Supporting access to
safe and professional healthcare

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

Annual report 2021/22

Ahpra & National Boards

In 2021/22

Registration

852,272 registered health practitioners in Australia, across 16 professions

- 26,552 (3.2%) more registrants than last year
- 20,781 registrants on the pandemic sub-registers
- 85,052 applications for registration
- 9,275 health practitioners identify as Aboriginal and/or Torres Strait Islander
- 184,353 students studying to be health practitioners

'The National Scheme has brought far more professionalism, independence, accountability and transparency to regulation. Our wide range of procedural processes may frustrate some, but they bring natural justice and evidence-based regulation to ensure that all healthcare professions provide a standard of care expected by the Australian community.'

National Board member

Accreditation

More than 840 approved programs of study delivered by more than 130 education providers

'I am proud of the way we have dealt with the relatively small number of practitioners who have not met expectations, and of the role we have played in protecting the public.'

National Board member

'We are making improvements and trying to be more culturally safe and aware, and embedding that in how we work. Not just within our team but outwardly as well.'

Staff member

Notifications

18,710 notifications made about 14,313 practitioners nationally

- That's 1.7% of all registered health practitioners and an increase of 6.2% from 2020/21
- 10,803 notifications about 8,380 practitioners received by Ahpra
- The most common concern was clinical care

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.

Compliance

2,568 practitioners monitored by Ahpra during the year to ensure compliance with restrictions placed on their registration for concerns about health, performance and/or conduct

Increasing representation

13 Aboriginal and/or Torres Strait Islander Board and committee members were appointed following targeted recruitment campaigns

'All members on the Board discuss, debate and challenge the prevailing thinking to make better decisions, remain contemporary and improve regulation.'

National Board member

'Australia has a world-class health system providing the highest quality services across an enormous geography. Of course it has faults, and mistakes are made. Making the system better can only be done with the close involvement of the people the system serves.'

Committee member

Legal

191 matters determined by tribunals

- 98.4% resulted in disciplinary action
- 103 appeals lodged in tribunals about National Board decisions
- 96 appeals finalised:
  - 11 no change
  - 46 withdrawn
  - 22 decision amended or substituted
  - 17 dismissed

10 successful prosecutions

499 advertising-related complaints received

317 new offence complaints received about title protection

This report provides Ahpra data, unless stated otherwise. As in 2019/20 and 2020/21, the 2021/22 data include practitioners on the temporary pandemic sub-registers. This affects some percentages. Due to rounding (to one decimal place), percentages may not add up to 100%.

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

The 'Most common types of complaint' 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.

Throughout the report, the term 'podiatrist' refers to both podiatrists and podiatric surgeons unless otherwise specified.

For definitions of words and phrases, refer to the list of common abbreviations and the glossary.

You will see photos of some of the health practitioners who serve our community and some Board and committee members and staff.

We have also included the insights of Board and committee members and staff.

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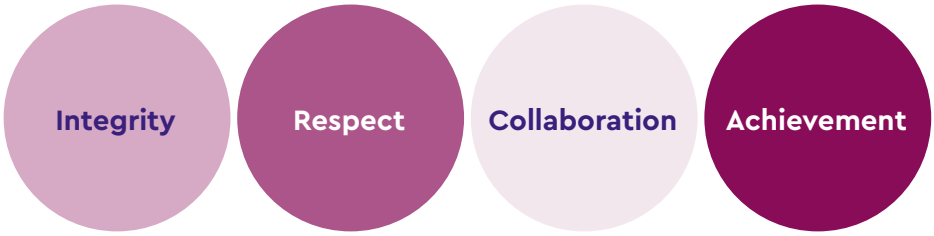


Working in partnership with 15 National Boards, the Australian Health Practitioner Regulation Agency (Ahpra) implements the National Registration and Accreditation Scheme (the National Scheme). The National Scheme regulates 16 health professions.

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.

Accreditation

We work with accreditation authorities to ensure that graduating students are suitably qualified and skilled to apply for registration as health practitioners.

Registration

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

Notifications

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

Compliance

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

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

Regulatory principles for the National Scheme

These regulatory principles underpin the work of the National Boards and Ahpra in regulating Australia's registered health practitioners, in the public interest. They shape our thinking about regulatory decision-making and have been designed to encourage a culturally safe and responsive, risk-based approach to regulation across all professions. The regulatory principles consider community expectations and reflect ministerial directions.

1. **The National Boards and Ahpra administer and comply with the Health Practitioner Regulation National Law**, as in force in each state and territory (the National Law). The scope of our work is defined by the National Law.

2. **Public protection is our paramount objective** in the National Registration and Accreditation Scheme. We act to support safe, professional practice and the safety and quality of health services provided by registered health practitioners.

3. **We protect the health and safety of the public** by ensuring that only registered health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.

4. In all our work we:
    a. **identify** the risks that we need to respond to
    b. **assess** the likelihood and possible consequences of the risks
    c. **respond** in ways that are culturally safe, proportionate, consistent with community expectations, and manage risks so we can adequately protect the public, and
    d. **take timely and necessary action** under the National Law.

This applies to all our regulatory decision-making, the development of standards, policies, codes and guidelines as well as the way we regulate individual registered health practitioners.

5. The primary purpose of our regulatory response is to **protect the public and uphold professional standards** in the regulated health professions. When we learn about concerns regarding registered health practitioners, we apply the regulatory response necessary to manage the risk, to protect the public.

6. Our responses **consider the potential risk of the registered health practitioner's health, conduct or performance** to the public including:
    - people vulnerable to harm, and
    - Aboriginal and Torres Strait Islander Peoples.

7. When deciding on regulatory responses, **we are fair and transparent, and consider the importance of maintaining standards of professional practice** that support community confidence in regulated health professions.

8. **We work with our stakeholders, including patient safety bodies, healthcare consumer bodies and professional bodies,** to protect the public. We do not represent the health professions, registered health practitioners or consumers. However, we work with practitioners and their representatives and consumers to achieve outcomes that protect the public.

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 and Queensland the process is different.

Ahpra ensures that, across Australia, all notifications and their outcomes are recorded and that the national register is accurate and complete.

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 and unregistered health practitioners' conduct, health and performance.

The National Boards don't handle notifications in New South Wales. 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 or, under the new joint consideration process, it may assign a complaint to Ahpra and the Boards.

OHO also handles 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

Ministerial Council	Australia's Health Ministers oversee the National Scheme
National Health Practitioner Ombudsman	Provides independent oversight of the bodies in the National Scheme
Agency Management Committee	Governs Ahpra and considers overall efficiency and effectiveness of the National Scheme
Ahpra	Implements the National Scheme in partnership with National Boards
National Boards	Regulate 16 health professions
State/territory/ regional boards and committees	Perform delegated regulation functions on behalf of National Boards
Accreditation authorities	Accredit programs of study for National Boards to approve and perform other accreditation functions

Introduction

The regulated health workforce

This year we continued our work to support community access to safe, professional healthcare. We regulated more than 850,000 health practitioners in 16 professions. Aspiring health practitioners have more than 840 approved programs of study. Australia-wide, 18,710 notifications were made about 14,313 health practitioners – the National Boards and Ahpra managed 10,803 of those notifications. Clinical care continues to be the most common concern. Consistent with other years, 1.7% of the registered health workforce received a notification, once again demonstrating that the vast majority of the health workforce practises safely.

Many notifications (over 60%) resulted in a National Board deciding that no further regulatory action was required, taking into account steps that may have already been put in place by a practitioner or their employer.

We work hard to be transparent, fair and accountable. And we know that the complaints process is stressful for notifiers and practitioners. While regulation can be challenging, it plays a critical role in maintaining access to safe, quality healthcare.

Highlights and initiatives

We worked with health services when the healthcare system was experiencing changing demands due to outbreaks of COVID-19. This included the pandemic sub-registers, which allow eligible, recently retired health practitioners to help in areas of need.

We continued our work to improve access to safer healthcare for everyone. To better understand barriers to making a complaint or notification, we conducted focus groups with communities who may find us inaccessible. We set up an Aboriginal and Torres Strait Islander Health Strategy Unit at a senior level to progress our cultural safety work. We revised the regulatory principles that underpin our decision making, making it clear that public protection is our paramount objective, and explicitly calling out that we need to consider the potential risk to people vulnerable to harm and to Aboriginal and Torres Strait Islander Peoples in our decision making. We sought to better support notifiers and witnesses in sexual boundary cases by establishing the Notifier Support Service, staffed by social workers.

We worked with practitioners and employers to support their professional practice. We updated the shared *Code of conduct*, embedding cultural safety, including greater clarity on clinical governance responsibilities for leaders, and providing more guidance for practitioners and employers to resolve disagreements within the workplace.

Operationally, we worked more often in the digital space, having in the first year of the pandemic converted many previously paper- or face-to-face-dependent processes to online. We worked in and out of our offices, and from home, in response to health directives and advice. Boards and committees met online. This willingness of our workforce and National Boards to adapt and make it work sits alongside a profound commitment to public safety.

We continued to adapt and respond to a changing regulatory environment and improve our own performance. Some of our initiatives:

In the face of safety concerns surrounding the growing practice of cosmetic surgery, Ahpra and the Medical Board of Australia commissioned the *Independent review of the regulation of medical practitioners who perform cosmetic surgery*.

We completed the future state design work for our transformation program, which lays the foundation for building new and streamlined business processes that will be digitally enabled.

We developed and published a service charter to make our commitments and obligations clear.

We established an independently chaired Accreditation Committee of the Agency Management Committee to provide independence, accountability and greater oversight.

We sought to amplify the voice of the community and ensure a diverse and inclusive membership in our re-named Community Advisory Council, one of our consultative forums.

We progressed a joint project with the Australian Commission on Safety and Quality in Health Care to identify how we can improve the experience of people making a health complaint about care from registered health practitioners.

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. We thank outgoing Committee member Dr Peggy Brown AO.

Agency Management Committee members

Ms Gill Callister PSM
Chair

Adjunct Professor
Karen Crawshaw PSM

Emeritus Professor
Arie Freiberg AM

Mr Jeff Moffet

Mr Lynton Norris

Ms Jenny Taing OAM

Ms Barbara Yeoh AM

Dr Susan Young

'Being on the Agency Management Committee has given me enormous insight into the complexity of regulating 850,000 health practitioners across 16 different domains.

Ahpra's challenge is to apply its role as a risk-based regulator in the context of a very difficult environment, such as COVID, workforce development and meeting the community's requirements for healthcare practitioners while being efficient and effective in its regulation.

Ahpra is one of the most important and complex regulators in Australia as it involves so many National Boards and competing interests.

Being able to contribute to the decision-making process and the regulatory discourse is a challenge and I am very pleased to be part of it. The interdisciplinary composition of the Committee is one of its great strengths, with all members bringing their knowledge and experience to the table.

The importance of health regulation cannot be overstated. It's central to the way we live.'

Emeritus Professor Arie Freiberg AM, Agency Management Committee member – from October 2020

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

Adjunct Professor Chi Eung Danforn Lim
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 Practice Board of Australia (to 22 Feb)

Ms Cara Miller
Chair, Medical Radiation Practice Board of Australia (from 23 Feb)

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 (to 11 Nov)

Mrs Judith Hannan
Chair, Optometry Board of Australia (from 2 Dec)

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

Regulatory response to COVID-19

In response to a request by the Australian Government, the Aboriginal and Torres Strait Islander Health Practice Board of Australia has continued to enable registration of Aboriginal and Torres Strait Islander Health Practitioners on the pandemic sub-register to provide additional support for the COVID-19 vaccination roll-out.

Policy updates

Practitioners have a professional responsibility to be familiar with and apply the *Code of conduct*. It is an important part of the Board's regulatory framework for protecting the public, and is used to evaluate a practitioner's conduct. The public can also use the code to better understand what they can expect from registered health practitioners.

Changes have only been made to the shared *Code of conduct* where they were needed to keep the code up to date, effective, clear and relevant. Importantly, there is a new section on Aboriginal and Torres Strait Islander health and cultural safety that includes the National Scheme's definition of cultural safety. Other changes include information about practitioners' responsibilities in relation to bullying and harassment, including the importance of addressing the issue in the workplace and the role of the National Board and Ahpra.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Issues this year

Aboriginal and Torres Strait Islander Health Practitioners faced extraordinary challenges as they responded to the needs of their communities during the ongoing COVID-19 pandemic as well as natural disasters. The Board acknowledges the significant efforts of Aboriginal and Torres Strait Islander Health Practitioners across Australia in adapting to the changing environment and continuing to provide exceptional service to their communities.

Health practitioners are rightly some of the most trusted professions in Australia. Most health practitioners practise safely and well – the vast majority of all Aboriginal and Torres Strait Islander Health Practitioners did not have any concerns reported about their conduct, health or performance.

Accreditation

The Board welcomed new members to its Accreditation Committee (ATSIHPAC), including a new Chair. The Accreditation Committee's functions include assessing, accrediting and monitoring programs of study that lead to registration. Its decisions are based on the accreditation standards approved by the Board. Our new members are settling in well and are very dedicated and passionate about the regulation of Aboriginal and Torres Strait Islander Health Practice.

The Board released the cross-profession *Supervised practice framework*.

Stakeholder engagement

The Board continues to have good relationships with its stakeholders. Although the pandemic meant that our collaborative efforts have been conducted electronically, we are meeting face to face where we can to continue our efforts to develop the profession and highlight the importance of Aboriginal and Torres Strait Islander Health Practitioners in creating a more culturally safe health environment for our Peoples and communities.

Ms Renee Owen

Board members

- **Ms Renee Owen (practitioner), Chair**
- Mr Bruce Brown (community)
- Ms Margaret McCallum (community)
- Mr Christopher O'Brien (practitioner)
- Ms Leanne Quirino (practitioner)
- Ms Iris Raye (practitioner) – from 13 Mar
- Ms Shirlene Sansbury (acting practitioner) – 13 Dec to 4 Feb
- Ms Abbey Shillingford (community)
- Mr Kenton Winsley (practitioner) – to 3 Feb

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

886 Aboriginal and Torres Strait Islander Health Practitioners

- → Up **6.9%** from 2020/21
- → **0.1%** of all registered health practitioners

100% were Aboriginal and/or Torres Strait Islander

76.2% female; **23.8%** male

Figure 2. Age

<25	25–34	35–44	45–54	55–64	65–74	>75
5.2%	23.3%	22.5%	23.9%	20.8%	4.3%	0.1%

Regulating

Notifications

10 notifications lodged with Ahpra about **9** Aboriginal and Torres Strait Islander Health Practitioners

- → **12** notifications about **10** Aboriginal and Torres Strait Islander Health Practitioners made Australia-wide, including HPCA and OHO data
- → **1.1%** of the profession

Figure 3. Sources of notifications

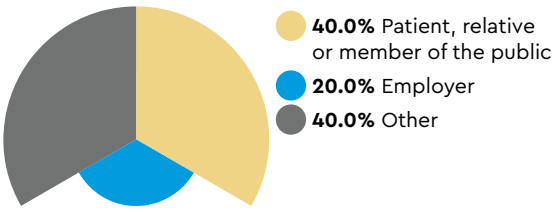
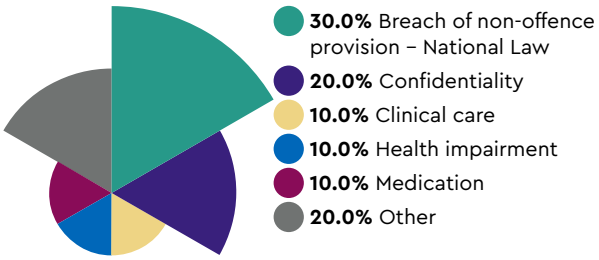


Figure 4. Most common types of complaint



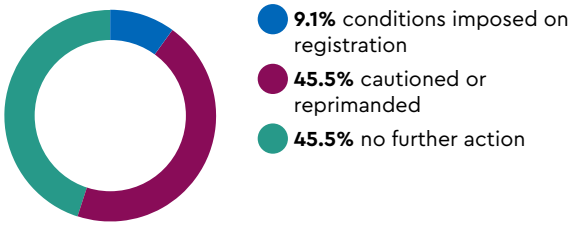
No immediate actions taken

1 mandatory notification received

- → about professional standards

Figure 5. Notifications closed

11 notifications closed



Monitoring

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

6 cases being monitored at 30 June:

- → **1** for health
- → **1** for performance
- → **4** for suitability/eligibility for registration

Criminal offence complaints

1 criminal offence complaint made

- → about title protection

1 closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

Appeals

No appeals lodged

Chinese medicine practitioners

From the Chair

Issues this year

This year the Chinese Medicine Board of Australia celebrated 10 years of national regulation of Chinese medicine in Australia. This anniversary provided a valuable opportunity to reflect on how important this development was for the profession, with Chinese medicine practitioners now part of a national registration system that works to ensure the Australian community have trust and confidence that registered health practitioners are competent, safe and qualified to practise.

Regulatory response to COVID-19

The Board continued to work with local jurisdictions to keep practitioners up to date with how local public health orders affected the profession. In August the Board joined co-regulators and the Therapeutic Goods Administration in publishing advice to the public on evidence-based information for COVID-19. In December the Board joined other National Boards providing guidance for practitioners on facilitating access to care in a COVID-19 environment.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Policy updates

In November the Board kicked off the first of the new regulatory examinations with multiple-choice examinations. These examinations were held again in March. The second half of the regulatory examination, the objective structured clinical examination (OSCE), will be piloted soon, with the first session to occur by the end of 2022.

The Board conducted public consultation on proposed revisions to two guidelines, *Guidelines on safe Chinese herbal medicine practice* and *Guidelines on infection prevention and control for acupuncture and related practices*. The Board received much valuable feedback from these consultations, and we thank the participants for taking the time to assist the Board. The annual review of the Board's *Nomenclature compendium* was also conducted.

The Board released the cross-profession *Supervised practice framework*.

Stakeholder engagement

In September the Board met with representatives of all professional organisations; as part of this meeting, members heard a fascinating presentation on the National Scheme's commitment to cultural safety and the elimination of racism in healthcare. In December the Board held a practitioner webinar and provided an update to practitioners on policy issues in Chinese medicine and emerging trends from notifications, and presented a case study that illustrated the notification process.

The Board reviewed and renewed its Reference Group membership this year, with a new membership to include representatives from the insurance industry as well as all education providers.

The Board was pleased to be able to meet face to face with the Chinese Medicine Council of New South Wales. The joint meeting was a great opportunity for the Board and the Council to exchange experiences and views.

Other news

We were delighted to learn that Ms Bing Tian was re-appointed in October for a second term on the Board. This year the Board has been focused on reviewing membership and recruiting to the various Board committees, and we appointed new members Dr Yun Shen PhD and Ms Christina Lam to the Board's Policy, Planning and Communications Committee (PPPCC) and the Board's Registration, Notifications and Compliance Committee respectively. In June we bade farewell to a long-standing member of the PPPCC, Ms Glenys Savage, whose contribution to the committee was highly valued.

Adjunct Professor Danforn Lim

Board members

- **Adjunct Professor Chi Eung Danforn Lim (practitioner), Chair**
- Ms Sophy Athan (community)
- Mr David Brereton (community)
- Ms Stephanie Campbell (community)
- Mr Luke Hubbard (practitioner)
- Mr Roderick Martin (practitioner)
- Dr Johanna Shergis (practitioner)
- Ms Bing Tian (practitioner)
- Ms Dina Tsiopelas (practitioner)

Ms Sylvia Sanders is the Executive Officer, Chinese Medicine.

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

Snapshot

4,839 Chinese medicine practitioners

- → Down **0.5%** from 2020/21
- → **0.6%** of all registered health practitioners

0.5% identified as Aboriginal and/or Torres Strait Islander

57.8% female; **42.2%** male

Figure 6. Age

<25	25–34	35–44	45–54	55–64	65–74	>75
0.2%	9.3%	23.2%	27.5%	24.8%	13.1%	1.9%

Figure 7. Divisions

Registered as:

- **98.1%** acupuncturist
- **64.6%** Chinese herbal medicine practitioner
- **24.0%** Chinese herbal dispenser

- → **36.2%** registered in one division
- → **40.9%** registered in two divisions
- → **22.9%** registered in three divisions

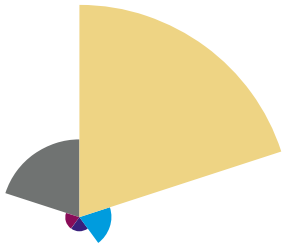
Regulating

Notifications

45 notifications lodged with Ahpra about **40** Chinese medicine practitioners

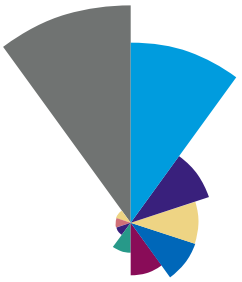
- → **76** notifications about **63** Chinese medicine practitioners made Australia-wide, including HPCA and OHO data
- → **1.3%** of the profession

Figure 8. Sources of notifications



- **60.0%** Patient, relative or member of the public
- **8.9%** Other practitioner
- **4.4%** Board initiated
- **4.4%** Health complaints entity
- **22.2%** Other

Figure 9. Most common types of complaint



- **24.4%** Clinical care
- **11.1%** Breach of non-offence provision – National Law
- **8.9%** Boundary violation
- **8.9%** Offence against other law
- **6.7%** Medication
- **4.4%** Health impairment
- **2.2%** Communication
- **2.2%** Behaviour
- **2.2%** Confidentiality
- **29.0%** Other

6 immediate actions taken

2 mandatory notifications received

- → **1** about professional standards

Figure 10. Notifications closed

36 notifications closed

- **16.7%** conditions imposed on registration or an undertaking accepted
- **5.6%** cautioned or reprimanded
- **11.1%** referred to another body or retained by a health complaints entity
- **66.7%** no further action

Monitoring

19 practitioners monitored for health, performance and/or conduct

763 cases being monitored at 30 June:

- → **5** for conduct
- → **1** for health
- → **4** for performance
- → **3** for prohibited practitioner/student
- → **750** for suitability/eligibility for registration

Criminal offence complaints

11 criminal offence complaints made

- → **10** about title protection
- → **1** about advertising breaches

11 closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

Appeals

No appeals lodged

Chiropractors

From the Chair

The Chiropractic Board of Australia built on planned initiatives to ensure the public continues to receive safe, competent and ethical care from chiropractors, and supported chiropractors to provide safe care, particularly in the challenging pandemic environment. For much of the year the Board continued to carry out its work remotely; however, it was pleased to be able to return to meeting with stakeholders and practitioners in person when possible.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Regulatory response to COVID-19

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

The Board continued its work with Ahpra to provide relevant information and updates. This included a joint statement from Ahpra and all National Boards, the Health Care Complaints Commission, the Office of the Health Ombudsman and the Therapeutic Goods Administration about reliable, evidence-based sources of information in relation to COVID-19 and vaccines; and a joint statement from Ahpra and all National Boards about facilitating access to care in the COVID-19 environment.

Standards, codes, guidelines and policies

Jointly with the National Boards and Ahpra, the Board released the revised *Regulatory principles*, which encourage a culturally safe, response- and risk-based approach to regulation.

The Board released the cross-profession *Supervised practice framework*.

Stakeholder engagement

We were able to return to face-to-face information forums in June for chiropractors in New South Wales and the Australian Capital Territory, with a joint forum with the Chiropractic Council of New South Wales that focused on the revised *Code of conduct* and gave chiropractors an opportunity to engage with the Board and the Council.

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 receive the Board's newsletter, which is issued to practitioners three times per year.

Evaluative judgement forum

In November, the Board held a successful virtual forum for all chiropractors and key stakeholders to explore the concept of evaluative judgement in learning in professional practice and particularly its applications to the health professions. Videos and resource materials were published on the Board's website.

Other news

The Board welcomed four new members, Ms Kim Barker, Mrs Colleen Papadopoulos and Mr Ken Riddiford (community members) and Dr Michael Shobbrook AM (practitioner member from the Australian Capital Territory). We thank outgoing members Dr Michael Badham (practitioner member from the Australian Capital Territory), Ms Anne Burgess AM and Mr Frank Ederle (community members) for their valuable contribution and commitment to the regulation of the chiropractic profession during their time on the Board.

Dr Wayne Minter AM

Board members

- **Dr Wayne Minter AM (practitioner), Chair**
- Ms Kim Barker (community) – from 23 Nov
- Dr Michael Badham (practitioner) – to 11 Nov
- Ms Anne Burgess AM (community) – to 11 Nov
- Dr Abbey Chilcott (practitioner)
- Mr Frank Ederle (community) – to 11 Nov
- Mrs Colleen Papadopoulos (community) – from 24 Nov
- Mr Ken Riddiford (community) – from 22 Nov
- Professor Anna Ryan (practitioner and medical practitioner)
- Dr Michael Shobbrook AM (practitioner) – from 22 Nov
- Dr Arcady Turczynowicz (practitioner)
- Ms Alison von Bibra (community) – to 2 Oct
- Dr Ailsa Wood (practitioner)

Ms Kirsten Hibberd is the Executive Officer, Chiropractic.

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

Snapshot

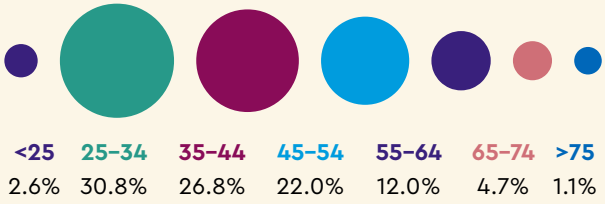
6,147 chiropractors

- → Up **3.0%** from 2020/21
- → **0.7%** of all registered health practitioners

0.8% identified as Aboriginal and/or Torres Strait Islander

41.7% female; **58.3%** male

Figure 11. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
2.6%	30.8%	26.8%	22.0%	12.0%	4.7%	1.1%

Regulating

Notifications

142 notifications lodged with Ahpra about **115** chiropractors

- → **214** notifications about **173** chiropractors made Australia-wide, including HPCA and OHO data
- → **2.8%** of the profession

Figure 12. Sources of notifications

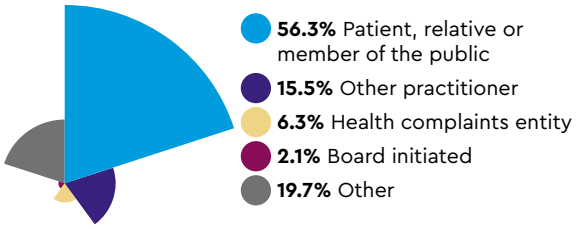
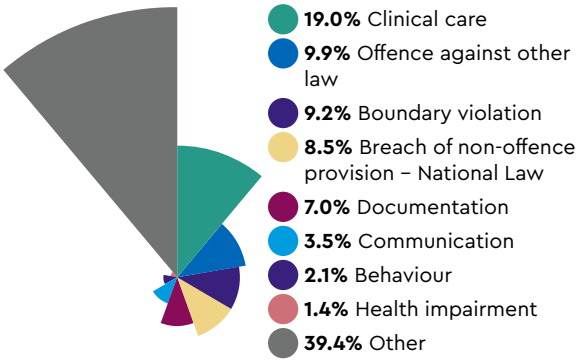


Figure 13. Most common types of complaint



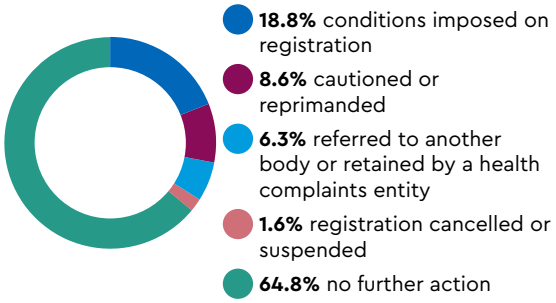
12 immediate actions taken

13 mandatory notifications received

- → **4** about professional standards

Figure 14. Notifications closed

128 notifications closed



Monitoring

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

39 cases being monitored at 30 June:

- → **10** for conduct
- → **2** for health
- → **13** for performance
- → **10** for prohibited practitioner/student
- → **4** for suitability/eligibility for registration

Criminal offence complaints

20 criminal offence complaints made

- → **9** about title protection
- → **6** about practice protection
- → **5** about advertising breaches

16 closed

Referred to an adjudication body

3 matters decided by a tribunal

No matters decided by a panel

Appeals

1 appeal lodged

Dental practitioners

From the Chair

The Dental Board of Australia achieves its role of protecting the public by setting standards to enter and remain in the dental profession, and by supporting practitioners to practise professionally. We focused on achieving these goals by working collaboratively and consultatively with the profession, our stakeholders and the public.

Highlights this year

The Board held its fifth biennial national conference, hearing from several presenters on the theme of *Trust and confidence through better understanding*. Engagement with stakeholders continued through regular meetings of the Dental Stakeholder Liaison Group. The Board's reviews and evaluations were highly consultative, incorporating the feedback of practitioners, stakeholders and the public. In May, the Board held its first face-to-face meeting since February 2020.

The Board released a revised *Code of conduct* in partnership with several other Boards.

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 included publishing information to help practitioners understand the impact of COVID-19 on continuing professional development requirements for maintaining an endorsement to practise conscious sedation.

Dental practitioner support

This year marks the second year of operation of the Dental Practitioner Support Service, the first 24/7, free, confidential, nationwide telephone and online service for all dental practitioners and students.

Accreditation

The Board continued to work closely with its accreditation authority, the Australian Dental Council (ADC), to oversee accredited programs of study that, when approved by the Board, lead to registration as a dental practitioner. The Board contributed to the ADC's review of the *Competencies for newly qualified dental practitioners*, which will come into effect for the ADC's accreditation processes in 2023.

Policy updates

The Board evaluated the implementation of its revised *Scope of practice registration standard* and *Guidelines for scope of practice*. The evaluation, which considered the views of stakeholders and practitioners, found no adverse impacts on patient safety or the quality of care provided by practitioners following the introduction of the revised standard.

Following consultation with other regulators, industry groups and professional associations, the Board released an updated fact sheet on teeth whitening.

The Board released the cross-profession *Supervised practice framework*.

New registration standards, guidelines and codes

The Board completed its review of the *Guidelines on infection control*, following public consultation. The outcome of the review was to replace the guidelines with supporting resources for practitioners, which were refined through dental practitioner user testing.

The Board's review of its *Specialist registration standard* is in its early stages.

Other news

The Board welcomed two new members, Mrs Julia Christensen (community member) and Dr Simon Shanahan (practitioner member). We thank outgoing members Winthrop Professor Paul Abbott (practitioner member) and Ms Alison Faigniez (community member) for their commitment and contribution to the work of the Board.

Dr Murray Thomas

Board members

- **Dr Murray Thomas (practitioner), Chair**
- Winthrop Professor Paul Abbott AO (practitioner) – to 11 Nov
- Mr Robin Brown (community)
- Dr Penelope Burns (practitioner)
- Mrs Julia Christensen (community) – from 1 Dec
- Ms Alison Faigniez (community) – to 11 Nov
- Ms Jacqueline Gibson-Roos (community)
- Mrs Kim Jones (community)
- Professor Richard Logan (practitioner)
- Mr Tan Nguyen (practitioner)
- Mrs Janice Okine (practitioner)
- Dr Kate Raymond (practitioner)
- Dr Simon Shanahan (practitioner) – from 26 Nov
- Ms Carolynne Smith (practitioner)

Ms Maja Doma is the Executive Officer, Dental, from 23 May. Ms Luisa Interligi was the Executive Officer, Dental, to 20 May.

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

Snapshot

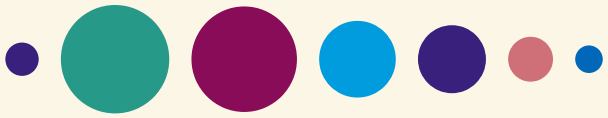
26,038 dental practitioners

- → Up **4.2%** from 2020/21
- → **3.1%** of all registered health practitioners

0.6% identified as Aboriginal and/or Torres Strait Islander

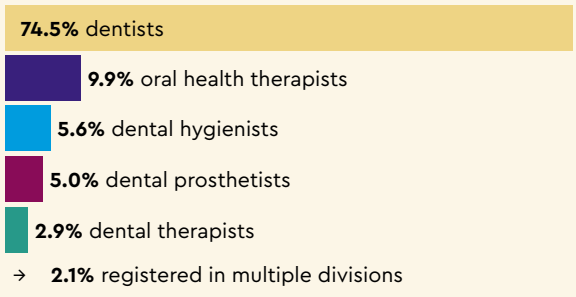
54.3% female; **45.7%** male

Figure 15. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
3.1%	28.9%	27.8%	17.7%	14.5%	6.7%	1.3%

Figure 16. Divisions



- → **2.1%** registered in multiple divisions

Regulating

Notifications

725 notifications lodged with Ahpra about **592** dental practitioners

- → **1,249** notifications about **1,021** dental practitioners made Australia-wide, including HPCA and OHO data
- → **3.9%** of the profession

Figure 17. Sources of notifications

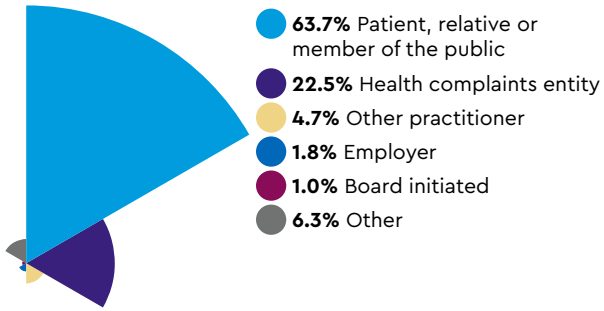
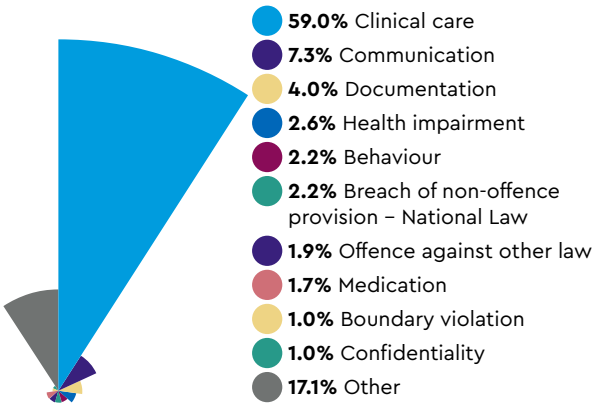


Figure 18. Most common types of complaint



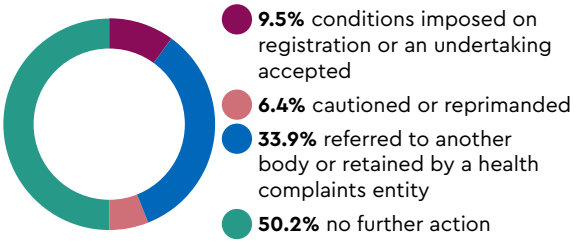
17 immediate actions taken

22 mandatory notifications received

- → **11** about professional standards

Figure 19. Notifications closed

749 notifications closed



Monitoring

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

149 cases being monitored at 30 June:

- → **10** for conduct
- → **13** for health
- → **84** for performance
- → **11** for prohibited practitioner/student
- → **31** for suitability/eligibility for registration

Criminal offence complaints

24 criminal offence complaints made

- → **9** about title protection
- → **11** about practice protection
- → **4** about advertising breaches

24 closed

Referred to an adjudication body

3 matters decided by a tribunal

1 matter decided by a panel

Appeals

2 appeals lodged

Medical practitioners

From the Chair

The 2021/22 year was challenging for many of us. The impact of COVID-19 has been felt deeply, both professionally and personally. Many of you will be feeling fatigued and maybe even disillusioned.

The Medical Board of Australia thanks you for your extraordinary work serving our communities under challenging circumstances.

Issues this year

COVID-19 continued to feature in our work with a range of policy decisions to support a surge workforce and to increase flexibility. The Board is delighted with the ongoing success of the Medical Training Survey (MTS) and is grateful for the support of doctors in training and other stakeholders. We are disturbed by MTS results across successive years highlighting unacceptable rates of bullying, harassment, discrimination and racism. Our Culture of Medicine Symposium aimed to build a common understanding of current problems and a shared commitment to a different future.

We continued our work to strengthen continuing professional development and improve complaints handling, and with Ahpra have commissioned an independent review into cosmetic surgery.

