- a best practice approach to monitoring compliance with restrictions.

The NRL is available at www.ahpra.gov.au/registration/monitoring-and-compliance/national-restrictions-library.

National Scheme

The National Registration and Accreditation Scheme for registered health practitioners was established by the Council of Australian Governments (COAG). In 2010, under the National Law, 10 professions became nationally regulated by a corresponding National Board. In 2012, four additional professions joined the National Scheme. In 2017 the Paramedicine Board of Australia was established and the regulation of paramedics began in late 2018.

No conviction recorded

No conviction recorded is an outcome that is available to a court after either a plea or finding of guilt. This is a common outcome for first offenders for 'low level' offences, which reflects the willingness of the legislature and the community to give first offenders, in certain circumstances, a second chance to maintain a reputation of good character.

No further action

No further action is taken when, based on the available information, the Board determines there is no risk to the public that requires regulatory action.

Notation

Records a limitation on the practice of a registrant. Used by National Boards to describe and explain the scope of a practitioner's practice by noting the limitations on that practice. The notation does not change the practitioner's scope of practice but may reflect the requirements of a registration standard.

Notifiable conduct

When a registered health practitioner has:

- practised their profession while intoxicated by alcohol or drugs
- engaged in sexual misconduct in connection with the practice of their profession
- placed the public at risk of substantial harm in the practice of their profession because they have an impairment, or
- placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

Notification

The National Board is 'notified' of an issue. The word 'notification' is deliberate and reflects that the Boards are not complaint resolution agencies.

A notification is a concern:

- about a practitioner or student, and
- that is about a matter that is a ground for a notification.

Notifications are raised with Ahpra on behalf of a National Board. Each notification must be assessed by a National Board.

National Boards gather information contained in notifications to help identify risks in the way an individual practitioner is practising a health profession.

Anyone can make a notification by raising a concern. Notifications can be made by contacting Ahpra on 1300 419 495 (within Australia), +61 3 9285 3010 (outside Australia) or visiting our complaints portal at www.ahpra.gov.au/notifications.

Raising a notification prompts a National Board to carry out a risk assessment. It uses the information provided in a single notification, together with other known information about a practitioner's type of practice, practice setting and history.

In response to a notification, a Board may:

- store the information provided in a notification, and take no further action on that occasion, or
- make further enquiries in relation to a practitioner, by investigating the practitioner, or requiring the practitioner to attend a health or performance assessment.

After making necessary enquiries in response to a notification and considering the information, a National Board or independent adjudication body may decide to take regulatory action.

The role of National Boards is to set standards that ensure safe practice. Notifications let us know when someone has a concern about the way a practitioner is practising. We respond to notifications with action to protect the public when a National Board believes, based on a risk assessment of the practitioner, this is necessary.

The *Let's talk about it* video series explains what happens when concerns are raised with us. The videos provide easy-to-follow information about the notifications process and address common questions from the public and practitioners. They can be accessed from www.ahpra.gov.au/notifications.

Notifier

A person or entity who makes a notification to Ahpra.

Offence against another law

Ahpra receives notifications about practitioners who have been charged or convicted of an offence contained in a law other than the National Law (that is, a criminal law). A Board may take action if committing that offence is conduct below the standard expected of a health practitioner or is otherwise in the public interest.

Practice

This definition of practice is used in a number of National Board registration standards. It means any role, whether remunerated or not, in which an individual uses their skills and knowledge as a practitioner in their regulated health profession. Practice is not restricted to the provision of direct clinical care. It also includes using professional knowledge in a direct non-clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services in the health profession.

Some National Boards have also issued guidance about when practitioners need to be registered.

Principal place of practice

The location declared by a practitioner as the address at which they mostly practise their profession. If the practitioner is not practising, or not practising mostly at one address, then the practitioner's principal place of residence is used.

If the location of the principal place of practice is in Australia, the following information is displayed on the *Register of practitioners*:

- suburb
- state
- postcode.

If the location is outside Australia, the following information is displayed on the *Register of practitioners*:

- international state/province
- international postcode
- country.

In rare cases, when a practitioner has demonstrated that their health and safety may be at risk from the publication of this information about their principal place of practice, a National Board may choose to not publish this information.