Regulatory responses to COVID-19

The Board made a number of decisions to support a surge workforce, reduce red tape and support medical practitioners by:

- establishing an additional pandemic sub-register, adding to the pool of doctors potentially able to support the COVID-19 response
- introducing flexibility for 2022 interns whose internship has been disrupted directly as a result of COVID-19
- publishing guidance and alerting practitioners about the Therapeutic Goods Administration's restrictions on prescribing ivermectin for COVID-19
- in partnership with Ahpra, other National Boards, the Health Care Complaints Commission, the Office of the Health Ombudsman and the Therapeutic Goods Administration, publishing a statement for patients and health consumers to support informed decision-making, particularly about sorting fact from fiction
- with Ahpra and the other National Boards, publishing a statement *Facilitating access to care in a COVID-19 environment: guidance for health practitioners*
- agreeing to temporarily accept additional English language tests.

Cosmetic surgery independent review

The Medical Board and Ahpra commissioned an independent review of patient safety issues in the cosmetic sector, including how to strengthen risk-based regulation of practitioners in an increasingly entrepreneurial part of the profession.

Mr Andrew Brown, previously the Queensland Health Ombudsman, led the review, which included public consultation.

Professional Performance Framework

The Board's Professional Performance Framework continues to guide the work of the Board. It aims to support registered medical practitioners in Australia to practise competently and ethically throughout their careers. 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
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

Most of the work described below relates to at least one pillar.

Medical Training Survey

The Medical Training Survey (MTS) is becoming a feature of the landscape for doctors in training. This year, 55% of doctors in training (more than 21,000) did the survey. Results show that the quality of training remains high, with improvements reported in all aspects of the quality of supervision. Of the surveyed trainees, 80% would recommend their current training position to other trainees.

Once again, we are deeply concerned about trainee feedback about the culture of medicine: 35% of doctors in training reported they had experienced or witnessed bullying, harassment or discrimination (including racism). It is even worse for Aboriginal and Torres Strait Islander doctors in training, with 52% reporting that they had experienced or witnessed these unacceptable behaviours.

Results are at www.medicaltrainingsurvey.gov.au. The MTS is one of the important ways the Board fosters collaborations to improve the culture of medicine.

Symposium on the culture of medicine

Consistently disturbing findings from the Medical Training Survey across three years led the Board to convene a symposium on the culture of medicine on 27 May. Strong evidence that poor culture is associated with poor patient outcomes places the culture of medicine firmly in scope for the Board.

The symposium shared evidence of poor culture but focused primarily on fostering a commitment to positive change.

Conference participants identified improved awareness and understanding of cultural safety, meaningful action on racism and collaborations to help effect change as a focus for future effort. We shared ideas about what we might do together to re-shape the complex system that creates the culture of medicine in this country.

CPD registration standard

Health Ministers approved the revised CPD (continuing professional development) registration standard, which is evidence-based. The revised standard aims to support medical practitioners to do high-value CPD that they can incorporate into their day-to-day practice and create a real and positive impact. An implementation group was established.

Specialist colleges will transition to become CPD homes by the end of 2022. Doctors who do their CPD through their specialist college will therefore meet the new CPD standard from 1 January 2023. Others have until 2024 to meet the revised standard.

Health checks for late career practitioners

The Board's plan for regular health checks for practitioners aged 70 and over reflects expert advice that increasing age is a known risk factor for poor performance. We developed a draft registration standard for these health checks and are preparing a Regulation Impact Statement for consultation. We expect that most late career practitioners will continue to practise in their usual way after health checks are introduced.

Guidance to support practitioners

Registration standard for acupuncture endorsement

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 revised registration standard for *Endorsement of registration for acupuncture for registered medical practitioners* defines the requirements, was approved by Ministers and took effect on 1 July 2022.

International medical graduates in hospitals

The Board published additional guidance for hospitals who employ international medical graduates (IMGs). The guidance supplements the Board's *Guidelines: supervised practice for international medical graduates*, which are based on the general practice environment. The information provides a framework for hospitals to propose alternative supervision arrangements.

Guidance for IMGs with limited registration for research

The Board published information for IMGs applying for limited registration for research positions. It provides guidance about the evidence an applicant must provide to show they meet the registration requirements.

The Board released the cross-profession *Supervised practice framework*.

Supervised practice framework

The framework applies to medical practitioners when supervision is used for the purposes of eligibility or suitability for registration. For example, when doctors are returning to practice after a prolonged absence, changing their scope of practice, or when they are not able to meet a requirement of a registration standard. It will also apply when a doctor is required to complete a period of supervised practice after a complaint.

The supervised practice framework does not apply to IMGs with limited or provisional registration, to interns with provisional registration or to vocational (specialist) trainees. Supervision requirements for these medical practitioners have not changed.

Telehealth

The Board reviewed and revised its *Guidelines on technology-based consultations*. It will consult on these in 2022/23.

Stakeholder engagement

Newsletters and media

The Board published 10 regular editions of the *Medical Board Update* and two editions of its medical student newsletter.

The Board responds to many media requests for comment on a range of issues. We also receive requests for comment about individual practitioners, but provide limited information, as permitted 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
- professional indemnity providers
- Drs4Drs – the Board provides about $2m funding annually for state-based health services for all medical practitioners and students.

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, including:

- regular meetings with the Chairs of state and territory boards
- a registration workshop
- the MBA annual conference – an online conference for all members of the Board and Ahpra staff.

Stakeholder engagement is a cornerstone of our regulatory approach and features across all pillars of the Professional Performance Framework.

Accreditation

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

New fields and specialties

The Board progressed rural generalist medicine as a new field of specialty practice within general practice to the second stage of assessment, which includes a detailed assessment, including public consultation.

The Board sought advice from the AMC about an application for recognition of clinical forensic medicine as a new specialty.

Managing complaints

The Board and Ahpra appreciate the enormous stress that many medical practitioners experience when a notification (complaint) is made about them. Our own research tells us that the longer it takes to resolve a notification, the more distressing it is for everyone involved.

The Board continues to make changes to improve the management of complaints, including:

1. changing the scope of the Sexual Boundaries Notifications Committee to include matters involving family violence
2. establishing a national committee to deal with all COVID-19-related notifications
3. continuing its risk-based approach, by dealing with low-risk matters quickly and focusing resources on high-risk matters; the Notifications Assessment Committee meets six times each week – a measure of the complaints-handling workload.

Dr Anne Tonkin

Board members

- **Dr Anne Tonkin (practitioner), Chair**
- Associate Professor Stephen Adelstein (practitioner)
- Mr Mark Bodycoat (community)
- Dr Kerrie Bradbury (practitioner)
- Professor Richard Doherty (practitioner) – to 11 Nov
- Ms Jayde Geia (community) – from 10 Dec
- Dr Samuel Goodwin (practitioner)
- Dr Daniel Heredia (practitioner) – from 2 Dec
- Ms Eileen Jerga AM (community)
- Associate Professor Hannah McGlade (community) – to 11 Nov
- Professor Constantine Michael AO (practitioner) – to 11 Nov
- Dr Andrew Mulcahy (practitioner)
- Dr Debra O'Brien (practitioner) – from 9 Dec
- 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.

Table 1. Specialties

198	addiction medicine
5,793	anaesthesia
633	dermatology
3,098	emergency medicine
34,654	general practice
1,126	intensive care medicine
355	medical administration
2,265	obstetrics and gynaecology
308	occupational and environmental medicine
1,087	ophthalmology
3,621	paediatrics and child health
383	pain medicine
439	palliative medicine
2,375	pathology
12,672	physician
4,409	psychiatry
452	public health medicine
453	radiation oncology
2,954	radiology
591	rehabilitation medicine
137	sexual health medicine
158	sport and exercise medicine
6,441	surgery
84,602	medical practitioners with specialties

Snapshot

131,953 medical practitioners

- → Up **2.2%** from 2020/21
- → **15.5%** of all registered health practitioners

0.5% identified as Aboriginal and/or Torres Strait Islander

45.1% female; **54.9%** male

Figure 20. Age

<25	25–34	35–44	45–54	55–64	65–74	>75
1.1%	25.9%	26.4%	19.7%	14.9%	8.8%	3.1%

Regulating

Notifications

6,176 notifications lodged with Ahpra about **4,652** medical practitioners

- → **10,873** notifications about **8,146** medical practitioners made Australia-wide, including HPCA and OHO data
- → **6.2%** of the profession

Figure 21. Sources of notifications

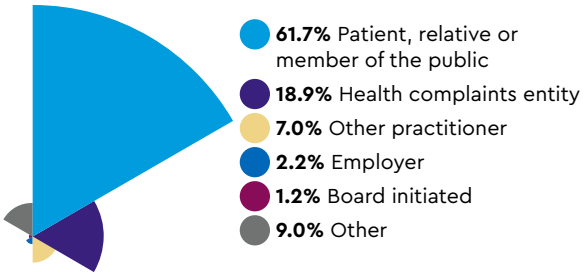
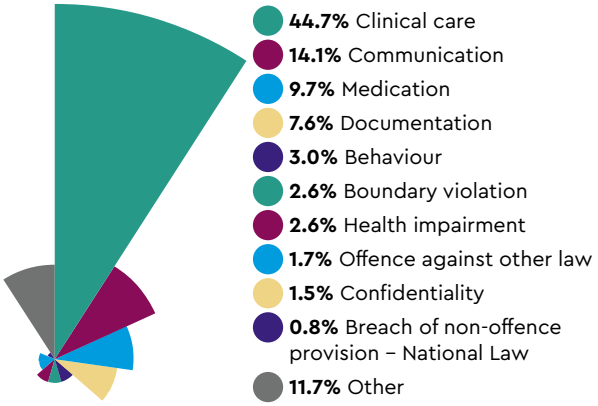


Figure 22. Most common types of complaint



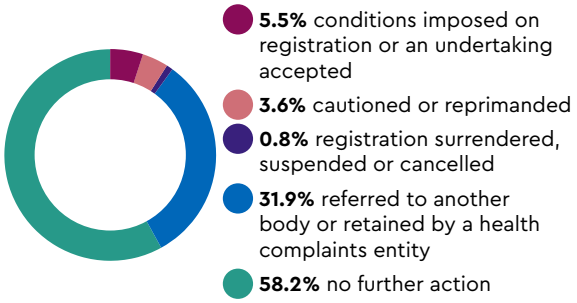
344 immediate actions taken

339 mandatory notifications received

- → **127** about professional standards

Figure 23. Notifications closed

5,874 notifications closed



Monitoring

1,000 practitioners monitored for health, performance and/or conduct during the year

1,303 cases being monitored at 30 June:

- → **146** for conduct
- → **187** for health
- → **278** for performance
- → **135** for prohibited practitioner/student
- → **557** for suitability/eligibility for registration

Criminal offence complaints

130 criminal offence complaints made

- → **88** about title protection
- → **2** about practice protection
- → **38** about advertising breaches
- → **2** other offences

119 closed

Referred to an adjudication body

92 matters decided by a tribunal

1 matter decided by a panel

Appeals

66 appeals lodged

Medical radiation practitioners

From the Chair

Issues this year

The impact and disruption of the COVID-19 pandemic continued to be a defining feature of our regulatory focus and how we worked, including holding most meetings virtually. Our regulation of the profession has again been heavily influenced by a multi-profession approach, particularly around advice for health practitioners on issues related to COVID-19.

Accreditation

In collaboration with the Medical Radiation Practice Accreditation Committee, the Medical Radiation Practice Board of Australia broadened the membership of the committee to include Aboriginal and Torres Strait Islander practitioners and senior clinical educators. These changes recognise the value that cultural safety and different perspectives have on the quality of accredited programs of study.

Policy and project updates

Coronial investigation

In November the Coroner's Court of Victoria released its findings into the death of Peta Hickey. The Board was requested to respond, and it responded to some of the coroner's recommendations. The Board published material on recognising and responding to acute deterioration and has elevated the discussion of continuous professional development in basic life support.

National exam guidelines

Following a Board review of its national exam guidelines that began in early 2021, the Board published revised guidelines in April 2022. The guidelines describe a candidate's obligations, exam rules, eligibility requirements and the pass mark.

Exam calibration

The national exam for medical radiation practice assesses whether a candidate can meet the minimum requirements for safe practice in the profession. Throughout 2021 the Board updated and developed new exams, and as part of its review decided to calibrate the new exams, using final year students and recent graduates to sit the exam, which informed the agreed pass mark.

Artificial intelligence

Advanced machine programming has been a feature of medical radiation practice for many years, but artificial intelligence and machine learning in healthcare has gathered momentum in the last 18 months. The Board engaged with several stakeholders involved with artificial intelligence research and education and is developing an AI statement.

Facilitating research

Through its newsletter the Board has continued to support ethics-approved research in medical radiation practice. Recent research projects include artificial intelligence perceptions and implementation, and a national study looking at consistency in shoulder imaging.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Pandemic sub-register

At 30 June there were 227 medical radiation practitioners on the pandemic sub-register.

Stakeholder engagement

The Board continued to meet with national and international stakeholders including the New Zealand Medical Radiation Practice Board, the Canadian Association of Medical Radiation Technologists, Medical Radiations Australia, the Australian Society of Medical Imaging and Radiation Therapy (ASMIRT), the Australian and New Zealand Society of Nuclear Medicine, the Australian Sonographers Association and others to discuss issues in medical radiation practice, the effect of COVID-19 and the workforce impact.

Representatives of the Board also attended the ASMIRT national conference in Queensland in May.

Ms Cara Miller

Board members

- **Mr Mark Marcenko (practitioner), Chair** – to 22 Feb
- **Ms Cara Miller (practitioner), Chair** – from 23 Feb
- Mr Richard Bialkowski (community)
- Ms Joan Burns (community)
- Mr Anthony Buxton (practitioner)
- Dr Susan Gould PhD (community)
- Mr James Green (practitioner)
- Ms Renea Hart (community)
- Mr Brendan McKernan (practitioner)
- Mr Travis Pearson (practitioner)
- Mrs Amber Summers (practitioner) – from 23 Feb
- Mr Roger Weckert (practitioner)
- Associate Professor Caroline Wright (practitioner)

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

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

Snapshot

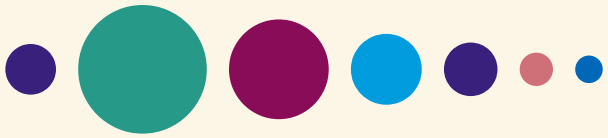
18,601 medical radiation practitioners

- → Up **4.2%** from 2020/21
- → **2.2%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

68.4% female; **31.6%** male

Figure 24. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
8.5%	36.2%	26.1%	15.8%	10.2%	3.0%	0.1%

Figure 25. Divisions

14,619 diagnostic radiographers

- → 13 of whom also nuclear medicine technologists
- → 2 of whom also radiation therapists

1,273 nuclear medicine technologists

2,709 radiation therapists

18,601 total

Regulating

Notifications

41 notifications lodged with Ahpra about **33** medical radiation practitioners

- → **70** notifications about **57** medical radiation practitioners made Australia-wide, including HPCA and OHO data
- → **0.3%** of the profession

Figure 26. Sources of notifications

- **29.3%** Patient, relative or member of the public
- **14.6%** Other practitioner
- **12.2%** Employer
- **12.2%** Health complaints entity
- **2.4%** Board initiated
- **29.3%** Other

Figure 27. Most common types of complaint

- **19.5%** Clinical care
- **17.1%** Behaviour
- **12.2%** Boundary violation
- **7.3%** Offence against other law
- **4.9%** Communication
- **4.9%** Confidentiality
- **4.9%** Health impairment
- **2.4%** Breach of non-offence provision – National Law
- **2.4%** Documentation
- **24.4%** Other

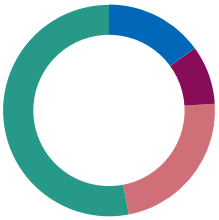
1 immediate action taken

9 mandatory notifications received

- → **4** about professional standards

Figure 28. Notifications closed

34 notifications closed



- **14.7%** conditions imposed on registration
- **8.8%** cautioned or reprimanded
- **23.5%** referred to another body or retained by a health complaints entity
- **52.9%** no further action

Monitoring

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

53 cases being monitored at 30 June:

- → **7** for health
- → **3** for performance
- → **6** for prohibited practitioner/student
- → **37** for suitability/eligibility for registration

Criminal offence complaints

No criminal offence complaints made or closed

Referred to an adjudication body

2 matters decided by a tribunal

No matters decided by a panel

Appeals

No appeals lodged

Nurses and midwives

From the Chair

This year

Nurses and midwives show strength during difficult times

Our inspiring nurses and midwives led us through another pandemic-affected year. As frontline responders, nurses and midwives stepped forward and encouraged the roll-out of the COVID-19 vaccination. We also watched as retired nurses and midwives quickly returned to the workforce through the pandemic sub-registers – more than 1,800 midwives and 15,000 nurses were on the sub-registers during the year. These nurses and midwives were crucial to the nation's vaccination efforts and supported our hospitals through these challenging times.

The Nursing and Midwifery Board of Australia (NMBA) and I also wish to recognise the continued strength and resilience shown by our nurses and midwives who are experiencing ongoing personal and professional pressure, not only related to the pandemic response but also due to the challenges caused by recent natural disasters across Australia. In these extreme circumstances, nurses and midwives continue to meet their responsibilities to their work and support their communities in the times when they need it the most. Thank you for all that you do.

Registration fee freeze

The NMBA approved a registration fee freeze for the second year in support of our nurses and midwives. We also acknowledged the significant amount of professional development nurses and midwives have done while navigating COVID-19 in clinical settings, by minimising the need for reporting the continuing professional development (CPD) of nurses and midwives at registration renewal.

New Board members

We welcomed two new community members, Ms Sonja Ilievska and Mrs Gemma Martin, to the NMBA, both with wide-ranging backgrounds in public health services. Professor Catherine Chamberlain, a midwife, educator and Trawlwoolway woman, also joined the NMBA as our newest practitioner member. With a combination of public and practitioner board members, the NMBA ensures its regulatory priorities remain fit for purpose and community focused.

Nurse & Midwife Support

The NMBA continues to work closely with Nurse & Midwife Support, a 24/7 national support service for nurses and midwives that provides confidential advice and referral. The NMBA made a commitment to a new suite of services to further support nurses and midwives:

- Notification navigator: free, accessible, professional, confidential, compassionate and individualised support throughout the notification process
- Interactive, guided wellbeing resources: evidence-informed resources to support the mental health and wellbeing of nurses and midwives
- New graduate support: resources to support the transition to independent practice/graduate years, and a mentoring program connecting early career professionals with experienced nurse and midwife mentors.

The NMBA acknowledges this unprecedented era in healthcare and its effect on nurses and midwives across the country.

Policy in nursing

Working in cosmetic procedures

With a critical lens on the standard of care across the medical cosmetic industry, the NMBA released a position statement for nurses working or wishing to work in the area of cosmetic medical and surgical procedures. The purpose of this statement is not to impose further regulation but rather to clarify a nurse's scope of practice in certain medical and surgical procedures.

This position statement includes guidance for:

- all nurses working in the area of cosmetic medical procedures, including specific advice for enrolled nurses, registered nurses and nurse practitioners
- cosmetic injections – detailed expectations of prescribers and the role of the registered nurse and enrolled nurse
- supervision requirements for enrolled nurses
- registered nurses with a sole qualification in mental health nursing, paediatric nursing or disability nursing wanting to practise in the area of cosmetic medical procedures.

Ahpra and the Medical Board of Australia are conducting a separate review into cosmetic surgery. The NMBA may amend the *Position statement: Nurses and cosmetic medical procedures* in future based on the recommendations of that review.

Retiring the RIP endorsement

The NMBA and health departments are ending the *Endorsement for scheduled medicines for registered nurses (rural and isolated practice)* (RIP endorsement), allowing rural and isolated practice registered nurses (RNs) to supply and administer certain scheduled medicines under local medicines and poisons legislation, policies and protocols without needing an endorsement.

Most states and territories in Australia already regulate the safe use of medicines by RNs through drugs and poisons legislation, local regulations and health service policies and/or protocols.

The two states that relied on the RIP endorsement within their legislation (Victoria and Queensland) have finalised alternative regulatory mechanisms for RNs to obtain, supply and administer certain scheduled medicines in rural and isolated practice settings. These changes enable RIP-endorsed RNs to continue their medicines practice without requiring an endorsement from the NMBA.

By removing the endorsement, the NMBA aims to minimise any overregulation and streamline the process for rural nurses to administer scheduled medicines.

Policy in midwifery

Health Ministers have agreed to extend the professional indemnity insurance (PII) exemption for privately practising midwives (PPMs) until 31 December 2023. For PPMs to be eligible for the exemption from PII for providing intrapartum care for home births, they must meet the *Safety and quality guidelines for privately practising midwives*.

These guidelines provide PPMs with clarity and support to practise their role with safety and quality, while facilitating workforce flexibility and access to services. The guidelines also apply to PPMs who provide care in discrete areas such as postnatal care, antenatal care and/or specialist lactation services. The NMBA has started a review of these guidelines and will consult with midwives in the review process.

Adjunct Professor Veronica Casey AM

Board members

- **Adjunct Professor Veronica Casey AM (practitioner), Chair**
- Mr David Carpenter (practitioner)
- Professor Catherine Chamberlain (practitioner) – from 24 Nov
- Ms Nicoletta (Maria) Ciffolilli (community) – to 11 Nov
- Ms Melodie Heland (practitioner) – to 11 Nov
- Dr Christopher Helms PhD (practitioner)
- Mr Max Howard (community) – to 11 Nov
- Ms Sonja Ilievska (community) – from 23 Nov
- Mrs Gemma Martin (community) – from 23 Nov
- Dr Jessica (Jessa) Rogers PhD (community)
- Ms Catherine Schofield (practitioner)
- Associate Professor Linda Starr (practitioner)
- Ms Annette Symes (practitioner)
- Mrs Allyson Warrington (community) – to 11 Nov
- 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.

Dual registered

28,095 registered as both nurse and midwife

- → Down **3.9%** from 2020/21
- → **3.3%** of all registered health practitioners

98.4% female; **1.6%** male

Table 2. Divisions, dual registration and endorsements

Nurses by division	
74,100	enrolled nurses
10,970	enrolled nurses and registered nurses
356,821	registered nurses
441,891	**total**

Nurses and midwives, dual registered	
113	enrolled nurses and midwives
97	enrolled nurses and registered nurses and midwives
27,885	registered nurses and midwives
28,095	**total**

Nurses with endorsements	
2,425	nurse practitioners
1,299	scheduled medicines (rural and isolated practice)
3,724	**total**

Midwives with endorsements	
1	midwife practitioner
860	scheduled medicines
861	**total**

Snapshot nursing

All nurses

469,986 nurses (including those also registered as midwives)

- → Up **2.5%** from 2020/21
- → **55.1%** of all registered health practitioners
- → **28,095** also hold registration in midwifery

1.4% identified as Aboriginal and/or Torres Strait Islander

88.3% female; **11.7%** male

Nurse-only registered

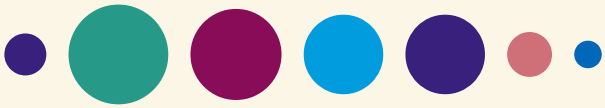
441,891 nurses

- → Up **2.9%** from 2020/21
- → **51.8%** of all registered health practitioners

87.7% female; **12.3%** male

Figure 29. Age

All nurses, including those also registered as midwives



<25	25–34	35–44	45–54	55–64	65–74	>75
6.4%	25.9%	22.7%	19.3%	18.5%	6.8%	0.4%

Regulating nurses

Notifications

1,940 notifications lodged with Ahpra about **1,593** nurses

- **2,970** notifications about **2,357** nurses made Australia-wide, including HPCA and OHO data
- **0.5%** of the profession

Figure 30. Sources of notifications

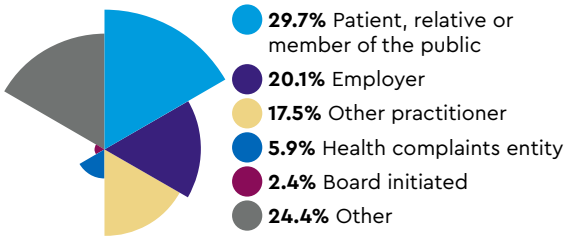
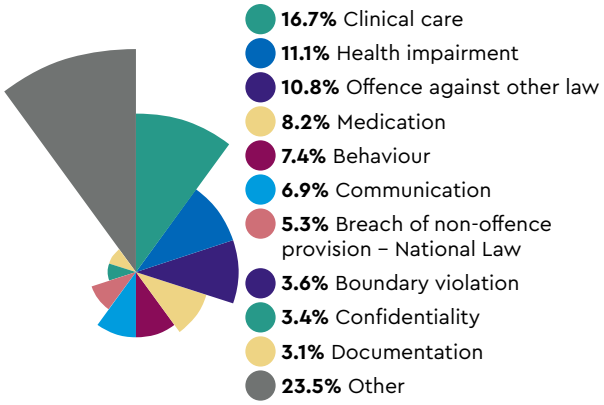


Figure 31. Most common types of complaint



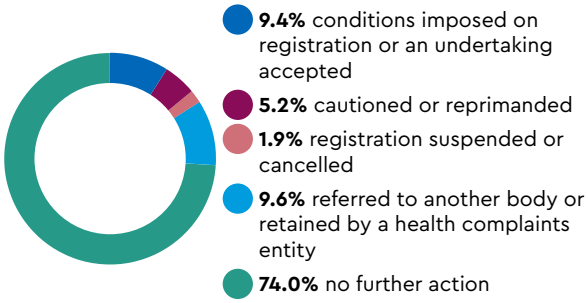
199 immediate actions taken

451 mandatory notifications received

- **193** about professional standards

Figure 32. Notifications closed

1,896 notifications closed



Monitoring

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

1,567 cases being monitored at 30 June:

- **121** for conduct
- **244** for health
- **69** for performance
- **227** for prohibited practitioner/student
- **906** for suitability/eligibility for registration

Criminal offence complaints

53 criminal offence complaints made

- **48** about title protection
- **3** about practice protection
- **2** about advertising breaches
- **1** directing or inciting unprofessional conduct/professional misconduct

62 closed

Referred to an adjudication body

60 matters decided by a tribunal

No matters decided by a panel

Appeals

17 appeals lodged

Snapshot midwives

All midwives

35,256 midwives (including those also registered as nurses)

- → Down **2.2%** from 2020/21
- → **4.1%** of all registered health practitioners
- → **28,095** also hold registration in nursing

1.5% identified as Aboriginal and/or Torres Strait Islander

98.7% female; **1.3%** male

Midwife-only registered

7,161 midwives

- → Up **5.5%** from 2020/21
- → **0.8%** of all registered health practitioners

99.7% female; **0.3%** male

Figure 33. Age

All midwives, including those also registered as nurses

<25	25–34	35–44	45–54	55–64	65–74	>75
3.7%	19.8%	17.6%	18.8%	27.8%	11.5%	0.7%

Regulating midwives

Notifications

113 notifications lodged with Ahpra about **99** midwives

- → **147** notifications about **131** midwives made Australia-wide, including HPCA and OHO data
- → **0.4%** of the profession

Figure 34. Sources of notifications

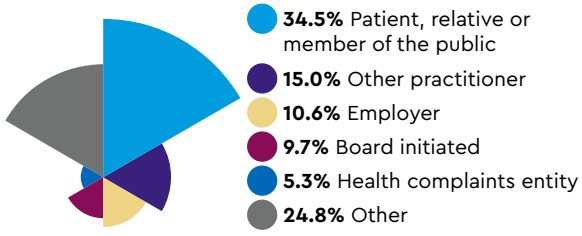
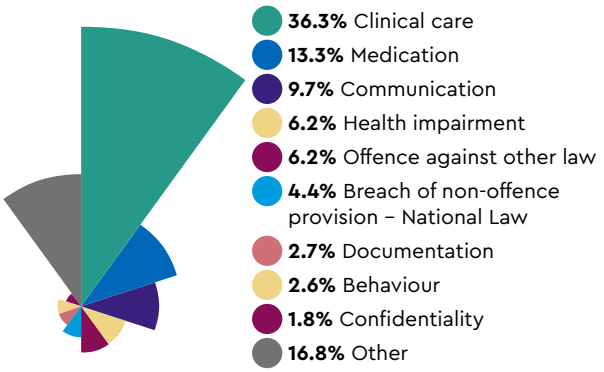


Figure 35. Most common types of complaint



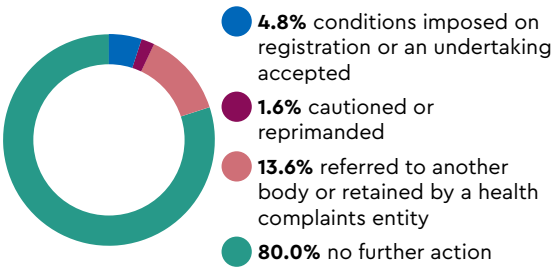
4 immediate actions taken

17 mandatory notifications received

- → **11** about professional standards

Figure 36. Notifications closed

125 notifications closed



Monitoring

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

42 cases being monitored at 30 June:

- → **3** for conduct
- → **4** for health
- → **6** for performance
- → **3** for prohibited practitioner/student
- → **26** for suitability/eligibility for registration

Criminal offence complaints

4 criminal offence complaints made

- → **3** about title protection
- → **1** about practice protection

5 closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

Appeals

No appeals lodged

Occupational therapists

From the Chair

Regulatory response to COVID-19

The Occupational Therapy Board of Australia continued to support practitioners to provide safe care in changing work environments. This work included:

- working with Ahpra and other National Boards to develop guidance on *Facilitating access to care in a COVID environment*
- releasing a joint statement with other National Boards, the Health Care Complaints Commission, the Office of the Health Ombudsman and the Therapeutic Goods Administration on COVID-19 and vaccines
- enabling the continuing registration of occupational therapists on the pandemic sub-register to give additional support for the COVID-19 vaccination roll-out.

The pandemic also continued to affect occupational therapy students, in particular on completion of their clinical placements. The Board maintained oversight of the issues affecting the education sector through its regular engagement with the Occupational Therapy Council of Australia Limited.

Joint reviews

The Board contributed to the scheduled review of the *Registration standard: English language skills* and the *Registration standard: Criminal history*. The Board also participated in the review of the *Regulatory principles for the National Scheme*.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Accreditation

The Board approved two new programs of study and continued to approve the accreditation of programs undergoing their scheduled reviews during the financial year. There are now 48 occupational therapy programs of study delivered by 24 education providers.

Stakeholder engagement

The Board held joint meetings with Occupational Therapy Australia (the national professional association) and the Occupational Therapy Council of Australia Limited. These meetings provided the chance to discuss emerging issues and to look for opportunities to enhance collaboration on similar activities that are being carried out across the respective organisations.

In October the Board held its sixth successful webinar for new and soon-to-be graduates, attended by almost 300 students, to help them understand their obligations on becoming a registered occupational therapist. The webinar continues to provide a valuable mechanism to communicate with new graduates about the logistics of the registration process and their obligations as practitioners.

Also in October, the Board celebrated the continued growth of the profession, with the registration of the 26,000th occupational therapist. The Board is also preparing to celebrate 10 years in the National Scheme. Both of these represent significant milestones in the national registration of the profession.

The Board held a webinar in June on notifications data. The webinar was attended by more than 600 practitioners and included a Q&A session with a panel of three Board members. The webinar provided a great opportunity to discuss the shared *Code of conduct* and the responsibilities of all practitioners.

The Board released the cross-profession *Supervised practice framework*.

Other news

The Board supports the National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025, and members are participating in the Moong-moong-gak cultural safety training program.

Ms Julie Brayshaw

Board members

- **Ms Julie Brayshaw (practitioner), Chair**
- Mr Darryl Annett (community)
- Ms Sally Cunningham (practitioner)
- Ms Roxane Marcelle-Shaw (community)
- Ms Jennifer Morris (community)
- Dr Claire Pearce PhD (practitioner)
- Associate Professor Justin Scanlan (practitioner)
- Ms Rebecca Singh (practitioner)
- Ms Angela Thynne (practitioner)

Ms Vathani Shivanandan was the Executive Officer, Occupational Therapy.

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

Snapshot

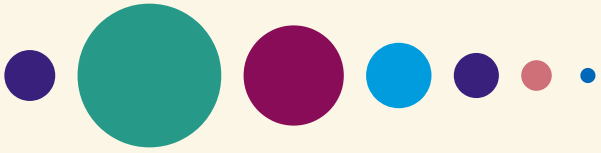
27,666 occupational therapists

- → Up **7.9%** from 2020/21
- → **3.2%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

90.0% female; **10.0%** male

Figure 37. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
9.0%	41.4%	26.2%	14.6%	7.3%	1.5%	0.1%

Regulating

Notifications

76 notifications lodged with Ahpra about **69** occupational therapists

- → **142** notifications about **117** occupational therapists made Australia-wide, including HPCA and OHO data
- → **0.4%** of the profession

Figure 38. Sources of notifications

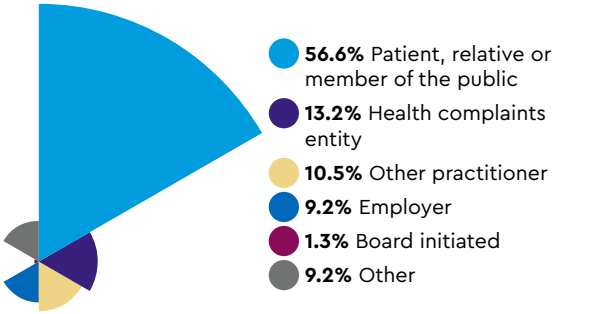
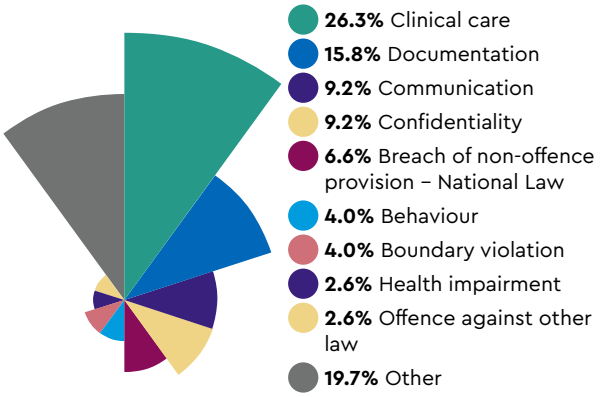


Figure 39. Most common types of complaint



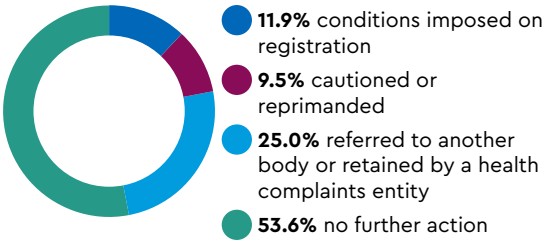
2 immediate actions taken

8 mandatory notifications received

- → **5** about professional standards

Figure 40. Notifications closed

84 notifications closed



Monitoring

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

100 cases being monitored at 30 June:

- → **4** for conduct
- → **3** for health
- → **1** for performance
- → **2** for prohibited practitioner/student
- → **90** for suitability/eligibility for registration

Criminal offence complaints

13 criminal offence complaints made

- → **12** about title protection
- → **1** other offence

12 closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

Appeals

No appeals lodged

Optometrists

From the Chair

Issues this year

The Optometry Board of Australia continued to deal with issues related to COVID-19. However, with the lifting of state border restrictions, we met face to face in March for the first time in two years. The Board considered how regulatory approaches could be modified to accommodate exceptional circumstances, and optometrists were added to the pandemic sub-register to support Australia's surge health workforce.

Regulatory response to COVID-19

We encouraged practitioners to continue to complete continuing professional development (CPD), while recognising the difficulty in meeting those 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 continued its financial hardship policy. The Board approved additional English-language tests to meet the English-language skills registration standard, in recognition of the changing international environment for international applicants.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Accreditation

In February, the Board approved the Optometry Council of Australia and New Zealand's (OCANZ) revised standards for the accreditation of Board-approved entry-level programs for optometry. These standards will come into effect in 2023 and include greater emphasis on the integration of Aboriginal and Torres Strait Islander cultural safety into optometry entry-level programs.

Policy updates

The Board added a new medicine to the approved list of topical medicines contained in Appendix B of the *Guidelines for use of scheduled medicines*. Endorsed optometrists are now considered qualified to administer, obtain, possess, prescribe and supply the dry eye medicine lifitegrast, for use for the purposes of the practice of optometry.

The Board released resources to help optometrists and their patients understand and apply the revised *Code of conduct*.

Stakeholder engagement

The Board once again convened its annual meeting of the Optometry Regulatory Reference Group in October, and increased its focus on engaging with consumer organisations and with Aboriginal and Torres Strait Islander Peoples.

Members of the Board provided virtual lectures on professional obligations to final-year optometry students graduating from a number of Board-approved courses in 2021.

The Board released the cross-profession *Supervised practice framework*.

Other news

The Board said farewell to three Board members: Mr Ian Bluntish, previous Chair and practitioner member from South Australia; Associate Professor Daryl Guest, practitioner member from Tasmania; and Ms Adrienne Farago, community member.

In December the Health Ministers appointed three new members to the Board: Mr Benjamin Graham, community member; Miss Renee Slunjski, practitioner member from South Australia; and Mr Martin Robinson, practitioner member from Tasmania. I started my first term as Chair of the Board and became the first woman to chair the Optometry Board of Australia.

Mrs Judith Hannan (Irvine)

Board members

- **Mr Ian Bluntish (practitioner), Chair** – to 11 Nov
- **Mrs Judith Hannan (Irvine) (practitioner), Chair** – from 2 Dec
- Mr Stuart Aamodt (practitioner)
- Dr Carla Abbott PhD (practitioner)
- Mr Anthony Evans (community)
- Mr Benjamin Graham (community) – from 13 Dec
- Ms Adrienne Farago (community) – to 11 Nov
- Associate Professor Daryl Guest (practitioner) – to 11 Nov
- Associate Professor Rosemary Knight (community)
- Mr Martin Robinson (practitioner) – from 2 Dec
- Miss Renee Slunjski (practitioner) – from 8 Dec
- 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

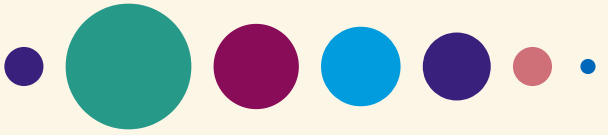
6,500 optometrists

- → Up **3.4%** from 2020/21
- → **0.8%** of all registered health practitioners

0.3% identified as Aboriginal and/or Torres Strait Islander

57.6% female; **42.4%** male

Figure 41. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
5.2%	34.8%	21.1%	18.6%	14.6%	5.2%	0.5%

Regulating

Notifications

35 notifications lodged with Ahpra about **32** optometrists

- → **68** notifications about **61** optometrists made Australia-wide, including HPCA and OHO data
- → **0.9%** of the profession

Figure 42. Sources of notifications

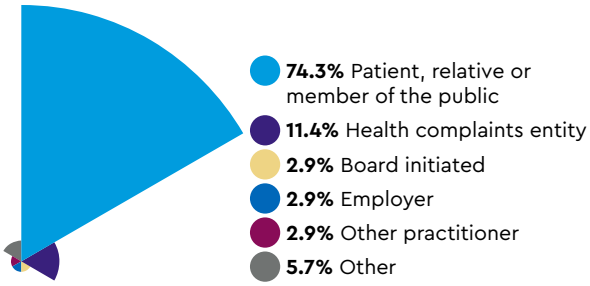
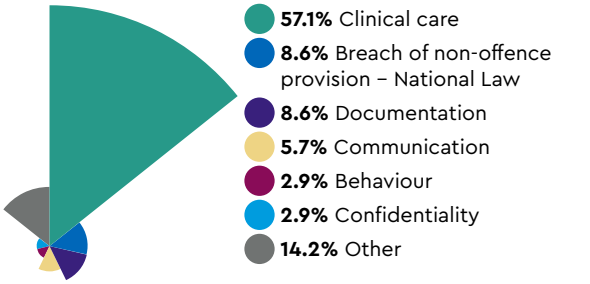


Figure 43. Most common types of complaint



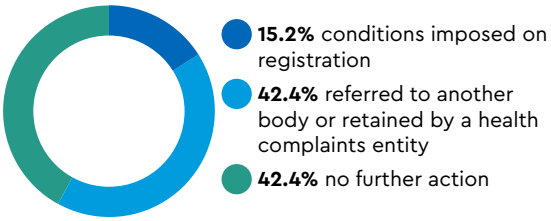
1 immediate action taken

2 mandatory notifications received

- → **1** about professional standards

Figure 44. Notifications closed

33 notifications closed



Monitoring

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

10 cases being monitored at 30 June:

- → **3** for performance
- → **1** for prohibited practitioner/student
- → **6** for suitability/eligibility for registration

Criminal offence complaints

4 criminal offence complaints made

- → **1** about title protection
- → **1** about practice protection
- → **2** about advertising breaches

4 closed

Referred to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

Appeals

No appeals lodged

Osteopaths

From the Chair

Issues this year

The COVID-19 pandemic continued to affect the way we work as a Board, with all Osteopathy Board of Australia and stakeholder meetings held online.

I attended regular Think Tank virtual meetings of osteopathy stakeholders from across Australia and was able to share updates and be in touch with the issues of access to education programs and healthcare during the pandemic.

Communication with osteopathy students and registrants continued through newsletters and on social media.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Regulatory response to COVID-19

The Board continued to contact registrants directly via newsletters and email with information about the impact of COVID-19 and the regulatory response for osteopaths, including extensions of regulatory requirements.

Accreditation

The revised *Osteopathic accreditation standards* (2021), developed by the Australian Osteopathic Accreditation Council, came into effect on 30 July 2021.

I met online every two months with the Chair and CEO of the Australian Osteopathic Accreditation Council.

The Board released the cross-profession *Supervised practice framework*.

Stakeholder engagement

Local

The Osteopathy Think Tank is organised by the association Osteopathy Australia, and is focused on education and workforce issues and information sharing. The Board and Ahpra have provided demographic data.

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

International

Regular meetings with the Osteopathy Council of New Zealand took place, and also with our UK counterparts, the General Osteopathic Council. These meetings provided valuable information-sharing on current and emerging issues, and a chance to debrief about responses to COVID-19 and the effects on the regulation of osteopathy.

I continue as a member of the Public Relations Committee of the Osteopathic International Alliance, which includes organising International Osteopathic Healthcare Week, celebrated in April 2022.

Other news

We farewelled two community members, Ms Judith Dikstein and Mr Joshua Hatten, who have made a valuable contribution and commitment to regulation during their time on the Board. Ms Dikstein was an inaugural member of another National Board in 2009, and has been a member of the Osteopathy Board of Australia since 2013.

We welcomed two new Board members, community member Ms Robyn Davis and practitioner member Dr Rebecca Malon, and have a vacancy for another community member.

Newer members are yet to meet all their colleagues face to face but the work of regulation continued smoothly during the year through virtual meetings.

Dr Nikole Grbin

Board members

- **Dr Nikole Grbin (practitioner), Chair**
- Ms Robyn Davis (community) – from 26 Nov
- Dr Pamela Dennis (practitioner)
- Ms Judith Dikstein (community) – to 11 Nov
- Ms Julia Duffy (community)
- Mr Joshua Hatten (community) – to 11 Nov
- Dr Rebecca Malon (practitioner) – from 1 Dec
- Dr Timothy McNamara (practitioner)
- Associate Professor Paul Orrock (practitioner)
- 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

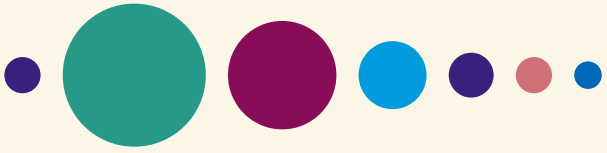
3,147 osteopaths

- → Up **6.6%** from 2020/21
- → **0.4%** of all registered health practitioners

0.6% identified as Aboriginal and/or Torres Strait Islander

54.3% female; **45.7%** male

Figure 45. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
4.2%	41.2%	28.8%	15.2%	6.6%	3.5%	0.6%

Regulating

Notifications

41 notifications lodged with Ahpra about **33** osteopaths

- → **68** notifications about **51** osteopaths made Australia-wide, including HPCA and OHO data
- → **1.6%** of the profession

Figure 46. Sources of notifications

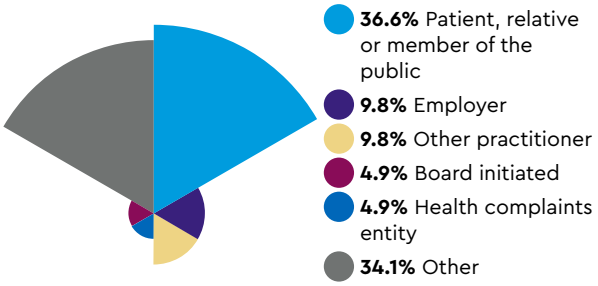
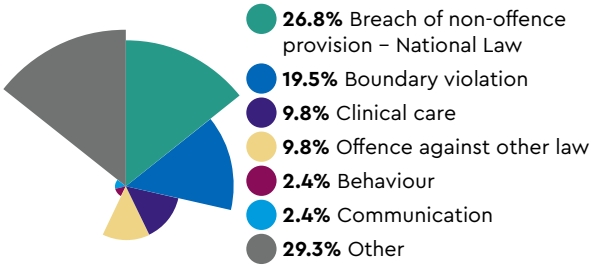


Figure 47. Most common types of complaint



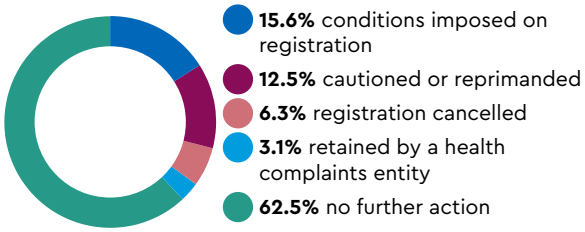
4 immediate actions taken

6 mandatory notifications received

- → **1** about professional standards

Figure 48. Notifications closed

32 notifications closed



Monitoring

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

15 cases being monitored at 30 June:

- → **3** for conduct
- → **1** for performance
- → **3** for prohibited practitioner/student
- → **8** for suitability/eligibility for registration

Criminal offence complaints

6 criminal offence complaints made

- → **4** about title protection
- → **1** about practice protection
- → **1** about advertising breaches

4 closed

Referred to an adjudication body

2 matters decided by a tribunal

No matters decided by a panel

Appeals

1 appeal lodged

Paramedics

From the Chair

Issues this year

The end of grandparenting on 1 December 2022 was a sentinel event in the program of work to establish paramedicine as a regulated health profession. After that date practitioners could only be qualified for registration by holding an approved or accepted qualification, a substantially equivalent qualification or a relevant qualification and successful completion of the paramedicine competence assessment.

Policy updates

To support this transition the Paramedicine Board of Australia developed and implemented a policy framework for the assessment of non-approved or non-accepted qualifications. This enabled suitably qualified paramedics from Australia and overseas to still apply for registration after the grandparenting provisions ended. We appreciate the ongoing work and commitment of the assessment consortium that performs the competency assessments on behalf of the Board. Despite the end of grandparenting, the number of registered paramedics continues to grow, with more than 23,000 paramedics now registered.

Regulatory response to COVID-19

Along with the other National Boards, the Board provided guidance and support to practitioners to help them practise safely and professionally in relation to official health orders and the COVID environment. The Board continued to identify opportunities where regulatory approaches could be applied flexibly while ensuring the health and safety of the public. The Board acknowledges the superb work done by registered paramedics and paramedic students who carried out and supported a wide variety of frontline and other health workforce roles during the response to the COVID-19 pandemic.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Standards, codes, guidelines and policies

The number of notifications continues to grow at a greater rate than the number of paramedics. The Board hopes that the revised *Code of conduct* will provide practitioners with enhanced clarity on their ethical and professional obligations, resulting in a reduction in the rate of notifications. The Board is committed to its role in ensuring public protection and will continue to take necessary and appropriate regulatory action when required.

Accreditation

Following an initial three years of establishing and starting the accreditation process for paramedicine programs of study, all positions on the inaugural Paramedicine Accreditation Committee were advertised for appointment for the next three-year term. After a very competitive expression of interest and selection process, the Board appointed two new members and reappointed six to the committee. Emeritus Professor Eileen Willis retired from the committee as the inaugural chair and the Board is grateful for her leadership and guidance during its first term.

The Board released the cross-profession *Supervised practice framework*.

Other news

Inaugural member Ms Jeanette Barker also retired from the Board. Jeanette has been an exceptional contributor to the establishment and ongoing success of the Board and her contribution will be missed.

My personal thanks must go to the Board and committee members for their ongoing work and support; and the Board notes its gratitude for the support of key stakeholders in its work, including professional bodies, educators, employers and health departments.

Professor Stephen Gough ASM

Board members

- **Professor Stephen Gough ASM (practitioner), Chair**
- Ms Jeanette Barker (community) – to 2 Mar
- 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

23,053 paramedics

- → Up **7.3%** from 2020/21
- → **2.7%** of all registered health practitioners

1.8% identified as Aboriginal and/or Torres Strait Islander

47.6% female; **52.3%** male

Figure 49. Age

<25	25–34	35–44	45–54	55–64	65–74	>75
11.1%	38.6%	21.3%	17.8%	9.9%	1.3%	0.0%

Regulating

Notifications

152 notifications lodged with Ahpra about **116** paramedics

- → **296** notifications about **213** paramedics made Australia-wide, including HPCA and OHO data
- → **0.9%** of the profession

Figure 50. Sources of notifications

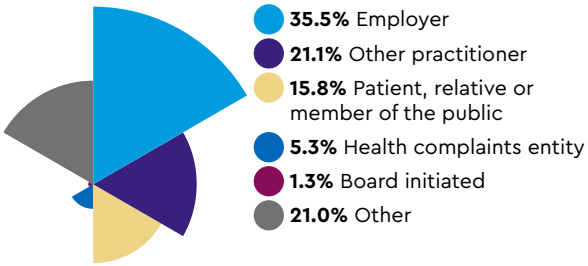
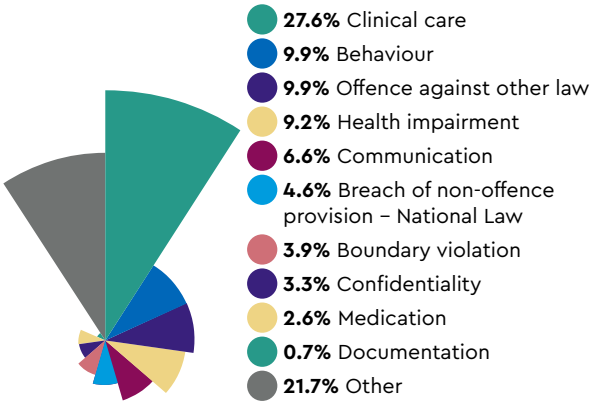


Figure 51. Most common types of complaint



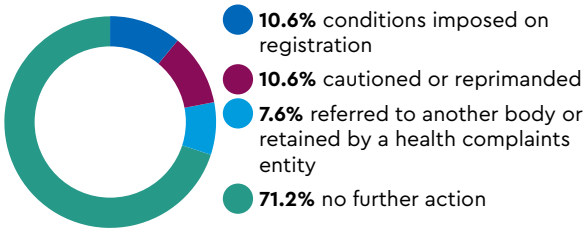
24 immediate actions taken

49 mandatory notifications received

- → **27** about professional standards

Figure 52. Notifications closed

132 notifications closed



Monitoring

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

252 cases being monitored at 30 June:

- → **7** for conduct
- → **13** for health
- → **1** for performance
- → **20** for prohibited practitioner/student
- → **211** for suitability/eligibility for registration

Criminal offence complaints

16 criminal offence complaints made

- → **15** about title protection
- → **1** about practice protection

17 closed

Referred to an adjudication body

1 matter decided by a tribunal

No matters decided by a panel

Appeals

2 appeals lodged

Pharmacists

From the Chair

Regulatory response to COVID-19

In response to requests from states and territories, the Pharmacy Board of Australia supported the existing workforce by continuing to register pharmacists on the pandemic sub-register for a further 12 months and by broadening the scope for practitioners to support the COVID-19 response. The Board also supported the 2021 pandemic sub-register, enabling more practitioners to join those on the 2020 sub-register. It also maintained existing measures to support pharmacists to meet their regulatory obligations during the pandemic, including:

- reducing the total number of supervised practice hours required for general registration to minimise delays in registering pharmacists affected by COVID-19
- delivering oral and written examinations using an online platform where required, given the need for social distancing and other issues such as extreme weather events.

Intern assessment

The Board continued collaborating with the Australian Pharmacy Council to broaden the range of tools for assessing interns' competence to practise. An implementation program started in 2022. The Board funded the development of workplace-based assessment tools to complement its current registration examination for interns. As part of the Board's ongoing work to improve the quality of examinations, it also surveyed examiners involved in the oral component of the registration examination to understand and improve their experience.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Review of registration standards and guidelines

A review of the *Guidelines on compounding of medicines* began and included an extensive initial round of stakeholder engagement, including two webinars. This enabled compounding pharmacists and stakeholders to provide insights on using the current guidelines and identified opportunities to improve and streamline them. To support a better understanding of the circumstances when compounded medicines are an appropriate treatment option, the Board also drafted a consumer information sheet to include in its public consultation on the revised guidelines.

The Board started a review of its registration standards and guidelines for pharmacists.

Supporting professional practice

The Board further developed its website to add information that supports pharmacists' professional practice. This included new case studies based on de-identified notifications cases, five newsletters and a directory to help pharmacists navigate important resources relevant to safe and competent pharmacy practice.

To inform stakeholders about options for pharmacist prescribing, the Board provided advice based on its published materials, which included a position statement on pharmacist prescribing. The Board continues to engage with stakeholders to highlight that pharmacists must be competent and appropriately trained to deliver any emerging services.

The Board resumed its face-to-face engagement with pharmacists and stakeholders by holding a stakeholder meeting in Hobart. This enabled it to hear firsthand about local issues affecting pharmacists and their practice, and to discuss its role of protecting the public.

The Board continued to provide annual funding to the Pharmacists' Support Service (PSS), a long-established service staffed by volunteer pharmacists who provide crisis telephone counselling, which offers valuable health support services to pharmacists and students across Australia.

Mr Brett Simmonds, Chair

Board members

- **Mr Brett Simmonds (practitioner), Chair**
- Mrs Elise Apolloni (practitioner)
- Ms Melissa Cadzow (community)
- Dr Alice Gilbert PhD (practitioner)
- Ms Joy Hewitt (practitioner) – to 11 Nov
- Mr Mark Kirschbaum (practitioner)
- Ms Hannah Mann (practitioner)
- Dr Suzanne Martin (veterinarian) (community)
- Dr Amy Page (practitioner) – from 26 Nov
- Dr Cameron Phillips PhD (practitioner)
- Dr Janet Preuss PhD (community)
- 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

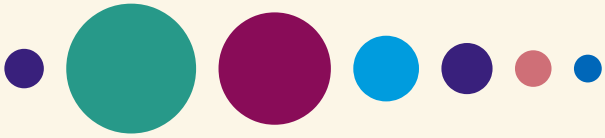
35,368 pharmacists

- → Up **0.3%** from 2020/21
- → **4.1%** of all registered health practitioners

0.3% identified as Aboriginal and/or Torres Strait Islander

63.7% female; **36.3%** male

Figure 53. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
5.2%	35.6%	30.4%	14.1%	9.2%	4.2%	1.3%

Regulating

Notifications

471 notifications lodged with Ahpra about **357** pharmacists

- → **1,048** notifications about **719** pharmacists made Australia-wide, including HPCA and OHO data
- → **2.0%** of the profession

Figure 54. Sources of notifications

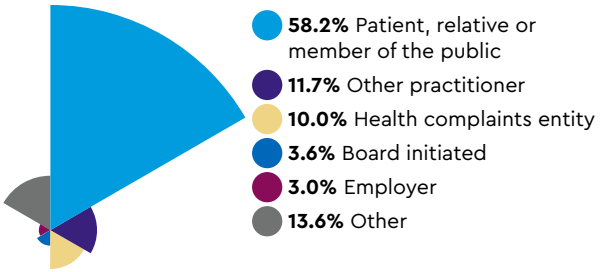
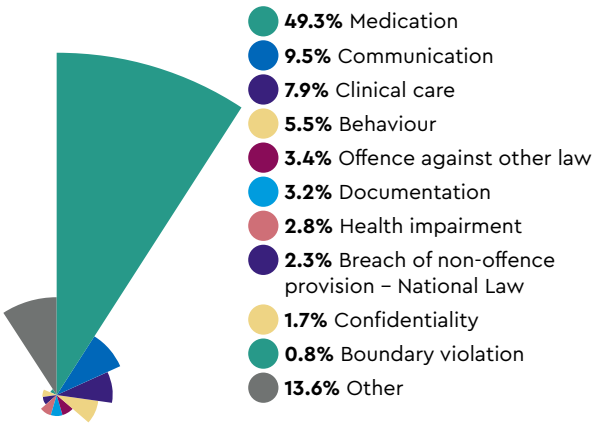


Figure 55. Most common types of complaint



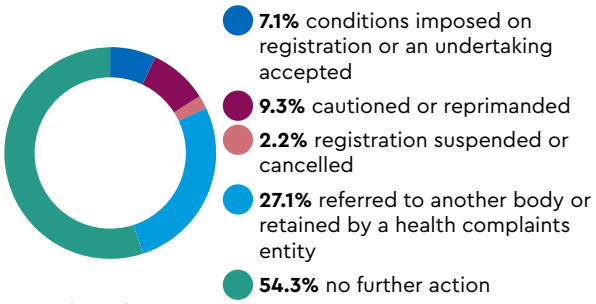
17 immediate actions taken

29 mandatory notifications received

- → **16** about professional standards

Figure 56. Notifications closed

451 notifications closed



Monitoring

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

151 cases being monitored at 30 June:

- → **18** for conduct
- → **13** for health
- → **17** for performance
- → **23** for prohibited practitioner/student
- → **80** for suitability/eligibility for registration

Criminal offence complaints

19 criminal offence complaints made

- → **15** about title protection
- → **2** about practice protection
- → **2** about advertising breaches

16 closed

Referred to an adjudication body

10 matters decided by a tribunal

No matters decided by a panel

Appeals

4 appeals lodged

Physiotherapists

From the Chair

Issues this year

The Physiotherapy Board of Australia continued to make progress on our strategic work. The Board's primary concern was the workforce issues created by the ongoing pandemic. To address these, it has supported the scheme-wide response strategies, such as the pandemic sub-register. The Board started to meet in person again in March, with a combination of face-to-face and online meetings.

Regulatory response to COVID-19

The Board continued to respond to the needs of the profession, healthcare services and the public by modifying the regulatory approach to support the profession through the pandemic. A flexible approach to continuing professional development and recency of practice requirements was maintained.

This work included enabling the continuing registration of physiotherapists on the pandemic sub-register to give additional support for the COVID-19 surge workforce and vaccination roll-out.

The Board released the cross-profession *Supervised practice framework*.

Policy updates

The Board has continued to work with the New Zealand Physiotherapy Board on a first review of the bi-national practice thresholds, with a focus on updating the wording in relation to cultural safety and digital competence.

The Board released a revised *Code of conduct* in partnership with several other Boards.

Stakeholder engagement

Given the ongoing and fluctuating travel restrictions, the Board relied mostly on online engagement methods. It held a series of webinars on physiotherapy and non-medical prescribing to gain a shared understanding of this concept.

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 moving our strategic projects forward.

Strategic projects

The Board further developed a background paper, building on a literature review and exploration report previously completed, on whether to endorse prescribing for physiotherapists. Due to COVID-19 restrictions, the Board conducted webinars to explore this concept further. We shared the paper with key stakeholders and received significant feedback. The next step is to engage with key stakeholders in person via a forum.

Following its workforce analysis work last year and given COVID's impact on the healthcare workforce, the Board is committed to exploring and understanding the physiotherapy workforce, practitioner wellbeing and the factors that influence it.

Ms Kim Gibson

Board members

- **Ms Kim Gibson (practitioner), Chair**
- Ms Sally Adamson (practitioner)
- Mrs Janet Blake (community)
- Mr David Cross (practitioner)
- Mrs Lynette Green (community) – to 11 Nov
- Dr Paula Harding PhD (practitioner)
- Ms Cherie Hearn (practitioner)
- Mr Peter Kerr AM (community) – to 11 Nov
- Emeritus Professor Sheila Lennon (practitioner)
- Ms Rosemary Mathlin (community) – from 26 Nov
- Mr Noel McRoberts (practitioner – acting) – to 11 Nov
- Mr Allan Renouf (community) – from 27 Nov
- Ms Elizabeth Trickett (practitioner)
- Ms Katherine Waterford (community)
- Mr Simon Watt (practitioner) – from 26 Nov

Ms Alison Abud is the Executive Officer, Physiotherapy.

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

Snapshot

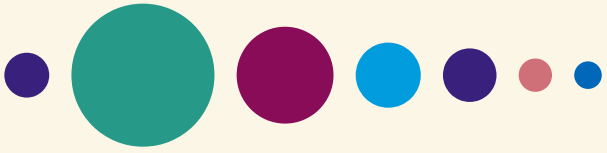
40,018 physiotherapists

- → Up **6.3%** from 2020/21
- → **4.7%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

64.7% female; **35.3%** male

Figure 57. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
6.9%	40.9%	25.1%	14.0%	9.6%	3.2%	0.3%

Regulating

Notifications

136 notifications lodged with Ahpra about **117** physiotherapists

- → **227** notifications about **196** physiotherapists made Australia-wide, including HPCA and OHO data
- → **0.5%** of the profession

Figure 58. Sources of notifications

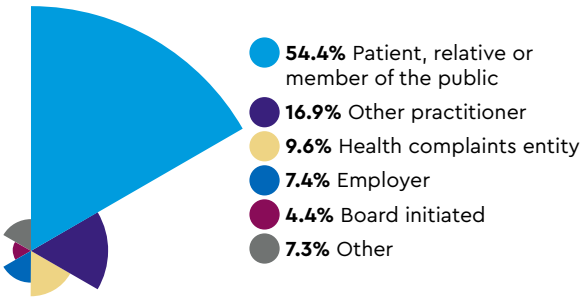
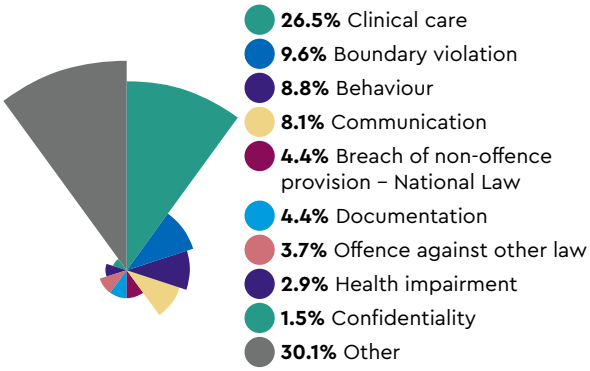


Figure 59. Most common types of complaint



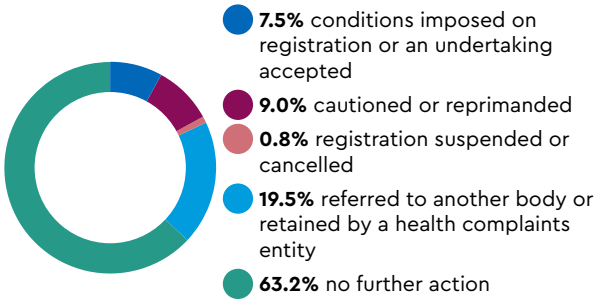
5 immediate actions taken

17 mandatory notifications received

- → **10** about professional standards

Figure 60. Notifications closed

133 notifications closed



Monitoring

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

47 cases being monitored at 30 June:

- → **13** for conduct
- → **4** for health
- → **3** for performance
- → **8** for prohibited practitioner/student
- → **19** for suitability/eligibility for registration

Criminal offence complaints

15 criminal offence complaints made

- → **13** about title protection
- → **2** about advertising breaches

13 closed

Referred to an adjudication body

3 matters decided by a tribunal

No matters decided by a panel

Appeals

1 appeal lodged

Podiatrists

From the Chair

Highlights this year

The Podiatry Board of Australia approved new professional capabilities for podiatrists and podiatric surgeons,[1] which took effect on 1 January 2022. They:

- describe the threshold or minimum level of professional capability needed for registration as a podiatrist or podiatric surgeon
- reflect contemporary podiatry and podiatric surgery practice in Australia
- are founded on person-centred, evidence-based practice
- make cultural safety a key component of safe care, particularly for Aboriginal and Torres Strait Islander Peoples.

We published an animated video and FAQs and met with stakeholders to support implementation.

We acknowledge the Podiatry Accreditation Committee for their work in developing and consulting on the professional capabilities.

Regulatory response to COVID-19

In response to the ongoing impact of the pandemic we continued to adopt a flexible approach to continuing professional development.

In September, Ahpra and the National Boards established the 2021 pandemic sub-register, enabling practitioners to return to practice for up to 12 months to support the COVID-19 response across Australia.

A joint statement on COVID-19 and vaccines was released by the National Boards, Ahpra, the Health Care Complaints Commission, the Office of the Health Ombudsman and the Therapeutic Goods Administration. The National Boards and Ahpra also published guidance for health practitioners about facilitating access to care in a COVID-19 environment.

Accreditation

The Podiatry Accreditation Committee reported on podiatry program monitoring, including impacts of COVID-19.

The Board approved new accreditation standards developed by the committee, including for entry-level podiatry programs; for podiatric surgery programs; and for education programs leading to qualifications for endorsement of registration for scheduled medicines. The standards started on 1 January. All programs are now assessed against the new accreditation standards.

The terms of the inaugural committee members ended on 30 June. Four members were reappointed for a three-year period, and the Board appointed two new members. We acknowledge the valuable contribution of retiring committee members Assistant Professor Sara Jones and Dr Lloyd Reed.

Registration standards, codes and guidelines

The Board's registration standard for *Specialist registration for the podiatry specialty of podiatric surgery* sets out the requirements for specialist registration. We consulted on a revised specialist registration standard as it was due for review. The changes consulted on were primarily editorial in nature to clarify existing requirements and no substantive changes were proposed.

The Board released the cross-profession *Supervised practice framework*.

Stakeholder engagement

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

The Board released a revised *Code of conduct* in partnership with several other Boards.

Other news

To support the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy, Board and committee members participated in cultural safety training. In December we welcomed new practitioner member Mr Anthony Short and community member Ms Raelene Harrison. The Board acknowledges the valuable contribution of retiring Board members Dr Paul Bennett and Dr Janice Davies OAM.

Associate Professor Cylie Williams

Board members

- **Associate Professor Cylie Williams (practitioner), Chair**
- Dr Paul Bennett (practitioner) – to 11 Nov
- Dr Janice Davies OAM (community) – to 11 Nov
- Ms Raelene Harrison (community) – from 2 Dec
- Ms Julia Kurowski (practitioner)
- Dr Kristy Robson PhD (practitioner)
- Mr Anthony Short (practitioner) – from 2 Dec
- Ms Shellee Smith (community)
- Mrs Kathryn Storer (practitioner)
- Professor Andrew Taggart (community)
- Mr Andrew van Essen (practitioner)

Ms Jenny Collis is the Executive Officer, Podiatry.

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

1 Throughout this report, the term 'podiatrist' refers to both podiatrists and podiatric surgeons unless otherwise specified.

Snapshot

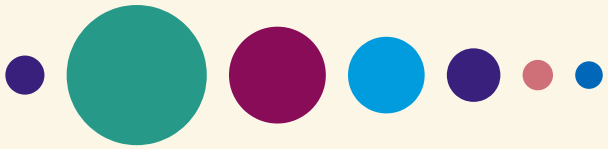
5,992 podiatrists

- → Up **3.6%** from 2020/21
- → **0.7%** of all registered health practitioners

0.8% identified as Aboriginal and/or Torres Strait Islander

59.1% female; **40.9%** male

Figure 61. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
5.0%	39.7%	25.0%	18.2%	10.1%	1.9%	0.2%

Table 3. Registration type

5,782	general
169	non-practising
41	general and specialist
5,992	**total**

Regulating

Notifications

63 notifications lodged with Ahpra about **57** podiatrists

- → **102** notifications about **89** podiatrists made Australia-wide, including HPCA and OHO data
- → **1.5%** of the profession

Figure 62. Sources of notifications

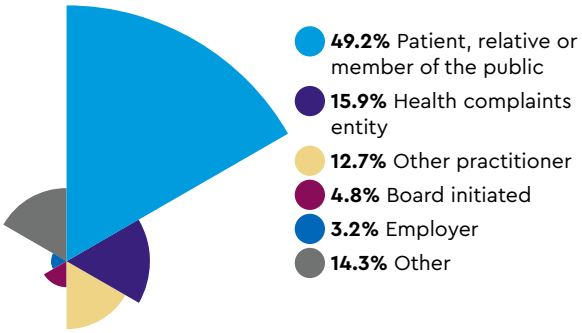
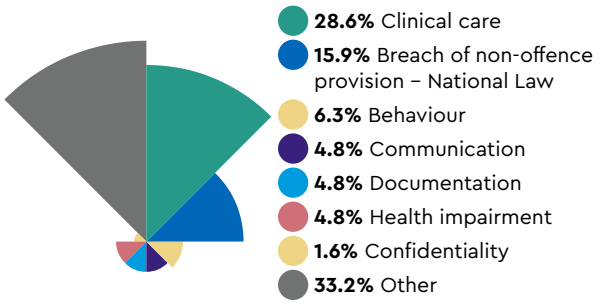


Figure 63. Most common types of complaint



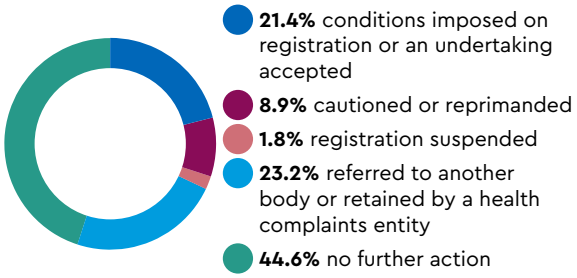
4 immediate actions taken

7 mandatory notifications received

- → **4** about professional standards

Figure 64. Notifications closed

56 notifications closed



Monitoring

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

22 cases being monitored at 30 June:

- → **2** for conduct
- → **2** for health
- → **8** for performance
- → **3** for prohibited practitioner/student
- → **7** for suitability/eligibility for registration

Criminal offence complaints

5 criminal offence complaints made

- → **3** about title protection
- → **2** about advertising breaches

4 closed

Referred to an adjudication body

1 matter decided by a tribunal

No matters decided by a panel

Appeals

No appeals lodged

Psychologists

From the Chair

Key projects

Developing a code of conduct

Work continued on developing a Board-authored *Code of conduct*.

We established a Code Expert Advisory Group (CEAG) to provide advice on drafting the code. The draft code incorporates all the research and development that we did during the year, as well as the CEAG advice on issues specific to psychological practice.

We also conducted significant testing of the draft code with key regulatory partners, including our co-regulators in Queensland and NSW. Overall, there was good regulatory alignment between the Psychology Board of Australia's draft code and the currently endorsed code of ethics. User feedback about how the Board's code could be applied in regulatory processes was also positive.

The next stage is wide-ranging consultation with the community, psychologists and other stakeholders. The Board will use the results of the public consultation to determine the final version.

Education and training reform

We are continuing our review of the competencies for general registration as part of the education and training reform (ETR) program of work (Stage two). The purpose of this stage of the ETR program is to update the competencies to ensure they are contemporary and that they clearly outline the expectations of the threshold competencies required for safe and effective psychology practice in Australia.

We have been laying the groundwork needed to ensure that refreshed competencies incorporate essential elements that are missing in the current competencies. This includes expanding the requirements for culturally safe and trauma-informed care when working with diverse groups, including Aboriginal and Torres Strait Islander Peoples, families and communities; and better explaining the competency requirements for reflective practice and self-care.

We have conducted preliminary consultation on our early draft competencies to test our proposals with key stakeholders. We are taking our time to carefully incorporate the feedback we have received to date, and to ensure that the competencies are thoughtfully improved.

We have also appointed two working groups to collaborate on the program of work, and to provide a forum for engagement.

Once we have finalised a set of draft competencies, we will conduct our usual wide-ranging public consultation to seek feedback.

Retirement of the 4+2 internship

Stage one of the ETR program involved a proposal to retire the 4+2 internship to streamline the pathways to registration. We announced this in 2019 and, following the agreed transition period, the 4+2 internship pathway closed to new applicants on 30 June 2022.