Qualifications

Professional qualifications that a practitioner must have to meet the requirements for registration in a profession. Undergraduate and postgraduate Australian qualifications recognised by National Boards are published on the National Boards' websites. Individual practitioners' approved qualifications are published on the *Register of practitioners*.

Prohibited practitioner/student

A prohibited practitioner or student is a person who is being monitored because they are subject to a cancellation order, suspension or a restriction not to practise. Alternatively, as an outcome of a notification they may have surrendered their registration or changed to non-practising registration.

Register of practitioners

Also known as the public register, the online national *Register of practitioners* is a publicly accessible database of all currently registered health practitioners with a principal place of practice in Australia. Ahpra also maintains a list of cancelled practitioners and a list of practitioners who have given an undertaking not to practise. You can search these databases at www.ahpra.gov.au/registration/registers-of-practitioners.

Registered health practitioner

An individual who is registered under the National Law to practise a health profession, other than as a student, or who holds a non-practising registration in a health profession under the National Law.

Registration expiry date

Date when a practitioner's current registration expires. Practitioners must apply to renew their registration annually. If the practitioner's name appears on the register, they are registered and can practise within the scope of their registration, consistent with any conditions or undertakings that apply.

Under the National Law, registrants who apply to renew on time can practise while their annual renewal application is being processed. Practitioners remain registered for one month after their registration expiry date. If they apply to renew their registration during this period, they are required to pay a late fee and can continue to practise while their application is being processed.

Registration number

Since March 2012, practitioners have been allocated one unique registration number for each profession in which they are registered. This number stays with the practitioner for life, even if they have periods when they are not registered. Practitioners registered in more than one profession have one registration number for each profession.

Registration status

The status of a registration can be:

- Registered: The practitioner is registered.
- Suspended: The registration has been suspended and the practitioner is not permitted to practise while suspended. The practitioner's name is published on the *Register of practitioners*.
- Cancelled: The registration has been cancelled and the practitioner is not permitted to practise. The practitioner's name is not published on the *Register of practitioners* but is published on the list of cancelled practitioners.

Registration type

The National Law defines the type of registration that a National Board can grant to an eligible practitioner. More information is available on the Ahpra website at www.ahpra.gov.au/support/glossary.

Regulatory action

Regulatory action is action taken by a National Board that affects a practitioner's registration.

It can be taken if a Board reasonably believes that a practitioner:

- has practised in a way that is or may be below the standard reasonably expected
- has behaved in a way that is or may be below the standard reasonably expected of the practitioner by the public or the practitioner's peers
- has or may have an impairment that could detrimentally affect a practitioner's ability to practise safely.

The regulatory actions that can be taken by a National Board are:

- cautioning a practitioner
- accepting an undertaking
- imposing a condition.

Regulatory action can also be taken by a health panel, a performance and professional standards panel (PPSP) or a responsible tribunal after it decides that:

- a practitioner has an impairment
- a practitioner has engaged in unprofessional conduct or unsatisfactory professional performance
- a practitioner has engaged in professional misconduct (tribunal only)
- a practitioner's registration was improperly obtained (tribunal only).

The regulatory actions that can be taken by a health panel, PPSP or a responsible tribunal are:

- imposing a condition
- cautioning a practitioner (PPSP or tribunal)
- reprimanding a practitioner for practising or behaving in a certain way (PPSP or tribunal)
- requiring a practitioner to pay a fine (tribunal only)
- suspending a practitioner's registration for a period of time (health panel or tribunal)
- cancelling a practitioner's registration, either temporarily or permanently (tribunal only)
- disqualifying a person from applying for registration for a specified time (tribunal only)
- prohibiting the person from providing a health service, or using a title (tribunal only).

A National Board can also refer a matter to another entity, including an HCE, if it thinks that another entity should be responsible for managing a concern.

Referrals of concerns to another entity are counted and reported on separately in this report.

Reprimand

A reprimand is a chastisement for conduct; a formal rebuke. Reprimands issued since the start of the National Scheme (1 July 2010, or 18 October 2010 in WA) are published on the *Register of practitioners*.