The 4+2 internship model served the profession well for many years; however, it is no longer the preferred training model for psychology in Australia. Provisional psychologists can choose from two contemporary pathways to general registration: the 5+1 internship or higher degree pathway.

Regulatory response to COVID-19

We continued to modify some of our regulatory requirements for psychologists due to the ongoing impact of the pandemic. This included continuing to deliver the national psychology exam online.

A hardship policy remains in place for psychologists and provisional psychologists who are experiencing genuine financial hardship due to COVID-19. Psychologists have also been included on the 2021 pandemic sub-register.

Ms Rachel Phillips

Board members

- **Ms Rachel Phillips (practitioner), Chair**
- Ms Mary Brennan (community) – to 11 Nov
- Ms Miranda Bruyniks (community) – from 2 Dec
- Professor Petrina Coventry (community) – from 3 Dec
- Ms Jade Gooding (practitioner) – to 30 Jan
- Ms Marion Hale (community)
- Ms Vanessa Hamilton (practitioner)
- Mr Peter Hooker (community) – to 11 Nov
- Dr Melissa Hughes (practitioner) – to 11 Nov
- Mr Christopher Joseph (community)
- Mr Timothy Ridgway (practitioner)
- Professor Jennifer Scott (practitioner)
- Dr Jennifer Thornton PhD (practitioner)
- Dr Robyn Vines PhD (practitioner) – from 6 Dec
- 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

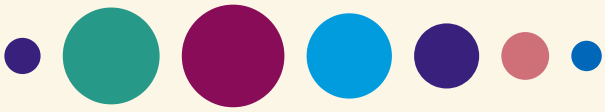
44,917 psychologists

- → Up **7.4%** from 2020/21
- → **5.3%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

80.4% female; **19.6%** male

Figure 65. Age



<25	25–34	35–44	45–54	55–64	65–74	>75
3.5%	25.0%	26.9%	21.1%	13.7%	8.0%	1.8%

Regulating

Notifications

637 notifications lodged with Ahpra about **528** psychologists

- → **1,148** notifications about **909** psychologists made Australia-wide, including HPCA and OHO data
- → **2.0%** of the profession

Figure 66. Sources of notifications

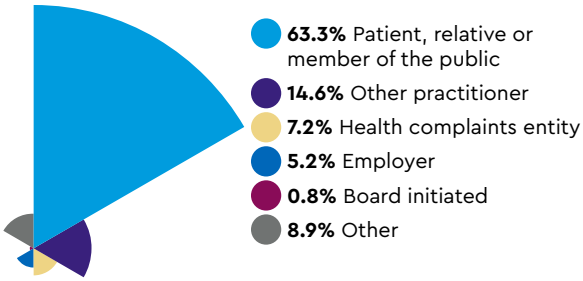
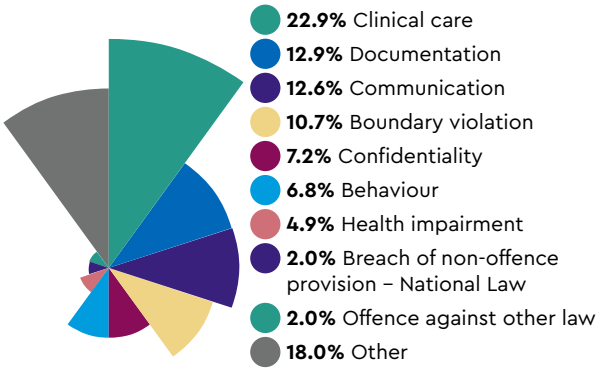


Figure 67. Most common types of complaint



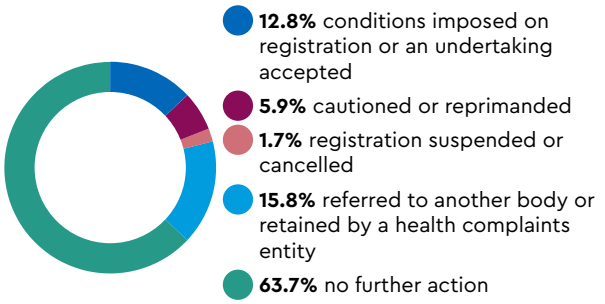
45 immediate actions taken

61 mandatory notifications received

- → **24** about professional standards

Figure 68. Notifications closed

576 notifications closed



Monitoring

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

221 cases being monitored at 30 June:

- → **52** for conduct
- → **20** for health
- → **49** for performance
- → **22** for prohibited practitioner/student
- → **78** for suitability/eligibility for registration

Criminal offence complaints

90 criminal offence complaints made

- → **83** about title protection
- → **7** about advertising breaches

95 closed

Referred to an adjudication body

14 matters decided by a tribunal

1 matter decided by a panel

Appeals

9 appeals lodged

Supporting the Boards

Appointments

Following a public advertising process, National Board members are appointed by the Ministerial Council, and state, territory and regional board members by the 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 668 statutory appointments (see Table 4), which included National Boards; National Board committees and panels (including advisory assessor panels); and state, territory and regional boards and committees.

Table 4. Statutory appointments

National Boards	100
National Board committees and panels	388
State, territory and regional boards	60
State, territory and regional committees	120
Total	**668**

We are working to increase the participation of Aboriginal and Torres Strait Islander Peoples through advertising and engagement strategies. Thirteen appointments were made, across seven National Boards, one regional board, two accreditation committees and one national committee.

Supporting good governance

Ahpra develops, manages and delivers a coordinated and integrated governance program, which responds to the needs of Board and committee members. The program has four key areas, aligned to the three-year regulatory 'life cycle' of members and Boards:

- orientation and induction of new members
- professional development, including member skills development
- Board effectiveness reviews
- documentation for good governance practice.

Orientation and induction

During the year, 27 new National Board members were provided with an orientation to the National Scheme and to their Board.

The orientation program was updated to include a face-to-face or Zoom introduction and three self-paced online learning modules focusing on key governance concepts.

Professional development

To support Board effectiveness and strengthen the partnership between Ahpra and National Boards, Ahpra engaged an external provider, Board Matters, to collaboratively develop a governance professional development program for Board members.

The annual National Registration and Accreditation Scheme Combined Boards Meeting is a flagship event in our regulatory calendar and a key part of professional development for Board members and Ahpra staff. The 2022 meeting was held virtually and attracted 312 participants. Ten sessions were offered over two successive half-days. Recordings of all sessions have been made available as an ongoing professional development resource.

Board effectiveness reviews

The Board effectiveness review program was updated. Reviews will be carried out annually over a rolling three-year cycle – Years 1 and 3 will be 'check-in' years while the Year 2 review will take a more formal, in-depth approach. Reviews will be based on an online survey, supplemented by interviews.

Survey questions were developed and approved in partnership with a Project Steering Committee including National Board Chairs.

Documentation to support good governance practice

These documents were developed, reviewed and/or updated:

- Board member manual
- new business rules for the payment of sitting fees
- *Code of conduct for Board and committee members*
- declaration of private interests framework for the National Scheme, including new procedures for declaring conflicts of interest.

Payments 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 that is required.

Table 5. Payments to Board Chairs

Range	Number of Chairs[1]	2021/22 total payments[2]
$0–$20,000	2	$26,067
$20,001–$40,000	6	$179,110
$40,001–$60,000	5	$264,534
$60,001–$80,000	1	$66,460
$80,000 plus	4	$371,443
Total	**18**	**$907,614**

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

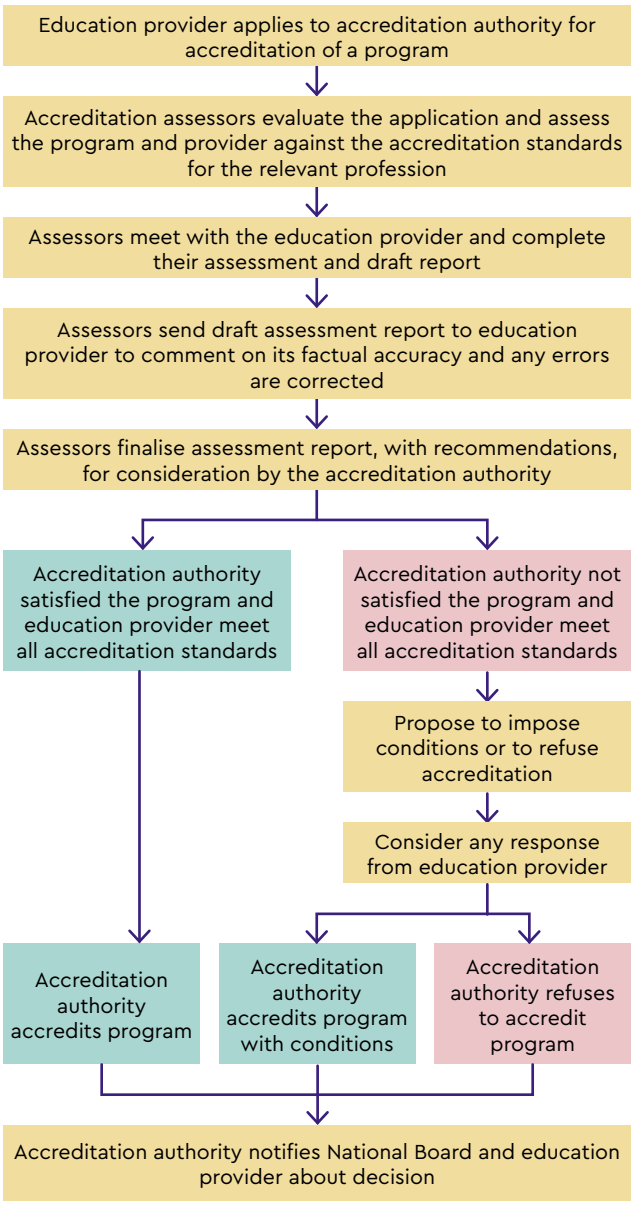
Accreditation

Accreditation helps ensure that people seeking registration are suitably trained, qualified and competent to practise as health practitioners.

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.

- More than **184,353** registered students were enrolled in approved programs.
- More than **840** programs of study were accredited and approved.
- More than **130** education providers delivered accredited and approved programs of study.
- Approved programs of study can be searched on our website.

Figure 69. The accreditation process



A new accreditation committee

In July, we established the independently chaired accreditation committee required by the Ministerial policy direction received in February 2021. This new committee of the Agency Management Committee provides independent and expert advice on accreditation reform and other accreditation matters to National Boards, accreditation authorities and Ahpra. Other external entities performing accreditation roles as part of the National Scheme, such as specialist colleges and postgraduate medical councils, take account of the committee's advice, where relevant.

The Accreditation Committee met four times; Professor Andrew Wilson is its independent chair. Its priority areas of work are supporting the future health workforce and strengthening accreditation systems. Specific deliverables reflect areas referred to the committee in Health Ministers' response to the independent review of accreditation systems in the National Scheme, *Australia's health workforce: strengthening the education foundation*.

Oversight

The Agency Management Committee provides a whole-of-scheme perspective on accreditation governance, accountability and transparency issues. This includes oversight of financial and reporting matters, and the agreements and terms of reference for accreditation authorities.

The Agency Management Committee discontinued its Accreditation Advisory Committee when the new independently chaired committee was established. Oversight of relevant accreditation matters, including governance and performance reporting, reverted to the Agency Management Committee in July.

The Accreditation Committee's work with the Agency Management Committee focused on refining the reporting requirements under the accreditation agreements and terms of reference, providing whole-of-scheme summaries of performance reports from the accreditation authorities, and preparing for the next scheduled review of accreditation arrangements that will start later in 2022.

We continued to support the Agency Management Committee to monitor and contribute to managing the broader impact of the COVID-19 pandemic and the challenges it presented for the National Scheme. This included ongoing changes to program delivery and risks of delayed course completion if students were unable to achieve the required capabilities before their expected graduation.

Funding

Nine 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 their Boards.

One National Board – Nursing and Midwifery – exercises accreditation functions related to education programs through an external council, and functions related to assessment of internationally qualified nurses and midwives (IQNM) through a committee established by the Board.

The National Boards contributed over $10 million of funding to these accreditation authorities (see Table 6).

Table 6. National Board funding contributions

Board	2021/22 $'000[1]	2020/21 $'000[1]
Aboriginal and Torres Strait Islander Health Practice	131	136
Chinese Medicine	108	91
Chiropractic	250	226
Dental	483[2]	454
Medical	3,409[3]	3,829
Medical Radiation	164	125
Nursing and Midwifery	2,938[3]	2,875[3]
Occupational Therapy	0	19
Optometry	343	333
Osteopathy	203[2]	199[3]
Paramedicine	111	291[3]
Pharmacy	749[2]	660
Physiotherapy	331	331
Podiatry	134	236[3]
Psychology	1,064	1,038
Total	**10,418**	**10,843**

1. Actual amounts. Requirements of the accounting standards may result in differences between these and the amounts in our financial statements.
2. Includes funding for accreditation-related projects.
3. Includes funding for the review of accreditation standards.

The work of the committees

Ahpra supported the accreditation committees for Aboriginal and Torres Strait Islander Health Practice, Chinese medicine, medical radiation practice, paramedicine and podiatry 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.

Ahpra supported the nursing and midwifery (assessment of IQNM) accreditation committee to oversee the outcomes-based assessment of the knowledge, clinical skills and professional attributes of internationally qualified nurses and midwives wanting to register in Australia.

Accrediting and monitoring programs

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

- 14 for Aboriginal and Torres Strait Islander Health Practice
- 9 for Chinese medicine
- 37 for medical radiation practice
- 19 for podiatry
- 1 for paramedicine with 9 accreditation assessments in progress.

The Paramedicine Accreditation Committee monitored 16 other Board-approved programs that are due to start their accreditation assessments in the next reporting year.

New and revised standards

We worked in collaboration with the Podiatry Accreditation Committee to submit proposed accreditation standards for podiatry and podiatric surgery, including endorsement for scheduled medicines, to the Podiatry Board of Australia for approval in September. These standards took effect on 1 January.

Policy and process

We supported the accreditation committees to:

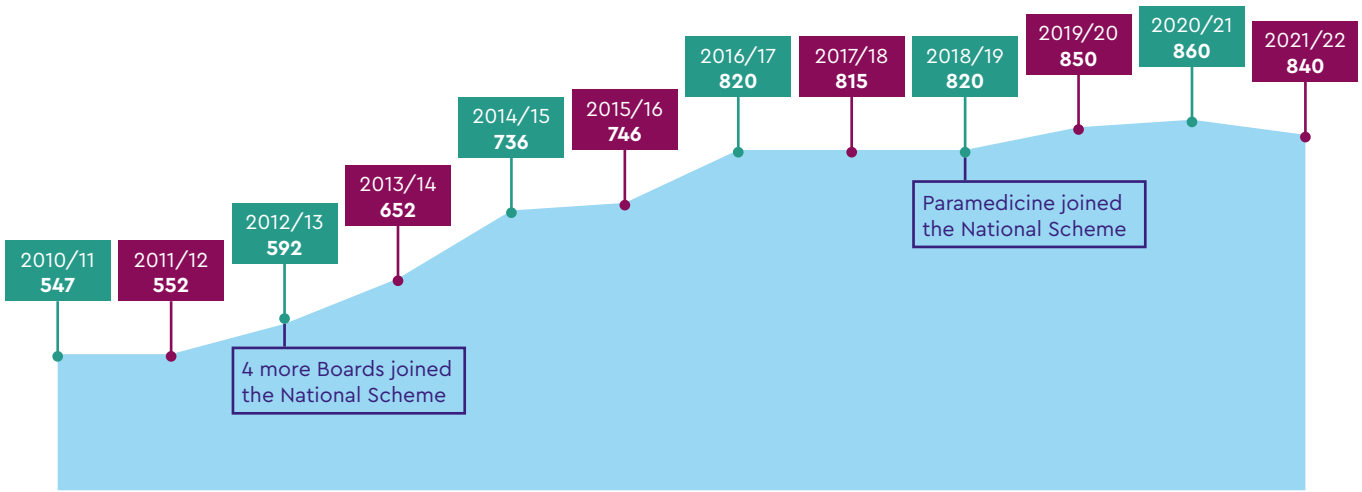
- develop and endorse *Guidelines for risk-based decision making* for implementation from 1 July 2022
- continue to implement specific monitoring to assure the relevant National Boards that all students are achieving the capabilities required for safe and competent practice before graduation, despite ongoing changes to program delivery under the COVID-19 public health orders
- continue to apply a flexible approach to monitoring education providers' compliance with accreditation standards, based on specific issues and risk profile – this flexible, risk-based model continued to enable 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 more than 100 approved programs across the five professions.

This work provides an opportunity for multiprofession approaches to accreditation.

Collaborative forum

The five 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 multiprofession and multi-entity nature and its consideration of issues affecting all accreditation entities.

Figure 70. Number of accredited courses since the National Scheme began



Registration

Snapshot

- **There are more than 850,000 registered health practitioners in Australia**
- The number of registered health practitioners grew by **3.9%** this year to **833,318** (without the inclusion of the practitioners on the pandemic response sub-register).
- Including practitioners on the sub-register, the number of registered health practitioners grew by **3.2%**, to **852,272** (see Figure 72 and Table 8).
- **97.4%** of all registered practitioners hold some form of practising registration.
- **86,558** practitioners hold specialist registration in an approved specialty.
- **25,509** practitioners hold endorsement to extend their scope of practice in a particular area because of an additional approved qualification.
- At 30 June, there were **20,781** dental practitioners, diagnostic radiographers, medical practitioners, midwives, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, podiatrists, psychologists and Aboriginal and Torres Strait Islander Health Practitioners on the 2021 pandemic response sub-register.
- The virtual education sessions we held for employers and stakeholders about the registration processes for international medical graduates led to an improvement in application documentation, timeliness and the customer experience.

Responding to the increasing pressure on Australia's health workforce was a priority, and we focused on playing our part fully.

We set up, maintained and adapted the pandemic sub-registers. National Boards adjusted some requirements to enable applicants to register or renew in the face of COVID-19 restrictions.

When borders re-opened, it was a priority to register overseas-qualified practitioners to assist governments, employers, healthcare workers and the public.

Figure 71. Registration numbers since the National Scheme began

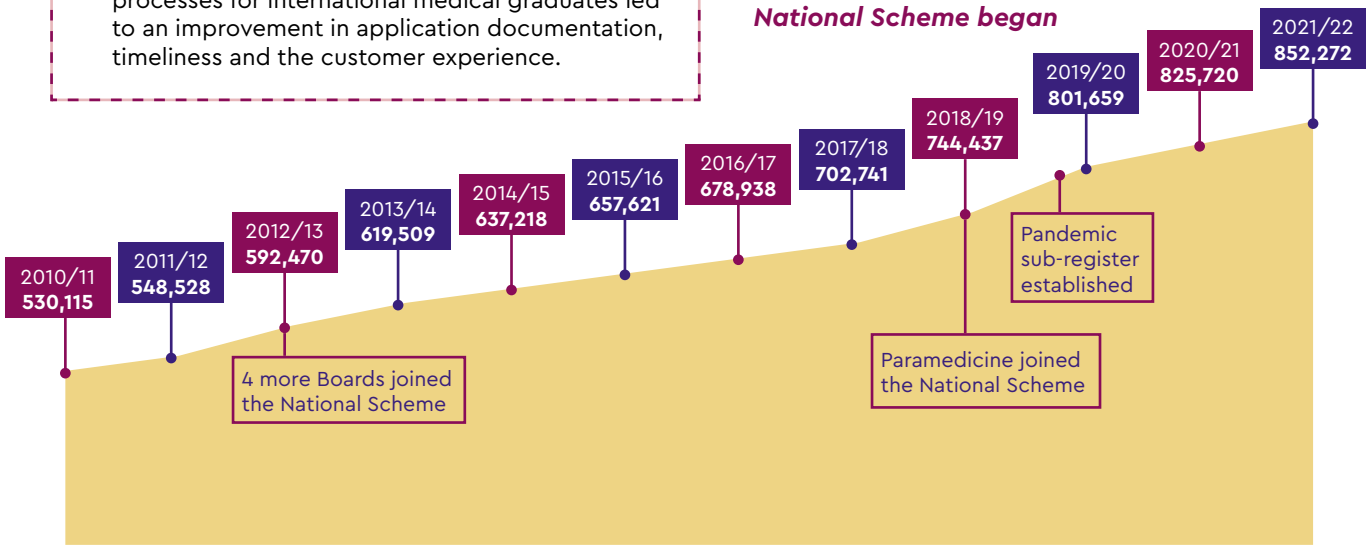
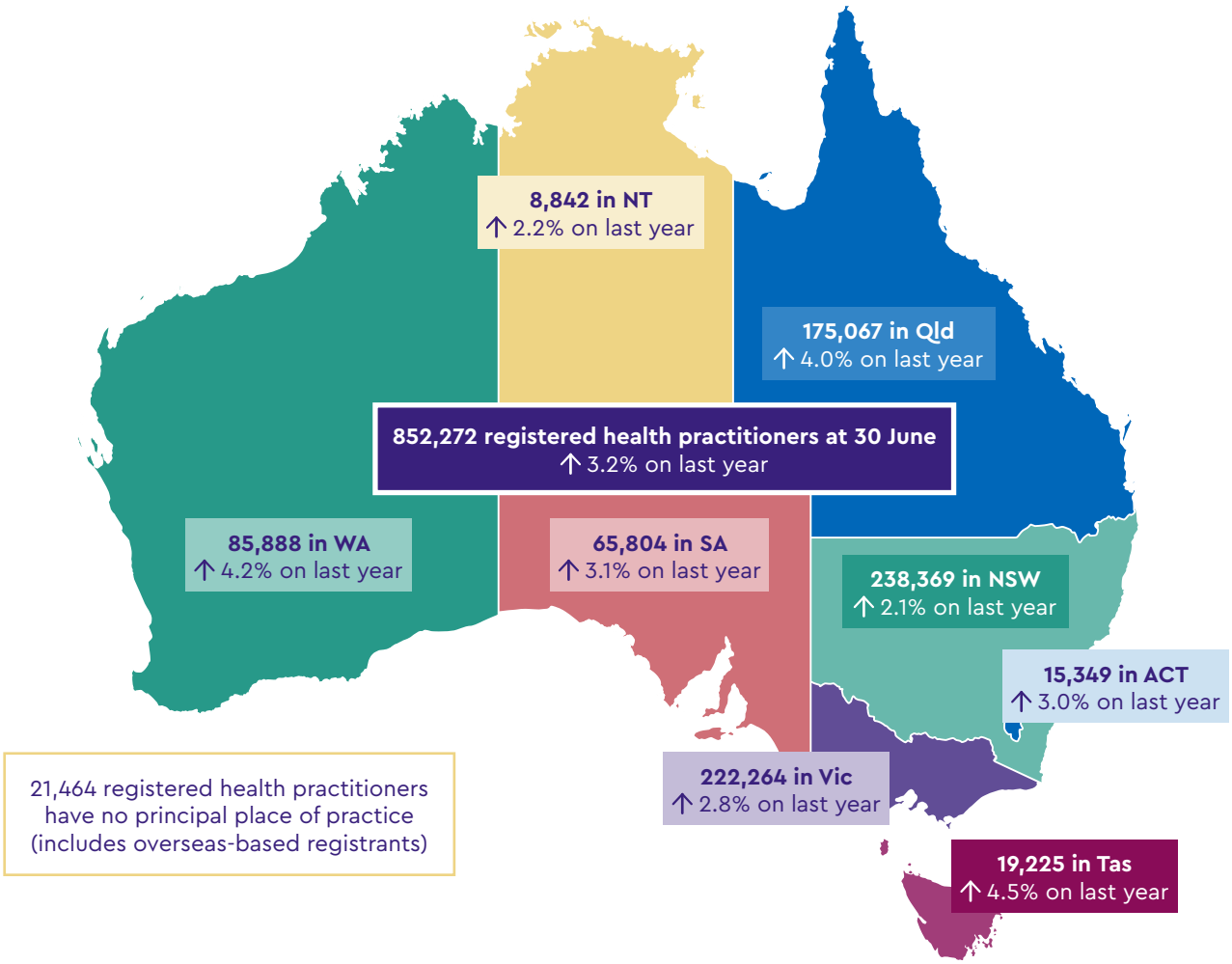


Figure 72. Health practitioners by state and territory (including pandemic sub-register)



End of year graduate survey

We successfully conducted our third graduate customer experience survey, with 29,184 registrants invited to participate in the voluntary survey and a response rate of 13.2%. Improved experience was evident across many areas, with 83.1% of all survey respondents satisfied overall with how their application was handled by Ahpra.

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.

Register of practitioners

You can check our *Register of practitioners* to see if someone is registered and if there are any special requirements on their registration.

We made the register easier to use. Changes include:

- increased prominence of the register on our websites to improve awareness of it
- improved search functionality, with predictive text and refined filters (including being able to search by gender and language spoken)
- simplified language and pop-up boxes with links to definitions of unfamiliar terms.

New graduate applications

- **44,098** applications were from new graduates, including nearly **24,340** nursing applications.
  - This is an increase from the previous year of 6.2% new graduate applications and 4.5% nursing applications.
- We received **32,861** applications for registration between mid-September and March, the peak registration period for new graduates.
  - This is a 4.1% increase from the previous year.
  - On average, the time to decide the outcome of a graduate application reduced to 6 days (from 9 days in 2020/21). We can only finish our assessment after receiving graduate lists from education providers. The time from receipt to finalisation of an application reduced to 47 days (from 52 days in 2020/21).

More than 85,000 people applied to be registered this year

All applications

- Ahpra received **85,052** applications for registration (see Table 7).
  - This is an increase of **0.5%** from last year.
- **90.8%** (77,186 applicants) sought practising registration.
- Applications for registration as a specialist in the medical profession decreased by **48.2%** from 8,931 to **4,628**.
  - Fewer applications were received because in 2020/21 we saw an increase in applications of 116.7% over the year before, due to changes to the *Health Insurance Act 1973*. Those legislation changes resulted in more specialist applications. The number of applications received this year is similar to 2019/20.

- We finalised **84,141** applications.
  - Of these, **1.9%** resulted in conditions being placed or a refusal of registration.
  - There was a **61.2%** reduction in the refusals of registration (137 this year compared to 353 last year) with only 43 nurses refused registration compared to 229 nurses last year. This was due to improvements in the assessment of overseas-qualified nurses and midwives.
- The time to decide the outcome of an application for registration was similar to last year:
  - median time of **2** days (also 2 days in 2020/21)
  - average of **20** days (17 days in 2020/21).
- After international border restrictions lifted, we had an increase in applications from overseas-qualified practitioners, some of whom had been waiting for years to come into the country. This surge of applicants increased the time taken to finalise applications.

Table 7. Applications finalised, by profession and outcome

Profession	Register	Register with conditions	Refuse application[1]	Withdrawn[2]	Total 2021/22	Total 2020/21
Aboriginal and Torres Strait Islander Health Practitioner	162	3		25	**190**	**145**
Chinese medicine practitioner	594	17	6	85	**702**	**494**
Chiropractor	421	3	3	14	**441**	**428**
Dental practitioner	1,789	28	5	85	**1,907**	**1,670**
Medical practitioner	17,496	317	45	514	**18,372**	**21,776**
Medical radiation practitioner	1,347	29	5	58	**1,439**	**1,518**
Midwife	1,879	26	5	56	**1,966**	**2,021**
Nurse	35,004	696	43	2,063	**37,806**	**36,606**
Occupational therapist	2,678	86	2	59	**2,825**	**2,540**
Optometrist	410	3		16	**429**	**403**
Osteopath	329	4	1	7	**341**	**314**
Paramedic	2,510	112	6	144	**2,772**	**2,651**
Pharmacist	3,490	57	3	70	**3,620**	**3,425**
Physiotherapist	3,574	20	2	140	**3,736**	**3,440**
Podiatrist	343	7		20	**370**	**389**
Psychologist	6,910	44	11	260	**7,225**	**6,412**
Total 2021/22	**78,936**	**1,452**	**137**	**3,616**	**84,141**	
Total 2020/21	**77,951**	**1,555**	**353**	**4,373**		**84,232**

1. If an applicant cannot demonstrate that they meet the eligibility, suitability and/or qualification requirements of the relevant National Board, their application will be refused.
2. If an application for registration is withdrawn by the applicant before a final decision is made, it is counted as withdrawn.

A service for employers to check registration

A total of 142 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.

How registration works

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.

Figure 73 shows how we decide an application for general registration.

Figure 73. The general registration process

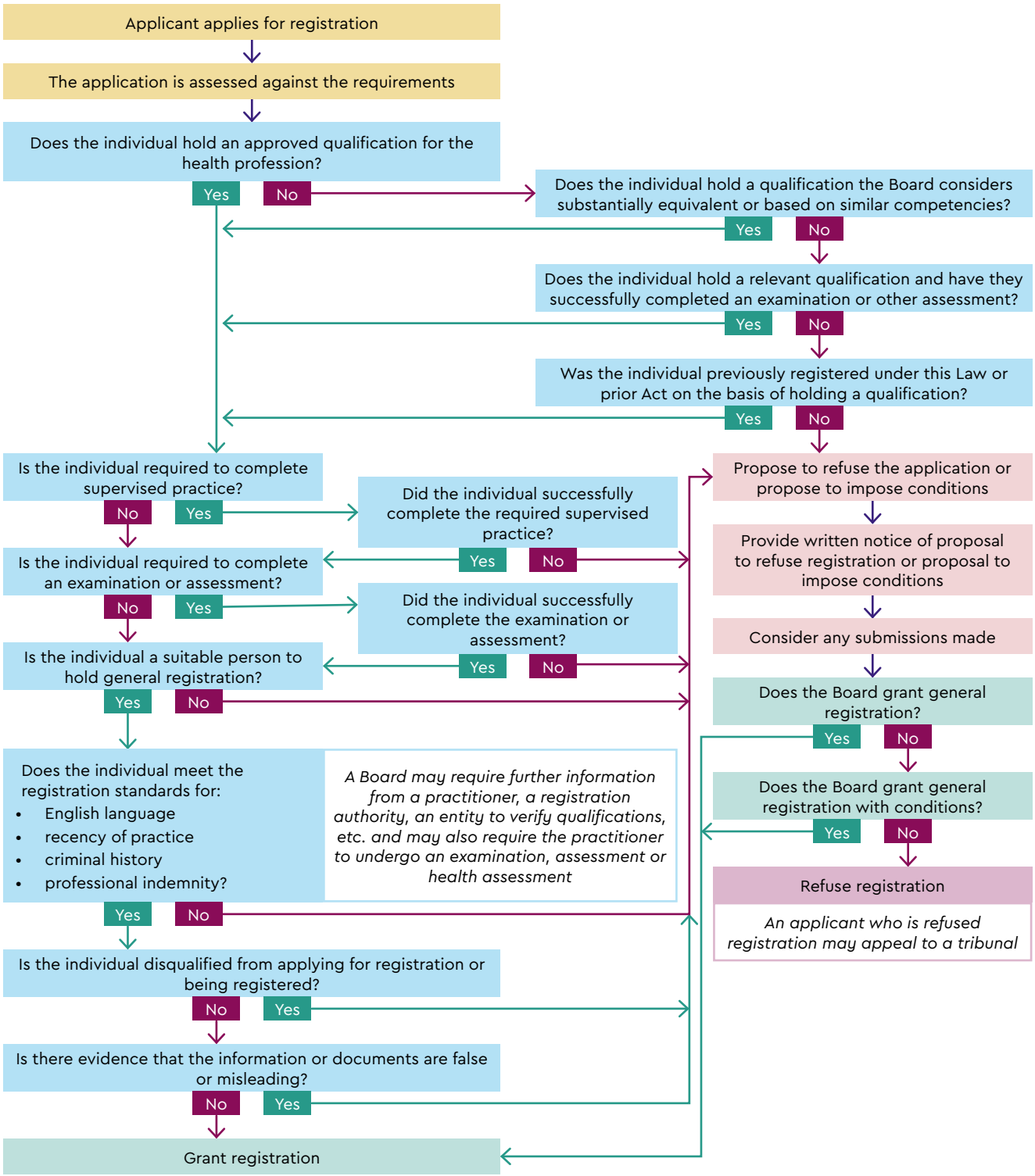


Table 8. Registered health practitioners (including pandemic sub-register), 30 June

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[1]	Total 2021/22[2]	Total 2020/21[2]	% Change 2020/21–2021/22
Aboriginal and Torres Strait Islander Health Practitioner	1	208	206	161	94	2	38	176		**886**	**829**	**6.9%**
Chinese medicine practitioner	67	1,941	12	885	203	46	1,297	267	121	**4,839**	**4,863**	**-0.5%**
Chiropractor	69	2,041	25	983	374	68	1,585	809	193	**6,147**	**5,968**	**3.0%**
Dental practitioner	472	7,677	177	5,312	2,135	432	6,233	2,970	630	**26,038**	**24,984**	**4.2%**
Medical practitioner	2,515	39,368	1,555	26,731	9,246	2,941	32,901	13,549	3,147	**131,953**	**129,066**	**2.2%**
Medical radiation practitioner	337	6,148	141	3,877	1,459	379	4,399	1,607	254	**18,601**	**17,844**	**4.2%**
Midwife	242	1,766	118	1,694	862	71	1,674	523	211	**7,161**	**6,785**	**5.5%**
Nurse	7,412	117,168	4,779	92,357	37,089	10,941	115,602	43,410	13,133	**441,891**	**429,258**	**2.9%**
Nurse and midwife[3]	486	7,657	487	5,822	1,809	662	7,987	2,933	252	**28,095**	**29,248**	**-3.9%**
Occupational therapist	465	7,463	237	5,635	2,207	399	7,070	3,794	396	**27,666**	**25,632**	**7.9%**
Optometrist	111	2,101	35	1,320	426	112	1,738	507	150	**6,500**	**6,288**	**3.4%**
Osteopath	46	651	6	303	48	54	1,919	66	54	**3,147**	**2,951**	**6.6%**
Paramedic	337	5,930	217	5,838	1,489	668	6,670	1,606	298	**23,053**	**21,492**	**7.3%**
Pharmacist	723	10,440	279	7,004	2,498	890	9,158	3,807	569	**35,368**	**35,262**	**0.3%**
Physiotherapist	821	11,586	244	7,877	3,134	643	9,742	4,597	1,374	**40,018**	**37,650**	**6.3%**
Podiatrist	82	1,685	36	1,049	554	124	1,857	533	72	**5,992**	**5,783**	**3.6%**
Psychologist	1,163	14,539	288	8,219	2,177	793	12,394	4,734	610	**44,917**	**41,817**	**7.4%**
Total 2021/22	**15,349**	**238,369**	**8,842**	**175,067**	**65,804**	**19,225**	**222,264**	**85,888**	**21,464**	**852,272**		**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**	

Table 8A. Registered health practitioners (excluding pandemic sub-register), 30 June

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[1]	Total 2021/22	Total 2020/21	% Change 2020/21–2021/22
Aboriginal and Torres Strait Islander Health Practitioner	1	199	203	159	94	2	38	170		**866**	**807**	**7.3%**
Chinese medicine practitioner	67	1,941	12	885	203	46	1,297	267	121	**4,839**	**4,863**	**-0.5%**
Chiropractor	69	2,041	25	983	374	68	1,585	809	193	**6,147**	**5,968**	**3.0%**
Dental practitioner	464	7,588	171	5,257	2,101	428	6,160	2,942	627	**25,738**	**24,984**	**3.0%**
Medical practitioner	2,491	38,973	1,543	26,470	9,119	2,897	32,556	13,400	3,138	**130,587**	**125,915**	**3.7%**
Medical radiation practitioner	331	6,075	141	3,827	1,446	375	4,341	1,588	250	**18,374**	**17,843**	**3.0%**
Midwife	241	1,750	114	1,664	849	71	1,642	518	209	**7,058**	**6,604**	**6.9%**
Nurse	7,209	113,415	4,671	89,518	35,810	10,634	112,118	42,016	12,967	**428,358**	**413,047**	**3.7%**
Nurse and midwife[3]	445	7,148	470	5,445	1,647	616	7,574	2,771	247	**26,363**	**26,620**	**-1.0%**
Occupational therapist	456	7,383	235	5,609	2,190	394	7,021	3,753	394	**27,435**	**25,632**	**7.0%**
Optometrist	110	2,092	35	1,309	421	112	1,731	505	150	**6,465**	**6,288**	**2.8%**
Osteopath	46	651	6	303	48	54	1,919	66	54	**3,147**	**2,951**	**6.6%**
Paramedic	337	5,930	217	5,838	1,489	668	6,670	1,606	298	**23,053**	**21,492**	**7.3%**
Pharmacist	718	10,210	277	6,875	2,446	879	9,010	3,746	565	**34,726**	**33,498**	**3.7%**
Physiotherapist	812	11,491	243	7,826	3,111	633	9,663	4,558	1,365	**39,702**	**37,643**	**5.5%**
Podiatrist	82	1,659	36	1,032	548	124	1,838	529	71	**5,919**	**5,783**	**2.4%**
Psychologist	1,149	14,410	286	8,162	2,152	786	12,300	4,686	610	**44,541**	**41,812**	**6.5%**
Total 2021/22	**15,028**	**232,956**	**8,685**	**171,162**	**64,048**	**18,787**	**217,463**	**83,930**	**21,259**	**833,318**		**3.9%**
Total 2020/21	**14,496**	**226,553**	**8,429**	**163,282**	**61,536**	**17,796**	**210,251**	**79,710**	**19,697**		**801,750**	

1. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
2. Includes practitioners registered on the temporary pandemic sub-register.
3. Registrants who hold dual registration as both a nurse and a midwife.