Specialty

There are currently three professions with specialist registration under the National Law: dental, medical and podiatry. The Ministerial Council is responsible for approving a list of specialties for each profession and for approving one or more specialist titles for each specialty on the list. The National Boards each decide the requirements for specialist registration in their profession.

Requirements for specialist registration vary across the professions that have specialist recognition (dental, medical and podiatry).

Spent conviction order

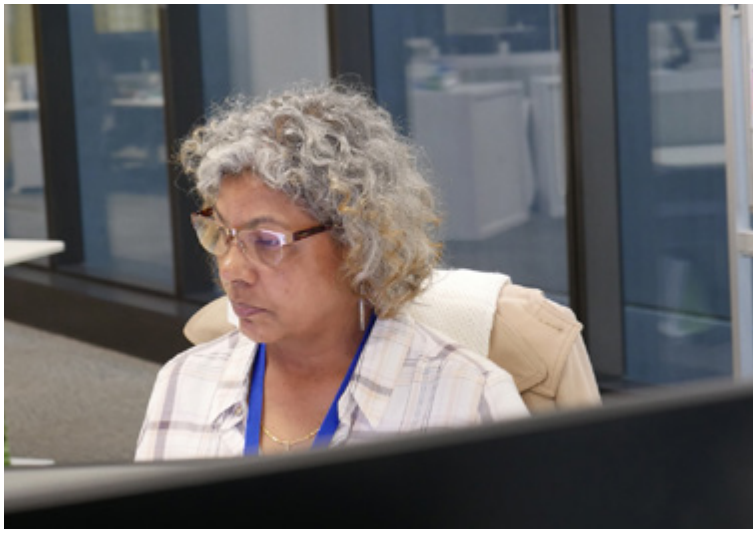
A spent conviction order is a court order that a criminal conviction is spent immediately. This means that the conviction does not need to be disclosed in many circumstances and the conviction will never appear on a standard National Police Clearance. However, the conviction still needs to be disclosed in some circumstances e.g. Working with Children Checks and when applying for registration as a health practitioner.

Standards

Standards refer to the registration standards for National Boards that define the requirements that applicants, registrants or students need to meet to be registered.

Student

A person whose name is entered in a student register as being currently registered as a student practitioner under the National Law.



Suspension

If a practitioner's registration is suspended, they are not eligible to practise. A tribunal has the power to suspend a practitioner's registration as a result of a hearing. A National Board also has the power to suspend a practitioner's registration pending other assessment or action, if it believes:

- there is serious risk to the health and safety of the public from the practitioner's continued practice of the profession, and that suspension is necessary to protect the public from that risk, or
- there are public interest grounds for suspending a practitioner's registration, because, for example, the practitioner has been charged with serious criminal conduct.

A health panel can suspend a practitioner's registration if the panel finds that the practitioner (or student) has an impairment and it is necessary to suspend the practitioner's registration to protect the public.

Undertaking

National Boards can accept an undertaking from a practitioner to limit their practice in some way if this is necessary to protect the public. The undertaking means the practitioner agrees to do, or to not do, something in relation to their practice of the profession. Current undertakings that restrict a practitioner's practice of the profession are published on the *Register of practitioners*. When a National Board or adjudication body decides the undertakings are no longer required to ensure safe practice, they are revoked and are no longer published. Current undertakings that relate to a practitioner's health are mentioned on the public register but details are not provided.

An undertaking is voluntary (but enforceable), whereas a condition is imposed on a practitioner's registration.

Unprofessional conduct

Unprofessional conduct is conduct that is of a lesser standard than that which might reasonably be expected of a health practitioner by the public or the practitioner's professional peers. A more extensive definition is available under section 5 of the National Law.

Each profession has a set of standards and guidelines that clarify the acceptable standard of professional conduct.

Unsatisfactory professional performance

This is when the knowledge, skill or judgement possessed, or care exercised by, a practitioner in the practice of the health profession in which they are registered is below the standard reasonably expected for a health practitioner with an equivalent level of training or experience.

Voluntary notification

A notification made on a voluntary basis. The grounds for a voluntary notification are set out in section 144 of the National Law.

Index

Not indexed: names and position titles, table and figure footnotes, financial statements, and appendices.

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