Criminal history checks

We check every applicant's criminal history before they are registered

- **75,543** results received from domestic and international criminal history checks of practitioners and/or applicants (see Table 9).
  - **8.6%** increase (compared with 69,571 in 2020/21).
- **3.8%** indicated a disclosable court outcome. Of these, only a few were serious enough to affect a practitioner's registration:
  - 15 cases where the check resulted in registration being granted with conditions
  - 6 cases where the check resulted in refusal to grant registration.

Table 9. Criminal history checks and disclosable court outcomes

State/territory[1]	2021/22		2020/21	
	Number of criminal history checks[2]	Number of disclosable court outcomes	Number of criminal history checks[2]	Number of disclosable court outcomes
ACT	1,473	43	1,504	37
NSW	19,015	770	18,584	680
NT	759	39	695	44
QLD	14,510	561	13,221	521
SA	6,303	253	5,414	260
TAS[3]	1,590	296	1,424	300
VIC	18,715	491	17,369	461
WA	8,366	430	6,943	401
No PPP[4]	4,812	16	4,417	19
Total 2021/22	**75,543**	**2,899**		
Total 2020/21			**69,571**	**2,723**

1. Data are by principal place of practice.
2. Refers to both domestic and international criminal history checks submitted.
3. 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.
4. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.

International applicants

The number of new registration applications received from overseas-qualified applicants is trending upwards and has shown a bounce back to pre-pandemic figures.

- We received 3,536 applications from international medical graduates (IMGs), a 39.7% increase on the 2,531 applications received last year.
- We received 2,373 applications from overseas-qualified practitioners across the allied health professions, which is 51.7% higher than the 1,564 applications received last year.
- We received 2,015 applications from overseas-qualified nurses and midwives. Internationally qualified nurses and midwives are now required to take an online qualification assessment to identify their pathway to registration.

Presenting in person

For registration to be granted, international applicants must present in person to prove their identity. In January 2022, international borders opened and applicants could resume travel to Australia. As part of our public safety measures during the COVID-19 pandemic, applicants were able to present in person at their intended place of employment (or education provider for postgraduate study) to prove their identity, rather than at an Ahpra office.

Applicants without an intended employer, or those who were unable to present at their intended place of employment due to border travel restrictions, could not complete this requirement. In response, we implemented a new process, which allowed applicants to virtually present in person via an online platform with an Ahpra staff member or with their employer. The virtual present-in-person process can only take place once the applicant is in Australia.

IMG employer virtual education sessions

During April and May, Ahpra delivered 10 virtual education sessions to employers and stakeholders in every state and a combined session for the territories. These sessions aimed to increase the knowledge and understanding of complex IMG registration processes and saw an improvement in application documentation, timeliness and the customer experience.

We continue to work with jurisdictions and provide advice on complex registration processes for overseas-qualified practitioners, including IMG pathways to registration and the IQNM qualification assessment process. This supports employers who are targeting recruitment of overseas-qualified practitioners to increase the health workforce and ease pressure on stretched health services.

Some applicants sit an exam

Internationally qualified nurses and midwives

IQNMs who wish to apply for registration in Australia are required to complete an online assessment of their qualification/s. 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 (MCQ) examination (knowledge test)
- an objective structured clinical examination (OSCE) (behavioural test).

The MCQ examinations are:

- Enrolled nurse – a paper-based exam coordinated by Ahpra and conducted at our offices around Australia.
- Registered nurse – the online 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; 3,390 candidates sat the exam (including re-sits).
- Midwife – an online exam conducted at Aspeq-managed facilities in Australia, New Zealand and internationally; 20 candidates sat the exam.

This year, 533 internationally qualified registered nurses participated in the registered nurse OSCE. The enrolled nurse OSCE and a midwife OSCE were held throughout the year.

Conducting all these exams has, to varying extents, been affected by restrictions related to the COVID-19 pandemic and border restrictions. The backlog of IQNs whose assessment was delayed by border closures has since been cleared and we continue to monitor the situation and respond accordingly.

Pharmacy, psychology, medical radiation practice exams

Ahpra coordinated the following exams:

- 1,691 pharmacy interns were assessed in the oral examination (practice) in October, February and June. All candidates sat the exam online in February due to COVID-19 restrictions. October and June saw a hybrid of online and face-to-face exams.
- 66 oral exams were held for pharmacy practitioners holding limited or general registration with conditions on their registration that required the completion of an examination in practice, or in law and ethics. These exams were offered monthly.
- 1,217 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.
- 61 candidates sat the quarterly national medical radiation practice examination. These exams were also offered by dual delivery, in a test centre or online.

Chinese Medicine Board regulatory exams

Following the pilot of a multiple-choice exam in 2021, 11 candidates sat the scenario-based multiple-choice exam. It was offered by dual delivery, meaning candidates could choose to sit the exam in a test centre (where available) or by online supervision. Candidates must successfully pass the multiple-choice exam to be eligible to take the objective structured clinical examination (OSCE). The OSCE was not held in 2021/22.

'The landscape is changing and we are making improvements and trying to be more culturally safe and aware, and embedding that in how we work.

Not just within our team but outwardly as well, and then looking at how that flows down to registration, our programs of study, how we communicate with people who are making notifications.'

Staff member

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.

Aboriginal and Torres Strait Islander Peoples in the workforce

Aboriginal and Torres Strait Islander Peoples are under-represented in our health workforce – this is something we are working with others to change

Based on the annual workforce survey results:

- Aboriginal and/or Torres Strait Islander Peoples' participation in the regulated health professions was **1.2%**.
- This is well short of the **3.2%** Aboriginal and Torres Strait Islander representation in the general population
- **100%** of Aboriginal and Torres Strait Islander Health Practitioners are Aboriginal and/or Torres Strait Islander. It is a requirement for registration in that profession.
- Paramedicine had the second highest representation with **1.8%** of their workforce identifying as Aboriginal and/or Torres Strait Islander.
- Midwifery (including dual-registered midwives and nurses) was next with **1.5%**, closely followed by nursing (including dual-registered) with **1.4%**.

Ahpra and the National Boards ask about Aboriginal and/or Torres Strait Islander cultural identity in various application and renewal processes. This enables a more comprehensive understanding of workforce trends and the proportion of the registrant base that identifies as Aboriginal and/or Torres Strait Islander across all health professions.

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

Survey participants who identified as Aboriginal and/or Torres Strait Islander graduates (1.8%) suggested:

- an Aboriginal and/or Torres Strait Islander Liaison Officer as an alternative contact
- more engagement in the registration process with Aboriginal and/or Torres Strait Islander students through their education providers.

Increasing participation in the registered health workforce is a goal of our Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. As one of the steps to help achieve this goal, we created seven identified positions in Registration, Research and Evaluation, Statutory Appointments and our Health Strategy Unit.

Table 10. Health practitioners who identified as Aboriginal and/or Torres Strait Islander, 2015 to 2021

Profession	Registrants[1]							
	2015	%	2017	%	2019	%	2021[2]	%
Aboriginal and Torres Strait Islander Health Practitioner[3]	514	100.0%	584	100.0%	670	100.0%	792	100.0%
Chinese medicine practitioner	19	0.4%	15	0.3%	21	0.4%	24	0.5%
Chiropractor	17	0.3%	25	0.5%	23	0.4%	45	0.8%
Dental practitioner	73	0.3%	98	0.4%	121	0.5%	150	0.6%
Medical practitioner	302	0.3%	399	0.4%	519	0.4%	604	0.5%
Medical radiation practitioner	64	0.4%	80	0.5%	114	0.7%	134	0.7%
Nurse and midwife	3,428	1.0%	4,136	1.1%	5,094	1.3%	6,160	1.4%
Nurse (including dual registered)	3,374	0.9%	4,053	1.1%	4,982	1.2%	6,025	1.4%
Midwife (including dual registered)	304	0.9%	336	1.0%	417	1.3%	486	1.5%
Occupational therapist	76	0.4%	89	0.4%	137	0.6%	201	0.7%
Optometrist	16	0.3%	11	0.2%	12	0.2%	16	0.3%
Osteopath	16	0.8%	17	0.7%	18	0.7%	18	0.6%
Paramedic					287	1.6%	409	1.8%
Pharmacist	68	0.2%	79	0.3%	98	0.3%	108	0.3%
Physiotherapist	142	0.5%	191	0.6%	239	0.7%	277	0.7%
Podiatrist	30	0.7%	30	0.6%	38	0.7%	48	0.8%
Psychologist	167	0.5%	199	0.6%	246	0.7%	289	0.7%
Total of overall health workforce[4]	**4,932**	**0.8%**	**5,953**	**0.9%**	**7,637**	**1.0%**	**9,275**	**1.2%**

Source: National Health Workforce Data Set (NHWDS) medical practitioners, nursing and midwifery, allied health, 2015–21

1. Practitioners who identified as being born in Australia and Aboriginal and/or Torres Strait Islander in a workforce survey conducted at renewal of registration.
2. Other than for nurses and midwives, 2021 figures are preliminary and may be subject to change.
3. The number in Table 10 is different from Table 8 due to when the data were extracted.
4. 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.

Response to workforce pressures – the pandemic sub-registers

The COVID-19 pandemic put Australia's health workforce under immense pressure. Following the request of Australia's Health Ministers for more experienced and qualified health practitioners to quickly return to practice, Ahpra and the National Boards established the 2020 pandemic sub-register.

In April 2021, this sub-register was extended to enable medical practitioners, nurses, midwives, pharmacists and Aboriginal and Torres Strait Islander Health Practitioners to help with the COVID-19 vaccination program.

In September 2021, the registration of practitioners was changed so they could work in any area supporting the COVID-19 response, not just vaccinations. We took this action in response to a request from states and territories for additional surge health workforce capacity to address the demand for practitioners due to the pandemic.

'We worked closely with jurisdictions and other stakeholders to connect people on the sub-register to specific jobs where they were needed, whether that was vaccination clinics, close contact teams or just an additional nurse within a country GP practice.'

Staff member

Also in September, Ahpra and the National Boards established a new sub-register (the 2021 sub-register), enabling practitioners from 12 regulated health professions to return to practice for up to 12 months, able to work to the full scope of their registration (subject to any notations).

The 2020 and 2021 sub-registers ran in parallel for a short time, until the 2020 sub-register closed on 5 April 2022. Practitioners on this sub-register either returned to their prior registration status (non-practising registration or unregistered), opted in to extend their temporary registration and be on the 2021 sub-register or applied to transition to the main *Register of practitioners*.

Renewals

Each year when they renew, health practitioners are required to make declarations and disclosures

- Ahpra renewed registration for **765,078** practitioners.
- **99.9%** of all eligible practitioners renewed online.

We made several changes to the renewals process:

- For the first time we asked practitioners whether they identify as Aboriginal and/or Torres Strait Islander. We will use this information to help us continue to develop culturally safe ways of working.
- We continued to review and update renewal information and the renewal questions on the online form to help practitioners better understand what they need to do to renew their registration.
- Timeframes for decision-making about declarations made by practitioners when renewing improved due to continued review and improvement of the initial risk-assessment model.
- For the first time, health practitioners who were yet to renew close to the cut-off date were sent text-message reminders in an effort to ensure continuity of registration. This SMS campaign resulted in a marked reduction in the number of practitioners who failed to renew and, therefore, reduced the number of fast-track applications received in the month following the end of the campaign.
- Boards continued to be flexible with health practitioners who had trouble meeting continuing professional development requirements because of the COVID-19 pandemic.
- We moved renewals from hard copy to online lodgement. This change helped improve assessment timeframes for practitioners by reducing unnecessary delays due to inaccuracies and time required to mail information. To accommodate practitioners who were unable to access the online platform for renewal, a verbal submission process was implemented. Fewer than 20 health practitioners accessed this service, and successfully finalised their applications for renewal.
- To help improve timeframes for renewals applications, we removed BPAY as a payment option. Online card payments are faster to process, which speeds up the renewals process.

Registered students

Education providers supply student information so students can be registered

Students are the health practitioners of the future

- **184,353** students were studying to be health practitioners through an approved program of study or clinical training program.

All National Boards except the Psychology Board register students. Psychology students receive provisional registration.

The student register isn't public.

Table 11. 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 2021/22[4,5]	Total 2020/21
Aboriginal and Torres Strait Islander Health Practice	322		**322**	**585**
Chinese medicine	1,574		**1,574**	**1,528**
Chiropractic	2,038	65	**2,103**	**2,322[6]**
Dental	4,613		**4,613**	**4,531**
Medical	20,835	45	**20,880**	**20,942**
Medical radiation practice	4,620	422	**5,042**	**5,192**
Midwifery[7]	4,006		**4,006**	**4,129**
Nursing[7]	103,025	525	**103,550**	**110,031**
Occupational therapy	10,566		**10,566**	**10,141**
Optometry	2,219	145	**2,364**	**1,756**
Osteopathy	1,465		**1,465**	**1,481**
Paramedicine[7]	7,897	18	**7,915**	**8,454**
Pharmacy	7,722		**7,722**	**7,298**
Physiotherapy	10,818	289	**11,107**	**10,144**
Podiatry	1,124		**1,124**	**1,280**
Total 2021/22	**182,844**	**1,509**	**184,353**	
Total 2020/21	**188,431**	**1,383**		**189,814[8]**

1. The number of students reported as undertaking an approved program of study/clinical training program (accurate at 30 June and does not account for fluctuations throughout 2021/22). 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. A course that has been approved by a National Board and that leads to a qualification for registration.
3. Clinical training is 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 processes, these data should not be objectively compared to previous years.
5. These 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.
6. This figure was incorrectly shown as 2,294 in the 2020/21 annual report.
7. To avoid double-counting, 3,337 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 [1,903]/midwifery [170] and nursing [1,264]/paramedicine [0]).
8. This figure was incorrectly shown as 189,786 in the 2020/21 annual report.

Audits

We audit practitioners to check that they comply with registration standards – the overwhelming majority do comply

Ahpra conducts regular audits of health practitioners on behalf of the National Boards. Our auditing provides additional assurance to the public, Boards and practitioners that registration requirements are understood and that practitioners are meeting required Board standards.

Since we began conducting audits, in 2012, most audited practitioners have been found to comply with registration standards.

Audit results

Routine audits resumed this year after being affected by COVID-19 in 2020/21. We completed 8,155 audits.

Figure 74. Audit outcomes

Some of the 1.48% with no audit action were because:

- 0.71% of practitioners 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
- 0.56% were referred to a co-regulatory jurisdiction to manage, to determine whether any further regulatory action was required.

How our audit process works

Registered practitioners are required to comply with a range of national standards. Each time a practitioner applies to renew their registration they must make a declaration that they have met the registration standards for their profession. During an audit, a practitioner is required to provide evidence to support the declarations made in the previous year's renewal of registration.

The standards that may be audited are:

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

All Boards have adopted an educational approach to conducting audits, seeking to balance the protection of the public with the use of appropriate regulatory force to manage those practitioners found to be less than fully compliant. Practitioners who are found to have not quite met the registration standard but who are able to provide evidence of achieving full compliance during the audit period are managed through education to achieve full compliance.

These practitioners are recorded as being 'compliant (education)' – these cases represented 0.02% of completed audits.

Compliance with registration standards

When an audit finds that a practitioner has not met the requirements of the registration standards, all Boards follow an approach that aims to work with the practitioner to ensure compliance before the next renewal period. This may include formally cautioning the practitioner about the importance of complying with registration standards.

All matters that involve issuing a caution or placing conditions on a registration are subject to a 'show cause' process. This process alerts the practitioner to the intended action and gives them an opportunity to respond before a decision is made.

Of the practitioners found to be non-compliant in 2021/22, 12 matters were referred to investigation, two resulted in some form of regulatory action being taken (such as cautions and imposition of conditions), and five resulted in no further action. In the 'no further action' matters, additional information was received from the practitioner that identified there was no risk to the public.

Notifications

Every registered practitioner is expected to behave safely and professionally.

We responded to more than **10,800** individual notifications, up 6.5% on last year.

Good outcomes of notifications are when we:

- confirm that the practitioner is practising safely and professionally and that we don't need to do anything
- help a practitioner improve their practice in line with concerns raised by a notifier, and ensure they commit to making those improvements
- have communicated with a notifier in a way that helps them understand the regulatory process and the reason for the outcome, and feel their concern was taken seriously
- encourage a practitioner with a health issue to seek support and care from another health practitioner.

If these outcomes are not possible, we can take regulatory actions that require a practitioner to:

- improve the standard of their behaviour or practice; for example, by undertaking training, supervision or mentoring
- take steps to manage a health impairment if it is compromising patient safety.

These more serious outcomes are achieved by us accepting an undertaking or imposing conditions on a practitioner's registration. The most serious matters are referred to tribunals.

How do we ensure that patients can trust practitioners and are safe in their care?

Patients, members of the public, employers and other practitioners sometimes encounter a practitioner who they believe is not practising safely or acting professionally.

Anyone can make a notification to Ahpra if they think a practitioner is practising unsafely. They can also tell us if they think the practitioner has a health impairment that is affecting their ability to practise professionally and safely and that poses a substantial risk to the public.

Notifications help us to identify:

- individual practitioners or students who need support or regulatory action to practise safely and professionally
- individual practitioners whose behaviour requires referral to a tribunal for disciplinary action
- barriers to safe professional practice that can be addressed by standards, codes and guidelines published by National Boards.

Notifications range in seriousness and we have developed different strategies to deal with them. We focus on improving safety and professionalism in the delivery of healthcare. We work with practitioners, employers, health services and other regulators to ensure that all registered practitioners are providing care to patients that is safe and professional.

Explaining the data

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

Who manages notifications?

If a practitioner is practising in New South Wales, Norfolk Island, Christmas Island or Antarctica, we cannot manage a notification about them. The Health Professional Councils Authority (HPCA) and the Health Care Complaints Commission (HCCC) manage complaints and concerns about practitioners in NSW. The Office of the Health Ombudsman (OHO) receives notifications about registered and unregistered practitioners in Queensland. We manage notifications about registered health practitioners if they are referred to us by OHO or if, under the new joint consideration process, they are assigned to us.

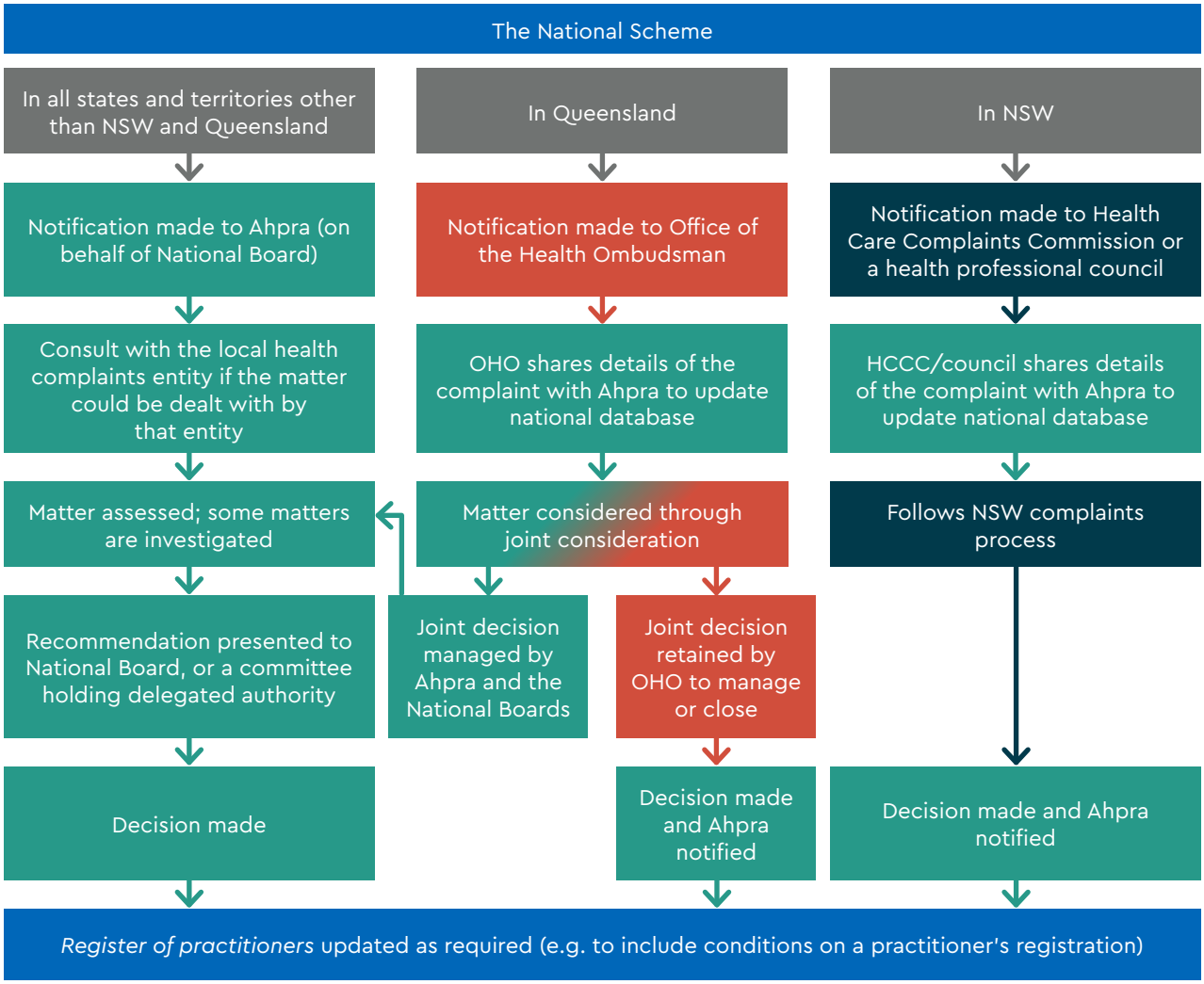
On 6 December, following an amendment to the National Law, Ahpra and OHO began jointly considering notifications in Queensland. Together we considered more than 2,100 new notifications, and just over half of those were referred to Ahpra to manage.

OHO closed more than 700 notifications about registered health practitioners following joint consideration, after agreeing with Ahpra that the concerns raised were not likely to result in regulatory action. A further 282 notifications were retained by OHO for further action; for example, investigation or other complaints-resolution activities.

The average time from OHO receiving the notification to the completion of the joint consideration process was 12 calendar days. This meant that, for matters that were retained by OHO to close, notifiers and practitioners were advised of the outcome in a significantly more timely way than was possible before joint consideration.

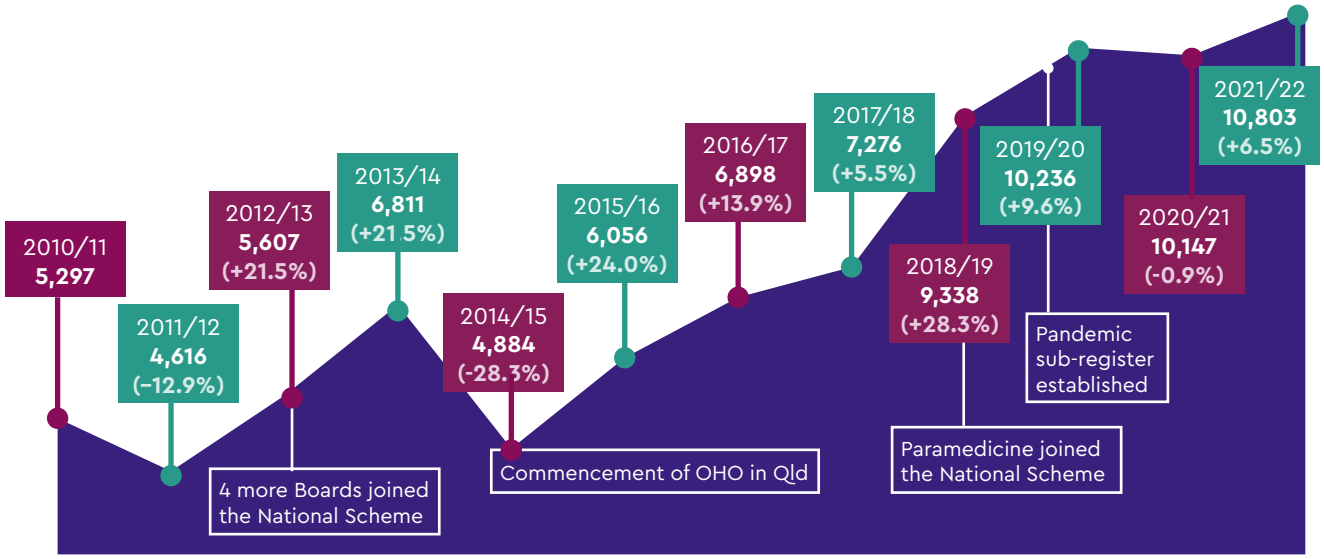
The notification process for NSW, Queensland and the other states and territories is outlined in Figure 75.

Figure 75. Notification process in each state and territory



How many notifications were made?

Figure 76. Notifications received by Ahpra since the National Scheme began



There were 18,710 notifications made about 14,313 practitioners across all jurisdictions. That's 1.7% of all registered health practitioners in Australia, and an increase of 6.2% from 2020/21. Some practitioners received more than one notification. Table 12 shows the number of notifications received and Table 13 gives the number of practitioners with notifications.

Tables 14 and 14A show the percentages of registered practitioners with notifications made about them.

Table 12. Notifications received, by profession and state or territory

Profession	Ahpra[1]									Ahpra subtotal	HPCA[5]	OHO[6]	Total 2021/22[7]	Total 2020/21[7]
	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]					
Aboriginal and Torres Strait Islander Health Practitioner			3	4				3		**10**	**1**	**1**	**12**	**10**
Chinese medicine practitioner	4			14	5		16	6		**45**	**27**	**4**	**76**	**64**
Chiropractor	3	1	1	38	9	5	75	9	1	**142**	**56**	**16**	**214**	**186**
Dental practitioner	16	5	2	174	75	21	268	139	25	**725**	**399**	**125**	**1,249**	**1,350**
Medical practitioner	212	64	80	1,378	623	159	2,540	889	231	**6,176**	**3,312**	**1,385**	**10,873**	**9,798**
Medical radiation practitioner				16	1	1	14	6	3	**41**	**25**	**4**	**70**	**55**
Midwife	3	1	5	43	13		29	10	9	**113**	**29**	**5**	**147**	**183**
Nurse	31	23	44	583	260	73	520	243	163	**1,940**	**834**	**196**	**2,970**	**3,283**
Occupational therapist	3	1		14	6	5	31	14	2	**76**	**53**	**13**	**142**	**135**
Optometrist	2		1	8	1	1	16	4	2	**35**	**25**	**8**	**68**	**55**
Osteopath	4			7	2		24	1	3	**41**	**17**	**10**	**68**	**35**
Paramedic	2	1	6	61	14	6	34	11	17	**152**	**124**	**20**	**296**	**290**
Pharmacist	7	1	2	87	44	14	168	54	94	**471**	**518**	**59**	**1,048**	**925**
Physiotherapist	3	1	1	30	10	6	59	20	6	**136**	**64**	**27**	**227**	**250**
Podiatrist				13	3	1	29	17		**63**	**30**	**9**	**102**	**79**
Psychologist	22	10	7	152	45	12	269	104	16	**637**	**366**	**145**	**1,148**	**1,148**
Total 2021/22	**312**	**108**	**152**	**2,622**	**1,111**	**304**	**4,092**	**1,530**	**572**	**10,803**	**5,880**	**2,027**	**18,710**	
Total 2020/21	**273**	**117**	**144**	**2,630**	**1,096**	**306**	**3,676**	**1,210**	**695**	**10,147**	**5,491**	**2,208**		**17,846**

1. Based on state or territory of the practitioner's principal place of practice.
2. Matters managed by Ahpra where the conduct occurred outside NSW.
3. Matters referred by OHO, or assigned during joint consideration with OHO, and managed by Ahpra and the National Boards.
4. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
5. Matters received and managed by the HPCA in NSW.
6. Matters received and managed by OHO in Queensland.
7. Includes matters managed by the HPCA and OHO.

Table 13. 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 2021/22[5]	Total 2020/21[5]
Aboriginal and Torres Strait Islander Health Practitioner		1	3	3				3		**10**	**9**
Chinese medicine practitioner	4	21		13	3		16	6		**63**	**49**
Chiropractor	3	45	1	45	8	5	56	9	1	**173**	**140**
Dental practitioner	16	330	2	252	64	17	229	104	7	**1,021**	**1,035**
Medical practitioner	148	2,553	67	2,067	536	134	1,897	700	44	**8,146**	**7,379**
Medical radiation practitioner		23		18		1	10	5		**57**	**39**
Midwife[6]	3	26	4	47	13		28	8	2	**131**	**135**
Nurse[7]	26	627	37	655	231	64	467	219	31	**2,357**	**2,483**
Occupational therapist	2	36		26	6	4	30	13		**117**	**124**
Optometrist	2	21	1	15	1	1	16	4		**61**	**44**
Osteopath	1	14		10	2		23	1		**51**	**30**
Paramedic	2	81	5	71	9	6	24	9	6	**213**	**215**
Pharmacist	7	314	2	123	37	10	141	53	32	**719**	**634**
Physiotherapist	3	56	1	52	8	5	49	19	3	**196**	**201**
Podiatrist		24		17	3	1	28	16		**89**	**63**
Psychologist	20	288	8	227	42	12	225	85	2	**909**	**903**
Total 2021/22	**237**	**4,460**	**131**	**3,641**	**963**	**260**	**3,239**	**1,254**	**128**	**14,313**	
Total 2020/21	**231**	**4,260**	**126**	**3,453**	**970**	**280**	**3,071**	**1,063**	**29**		**13,483**

1. Numbers for each state, territory and profession are based on distinct registrants whose profession has been identified.
2. Includes matters managed by the HPCA, as well as notifications managed by Ahpra about a practitioner with a PPP in NSW.
3. Matters referred by OHO, or assigned during joint consideration with OHO, and managed by Ahpra and the National Boards.
4. No principal place of practice (No PPP) 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 both nursing and midwifery registration.
7. Includes registrants with nursing registration or with both nursing and midwifery registration.

Table 14. 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 2021/22	Total 2020/21
Aboriginal and Torres Strait Islander Health Practitioner		0.5%	1.5%	1.9%				1.7%		**1.1%**	**1.1%**
Chinese medicine practitioner	6.0%	1.1%		1.5%	1.5%		1.2%	2.2%		**1.3%**	**1.0%**
Chiropractor	4.3%	2.2%	4.0%	4.6%	2.1%	7.4%	3.5%	1.1%	0.5%	**2.8%**	**2.3%**
Dental practitioner	3.4%	4.3%	1.1%	4.7%	3.0%	3.9%	3.7%	3.5%	1.1%	**3.9%**	**4.1%**
Medical practitioner	5.9%	6.5%	4.3%	7.7%	5.8%	4.6%	5.8%	5.2%	1.4%	**6.2%**	**5.7%**
Medical radiation practitioner		0.4%		0.5%		0.3%	0.2%	0.3%		**0.3%**	**0.2%**
Midwife[5]	0.4%	0.3%	0.7%	0.6%	0.5%		0.3%	0.2%	0.4%	**0.4%**	**0.4%**
Nurse[6]	0.3%	0.5%	0.7%	0.7%	0.6%	0.6%	0.4%	0.5%	0.2%	**0.5%**	**0.5%**
Occupational therapist	0.4%	0.5%		0.5%	0.3%	1.0%	0.4%	0.3%		**0.4%**	**0.5%**
Optometrist	1.8%	1.0%	2.9%	1.1%	0.2%	0.9%	0.9%	0.8%		**0.9%**	**0.7%**
Osteopath	2.2%	2.2%		3.3%	4.2%		1.2%	1.5%		**1.6%**	**1.0%**
Paramedic	0.6%	1.4%	2.3%	1.2%	0.6%	0.9%	0.4%	0.6%	2.0%	**0.9%**	**1.0%**
Pharmacist	1.0%	3.0%	0.7%	1.8%	1.5%	1.1%	1.5%	1.4%	5.6%	**2.0%**	**1.8%**
Physiotherapist	0.4%	0.5%	0.4%	0.7%	0.3%	0.8%	0.5%	0.4%	0.2%	**0.5%**	**0.5%**
Podiatrist		1.4%		1.6%	0.5%	0.8%	1.5%	3.0%		**1.5%**	**1.1%**
Psychologist	1.7%	2.0%	2.8%	2.8%	1.9%	1.5%	1.8%	1.8%	0.3%	**2.0%**	**2.2%**
Total 2021/22	**1.5%**	**1.9%**	**1.5%**	**2.1%**	**1.5%**	**1.4%**	**1.5%**	**1.5%**	**0.6%**	**1.7%**	
Total 2020/21	**1.6%**	**1.8%**	**1.5%**	**2.1%**	**1.5%**	**1.5%**	**1.4%**	**1.3%**	**0.1%**		**1.6%**

Table 14A. 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 2021/22	Total 2020/21
Aboriginal and Torres Strait Islander Health Practitioner		0.5%	1.5%	1.9%				1.8%		**1.2%**	**1.1%**
Chinese medicine practitioner	6.0%	1.1%		1.5%	1.5%		1.2%	2.2%		**1.3%**	**1.0%**
Chiropractor	4.3%	2.2%	4.0%	4.6%	2.1%	7.4%	3.5%	1.1%	0.5%	**2.8%**	**2.3%**
Dental practitioner	3.4%	4.3%	1.2%	4.8%	3.0%	4.0%	3.7%	3.5%	1.1%	**4.0%**	**4.1%**
Medical practitioner	5.9%	6.6%	4.3%	7.8%	5.9%	4.6%	5.8%	5.2%	1.4%	**6.2%**	**5.9%**
Medical radiation practitioner		0.4%		0.5%		0.3%	0.2%	0.3%		**0.3%**	**0.2%**
Midwife[5]	0.4%	0.3%	0.7%	0.7%	0.5%		0.3%	0.2%	0.4%	**0.4%**	**0.4%**
Nurse[6]	0.3%	0.5%	0.7%	0.7%	0.6%	0.6%	0.4%	0.5%	0.2%	**0.5%**	**0.6%**
Occupational therapist	0.4%	0.5%		0.5%	0.3%	1.0%	0.4%	0.3%		**0.4%**	**0.5%**
Optometrist	1.8%	1.0%	2.9%	1.1%	0.2%	0.9%	0.9%	0.8%		**0.9%**	**0.7%**
Osteopath	2.2%	2.2%		3.3%	4.2%		1.2%	1.5%		**1.6%**	**1.0%**
Paramedic	0.6%	1.4%	2.3%	1.2%	0.6%	0.9%	0.4%	0.6%	2.0%	**0.9%**	**1.0%**
Pharmacist	1.0%	3.1%	0.7%	1.8%	1.5%	1.1%	1.6%	1.4%	5.7%	**2.1%**	**1.9%**
Physiotherapist	0.4%	0.5%	0.4%	0.7%	0.3%	0.8%	0.5%	0.4%	0.2%	**0.5%**	**0.5%**
Podiatrist		1.4%		1.6%	0.5%	0.8%	1.5%	3.0%		**1.5%**	**1.1%**
Psychologist	1.7%	2.0%	2.8%	2.8%	2.0%	1.5%	1.8%	1.8%	0.3%	**2.0%**	**2.2%**
Total 2021/22	**1.6%**	**1.9%**	**1.5%**	**2.1%**	**1.5%**	**1.4%**	**1.5%**	**1.5%**	**0.6%**	**1.7%**	
Total 2020/21	**1.6%**	**1.9%**	**1.5%**	**2.1%**	**1.6%**	**1.6%**	**1.5%**	**1.3%**	**0.1%**		**1.7%**

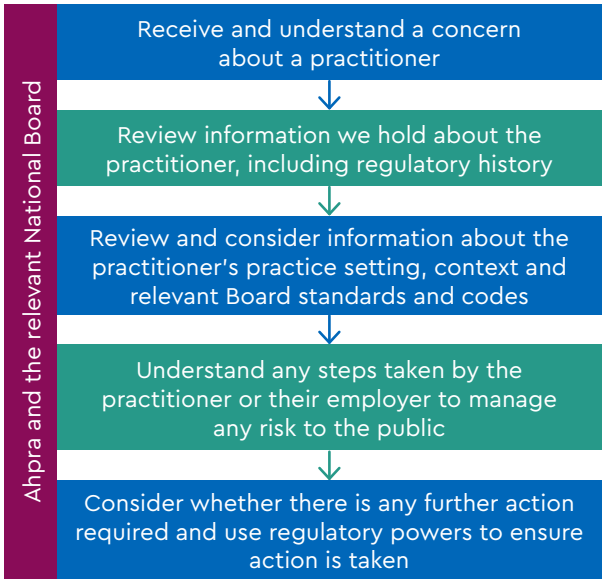
1. Numbers for each state, territory and profession are based on distinct registrants whose profession has been identified.
2. Includes matters managed by the HPCA, as well as notifications managed by Ahpra about a practitioner with a PPP in NSW.
3. Includes matters managed by OHO, as well as those referred to Ahpra by OHO about a practitioner with a PPP in Queensland.
4. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
5. Includes registrants with midwifery or with both nursing and midwifery registration.
6. Includes registrants with nursing registration or with both nursing and midwifery registration.

How notifications work

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

We are a professional standards regulator. That means we will take action where it's needed to keep patients safe in the future. We rely on the public to raise concerns. Because we are not a complaints-resolution agency, we can't help patients get a refund or an apology. Our process for managing notifications is outlined in figures 77 and 79.

Figure 77. How we manage concerns



Who makes notifications?

Figure 78 shows the sources of notifications. We received most notifications (**54.6%**) from patients, their families and friends, and other members of the public; this is slightly higher than last year (**50.8%**).

We received some notifications (**16.3%**) from health practitioners and employers.

We received **2,251** 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.

Figure 78. Who makes notifications?

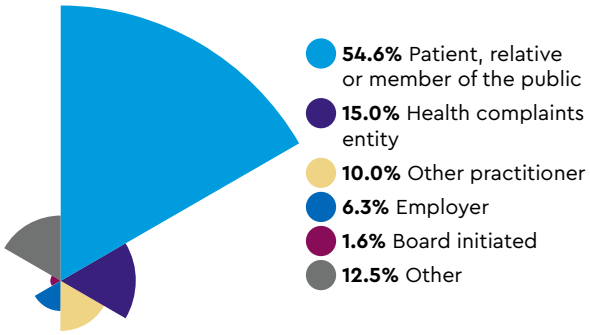
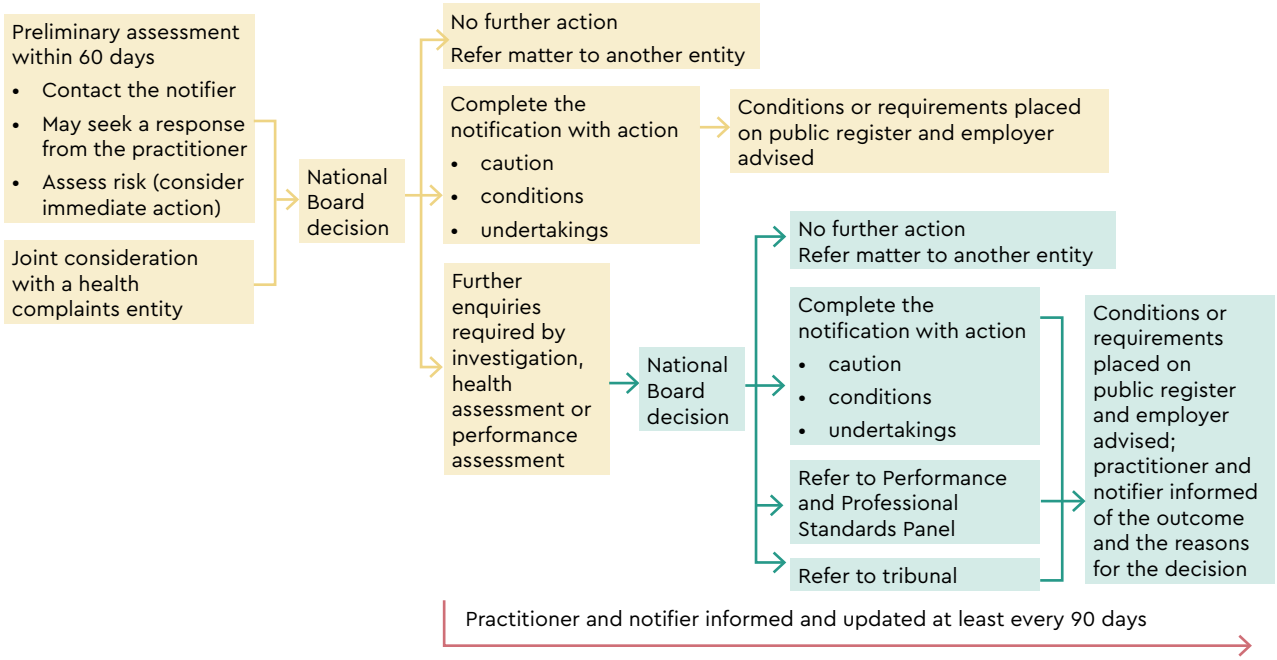


Figure 79. The notifications process



What are notifications about?

Clinical care was the most common type of complaint received either as a single concern or one of multiple concerns in a notification (see Table 16).

In 2021/22, 6,983 (**64.6%**) notifications were about a single concern, 2,520 notifications (**23.3%**) were about two concerns, and 1,300 (**12.0%**) about three or more concerns (see Table 15).

Table 15. The number of concerns raised

Number of concerns raised	Number of notifications
1	6,983
2	2,520
3–4	1,158
5–7	126
8–14	16

Table 16. The five most common concerns

Complaint category[1]	Number of times the concern was raised
Clinical care	5,229
Communication	1,848
Pharmacy/medication	1,422
Other[2]	1,067
Documentation	967

1. Either as a single concern or one of multiple concerns received in a notification.
2. Includes two concern types: 'Other conduct issue' and 'Anti-vaccination advice'.

Notifications performance

Outcomes

There are a number of possible outcomes for notifications (see tables 17 and 18). The aim is to ensure that the public is protected and that practitioners are safe to practise.

Table 17. 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 2021/22[2]	Total 2020/21[2]
Aboriginal and Torres Strait Islander Health Practitioner	5				5		1				**11**	**9**
Chinese medicine practitioner	24	3	1	1	2		5				**36**	**32**
Chiropractor	83	3	5		11		24		1	1	**128**	**80**
Dental practitioner	376	98	156	8	48		63				**749**	**757**
Medical practitioner	3,418	693	1,181	38	209		287	1	16	31	**5,874**	**5,445**
Medical radiation practitioner	18	4	4		3		5				**34**	**31**
Midwife	100	11	6	1	2		5				**125**	**116**
Nurse	1,402	81	100	16	99		162		15	21	**1,896**	**2,021**
Occupational therapist	45	11	10	1	8		9				**84**	**70**
Optometrist	14	7	7				5				**33**	**50**
Osteopath	20		1		4		5			2	**32**	**19**
Paramedic	94	2	8		14		14				**132**	**126**
Pharmacist	245	87	35	5	42		27		5	5	**451**	**476**
Physiotherapist	84	10	16	1	12		9			1	**133**	**130**
Podiatrist	25	4	9	2	5		10		1		**56**	**44**
Psychologist	367	39	52	7	34		67		2	8	**576**	**715**
Total 2021/22	**6,320**	**1,053**	**1,591**	**80**	**498**	**0**	**698**	**1**	**40**	**69**	**10,350**	
Total 2020/21	**7,193**	**354**	**1,136**	**128**	**506**	**5**	**730**	**1**	**28**	**40**		**10,121**

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 18. 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 2021/22	Total 2020/21
No further action[1]	1	2	16	130	380	3	9	219	9	6	4	28	199	13	6	72	**1,097**	**910**
No jurisdiction[2]		2	1	6	79	2	1	34	2		2	6	11	1		23	**170**	**112**
Discontinued	1	8	23	218	2,362	12	23	378	33	12	3	28	274	31	10	202	**3,618**	**2,901**
Withdrawn		1		12	108	1		17	2				15	1		9	**166**	**163**
Make a new complaint																	**0**	**0**
Refer all or part of the notification to another body		3	8	20	144		1	21	2	1		5	32	3	1	22	**263**	**171**
Caution				8								1	4				**13**	**12**
Reprimand				3	18			6					1			1	**29**	**16**
Orders – no conditions				1													**1**	**0**
Finding – no orders																	**0**	**1**
Counselling/ interview		3	10	13	23	3	4	90	1		1	5	101	16	1	6	**277**	**132**
Resolution/ conciliation by HCCC								2									**2**	**2**
Fine																	**0**	**0**
Refund/ payment/ withhold fee/ re-treat																	**0**	**0**
Conditions by consent					52		1	38				1	9		1		**102**	**185**
Order – impose conditions; would be conditions if registered		1		15	85			26		1		4	15	1	2	3	**153**	**153**
Accept surrender					27			10				6				3	**46**	**28**
Accept registration type change to non-practising					10			6					2				**18**	**22**
Suspend				4	13			4					3				**24**	**30**
Cancelled registration/ disqualified from registering		2		1	34			18		1			29	2		4	**91**	**82**
Total 2021/22	**2**	**22**	**58**	**431**	**3,335**	**21**	**39**	**869**	**49**	**21**	**10**	**84**	**695**	**68**	**21**	**345**	**6,070**	
Total 2020/21	**1**	**28**	**58**	**462**	**2,678**	**10**	**54**	**783**	**29**	**11**	**7**	**67**	**345**	**73**	**19**	**295**		**4,920**

Source: The data in this table were supplied by the HPCA. NSW legislation provides for a range of outcomes for complaints in NSW. Some of these map to outcomes available under the National Law; 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.

Timeliness

We know that timeliness in managing notifications is important to notifiers and practitioners. It is important to us also and we continue to work to improve our timeliness.

Tables 20 and 21 show the number of notifications open at 30 June, by length of time, stage, profession and state or territory. There was an 8.2% increase in open notifications.

Several factors placed pressure on our notifications timeframes:

- There was an increase in the number of cases referred to tribunal. These cases usually require more effort to manage than lower risk, lower complexity cases.
- There was an increase in the number of notifications we received about behaviour associated with public health responses to the COVID-19 pandemic. We established a COVID Taskforce, diverted some resources to this area, and developed strategies to manage these notifications.
- Like many organisations, Ahpra dealt with COVID-related resource challenges throughout the year, and this sometimes had an impact on our performance.

We closed more than 70% (7,749) of notifications following assessment (see Table 19).

Just over 70% of all closed notifications were closed on average in less than six months (see Figure 80).

Table 19. Notifications closed, by stage at closure

Profession	Assessment		Investigation		Health or performance assessment		Panel hearing		Tribunal hearing		Subtotal		Total 2021/22	Total 2020/21
	Ahpra	HPCA[1]	Ahpra	HPCA	Ahpra	HPCA	Ahpra[2]	HPCA	Ahpra[3]	HPCA[4]	Ahpra	HPCA		
Aboriginal and Torres Strait Islander Health Practitioner	2	2	9								11	2	**13**	**10**
Chinese medicine practitioner	26	18	8	1	2			1		2	36	22	**58**	**60**
Chiropractor	75	58	48		2				3		128	58	**186**	**138**
Dental practitioner	581	388	153	2	12	4	1	19	2	5	749	418	**1,167**	**1,210**
Medical practitioner	4,569	2,895	1,130	43	81	181		135	94	51	5,874	3,305	**9,179**	**8,102**
Medical radiation practitioner	19	21	11		2				2		34	21	**55**	**41**
Midwife	101	38	21		3			1			125	39	**164**	**170**
Nurse	1,273	727	492	14	72	39		55	59	24	1,896	859	**2,755**	**2,801**
Occupational therapist	73	48	9		2	1					84	49	**133**	**99**
Optometrist	29	19	4			1		1			33	21	**54**	**61**
Osteopath	19	10	11						2		32	10	**42**	**26**
Paramedic	84	69	42		5	7		7	1		132	83	**215**	**193**
Pharmacist	345	602	94	7	2	28		21	10	30	451	688	**1,139**	**813**
Physiotherapist	98	58	29		3	5		3	3	2	133	68	**201**	**203**
Podiatrist	47	17	7		1	2		2	1		56	21	**77**	**63**
Psychologist	408	325	144	1	10	8		5	14	5	576	344	**920**	**1,009**
Total 2021/22	**7,749**	**5,295**	**2,212**	**68**	**197**	**276**	**1**	**250**	**191**	**119**	**10,350**	**6,008**	**16,358**	
Total 2020/21	**7,335**	**4,103**	**2,478**	**49**	**171**	**322**	**16**	**285**	**121**	**119**	**10,121**	**4,878**		**14,999**

1. Matters managed by the HPCA in NSW.
2. Excludes two matters that proceeded from compliance monitoring. Data in the Board reports within pages 10 to 43 might vary from the data in this table given this adjustment.
3. Includes four matters that did not progress to a tribunal: in two matters the decision to refer to a tribunal was repealed; in one matter the Board decided not to proceed to tribunal; in one matter the practitioner was deceased. Excludes three matters that proceeded from compliance monitoring. Data in the Board reports within pages 10 to 43 might vary from the data in this table given these adjustments.
4. Excludes appeals.

Table 20. 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 2021/22	Total 2020/21
Assessment	1,263	866	446	58	1		**2,634**	**2,039**
Health or performance assessment	47	44	45	24	59	20	**239**	**286**
Investigation	408	414	418	333	657	351	**2,581**	**2,818**
Panel hearing	4						**4**	**1**
Subtotal 2021/22	**1,722**	**1,324**	**909**	**415**	**717**	**371**	**5,458**	
Subtotal 2020/21	**2,282**	**1,052**	**491**	**379**	**643**	**297**		**5,144**
Tribunal hearing[1]	78	78	79	75	88	112	**510**	**371**
Total 2021/22	**1,800**	**1,402**	**988**	**490**	**805**	**483**	**5,968**	
Total 2020/21	**2,323**	**1,090**	**519**	**419**	**765**	**399**		**5,515**

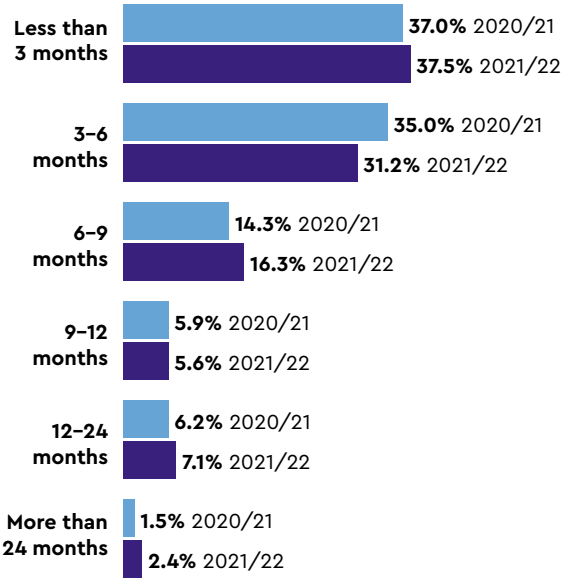
1. Tribunal proceedings are conducted in accordance with timetables set by the responsible tribunal in each jurisdiction. There were also five compliance breaches before tribunals at 30 June 2022.

Table 21. Open notifications by profession and state or territory, 30 June

Profession	Ahpra[1]									Ahpra subtotal	HPCA[3]	Total 2021/22	Total 2020/21
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]				
Aboriginal and Torres Strait Islander Health Practitioner				2	1			1		**4**	**0**	**4**	**6**
Chinese medicine practitioner	5			8	5		9	5		**32**	**26**	**58**	**45**
Chiropractor	1	1		38	5	2	49	10	2	**108**	**20**	**128**	**115**
Dental practitioner	7	2	1	132	39	7	96	57	8	**349**	**274**	**623**	**664**
Medical practitioner	76	39	34	1,011	270	77	1,158	433	50	**3,148**	**1,452**	**4,600**	**4,334**
Medical radiation practitioner				17		1	13	2		**33**	**10**	**43**	**32**
Midwife	2		1	17	5		15	6	2	**48**	**5**	**53**	**74**
Nurse	19	20	25	380	176	50	364	136	41	**1,211**	**362**	**1,573**	**1,558**
Occupational therapist	1			10	3	1	10	7		**32**	**25**	**57**	**62**
Optometrist			1	3	1		8	2		**15**	**7**	**22**	**16**
Osteopath	1			6	2		18	1		**28**	**19**	**47**	**32**
Paramedic	3	1	3	56	10	8	29	5	4	**119**	**80**	**199**	**139**
Pharmacist	4		3	67	19	10	96	34	13	**246**	**286**	**532**	**692**
Physiotherapist	4	1	2	19	13	5	36	19		**99**	**38**	**137**	**139**
Podiatrist				10	3	1	6	12		**32**	**22**	**54**	**37**
Psychologist	15	6	7	135	28	9	188	75	1	**464**	**170**	**634**	**557**
Total 2021/22	**138**	**70**	**77**	**1,911**	**580**	**171**	**2,095**	**805**	**121**	**5,968**	**2,796**	**8,764**	
Total 2020/21	**173**	**71**	**88**	**1,409**	**577**	**182**	**2,051**	**788**	**176**	**5,515**	**2,987**		**8,502**

1. Based on state or territory of the practitioner's principal place of practice.
2. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
3. Matters managed by the HPCA in NSW.

Figure 80. Average time to close notifications



Experiences of notifiers and practitioners

The healthcare experiences of patients and carers can have a real and lasting impact on them. When care does not go as expected, it is important that they have the trust and confidence to raise their concerns with us. At the same time, health practitioners need confidence that those concerns will be managed in a fair and appropriate way.

Since 2017, we have asked all notifiers and practitioners to participate in an end-of-notification survey. Through this survey, we listen systematically to the voices of both notifiers and practitioners to better understand their experience of our notifications process. We also conduct semi-structured interviews with people who have recently been through the experience. These voices have helped to shape many improvements to the way we manage notifications.

We have heard that both groups want the process to be (and to feel) fair. They want our communication to be helpful, informative and regular. And it is important to them that we work in a timely way. We have also heard that the experience is stressful, particularly for practitioners.

We began a project in late 2021 to better understand the factors contributing to practitioners' distress and how we might decrease it. The work focuses on practitioners who experience extreme distress and whose health and wellbeing may be significantly affected as a result. Working with an expert advisory group, we have conducted first-person practitioner interviews and analysis of recent serious incidents affecting practitioners who were going through a regulatory process. We expect to have practical recommendations arising from this work by the end of 2022.

Both notifiers and practitioners have told us they want the process to feel more 'human', and one of the best ways to achieve that is to speak directly to them, rather than relying on written correspondence. We have responded by making a commitment to telephone all notifiers and practitioners and to build that commitment into our updated *Service charter*.

Another example involves notifiers expressing frustration with the outcome of their matter. Notifiers often raise matters with us that we assess as not requiring regulatory action due to no ongoing risk to the public. But we know that the healthcare experience was disappointing for that patient or carer. In the past, these matters might have been closed by us relatively quickly with no further action. However, in certain circumstances, we recognise that it is most appropriate for the matter to be referred to a health complaints entity (HCE) for consideration. HCEs can help facilitate other outcomes, such as an apology, which can be very important for patients and carers. This is part of our commitment to helping ensure that matters are dealt with by the most appropriate agency based on both the concerns raised and the outcomes sought by the notifier.

COVID-19 Taskforce

The COVID-19 pandemic presented significant challenges for us all.

We received **1,303** notifications about practitioners in which the notifier raised a health, conduct or performance concern related to the COVID-19 pandemic. This accounted for **12%** of all notifications received.

We categorised a notification as 'COVID-19 related' if it included a concern about:

- clinical care when seeking or receiving COVID-19 advice, vaccination or treatment
- COVID-19 impacting a patient's ability to seek help or treatment from a practitioner or service
- inappropriate practitioner behaviour relating to the pandemic; for example, that the practitioner failed to comply with public health orders such as mask mandates
- a practitioner's practice not being COVID-safe
- a practitioner providing false or misleading information to patients or the public about COVID-19
- a practitioner undermining a public health campaign by providing false vaccination certificates or providing exemptions that were not in accordance with Australian Technical Advisory Group on Immunisation (ATAGI) guidelines
- a practitioner's online behaviour in debate about the pandemic breaching a National Board code of conduct.

During the peak period of September to December 2021, we received an average of 36 COVID-19-related notifications each week.

To triage, assess and manage the additional notifications, we created a COVID-19 Taskforce.

Creating this team and ensuring we had enough staff to manage the notifications took some time. This meant lower-risk concerns related to COVID-19 were not acted on immediately. We responded first to cases where we believed there was an ongoing risk to the public.

Not all of the COVID-19 notifications we received required regulatory action to be taken. No action was taken in approximately 50% of all COVID-19-related notifications. We were able to resolve a small number of complaints quickly after contacting the practitioner and discussing the matter with them.

There were **186** open COVID-19 investigations at 30 June. While some of those may also be closed without action, others will be referred to responsible tribunals.

By June 2022, receipt of COVID-19-related notifications reduced to an average of approximately **5 per week**.

The COVID-19 Taskforce will conclude early in 2022/23. Cases that remain open after this date will continue to be managed within our regular teams.

How we work

Some cases are closed quickly

When someone raises a concern that is not grounds for a notification or not about a person registered under our National Law, it is closed within a few days of being received (see Table 23).

When this happens, we let the person who raised the concern know, explaining why it has been closed.

If the subject matter of the concern is better dealt with by a complaints body, we refer it to that body. This was the case with **1,041** notifications, which were **10.3%** of notifications received.

We close cases earlier when the concern:

- is a one-off occurrence that is minor in nature and does not require action by us
- is the result of a misunderstanding or miscommunication that does not compromise safety
- does not indicate that a practitioner's standard of practice is unsafe.

These types of concerns accounted for **29.6%** of our decisions to close cases early following an initial assessment.

We may also close a notification more quickly if it is clear that the practitioner or the place where they work has acted on the subject matter of the concern. We call this *collaborative regulation*. Practitioners and workplaces may work together to resolve many of the concerns that are shared with us.

- Where a practitioner addressed the issues that were raised about them (we call this *good individual risk controls*), **6.4%** of our decisions resulted in earlier case closure (645 cases).
- Where the practitioner's workplace or employer addressed the issues that were raised (we call this *good organisational risk controls*), **4.0%** of our decisions resulted in earlier case closure (402).

No further action

We referred more notifications to health complaints entities (HCEs) this year and as a result, our proportion of matters with no further action decreased (61.1%, compared with 71.1% in 2020/21; see Table 22). That means that, instead of closing the matter after an initial assessment, we referred it to an HCE, where appropriate. This is part of our commitment to help notifiers be at the right place – to ensure their matter is dealt with by the appropriate agency based on the concerns they raised and the outcomes they seek. To achieve this, we moved to a national approach for consultations with HCEs, improved the way we record outcomes and collaborated effectively with HCEs.

Table 22. Closed notification outcomes

Closed notification outcomes	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
No further action	68.6%	72.0%	69.5%	69.5%	71.1%	**61.1%**
Caution or reprimand	14.2%	11.5%	7.4%	4.6%	5.0%	**4.8%**
Impose conditions	10.6%	9.7%	8.0%	7.3%	7.2%	**6.7%**
Accept undertaking	2.2%	2.2%	1.2%	1.1%	1.3%	**0.8%**
Refer to a HCE or other entity	3.2%	3.4%	12.9%	16.5%	14.7%	**25.5%**
Registration surrendered, suspended or cancelled	1.2%	1.0%	0.9%	0.9%	0.7%	**1.1%**
Registrant fined		0.2%	0.1%	0.1%	<0.1%	**0.0%**

Table 23. Cases closed for lack of grounds

	Number of cases		
Reason for closing	**2019/20**	**2020/21**	**2021/22**
No grounds	235	212 (down 9.8%)	**404 (up 90.6%)**
Not about a registered practitioner or student	100	141 (up 41.0%)	**186 (up 31.9%)**

'Employer engagement is one of the areas where we can get a big improvement, such as in decreasing some of the notifications that we have less need for – like HR issues that the employer can manage. If we can support employers to support practitioners to practise in a safe and confident way, it delivers our aim of protecting the public.'

Staff member

Investigating more serious cases

Some issues can be more serious and we have options to help us better understand and address the issues raised. We can gather more information about the practitioner or an incident that has been raised with us informally or through an investigation.

We prefer to use collaborative approaches to gather information. This includes engaging with notifiers, practitioners, workplaces and employers if they will cooperate with our enquiries. For many notifications, less formal engagement with practitioners is enough to ensure we play our role in public protection.

Table 24. Cases referred for investigation, or health or performance assessment

	2019/20	2020/21	2021/22
Number of cases	2,600	2,849 (up 9.6%)	**2,340 (down 17.9%)**

We can ask other practitioners who are registered in the same profession as the practitioner to speak with and observe them in practice (a *performance assessment*).

We can also ask a psychiatrist, occupational physician, addiction medicine specialist or psychologist to review the practitioner and assess whether they have an impairment that poses a substantial risk to the public (a *health assessment*).

We understand the impact that a formal investigation can have on the person being investigated – being the subject of an investigation is often stressful. We strive to find alternative ways of managing notifications that avoid the stress of an investigation, and try to limit investigations to cases when there is a potential risk to the public and we lack sufficient information to make a properly informed decision.

Sometimes the seriousness of an individual notification or pattern of notifications by a practitioner means an investigation is necessary.

- **2,519** notifications about **1,749** practitioners were referred for investigation.
- **22.6%** of all notifications were referred for investigation (down from 27.4% in 2020/21 and 26.2% in 2019/20).

It was much more likely this year that an investigation involved more than one notification about the same practitioner – 46.0% of the practitioners who had an investigation start this year were the subject of more than one notification, up from 35.5% in 2020/21. One-off concerns were more readily able to be resolved without a formal investigation.

Strengthening practice

Our role is to protect, not to punish

We take our role of protecting the public seriously.

We work with practitioners who are the subject of a notification to strengthen their practice whenever possible. *Stronger, safer practice* can be achieved when a practitioner:

- understands what led to the notification
- reflects on the causes of the notification
- takes accountability for managing the causes of the concern or notification
- demonstrates to us that they are taking appropriate actions about the cause of the notification.

This can be supported by:

- workplaces that seek to continually improve policies or practices that might have room for improvement
- action taken by employers to ensure their employees understand the risks and consequences of unsafe practice
- other regulators sharing investigations or outcomes with us that indicate a concern has been addressed with the practitioner
- action by us to caution a practitioner for the thing that they did that contributed to a safety or professionalism concern
- additional action by us that is published on the national *Register of practitioners* as a condition or undertaking.

Our role is not to punish a practitioner, even though at times our response is a penalty. We only impose a *regulatory outcome* if this action is necessary to ensure the practitioner practises safely and professionally.

The likelihood that we will need to take *regulatory action* to ensure safe professional practice increases according to the:

- level of risk that the lapse in safety or professionalism led to
- level of insight into a problem that a practitioner demonstrates and the extent to which they and their workplace have responded to it
- number of times that a person has been reported to us for safety or professionalism issues
- nature of care that the person provides
- nature of the setting in which they deliver care
  - if there are not strong organisational supports evident, it is more likely that we will need to consider a regulatory control
- level of oversight that might already be in place to ensure the practitioner practises safely and professionally.

These four case studies illustrate our efforts to strengthen practice.

Safe prescribing

We received a notification about a medical practitioner from a Coroner's Court. It was the first notification ever made about them.

The Coroner was concerned that the medical practitioner prescribed a large amount of benzodiazepine to a patient without having valid Schedule 8 approvals to do so, for a period before the patient's death. Despite this concern, the Coroner determined that this was not a major causative factor in the patient's death.

From speaking with the practitioner, Ahpra staff (including a clinical advisor) learned the following:

- approvals for Schedule 8 medications had been sought by and provided to the practitioner for other patients, but had been overlooked for this patient
- the prescribing occurred before the digitisation of the practitioner's practice records
- the practice record system is now fully digitised, including providing relevant alerts for a prescriber when a prescription requiring a permit under state health regulations is entered, reducing the risk of a repeat of this concern
- the practitioner now makes use of the relevant state-based safe script program to ensure a patient has not filled prescriptions for the medication in excess of the limits or outside the timeframe prescribed.

Our subsequent assessment included a review of the risk controls now in place to mitigate the risk that this would occur in the future.

The Medical Board of Australia was able to quickly close the notification, confirming the presence of the risk controls implemented by the practitioner with the Coroner's Court.

Continuing practitioner education

We received a notification about a paramedic. The case involved the death of a patient due to an airway blockage not being identified.

The paramedic told us that they felt blamed for the incident, which occurred during a highly traumatic and fast-paced episode of care. The paramedic had, in their mind, acted quickly and professionally to attempt to have the patient transferred to hospital care.

Ahpra's goal in ensuring safe, professional care was explained to the practitioner. We confirmed that our actions are designed to ensure safety, not to be punitive.

The paramedic confirmed that after the incident, they had partially completed a training program spanning several months through their employer, which included supervision and reflective practice. The employer was a large paramedic service with effective processes and guidelines in place to monitor and improve staff performance and ensure patient safety.

The paramedic willingly shared evidence of reflection undertaken with their employer and evidence of completion of the further education. The employer confirmed that the training program adequately resolved gaps in knowledge and skills required to manage similar clinical incidents.

The Paramedicine Board of Australia relied on the strong individual and organisational risk controls in its decision, deciding that no further action was required.

'For many notifiers, coming to us is already part of one of the most stressful and important experiences in their lives – because they've had a healthcare experience that really had an effect on them – and most people don't do this lightly.

The most rewarding thing about my job is when we can make changes, even small changes, that can improve those experiences for those people.'

Staff member

Workplace risk controls

We received a series of notifications in quick succession about a medical practitioner who had been subject to several previous notifications. Some of them had resulted in actions by the Medical Board of Australia, including a caution.

The practitioner's care of patients was being affected by interpersonal issues between the practitioner and their colleagues. These had been the subject of complaints to the practitioner's employer, who had suspended the practitioner on full pay. The suspension had been in place for nearly two years while the employer conducted an internal investigation.

The investigation concluded with reprimanding the practitioner about the way they communicated with their co-workers. The employer directed the practitioner to complete further education, including on communication and behaviour.

Ahpra considered whether the risk controls applied by the workplace were adequate to address the risks identified. The practitioner was invited to provide any other information about the way in which they had responded to the complaints.

The medical practitioner and their supervisor had implemented:

- peer-led discussions about all relevant admissions in the previous 24 hours and discussions about contemporary best-practice surgical literature relevant to their area of practice
- monthly reviews by supervisors of cases, complications and transfers through a surgical audit conducted with other surgical units
- weekly intensive-care-unit meetings with other consultants about recent surgical and non-surgical case discussions
- monthly pathology meetings at which all specimens were reviewed
- monthly x-ray sessions at which all cases were reviewed.

The workplace, which was remote from a major tertiary centre, had also implemented closer working relationships with the practitioner's colleagues at a major tertiary hospital in the nearest capital city.

The Board required the practitioner to complete additional education in a further practice area. It noted the individual and organisational risk controls that had been put in place to ensure the safety of future patients.

Drug screening

We received a notification about a registered nurse who had addiction issues (amphetamine, cannabis and opioids). The nurse was very open with us. They acknowledged the addictions and provided evidence of seeking treatment and support. The addiction issues had led to instances of unprofessional practice that posed a risk to patient safety.

The Nursing and Midwifery Board of Australia considered that it would be appropriate for the nurse to:

- continue to see their treating practitioners
- undergo urine drug screening and hair analysis (drug screening) frequently, sometimes daily.

The nurse was anxious. They accepted the need for conditions and wanted to ensure they addressed their issues. As they cared for young children, it would be difficult logistically to attend drug screening at the frequency proposed.

The nurse was on parental leave at the time that issues were reported to us. They were not intending to return to work immediately but they could not bring their children to the testing centre.

As part of a parental agreement, some drug screening arrangements were already in place.

We identified:

- the effect that the frequency of testing sought could have on the nurse's ability to return to work
- the financial burden that drug screening posed
- the onerous nature of a requirement to undergo two separate sets of drug screening (for Ahpra and as part of the parental agreement).

While public protection was our primary concern, we sought options that would have a lower impact on the practitioner. We worked with the practitioner, the case officer who was managing the parental agreement, and our pathology provider to understand the testing frequency and methods.

We achieved a result that meant existing drug screening results could be shared with us to build a picture of compliance. Any additional screening would only begin a month before any intention to return to work, and after further consideration of the interim results from the department that was overseeing the parental agreement.

Students

Notifications are made about students too

There are limited grounds for making notifications about students compared to registered health practitioners. A voluntary notification can be made about a student's criminal history, impairment or if they have not complied with a restriction on their registration as a student.

There is only one ground for a mandatory notification – an education provider needs to tell us when they have formed a reasonable belief that a student has an impairment that may place a patient at substantial risk of harm when the student is doing clinical training.

- **35** notifications were made to Ahpra about students; this is down from 42 last year
- **2** notifications resulted in conditions or undertakings affecting a student's registration, compared to 7 last year

Tables 25 and 26 summarise notifications about students.

Table 25. Student notifications received

Profession	Ahpra[1]									Ahpra subtotal	HPCA[3]	OHO[4]	Total 2021/22	Total 2020/21
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]					
Aboriginal and Torres Strait Islander Health Practitioner										**0**	**1**		**1**	**0**
Chinese medicine practitioner										**0**			**0**	**1**
Chiropractor										**0**			**0**	**1**
Dental practitioner				2						**2**		**1**	**3**	**3**
Medical practitioner									11	**11**	**10**		**21**	**12**
Medical radiation practitioner										**0**			**0**	**3**
Midwife									1	**1**	**1**		**2**	**1**
Nurse									16	**16**	**21**	**2**	**39**	**51**
Occupational therapist										**0**	**1**		**1**	**1**
Optometrist										**0**	**1**		**1**	**0**
Osteopath									1	**1**			**1**	**0**
Paramedic									2	**2**	**1**		**3**	**2**
Pharmacist							1			**1**	**2**		**3**	**7**
Physiotherapist									1	**1**	**1**		**2**	**1**
Podiatrist										**0**			**0**	**0**
Psychologist										**0**	**4**		**4**	**1**
Total 2021/22	**0**	**0**	**0**	**2**	**0**	**0**	**1**	**0**	**32**	**35**	**43**	**3**	**81**	
Total 2020/21	**0**	**0**	**0**	**4**	**0**	**0**	**1**	**2**	**35**	**42**	**40**	**2**		**84**

1. Based on state or territory of the student's principal place of practice.
2. No principal place of practice (No PPP) includes students with an overseas or unknown address.
3. Matters received and managed by the HPCA in NSW.
4. Matters received and managed by OHO in Queensland.

Table 26. Outcomes of notifications about students by stage at closure

Stage at closure		Assessment	Health or performance assessment	Investigation	Panel hearing	Tribunal hearing	Total 2021/22	Total 2020/21
No further action	Ahpra	26	1	8			35	31
	HPCA[1]	5	1				6	12
Impose conditions	Ahpra		1				1	7
	HPCA				8		8	4
Accept undertaking	Ahpra		1				1	0
	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	1
Refer to other entity	Ahpra	1					1	0
	HPCA	7					7	3
Discontinue	Ahpra						0	0
	HPCA	16					16	25
Counselling	Ahpra						0	0
	HPCA	2					2	0
Surrender	Ahpra						0	0
	HPCA						0	0
Withdrawn	Ahpra						0	0
	HPCA						0	0
Total 2021/22		57	4	9	8	0	78	
Total 2020/21		56	9	11	7	0		83

1. Matters managed by the HPCA in NSW.

Mandatory notifications

Practitioners have mandatory reporting obligations

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

Data about mandatory notifications are presented in tables 27, 28 and 29.

'Ahpra and the National Boards are interested in safe and effective practice, and that's the same thing nearly every health professional is interested in. Our regulatory role is quite hard-edged – if you've done something wrong there's a notification. But we've got an enabling role as well, which goes back to our strategy of trying to assist practitioners to be safe within a system.'

Staff member

Mandatory notifications made up **9.6%** of notifications received.

- We received **1,033** mandatory notifications; **18.4%** fewer than in 2020/21**.**
- **43.7%** were about nurses (451).
- **33%** were about medical practitioners (339).
- The number of mandatory notifications about impairment (**407**) reduced from 453 in 2020/21.
- Immediate action arising from mandatory notifications was considered on **378** occasions and taken **215** times.

Table 27. Mandatory notifications received

Profession	Ahpra[1]									Ahpra subtotal	HPCA[5]	OHO[6]	Total 2021/22	Total 2020/21[7]
	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]					
Aboriginal and Torres Strait Islander Health Practitioner			1							**1**			**1**	**5**
Chinese medicine practitioner					1		1			**2**	**1**	**1**	**4**	**2**
Chiropractor	1		1	1			9	1		**13**	**5**	**1**	**19**	**9**
Dental practitioner	2			2	3	2	5	6	2	**22**	**14**		**36**	**42**
Medical practitioner	11	6	10	46	37	18	132	70	9	**339**	**124**	**26**	**489**	**522**
Medical radiation practitioner				1		1	4	3		**9**	**1**		**10**	**11**
Midwife			2	4	3		4	4		**17**	**5**		**22**	**45**
Nurse	7	6	22	75	71	27	158	78	7	**451**	**156**	**27**	**634**	**897**
Occupational therapist					2	2	2	2		**8**	**3**	**1**	**12**	**19**
Optometrist							2			**2**			**2**	**8**
Osteopath	2						3		1	**6**	**2**		**8**	**2**
Paramedic	1		3	14	5	3	19	3	1	**49**	**43**	**2**	**94**	**86**
Pharmacist	1		1	3	7	1	6	7	3	**29**	**12**	**5**	**46**	**68**
Physiotherapist	1			1	2	2	8	2	1	**17**	**7**	**4**	**28**	**29**
Podiatrist							1	6		**7**	**1**		**8**	**9**
Psychologist	3	1	2	11	9	2	17	12	4	**61**	**36**	**5**	**102**	**102**
Total 2021/22	**29**	**13**	**42**	**158**	**140**	**58**	**371**	**194**	**28**	**1,033**	**410**	**72**	**1,515**	
Total 2020/21	**29**	**20**	**23**	**247**	**192**	**72**	**420**	**230**	**33**	**1,266**	**509**	**81**		**1,856**

1. Based on state or territory of the practitioner's principal place of practice (PPP).
2. Matters managed by Ahpra where the conduct occurred outside NSW.
3. Matters referred by OHO, or assigned during joint consideration with OHO, and managed by Ahpra and the National Boards.
4. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
5. Mandatory notifications received and managed by the HPCA in NSW.
6. Matters received and managed by OHO in Queensland.
7. Includes matters managed by the HPCA and OHO.

Table 28. Grounds for mandatory notifications, by profession

Profession	Standards		Impairment		Alcohol or drugs		Sexual misconduct		Total 2021/22		Total 2020/21	
	Ahpra	HPCA[1]	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA
Aboriginal and Torres Strait Islander Health Practitioner	1								**1**	**0**	**4**	**1**
Chinese medicine practitioner	1	1					1		**2**	**1**	**1**	**1**
Chiropractor	4	4	7				2	1	**13**	**5**	**5**	**4**
Dental practitioner	11	10	8	4	2		1		**22**	**14**	**38**	**4**
Medical practitioner	127	91	149	17	17	3	46	13	**339**	**124**	**375**	**128**
Medical radiation practitioner	4	1	2				3		**9**	**1**	**7**	**4**
Midwife	11	5	5		1				**17**	**5**	**31**	**14**
Nurse	193	104	178	17	49	25	31	10	**451**	**156**	**602**	**251**
Occupational therapist	5	1	3	1				1	**8**	**3**	**13**	**6**
Optometrist	1		1						**2**	**0**	**6**	**2**
Osteopath	1	2	2				3		**6**	**2**	**1**	**0**
Paramedic	27	29	16	4	2	5	4	5	**49**	**43**	**50**	**23**
Pharmacist	16	12	11		2				**29**	**12**	**42**	**25**
Physiotherapist	10	5	1	1			6	1	**17**	**7**	**18**	**8**
Podiatrist	4	1	2		1				**7**	**1**	**6**	**3**
Psychologist	24	24	22	6	4	1	11	5	**61**	**36**	**67**	**35**
Total 2021/22	**440**	**290**	**407**	**50**	**78**	**34**	**108**	**36**	**1,033**	**410**		
Total 2020/21	**589**	**343**	**453**	**86**	**99**	**41**	**125**	**39**			**1,266**	**509**

1. Matters managed by the HPCA in NSW.

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

- **29.8%** of completed mandatory notifications resulted in regulatory action being taken (compared to 13.4% for all notification categories).

Regulatory action taken in response to mandatory notifications was down from 31.3% in 2020/21.

Table 29. 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 2021/22	Total 2020/21
Discontinued/ proceedings withdrawn	**Ahpra**																	**0**	**0**
	HPCA			1	2	45		1	21	2		1	2	3	5		7	**90**	**89**
Changed to non-practising	**Ahpra**																	**0**	**0**
	HPCA					2			1									**3**	**9**
Other/no jurisdiction	**Ahpra**																	**0**	**0**
	HPCA[1]					10		1	15				5				2	**33**	**34**
Counselling	**Ahpra**																	**0**	**0**
	HPCA			1		2		3	33					4	2			**45**	**18**
No further action	**Ahpra**		1	5	21	279	2	17	311	2	1	4	24	15	14	5	46	**747**	**718**
	HPCA	1		2	3	25		2	75	1			12	12			12	**145**	**151**
Refer notification to another body	**Ahpra**					4			2				1	2			1	**10**	**11**
	HPCA			1		12			2						1		4	**20**	**24**
Health complaints entity to retain	**Ahpra**																	**0**	**0**
	HPCA																	**0**	**0**
Fine registrant	**Ahpra**																	**0**	**3**
	HPCA																	**0**	**0**
Orders – no conditions	**Ahpra**																	**0**	**0**
	HPCA																	**0**	**0**
Caution or reprimand	**Ahpra**	2		1	2	29			25	3			7	4	3		7	**83**	**77**
	HPCA					1			3				1				1	**6**	**7**
Accept undertaking	**Ahpra**				2	11		1	10	1				2		1	1	**29**	**32**
	HPCA																	**0**	**0**
Impose conditions	**Ahpra**	1		2	3	56	3	3	80	3	1		5	7	4	3	7	**178**	**193**
	HPCA[2]				2	21			32		1		3	3	1		2	**65**	**113**
Accept surrender of registration	**Ahpra**																	**0**	**0**
	HPCA					5			5				2				2	**14**	**4**
Suspend registration	**Ahpra**					1			7					1				**9**	**11**
	HPCA				1	2			2									**5**	**4**
Cancel registration/ disqualify	**Ahpra**					11			8					2	1		1	**23**	**16**
	HPCA					7			4		1			1	1		2	**16**	**14**
Total 2021/22	**Ahpra**	**3**	**1**	**8**	**28**	**391**	**5**	**21**	**443**	**9**	**2**	**4**	**37**	**33**	**22**	**9**	**63**	**1,079**	
	HPCA	**1**	**0**	**5**	**8**	**132**	**0**	**7**	**193**	**3**	**2**	**1**	**25**	**23**	**10**	**0**	**32**	**442**	
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**

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

Immediate action

National Boards can take immediate action when serious concerns are raised – this interim action protects the public while more information is obtained

When we are worried that there is a serious risk to public safety, or it is otherwise in the public interest, we can take immediate action while we make further enquiries.

Table 30 shows that immediate action was taken:

- **685** times – **14.7%** (88) more than in 2021/22
- on **6.3%** of notifications received.

A slightly higher proportion of immediate action was taken as a percentage of notifications received this year than in previous years (6.3% in 2021/22, 5.9% in 2020/21, 5.7% in 2019/20 and 4.1% in 2018/19).

Being the subject of an immediate action by a Board can be extremely daunting. We will only use our immediate action powers when:

- there is a serious risk to the public
- we believe a practitioner's registration has been improperly obtained, because they have provided misleading information when applying for registration
- the practitioner holds registration outside Australia, and that registration has been suspended or cancelled by another regulator
- there is a clear and compelling reason to suspend the practitioner's registration, based on public interest reasons (including, for example, that a practitioner has been charged with or convicted of serious criminal behaviour).

Table 30. Immediate action cases

Profession	No action taken			Action taken[1]												Decision pending[2]			Total 2021/22			Total 2020/21		
				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**	**0**	**0**	**1**	**1**	**0**
Chinese medicine practitioner	6			1						2	5	1	3			1			**13**	**5**	**1**	**6**	**8**	**2**
Chiropractor	15			8						4	4	1							**27**	**4**	**1**	**22**	**5**	**1**
Dental practitioner	16	2		3	6					6	10		8			1			**34**	**18**	**0**	**36**	**19**	**2**
Medical practitioner	306	33	6	153	20	5		18		137	83	13	54			27		2	**677**	**154**	**26**	**371**	**172**	**14**
Medical radiation practitioner	7				2					1	1								**8**	**3**	**0**	**8**	**1**	**0**
Midwife	6	1	1		1			1		3	3		1			1			**11**	**6**	**1**	**14**	**6**	**0**
Nurse	172	37	5	95	21	7	3	4		49	87	12	52			19		4	**390**	**149**	**28**	**341**	**154**	**21**
Occupational therapist				2	2														**2**	**2**	**0**	**4**	**4**	**0**
Optometrist	1			1															**2**	**0**	**0**	**2**	**0**	**0**
Osteopath	2			4	1						2	1							**6**	**3**	**1**	**6**	**1**	**0**
Paramedic	13	6		17	8					5	7	2	2						**37**	**21**	**2**	**29**	**11**	**5**
Pharmacist	26	11		11	17	3	1			5	43	1				2		1	**45**	**71**	**5**	**31**	**91**	**5**
Physiotherapist	15	2	1	2						1	3	2	2					1	**20**	**5**	**4**	**12**	**6**	**3**
Podiatrist	2			1						3	3								**6**	**3**	**0**	**4**	**3**	**0**
Psychologist	33	2	2	16	3	1				20	12	3	9			3		2	**81**	**17**	**8**	**44**	**19**	**7**
Total 2021/22	**621**	**94**	**15**	**314**	**81**	**16**	**4**	**23**		**236**	**263**	**36**	**131**	**0**		**54**	**0**	**10**	**1,360**	**461**	**77**			
Total 2020/21	**243**	**91**	**24**	**260**	**106**	**4**	**20**	**16**		**186**	**288**	**25**	**131**	**0**		**91**	**0**	**7**				**931**	**501**	**60**

1. Cases where immediate action has been initiated under Part 8, Division 7 of the National Law.
2. In those cases where immediate action was initiated towards the close of the reporting year, an outcome decision has not been finalised.
3. Matters managed by the HPCA in NSW.
4. HPCA data exclude matters that were considered for immediate action but did not proceed to a hearing, other than matters where the case did not proceed because the practitioner surrendered registration.
5. Matters received and managed by OHO in Queensland.

Table 31. Immediate action taken

Type of immediate action taken	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Registration surrendered	0.3%	0.2%	2.9%	2.6%	3.4%	**0.6%**
Accepted undertaking	21.6%	27.3%	29.9%	23.4%	21.9%	**19.1%**
Imposed conditions	45.9%	42.0%	33.9%	34.7%	31.2%	**34.5%**
Suspended	32.2%	30.4%	33.3%	39.3%	43.6%	**45.8%**

Referring professional misconduct to a tribunal

When a practitioner's behaviour is significantly below a reasonable standard of practice, when a practitioner engages in multiple instances of poor performance, or when a practitioner behaves in a way that the public would view as untrustworthy, we refer the practitioner to a responsible tribunal.

A National Board *must* refer a practitioner whose behaviour is considered to be professional misconduct to a responsible tribunal.

There was a **91.1%** increase in the number of notifications referred to a responsible tribunal by a National Board. The most common referrals were for concerns about boundary violations (**30.8%**).

'Across the developed world there is an increasing awareness among the general public about what is and isn't appropriate in terms of practitioner behaviour. Concerns about how a practitioner has interacted with female patients in particular have increased greatly over the past couple of years, and we have grown more sophisticated in terms of how we deal with them.'

Staff member

Professional boundaries

There must be proper boundaries in a practitioner–patient relationship

We received **925** notifications involving a possible failure to maintain appropriate professional boundaries (see Table 32). These can include comments made by a practitioner to a patient during a consultation, or even online, that are deemed inappropriate when considered against the relevant Board's code of conduct. Or they can involve inappropriate sexual relationships or even unlawful sexual acts. This was:

- **63%** more than we received last year (568)
- **81.4%** were made about practitioners in three professions:
  - medical practitioners 43%
  - nurses 26%
  - psychologists 13%.

The increase in the number of boundary violation matters can be attributed to the inclusion of new concern types, which are consistent with Ahpra and the National Boards' condemnation of sexism, sexual harassment or gendered violence in healthcare and expectations of practitioners to maintain respectful, professional practice (see the position statement *No place for sexism, sexual harassment or violence in healthcare* – www.ahpra.gov.au/News/2021-06-30-no-place-for-sexism-sexual-harassment-or-violence-in-healthcare).

The concerns raised by notifiers include:

- inappropriate or sexualised remarks, comments or electronic exchanges
- touching of a patient in a place the patient thinks is intimate, when the patient did not believe that consent had been provided
- other forms of physical contact that a notifier believes were not appropriate
- sexual offending, of any kind, by a practitioner
- rough or painful examination or treatment
- sexism, aggressive behaviour or violence, or harassment of peers, patients or others.

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

Boundary notifications had a higher proportion of suspensions through immediate action (**29.0%**) compared to all notifications (24.0%).

In **17.2%** of cases, Boards imposed conditions.

In **6.3%** of cases, Boards accepted an undertaking.

In **47.5%** of cases, after consideration, Boards decided not to take immediate action.

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

- **6.2%** boundary notifications resulted in a caution or reprimand (compared to 4.8% for all notifications)
- **10.6%** boundary notifications resulted in conditions being imposed on a practitioner's registration (compared to 6.8% for all)
- **4.3%** boundary notifications resulted in a practitioner's registration being surrendered, suspended or cancelled (compared to 1.1% for all).

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

- **50.3%** were closed following an investigation (compared to 21.4% for all notifications)
- **41.8%** were closed at assessment (compared to 74.9% for all notifications)
- **6.5%** were closed after referral to a tribunal (compared to 1.8% for all notifications).

Table 32. Boundary notifications received

Profession	ACT	NSW[1]	NT	QLD[2]	SA	TAS	VIC	WA	No PPP[3]	Total 2021/22	Total 2020/21
Aboriginal and Torres Strait Islander Health Practitioner										**0**	**0**
Chinese medicine practitioner	1			1	3			1		**6**	**3**
Chiropractor				3	1	1	8	2	1	**16**	**15**
Dental practitioner	2			10	1	1	20	11	2	**47**	**7**
Medical practitioner	15	3	8	65	37	23	163	67	16	**397**	**302**
Medical radiation practitioner				1			1	3	1	**6**	**8**
Midwife							2		1	**3**	**3**
Nurse	7	3	11	39	35	9	76	39	18	**237**	**111**
Occupational therapist					1	1	5	1	1	**9**	**7**
Optometrist							1			**1**	**3**
Osteopath	2			1	1		4		1	**9**	**2**
Paramedic			3	7	1	1	6	1	1	**20**	**18**
Pharmacist	1			2	2	2	11	5	4	**27**	**4**
Physiotherapist				3	2		15	3		**23**	**24**
Podiatrist							4	1		**5**	**0**
Psychologist	3		1	32	9	5	42	24	3	**119**	**61**
Total 2021/22	**31**	**6**	**23**	**164**	**93**	**43**	**358**	**158**	**49**	**925**	
Total 2020/21	**25**	**7**	**9**	**119**	**65**	**21**	**225**	**73**	**24**		**568**

1. Matters managed by Ahpra where the conduct occurred outside NSW.
2. Matters referred by OHO, or assigned during joint consideration with OHO, and managed by Ahpra and the National Boards.
3. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.

Notifier Support Service

The Notifier Support Service started in August. The service is part of Ahpra and the National Boards' ongoing work to improve the experience of notifiers in matters involving sexual boundary breaches and misconduct. Notifiers help us to keep the community safe by raising serious concerns about practitioners. The service is only offered to notifiers who have been personally affected by the concerns raised.

The notification process is often emotionally challenging and complex to navigate, and a range of factors may affect a person's participation. Notifiers are referred to the service by notifications and legal staff and they then opt in if they would like to receive support. Referral guidance has been developed to help staff identify who may benefit from the service. For example, factors such as experiences of trauma, mental health, cultural safety, diversity needs and access to support can affect the notifier experience.

Two qualified social workers provide emotional support and help explain how our processes work. Through providing procedural information they prepare notifiers/witnesses about what to expect and help guide them through the experience with us. The social workers do not provide therapeutic counselling or advocacy for the notifier but can suggest services that may be helpful and offer other targeted support.

Using a trauma-informed approach, our social workers work in partnership with regulatory and legal advisors to help respond to the emotional impact experienced by notifiers. The social workers may also become a consistent point of contact once matters are referred to a tribunal.

By providing this support, we aim to reduce the re-traumatisation that may occur and help notifiers engage and participate throughout all stages of the process.

Since the service began, 149 referrals have been made by notifications and legal staff. About half of these matters have been or are currently in investigation, with the rest at tribunal or subject to immediate action.

Initial feedback from notifiers/witnesses accepting the service has been extremely positive. It has also been welcomed and overwhelmingly endorsed by National Boards and Ahpra as addressing an unmet need.

The service is currently in its pilot phase and will be evaluated in 2022/23.

'I felt supported by the Notifier Support Service who recently helped me to engage with a notifier. There were sensitive issues involved, and their empathetic and relationship-based approach improved the experience for both the notifier and me.'

Regulatory advisor

'I started the process before the Notifier Support Service was available and had to spend time trying to navigate the situation by myself. The difference once I was hooked into a support person was remarkable. It made me feel like I wasn't going through it alone. I had someone to talk to that understood the processes and what was happening.'

Notifier

Christine Gee

Ms Christine Gee has been a community member of the Queensland Board of the Medical Board of Australia since December 2014. In November, Christine was awarded the Australian Council on Healthcare Standards Gold Medal for 2021 – its highest award.

'I love the work I do with the Medical Board and Ahpra, particularly the work of the National Special Issues Committee (NSIC) of which I am Chair. While it is challenging and at times confronting, it is also rewarding.

This work as part of a leading initiative in transforming the regulatory management of sexual boundary and family violence notifications is a significant career and personal highlight.

The Medical Board and Ahpra are leading the way internationally in this important area.

Sexual boundary notifications are made about less than 0.1% of the medical workforce in Australia each year. However, when concerns about sexual boundary breaches are made, they are most often serious, having significant impacts on individual victims and a permanent, tangible impact on the public's trust in medical and other health practitioners.

Family violence occurs across all socio-economic backgrounds and cultures. Vulnerable victims of family violence must feel safe and confident that any health services that they access are not being provided by medical practitioners who are themselves perpetrators of family violence.

Both sexual boundary violations and family violence matters are an increasingly important issue for medical regulators.

As regulators, our overriding goal is to protect the public. Medical practitioners have an important role to play in preventing and identifying family violence, supporting victims/survivors and offering referral pathways. Medical practitioners have a similarly important role in the treatment of victims of sexual violence and assault.

I am an ardent believer that a patient focus is essential to ensuring safety and quality in healthcare.'

Legal action

We prosecute people who pretend to be registered health practitioners when they are not. The most serious allegations are decided by independent panels and tribunals.

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

We publish summaries of court and tribunal decisions to create opportunities for professional learning.

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.

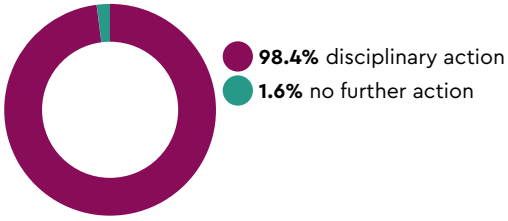
We include links to published adverse tribunal (disciplinary) decisions and court outcomes for a practitioner on the *Register of practitioners*, if the name of the practitioner has not been suppressed by the court or tribunal.

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 *Register of cancelled practitioners*.

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

- **515** tribunal proceedings (510 notifications, 5 compliance breaches) were ongoing at 30 June, compared with 374 matters last year. National Boards referred more matters to a tribunal, with **344** referrals made this year compared to 180 last year.
- **191** tribunal matters were finalised:
  - **187** matters about **109** practitioners were decided by a tribunal; **98.4%** resulted in disciplinary action (see Figure 81).
  - **4** matters were withdrawn or did not proceed to a tribunal because: the practitioner was deceased (**1** matter), in **2** cases a Board decided to repeal the decision to refer the matters to the tribunal and in **1** matter the Board decided not to proceed to file the matter in the tribunal.
  - National Boards continue to appropriately identify the thresholds for referring a matter to a tribunal to protect the public.
- **3** matters were decided by panels, all of which resulted in regulatory action. Panels are established by the Boards and include members from the community and relevant health profession. Health panels must include a medical practitioner.

Figure 81. Matters decided by 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
- inappropriate commentary on social media
- dishonest and/or misleading conduct including during an Ahpra investigation and/or at renewal of registration
- practising while unregistered and failing to hold appropriate professional indemnity insurance
- inadequate clinical management and/or medical mismanagement
- issuing vaccination exemptions not in accordance with legislation.

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

- inappropriate sexual contact and unlawful sexual assault (conviction) and inappropriate sexual comments made to a patient (7.5 years)
- failing to comply with conditions imposed on registration, stalking and/or intimidating a female neighbour and conviction of disturbing the public peace (3 years)
- misappropriating medication as a pharmacist, failing to hold professional indemnity insurance for a period of time and convictions related to altering a prescription, unlawful possession of Alprazolam, using a Schedule 8 poison for self-administration without prescription and altering records (1 year).

Published summaries

We published **71** summaries about publicly available court or tribunal decisions. Some decisions are not published for privacy reasons or due to suppression orders applied by the court or tribunal. Other decisions may not be published until the next reporting year, once a tribunal's full decision and orders have been publicly released.

Appeals

Decisions can be appealed

- **103** appeals were lodged about decisions made by National Boards (see Table 33).
- The number of appeals lodged this year was slightly lower than in 2020/21, when there were 106 lodged.
- The majority were from professions that have a higher number of regulatory decisions, such as medical practitioners (66) and nurses (17).
- **96** were finalised (see Table 34).
- **91** were not yet decided at 30 June.

Figure 82. Appeals managed

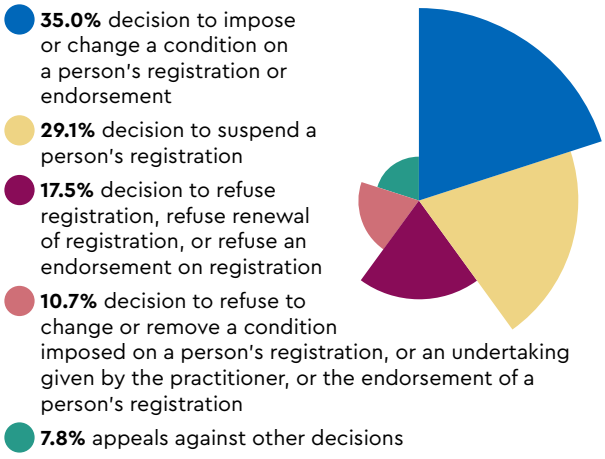


Figure 83. Appeals finalised

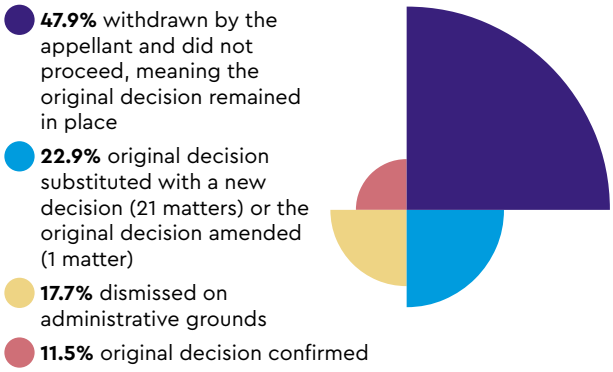


Table 33. Appeals lodged, by profession and jurisdiction

Profession	Ahpra[1]								Ahpra subtotal	HPCA[2]	Total 2021/22	Total 2020/21
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA				
Aboriginal and Torres Strait Islander Health Practitioner									**0**		**0**	**0**
Chinese medicine practitioner									**0**		**0**	**1**
Chiropractor				1					**1**		**1**	**1**
Dental practitioner	1			1					**2**		**2**	**13**
Medical practitioner	1	6	1	11	5	1	25	16	**66**	20	**86**	**75**
Medical radiation practitioner									**0**		**0**	**1**
Midwife									**0**		**0**	**0**
Nurse			1	5	3	3	5		**17**	2	**19**	**19**
Nurse and midwife[3]									**0**		**0**	**1**
Occupational therapist									**0**		**0**	**0**
Optometrist									**0**		**0**	**2**
Osteopath							1		**1**		**1**	**0**
Paramedic							2		**2**	1	**3**	**1**
Pharmacist				1			1	2	**4**	7	**11**	**23**
Physiotherapist					1				**1**	1	**2**	**1**
Podiatrist									**0**		**0**	**2**
Psychologist	1	1		2	1	1	3		**9**	2	**11**	**8**
Total 2021/22	**3**	**7**	**2**	**21**	**10**	**5**	**37**	**18**	**103**	**33**	**136**	
Total 2020/21	**2**	**6**	**2**	**29**	**12**	**2**	**43**	**10**	**106**	**42**		**148**

1. Based on state or territory of the practitioner's principal place of practice.
2. Matters managed by the HPCA in NSW.
3. Registrants who hold dual registration as both a nurse and a midwife.

'The initial challenge during the pandemic was finding virtual ways to deliver legal services. However, a couple of years on, many law practices, tribunals and courts are embracing technology.

This new way of working may have been inconceivable to some in the legal profession, which has traditionally had entrenched ways of operating.

The pandemic (despite the considerable physical and emotional toll it has taken) has been a catalyst for some positive changes and innovations.'

Staff member

Table 34. 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 2021/22		Total 2020/21	
	Ahpra[1]	HPCA[2]	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA
Appeal against a tribunal decision		3				1	1		6		7	4	6	1
Decision to impose conditions on a person's registration under section 178	2				7		14		3		26	0	34	1
Decision to impose or change a condition on a person's registration or the endorsement of the person's registration	1			1	1	3	2	11		1	4	16	5	15
Decision to refuse to change or remove a condition imposed on the person's registration or the endorsement of the person's registration	1				1		6	2	1		9	2	6	7
Decision to refuse to revoke an undertaking							1				1	0	0	0
Decision to refuse to endorse a person's registration					1		1				2	0	0	0
Decision to refuse to register a person	1				1		9	1	1		12	1	13	1
Decision to refuse to renew a person's registration		1	1								1	1	2	0
Decision to reprimand a person											0	0	0	0
Decision to suspend a person's registration	5	2			10	1	12	6			27	9	27	14
Other	1			1					4		5	1	2	1
Not an appellable decision									1		1	0	0	0
Judicial review									1	1	1	1	0	0
Total 2021/22	**11**	**6**	**1**	**2**	**21**	**5**	**46**	**20**	**17**	**2**	**96**	**35**		
Total 2020/21	**15**	**5**	**4**	**1**	**12**	**6**	**47**	**25**	**17**	**3**			**95**	**40**

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

Criminal offences

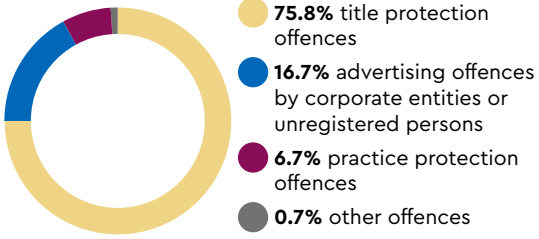
We investigate and, where appropriate, prosecute allegations of criminal offences.

- **418** criminal offence complaints were received
  - **75.8%** related to alleged unlawful use of title and unlawful claims to registration
- **403** criminal offence complaints were considered and closed
- **223** 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
  - **56** complaints were closed

Types of criminal offence

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

Figure 84. Offence complaints received



See page 92 for compliance checks related to advertising.

Figure 85. Offence complaints open, 30 June

One way we ensure access to safe, professional healthcare is to investigate and, where appropriate, prosecute people alleged to have committed criminal offences under the National Law (see Table 35). Only registered practitioners can use protected titles for their profession. It is also an offence to claim to be qualified to practise in a health profession or hold yourself, or someone else, out as a registered health practitioner. Penalties of up to three years' imprisonment and/or a $60,000 fine can be imposed on individuals who commit these offences, and fines of up to $120,000 for companies.

Ahpra successfully prosecuted a number of people found to have committed criminal offences, including:

- 'fake' practitioners with no relevant formal qualifications, who held themselves out to patients and employers as registered practitioners
- practitioners who continued to practise after their registration was suspended by tribunals or a National Board
- people who started work as registered practitioners despite failing to complete their university degree, or failing to meet other registration pre-requisites, and therefore were not registered
- practitioners who continued to practise after they failed to renew their registration, even after they realised they were not registered.

The first sentence of imprisonment under the National Law was handed down this year, which demonstrates the seriousness with which the courts view this type of offending. Courts have repeatedly commented that protection of the public is a paramount consideration under the National Law and that people who unlawfully hold themselves out as health practitioners present a real risk to patients.

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

- **14** proceedings completed in the courts for offences (including 3 appeals)
- **1** matter pending appeal at 30 June.

Outcomes show that Ahpra continues to identify appropriate thresholds for referring offence complaints for prosecution (Table 36).

- **10** prosecutions resulted in a finding of guilt against the defendant; one case was formally discharged; in one case charges were withdrawn
- **6** prosecutions and **1** appeal ongoing at 30 June.

Table 35. Criminal offence complaints received and closed, by type of offence and profession

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 2021/22[1]		Total 2020/21[1]	
	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed
Aboriginal and Torres Strait Islander Health Practitioner	1	1									1	1	1	2
Chinese medicine practitioner	10	8			1	3					11	11	9	14
Chiropractor	9	8	6	4	5	4					20	16	18	15
Dental practitioner	9	12	11	10	4	2					24	24	22	32
Medical practitioner	88	88	2	1	38	26			2	4	130	119	104	105
Medical radiation practitioner											0	0	3	6
Midwife	3	4	1	1							4	5	6	6
Nurse	48	57	3	1	2	3		1			53	62	89	72
Occupational therapist	12	12							1		13	12	14	10
Optometrist	1	1	1	1	2	2					4	4	3	5
Osteopath	4	2	1	1	1	1					6	4	4	5
Paramedic	15	16	1	1							16	17	18	21
Pharmacist	15	14	2		2	2					19	16	16	16
Physiotherapist	13	9			2	4					15	13	25	31
Podiatrist	3	4			2						5	4	0	1
Psychologist	83	86			7	9					90	95	119	121
Unknown[2]	3	3			4	4					7	7	0	0
Total 2021/22	**317**	**325**	**28**	**20**	**70**	**60**	**0**	**1**	**3**	**4**	**418**	**410**		
Total 2020/21	**343**	**356**	**34**	**11**	**70**	**87**	**2**	**3**	**2**	**5**			**451**	**462**

1. All offences under the National Law, not only offences about advertising, title and practice protection.
2. Ahpra also received offence complaints about unregistered persons.

Table 36. Completed prosecutions

Date of decision	Jurisdiction	Relevant Board	Type of offence	Outcome
14 July 2021	Vic	Dental	Holding out as a registered practitioner and performing restricted dental acts after registration lapsed	Fined $5,000 and ordered to pay $6,621 of Ahpra's legal costs. No conviction recorded.
8 September 2021	Qld	Nursing and Midwifery	Holding out as a registered practitioner after registration lapsed	Convicted after failing to appear. Fined $8,000 and ordered to pay $1,500 of Ahpra's legal costs.
3 December 2021	Vic	Nursing and Midwifery	Using a protected title and holding out as a registered practitioner when never registered	Formally discharged without finding of guilt or conviction pursuant to a Diversion Program order. Required to pay $4,030 compensation to the victim with a letter of apology, and to pay $6,500 of Ahpra's legal costs.
20 January 2022 (first instance) 24 March 2022 (appeal)	NSW	Medical	Claiming to be qualified to practise as a health practitioner after failing to graduate university	Convicted and sentenced to two years' imprisonment to be served in the community by way of intensive corrections order (ICO), fined $10,000 and ordered to pay $3,400 of Ahpra's legal costs. On appeal against sentence, the ICO was reduced to 18 months with all other orders confirmed.
25 January 2022 (appeal)	Qld	Medical	Employer holding out a staff member as a registered health practitioner	Defendant fined $6,000 after a trial in October 2020, no conviction recorded. Defendant's appeal against the finding of guilt dismissed and defendant ordered by consent to pay $6,000 of Ahpra's legal costs.
14 February 2022	Vic	Medical	Holding out as a registered practitioner and obstructing an inspector while suspended	Convicted and sentenced to a 24-month community corrections order, including a requirement to perform 300 hours community service and undergo health treatment. Ordered to pay $30,643 of Ahpra's legal costs.
17 March 2022	Qld	Chiropractic	Holding out as a registered practitioner while suspended	Charges withdrawn; no longer considered to be in the public interest given a change in the personal circumstances of the defendant.
29 March 2022 (first instance) 28 June 2022 (appeal)	NSW	Nursing and Midwifery	Holding out as a registered practitioner before registration granted	Convicted, fined $6,600 and sentenced to a 12-month community corrections order (CCO) and a seven-month intensive corrections order (ICO). Ordered to pay $6,530 of Ahpra's legal costs. On the defendant's appeal against sentence, fines reduced to $3,300, and the ICO set aside and replaced with a three-year CCO. Costs order confirmed.
7 April 2022	Vic	Nursing and Midwifery	Holding out as a registered practitioner after registration lapsed	Fined $2,000 and ordered to pay $3,500 of Ahpra's legal costs. No conviction recorded.
12 May 2022	NSW	Nursing and Midwifery	Holding out as a registered practitioner when never registered	Convicted after failing to appear. Arrested on conviction warrant and sentenced to $3,000 fine and ordered to pay $7,200 of Ahpra's legal costs.
12 May 2022	Vic	Nursing and Midwifery	Holding out as a registered practitioner after surrendering registration	Found guilty after a trial. Convicted and sentenced to a three-year adjourned undertaking with conditions, including paying $1,000 to the Court fund and $500 of Ahpra's legal costs. Ahpra has lodged an appeal against sentence.
14 June 2022	Qld	Psychology	Holding out as a registered practitioner when never registered	Fined $7,000, with no costs order sought. No conviction recorded.

Compliance

We monitor any restrictions that are placed on a practitioner's registration and ensure that they comply with advertising requirements.

- **4,740** cases involving **4,735** practitioners were being actively monitored by Ahpra at 30 June.
- When combined with the **1,237** cases being monitored by the HPCA in NSW and OHO in Queensland, this is **less than 1%** of all registered health practitioners.

Restrictions allow practitioners to start or continue providing healthcare while keeping the public safe

Monitoring streams

- **Conduct**
- **Health**
- **Performance**
- **Prohibited practitioner/student**
- **Suitability/eligibility**

There was a 1.9% increase in cases being monitored from 2020/21. The number of monitored cases tends to follow the trend in registration numbers.

Of the 4,740 cases at 30 June (see tables 37 and 38):

- **2,814** cases (**59.4%**), the majority, were about suitability/eligibility for registration
- **1,449** cases (**30.6%**) were about conduct, health or performance
  - **541** for performance
  - **514** for health
  - **394** for conduct
- **477** cases (**10.1%**) related to prohibited practitioners/students.

Quite often practitioners feel that the relationship we have with them is an adversarial one. They think that Ahpra is never going to agree with or understand them. But realistically, so much of our compliance work is focused on assisting practitioners to be able to comply with their restrictions and provide a service to the public in a safe way.

Our objective, yes, is to protect the public – but a lot of times that objective aligns with the objectives of the practitioners. They just want to get back to work, they want as quickly and as reasonably as possible to have their restrictions removed, and so do we.

Staff member

Table 37. Active monitoring cases at 30 June, by profession and stream

Profession	Conduct			Health			Performance			Prohibited practitioner/ student	Suitability/ eligibility[1]	Total 2021/22			Total 2020/21		
	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	Ahpra	Ahpra[2]	HPCA[2]	OHO[3]	Ahpra[2]	HPCA[2]	OHO[3]
Aboriginal and Torres Strait Islander Health Practitioner				1			1				4	**6**	**0**	**0**	3	1	0
Chinese medicine practitioner	5	10	4	1	1		4	6	1	3	750	**763**	**17**	**5**	786	18	4
Chiropractor	10	9	1	2	1		13			10	4	**39**	**10**	**1**	41	9	1
Dental practitioner	10	15	2	13	15		84	28		11	31	**149**	**58**	**2**	165	65	3
Medical practitioner	146	182	28	187	115		278	181	5	135	557	**1,303**	**478**	**33**	1,209	487	29
Medical radiation practitioner		2		7	1		3			6	37	**53**	**3**	**0**	63	1	0
Midwife	3	4		4	3		6	2		3	26	**42**	**9**	**0**	49	9	0
Nurse	121	94	18	244	169		69	74	4	227	906	**1,567**	**337**	**22**	1,519	348	23
Occupational therapist	4	2		3	2		1			2	90	**100**	**4**	**0**	87	5	0
Optometrist		1					3	1		1	6	**10**	**2**	**0**	13	1	0
Osteopath	3	6	1				1			3	8	**15**	**6**	**1**	13	3	1
Paramedic	7	17	2	13	17		1			20	211	**252**	**34**	**2**	240	22	2
Pharmacist	18	81	5	13	18		17	29		23	80	**151**	**128**	**5**	145	148	1
Physiotherapist	13	6	5	4	3		3			8	19	**47**	**9**	**5**	61	11	4
Podiatrist	2			2	7		8	3		3	7	**22**	**10**	**0**	21	7	0
Psychologist	52	15	7	20	22		49	12		22	78	**221**	**49**	**7**	235	41	5
Total 2021/22	**394**	**444**	**73**	**514**	**374**	**0**	**541**	**336**	**10**	**477**	**2,814**	**4,740**	**1,154**	**83**			
Total 2020/21	**396**	**462**	**62**	**508**	**375**	**0**	**563**	**339**	**11**	**449**	**2,734**				**4,650**	**1,176**	**73**

1. Ahpra monitors compliance cases in the 'suitability/eligibility' stream in NSW.
2. The Ahpra data structure provides reports by monitoring cases established rather than by registrants being monitored. This is because a registrant may have a set of restrictions (conditions or undertakings) in more than one stream. The 4,740 Ahpra monitoring cases relate to 4,735 registrants. The data provided by the HPCA report the number of registrants being monitored.
3. In Queensland, Ahpra monitors all stream cases except where the restrictions are imposed by OHO as immediate registration actions. The OHO data count each of these actions separately, and not by practitioner under monitoring. In a small number of circumstances, one practitioner may be monitored in relation to more than one immediate registration action. A single immediate registration action may relate to more than one stream. These cases have been categorised according to the stream that comprises the bulk of the immediate registration action. These data exclude interim prohibition orders against registered practitioners that are currently being monitored.

Conditions, undertakings or restrictions?

Many practitioners find restrictions difficult, but they are a way of allowing practitioners to provide healthcare while keeping the public safe.

Restrictions can be put in place during the initial application or renewal process; for example, when a practitioner is:

- returning to practice after an absence
- changing their scope of practice
- not fully meeting the eligibility requirements or other registration standards.

A National Board may decide that a practitioner can be registered and provide healthcare while the shortfall is addressed through supervision, additional education, mentoring or limiting scope of practice.

Restrictions can also be used in response to a notification where a Board believes that:

- a practitioner has demonstrated performance or conduct that is unsatisfactory
- a practitioner has or may have a health impairment that may affect public safety
- it is in the public interest.

For example, a practitioner alleged to have entered into an inappropriate sexual relationship with a patient may be prohibited from seeing patients of that gender while the investigation is underway, under the process of immediate action. A practitioner with an alcohol-use disorder may be required to conduct supervised breath tests before each shift.

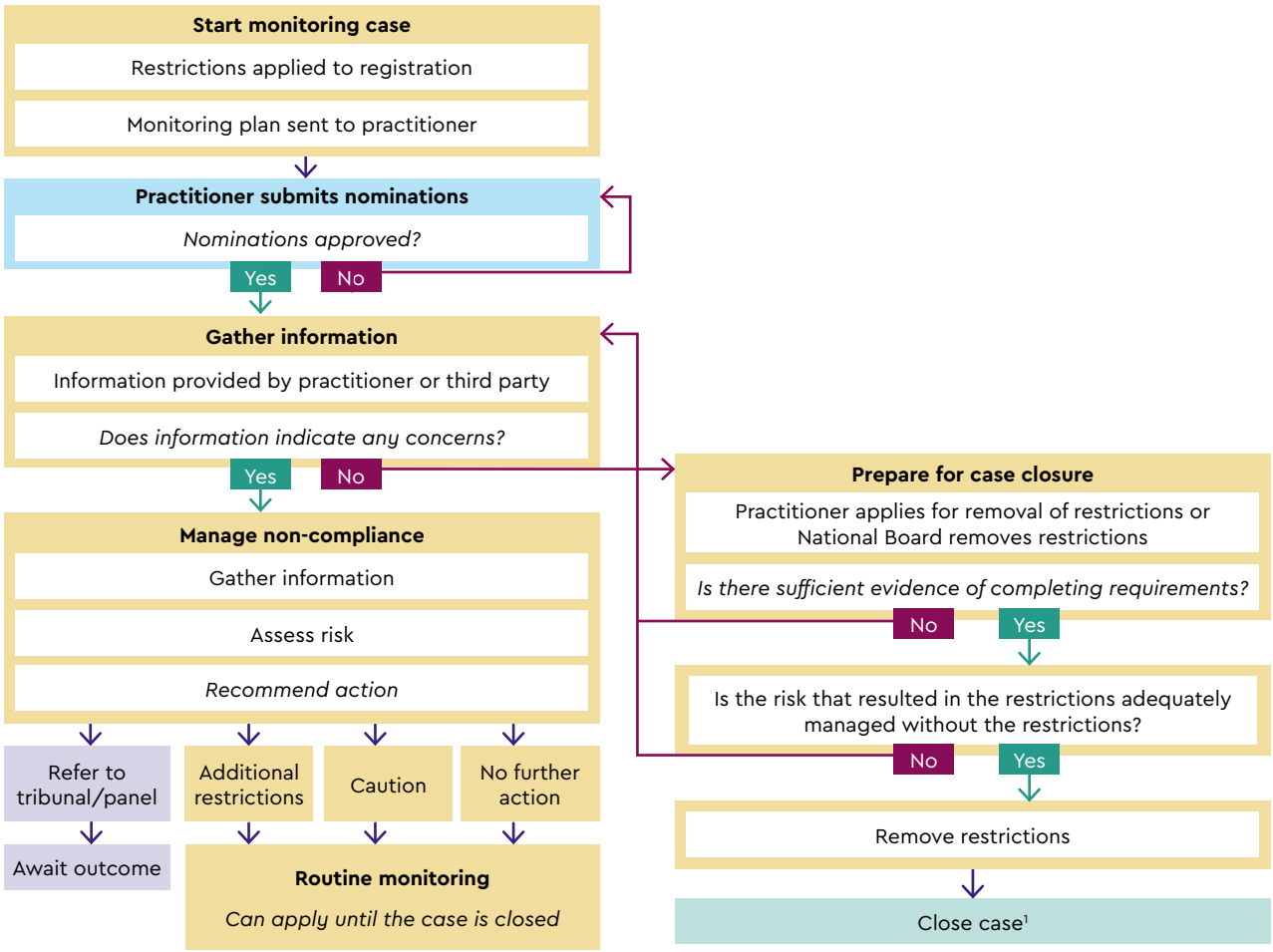
Where a Board imposes the requirements, we use the term *conditions*. Sometimes a practitioner is aware of what they need to do and provides an enforceable *undertaking* that they will meet additional requirements. We use the term *restrictions* to include both conditions and undertakings.

Table 38. Active monitoring cases at 30 June, by state or territory

Stream	Ahpra									Ahpra subtotal[3]	HPCA[4]	OHO[5]	Total 2021/22	Total 2020/21
	ACT	NSW[1]	NT	QLD	SA	TAS	VIC	WA	No PPP[2]					
Conduct	10	3	9	90	60	17	150	52	3	**394**	**444**	**73**	**911**	**920**
Health	10	7	9	188	61	21	147	65	6	**514**	**374**		**888**	**883**
Performance	15	8	10	173	68	22	174	68	3	**541**	**336**	**10**	**887**	**913**
Prohibited practitioner/student	9	1	11	103	78	16	182	66	11	**477**			**477**	**449**
Suitability/eligibility[6]	65	1,028	11	494	183	49	586	295	103	**2,814**			**2,814**	**2,734**
Total 2021/22	**109**	**1,047**	**50**	**1,048**	**450**	**125**	**1,239**	**546**	**126**	**4,740**	**1,154**	**83**	**5,977**	
Total 2020/21	**93**	**1,059**	**65**	**996**	**462**	**112**	**1,206**	**556**	**101**	**4,650**	**1,176**	**73**		**5,899**

1. Includes cases to be transitioned from Ahpra to the HPCA for conduct, health and performance streams.
2. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
3. The Ahpra data structure provides reports by monitoring cases established rather than by registrants being monitored. This is because a registrant may have a set of restrictions (conditions or undertakings) in more than one stream. The 4,740 Ahpra monitoring cases relate to 4,735 registrants.
4. The data provided by the HPCA report the number of registrants being monitored. The HPCA monitors practitioners in relation to health, performance and conduct in NSW.
5. OHO data count by immediate registration action, and not by practitioner under monitoring. In a small number of circumstances, one practitioner may be monitored in relation to more than one immediate registration action. A single immediate registration action may relate to more than one stream. These cases have been categorised according to the stream that comprises the bulk of the immediate registration action. These data exclude interim prohibition orders against registered practitioners that are currently being monitored.
6. Ahpra monitors compliance cases in the 'suitability/eligibility' stream in NSW.

Figure 86. How monitoring works



1. When a practitioner's registration is suspended or cancelled by a tribunal, a case is not closed, but may be maintained as a 'prohibited practitioner case'.

How we monitor

We gather information to monitor health practitioners and students with restrictions on their registration or whose registration has been suspended or cancelled, and to assess compliance with restrictions. The types of information we gather are listed in the restrictions. Monitoring plans are used to guide our monitoring and compliance activities, and to help practitioners understand what is required of them and how to comply with the restrictions (see Figure 86).

For example, a practitioner subject to supervision restrictions is required to find a potential supervisor and nominate them for Board approval. The monitoring plan shows the practitioner when the supervision plan and forms are due, how to access them from our website, and where to submit the information. After we receive the supervision plan and the Board approves the supervisor, we receive routine reports from the supervisor to confirm that the practitioner is progressing as expected. Once the practitioner has achieved the required hours of supervision or the required standard of competence, they can apply to have the restrictions reviewed. We seek a final report from the supervisor, and the Board considers removal of the restrictions.

We have a National Restrictions Library on our website (www.ahpra.gov.au/Registration/Monitoring-and-compliance/National-Restrictions-Library) and we use the same wording about restrictions for similar cases. This ensures that the restrictions are achieving the desired outcome, are understood by practitioners and that we can develop consistent monitoring plans.

Where a practitioner does not do what the restrictions require, we first seek an explanation from them. The Board may choose to take additional regulatory action, such as a caution or additional restrictions, to ensure the public remains protected.

Prohibited practitioners

We also monitor a group of practitioners who are not permitted to practise because they have had their registration cancelled or suspended, have surrendered their registration or are restricted from practising.

- Tribunals have the power to **cancel** a practitioner's registration – these practitioners must reapply for registration after an imposed minimum period of time.
- Tribunals and panels can **suspend** a practitioner's registration – these practitioners have their registration reinstated at the completion of the period of suspension.
- Boards are able to suspend a practitioner through an **immediate action** while awaiting completion of an investigation or an assessment.
- Boards can impose conditions or accept undertakings that **restrict the practitioner from practising** until some other requirement is met.
- Some practitioners who are subject to a notification may **surrender** their registration or request a non-practising form of registration.

We monitor these practitioners to confirm they are not practising. We do this by communicating with former employers, conducting site visits, checking advertising and ensuring that the original issues are reviewed if the practitioner subsequently applies for practising registration.

Compliance activities and initiatives

We publish additional guidance to help practitioners understand our processes

We recognise that having to comply with restrictions can be confusing and stressful for practitioners. We published additional guidance to help practitioners understand our processes, including information on how to ask the Board to change or remove restrictions, and on the evidence that a Board is likely to need to help in making the right decision.

Supervision is our most common restriction category, so we have provided extra advice on the expectations of supervisors and supervisees. For most professions we have a common *Supervised practice framework* with extensive guidance and templates.

We have also published a frequently asked questions page on our website and continue to improve the language in our correspondence to make it clear to practitioners what they need to do next.

Restrictions most often placed on practitioners

Each restriction on a practitioner's registration is assigned a restriction category. Where a practitioner is subject to multiple restrictions they will have multiple restriction categories – this results in a greater number of total restrictions on practitioners than total cases being monitored.

The top 10 restriction categories by volume being monitored by Ahpra at 30 June contained 6,314 restrictions (see Table 39).

- **65.9%** (4,162) of restrictions in the top 10 restriction categories were imposed following assessment of an application for registration or renewal of registration.
- **34.1%** (2,152) of the restrictions in the top 10 restriction categories were imposed because of a finding made by a National Board, panel or tribunal about a practitioner's health, performance or conduct.

Table 39. Top 10 restriction categories, 30 June

Restriction category	Total
Requirement for supervision	**1,628**
Restriction on practice and employment	**1,604**
Undertake education	**524**
Undertake assessment	**500**
Attend treating practitioner	**478**
Restriction on scope of practice	**430**
Prohibition on practice	**358**
Restriction on workplace location	**297**
Requirement to practise under indirect and remote supervision	**255**
Requirement to have a mentor	**240**

Outcomes from monitoring cases

We close a monitoring case when the restrictions are no longer required.

When a practitioner has completed the requirements of the restrictions they can apply to the Board to remove the restrictions. The case is then closed.

When a practitioner's registration is not renewed we close the case but retain important information to ensure that we consider the practitioner's regulatory history for any subsequent applications.

During the year we created **2,129** new monitoring cases and closed **2,037**, leading to an increase in overall cases. Of the cases we closed:

- **1,325** cases were closed because the restrictions were removed
- **651** were closed because the practitioner was no longer registered
- **61** were closed for other reasons.

Investigating complaints about advertising

Assessment of complaints

We assessed **499** advertising complaints. Of these:

- **70** were complaints about corporate entities or unregistered persons, or assessed as serious-risk complaints
- **429** were lower risk complaints about registered health practitioners and assessed under the *Advertising compliance and enforcement strategy*:
  - **299** were assessed as lower risk potential breaches (157 in 2020/21, 412 in 2019/20); this represents a return towards pre-COVID numbers
  - **130** cases had no breach identified.

A further **15** enquiries were 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.

Sometimes practitioners do not realise what they are not allowed to claim when they advertise. We provide information to help them. An example would be where a chiropractor claims that treatment can boost immune functions but there is no acceptable evidence to validate this claim. Removal of the claim would result in closure of the complaint.

Where practitioners fail to correct their advertising, we propose to take regulatory action by imposing conditions on the practitioner's registration. There were 97 instances of practitioners correcting their advertising following a formal proposal to take regulatory action, and no instances where we needed to impose conditions.

See page 85 for action taken about advertising that is unlawful.

Proactive advertising strategy

Work continued our two-year-long advertising audit of a random sample of 1,231 practitioners across 13 health professions.

We search for any advertising by each practitioner across the internet, including social media, and assess a sample of the content we find against our guidelines for advertising a regulated health service. This audit supplements our complaints-based approach to advertising breaches and helps us understand the rates of advertising in each profession along with the frequency of issues identified and any common themes. We use the information to improve our guidelines and website, and our engagement with practitioners.

Improving health practice

Research and evaluation to improve regulation

Projects

Research projects focused on:

- gaining ethical approval for the evaluation of the COVID-19 pandemic sub-register
- publishing snapshots of trend data for all professions
- literature and rapid evidence reviews on:
  - reflective practice as a protective factor for health practitioner continuing professional development (CPD)
  - systematic review of the evidence and efficacy of CPD and recency of practice requirements for health practitioner regulation
- beginning agency-wide multiyear work examining trust and confidence in regulatory functions across a broad range of stakeholders.

Our research and evaluation work improves our regulatory effectiveness and helps us become an evidence-informed regulator

Access to data for research

The comprehensive national regulation data that Ahpra collects have registration, workforce planning, demographic, commercial and research value, but 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. A summary of the requests we received is shown in Table 40.

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 40. Requests for access to data for research

Type of data access request	Number of requests	Information able to be provided	Approved for release
Request to contact or survey practitioners	9	2	2
Copies or extracts of the *Register of practitioners*	30	24	24
Quantitative statistics (regulatory data)	37	16	15
Research data	1		
Other (general information)	29	7	7
Total	**106**	**49**	**48**

Research ethics

We used the ethics pathway established with the Prince Charles Hospital Human Ethics Committee in line with best practice research and the National Health and Medical Research Council's ethical requirements. Ethics approval was granted for 14 projects, including:

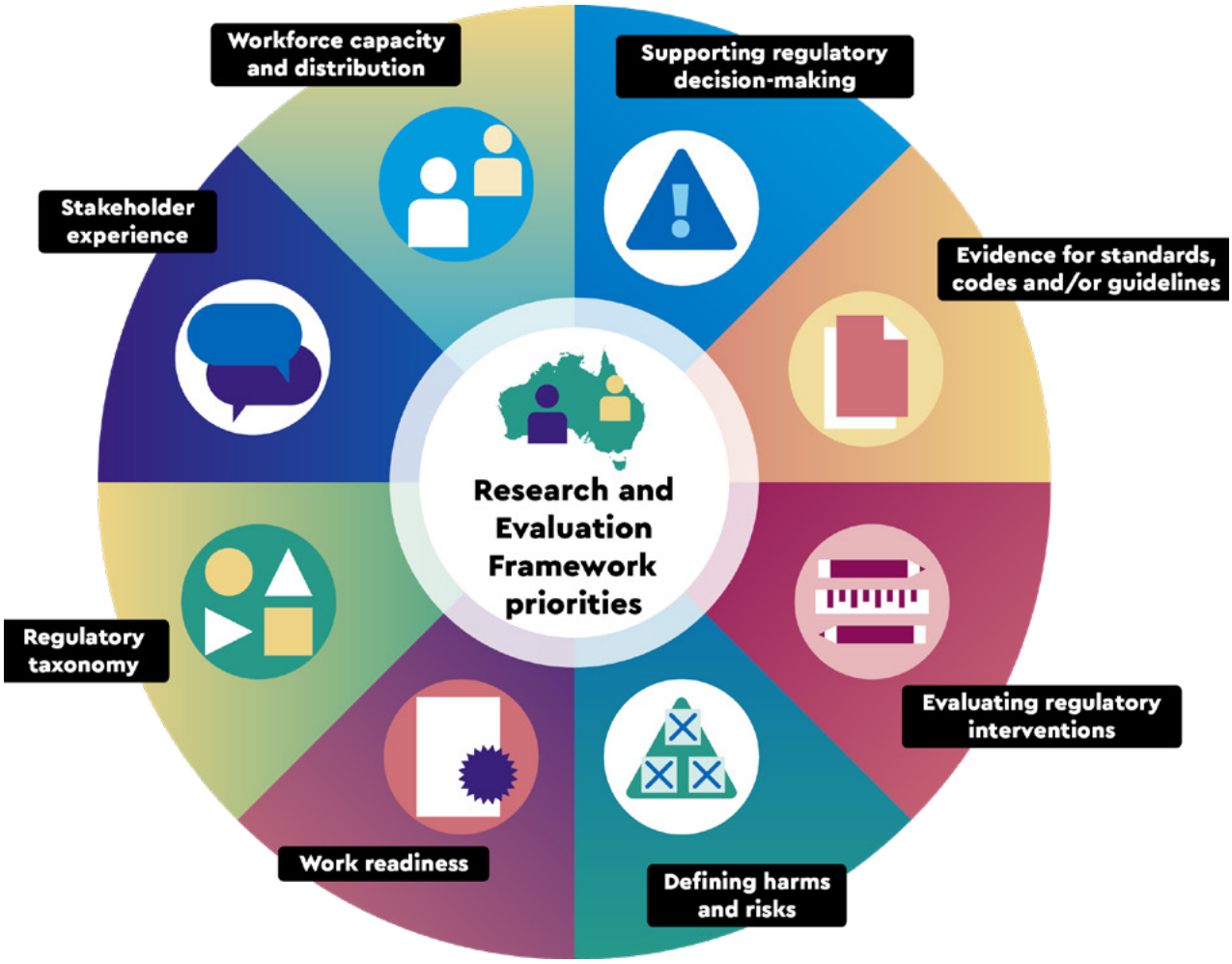
- Workforce trends of Ahpra-regulated professions
- Exploring positive experiences of the notification process
- Notifier Support Service evaluation
- Examination of notifications involving people of Aboriginal and/or Torres Strait Islander origin
- Coronial inquest analysis
- Identifying and minimising the risk of self-harm and suicide in practitioners with a current regulatory matter: a quality improvement project
- Identifying and minimising the risk of distress in practitioners subject to regulatory action: a quality improvement project
- Post-implementation review of the professional capabilities for medical radiation practice
- Pandemic response 2020 and 2021 sub-registers: data analysis, surveys, interviews and notifications about practitioners on the sub-register
- Operation Reset evaluation
- Identifying and improving stakeholder access and use of the Medical Training Survey (MTS): an impact assessment plan.

We developed a research and evaluation policy and supporting processes for Ahpra and the National Boards, including an internal Advisory Committee to provide advice about when an ethics review is required.

Publications

We produced two publications in peer-reviewed health journals, to share knowledge:

- Biggar S, Fletcher M, Van Der Gaag A & Austin Z (2022). 'Finding space for kindness: public protection and health professional regulation', *International Journal for Quality in Health Care*, 34(3). https://doi.org/10.1093/intqhc/mzac057
- Main P & Anderson S (2022). 'Evidence for continuing professional development and recency of practice standards for regulated health professionals in Australia: protocol for a systematic review', *JMIR Research Protocols*, 11(4). https://doi.org/10.2196/28625



Collaborating on shared policy issues

The National Boards and Ahpra regularly collaborate on shared policy issues that affect professions similarly. This collaboration facilitates effective and collaborative care, supports good interprofessional 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

As the COVID-19 pandemic continued, registered health practitioners played a pivotal role in treating and containing COVID-19 and supporting the national vaccination program. We continued to work with the National Boards to support timely, proactive regulatory responses. As part of our efforts to support health practitioners, we:

- extended the modification to the National Boards' English language skills standard test pathway
- temporarily approved additional English language tests.

Supporting professional practice

We published a new *Resources* section on the Ahpra website (www.ahpra.gov.au/Resources) to create a helpful hub to support practitioners' professional practice and help the public make safer health choices.

We also issued several position statements to provide further advice and guidance on the National Boards' expectations of registered health practitioners in response to emerging issues about the COVID-19 pandemic, including *Facilitating access to care in a COVID-19 environment: Guidance for health practitioners*.

'Employers are our partners in helping protect the public.

We need to work with them so they can get greater clarity of their responsibilities within our regulatory systems.'

Staff member

Policy support and coordination

Ahpra develops policy resources and tools to support regulatory policy development and provides policy advice to the National Boards. Together with the National Boards we provided input to external policy consultations and reviews for:

- Australian Government Department of Health review of Declaration of Relevant Professional Bodies under the *Health Insurance Act 1973*
- Australian Government Department of Health consultation on proposed refinements to the framework for regulation (by the Therapeutic Goods Administration) of personalised medical devices
- Victorian Department of Health consultation on authorising additional surge workforce to participate in Victoria's COVID-19 vaccination program
- ACT Health Directorate consultation on temporary COVID-19 vaccine authorisations at public clinics
- Australian Commission on Safety and Quality in Health Care (ACSQHC) consultation on Intellectual Disability Resources
- Victorian Department of Health Public Health Emergency Orders
- National Skills Commission (NSC) Skills Priority List Stakeholder Survey
- Victorian Department of Health – Amendment of Secretary Approvals for Nurse Immunisers and Pharmacist Immunisers
- National Prescribing Service (NPS) MedicineWise Prescribing Competencies Framework
- Victorian Government – Consultation paper – Non-fatal strangulation
- NSW Ministry of Health consultation – Draft Medicines, Poisons and Therapeutic Goods Bill.

Work progressed

So that the National Boards' regulatory requirements remain contemporary and relevant, we:

- established a *Supervised practice framework*, which allows for a responsive and risk-based approach to supervised practice across the National Scheme for 13 professions (with some profession-specific exclusions)
- finalised and published a revised shared *Code of conduct*, which applies to practitioners in 12 professions – the revised code supports good patient care and the delivery of services within an ethical framework, helping to keep the public safe; it was published in English, one-page summaries were published in five other languages, and an Easy English version was developed, which will be published in late 2022
- continued work on a joint review for 14 professions of the English language skills registration standards (ELS standards), to start public consultation on revised draft ELS standards in July 2022.

Regulatory insights

Our work gives us 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 to 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.

In the past year, we identified risks to the public and for practitioners in five areas.

Professional indemnity insurance

Most cases we see of lapsed professional indemnity insurance (PII) are accidental occurrences.

The professional indemnity insurance registration standard is an important part of protecting the public by addressing the risk posed by uninsured practitioners. The requirement to have PII in place ensures financial protection for both practitioners and the public in the event of an adverse occurrence.

Some employers provide PII but not all. It is the responsibility of all practitioners to ensure both they and their patients are protected.

To manage this risk

- Practitioners are encouraged to be aware of what, if any, insurance their employer has in place, and remember that general public liability insurance is not sufficient to meet the registration standard.
- Technology can be a great assistance for reminders – practitioners can use diaries or calendars to monitor their PII renewals, or use any other method they currently employ to remember to pay a regular bill or take a regular action.
- Practitioners should take care to keep their insurance provider up to date with their current contact details, and add their PII provider to any checklists of details to update if they are changing or leaving jobs or moving home.
- It is essential that practitioners consider very carefully the declarations they make at each registration renewal. A declaration that you won't practise without having PII in place is a serious statement and a practitioner may face disciplinary procedures if it turns out to be incorrect.
- If a practitioner discovers at renewal or at any other time that they have practised without adequate PII, the smoothest way to resolve this is to promptly advise the regulator, address the omission and seek retrospective cover.

Complaints handling

Health consumer feedback is a valuable part of the quality improvement cycle. Complaints help to identify areas in need of improvement and uncover any real or potential failures from a consumer perspective.

Every day Ahpra learns about complaints to practitioners that are not managed well and have been escalated to us. These range from a failure by a practitioner to respond to a patient's needs, to an unsatisfactory open disclosure process, and everything in between. When a notifier tells us that they complained to a practitioner before notifying us, this means that the practitioner had an opportunity to avoid the notification by resolving it directly with the notifier.

To manage this risk

- There are multiple pathways and platforms for complaints, and a wide variety of supporting tools for practitioners on how to manage complaints.
- First and foremost, consumers and carers deserve to be treated with respect and dignity, and to have their concerns treated as genuine and to be properly followed up on. Practitioners can demonstrate this respect through taking the time to provide a considered response and to share information on how they intend to prevent a future occurrence. For example, practitioners may wish to consider:
  - if their complaints-management approach is one of learning and continuous improvement or one that is more defensive
  - whether they could benefit from understanding more about complaints management as part of their continuous professional development
  - applying an approach more consistent with the National Safety and Quality in Health Service's Partnering with Consumers Standard to get better outcomes in relation to patient complaints.
- When dealing with a person who has made a complaint, practitioners can use this as an opportunity to consider how they could have avoided the complaint by managing the interaction differently.

Informed consent

Informed consent is a critical part of a patient's relationship with their whole healthcare team, and consumer expectations of accountability and responsibility continue to grow. Informed consent procedures must include providing information to patients in a way they can understand before seeking their consent, and clearly explaining the risks and benefits of the proposed treatment. A shared understanding between the practitioner and patient helps to avoid future confusion.

Any kind of physical examination that is poorly explained or conducted can result in patient distress and a notification.

Managing informed consent well can prevent dissatisfaction and misunderstandings later. It is essential for practitioners to consider if the patient understands the information provided, keeping in mind that most patients do not have the same knowledge and experience of healthcare and procedures as the practitioner. This is especially important where a patient's cultural experience or background may mean they have different expectations to the practitioner.

To manage this risk

- Practitioners can reflect on their practice and ensure they are up to date in contemporary approaches to informed consent discussions. The expectations of Boards are recorded in their codes of conduct and regularly supported by information distributed from professional associations and organisations. There are many educational and other resources available from reputable professional sources to support best practice.
- Remember that informed consent is individual to each patient and that what is sufficient for one person may not be so for another. Take the time to ensure your patient understands and is comfortable with the treatment plan, including its limitations and risks.
- Maintaining clear, accurate and contemporaneous clinical records will assist in demonstrating a commitment to best-practice informed consent should there be a need to resolve issues in the future.

Social media

Being a registered health practitioner carries a level of respect and expectation in our communities and a high level of trust. When practitioners post or share information on social media, the public might give that information more weight than that coming from other commenters, and view it in the context of the practitioner's professional knowledge.

To manage this risk

- Practitioners should manage social media privacy settings carefully to ensure they are engaging with people they trust and want to communicate with.
- Practitioners should take care to maintain careful boundaries between personal and professional personas. If a practitioner is providing a professional opinion or one that reflects on the professional opinion of others, the practitioner will need to consider compliance with the relevant code of conduct.
- Social media is not a place to engage with patients and consumers as the boundaries can easily become blurred between personal and professional. This can happen regardless of the intent with which a practitioner takes part in an interaction.
- If engaging with consumers on social media is part of a practice's structured communication approach, it's important to apply usual workplace practices and good record-keeping requirements.

Providing care to family and friends

The requirements of Boards around providing care to family and friends vary by profession, and practitioners should make sure they are aware of their professional obligations.

It's also important to be aware of local requirements – states and territories have specific rules preventing prescribing to friends and families, which practitioners also need to meet.

The risks of providing care (including prescribing) to family and friends include potential lack of impartiality, lack of clarity on expectations and the potential for boundaries to be blurred.

Providing *ad hoc* care to family and friends can prevent them from seeking appropriate support or more specialised care from the wider healthcare community and could, despite good intentions, compromise their care.

To manage this risk

- It is preferable not to provide care to family and friends and to keep personal and professional boundaries separate.
- Directly engaging with a primary treating team is the best pathway to care. Supporting family and friends to access care from an appropriate colleague is the best way to help.
- If a practitioner does provide care to family or a friend, including a prescription or medication, they should maintain good records, communicate with other professionals involved in care, and support safe transition of care to another practitioner at the earliest opportunity.

Strategy

Arranging our strategy into themes helps us to communicate how we will achieve our vision

Regulatory effectiveness

Efficient and effective core regulatory functions include being responsive to the rapidly evolving nature and scope of health practitioner practice and ensuring that our management approaches achieve long-term sustainability.

Initiatives

- **Implementing a risk-assessment and control framework** to manage investigations. We established new processes managing investigations, provided new resources and guidance to support our investigation teams and increased the number of completed investigations.
- **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. A new cost allocation framework was approved by the National Boards and moved to the next stage of consultation.
- **Building a contemporary and user-friendly technological interface** for our regulatory operations. The preparation stage was completed and the detailed design stage is underway.
- **Implementing an Enterprise Project Methodology**, which has standardised our approach to project management and enabled greater oversight of the status of our projects.

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.
- **Improving and promoting the search function of the public register** and improving the quality of published information on registered health practitioners. Phase 2 of this initiative was on track for release in late 2022.

Trust and confidence

We are focused on strengthening the trust and confidence that the public, health practitioners, organisational partners and other stakeholders have in the National Scheme.

Initiatives

- **Continuing to provide 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. Despite the challenges of conducting face-to-face learning, 1,443 participants have enrolled in the program, and 1,082 have completed it since it began in February 2021.
- **Providing easier access to information** for all Ahpra stakeholders. We began redesigning our website.

Capability and culture

We are working to create 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.

Initiatives

- **Developing a 'culture roadmap'** that defines our aspirational culture. In the 'discovery' phase we identified a strong connection between employees' personal values and Ahpra's values of integrity, respect, collaboration and achievement.
- **Continuing to implement a Leadership Development Framework** and supporting programs to continuously improve management and leadership capabilities. Surveys about Ahpra's COVID-19 response revealed that most staff are comfortable with how our leaders engaged with them during the pandemic. A 'Foundations of leadership' program was launched in September for new and emerging leaders.
- **Supporting our people through our flexible working policy**, for better balance of work and personal commitments.
- **Expanding our wellbeing program** to create psychologically safe workplaces and ensure easily accessible programs and support services are in place. Our 'Leading with care' and 'Reflective practice' programs were implemented to reduce risk of vicarious trauma.
- **Continuing to implement actions from the Ahpra Aboriginal and Torres Strait Islander Employment Strategy 2020–2025**. Targeted recruitment activities saw application rates from Aboriginal and Torres Strait Islander–identified candidates more than double in the 12 months to 30 June 2022.

Engagement

We take actions to improve notifier and practitioner experience.

We try to understand how practitioners who have a notification made about them or people who notify us about a practitioner find that experience because we want to make that process easier for them.

Things like the communication they have with us, how much time it takes or their understanding of the outcome. We want to improve what we do to make that experience better for everyone.

Access project

We have an extensive approach to engagement with a very broad cross-section of external stakeholders. With public safety at the core of what we do, it's essential that the National Scheme is accessible to the public. This year, a primary aim of our engagement work was to listen to communities who may find us harder to access.

Most community leaders we spoke with felt there was little knowledge of health complaints systems within their community. Concern about future care, lack of understanding of the system and the rights of consumers, as well as cultural beliefs were commonly noted as barriers to making a complaint or notification.

> **It's not easy to raise the complaint directly with the GP or health professional in our culture, it's not easy to say that 'you're doing a bad job', that sort of thing ... In our culture it's not easy to give feedback directly to the person doing a bad job.**
>
> Participant, Vietnamese focus group

When asked how they would respond to a poor or unsafe experience of healthcare, most focus group participants said they would not complain.

> **I choose queer-friendly doctors. If I can't find them locally, sometimes I make the 1,000 km roundtrip drive to Perth to find them.**
>
> Participant, LGBTQIA+ focus group

The emerging themes about trust, clear information and the importance of signalling and providing a safe experience inform Ahpra's work to ensure accessibility for all communities.

Understanding practitioners' perceptions of us

We surveyed a random sample of health practitioners for the fourth consecutive year, hearing from 14,551 respondents across the registered professions. We found a strong association between practitioners' understanding of our work and their sentiment toward us: practitioners who rated their understanding higher tended to have more positive views.

We also used a machine learning technique called topic modelling to explore themes of trust and distrust across the thousands of free text responses to the survey. Topic modelling clusters similar words or phrases to reveal patterns in qualitative data. We found that distrust was coloured heavily by the response to the COVID-19 pandemic, and that trust related to statements about the perceived impartiality, value of work, and quality of people within Ahpra and the National Boards.

We are using the findings of this survey to develop a more comprehensive five-year plan for research that will support activities to strengthen trust and confidence in our work.

Service charter

Ahpra released an updated *Service charter*, which identifies high-level principles that guide our work and help us meet our vision for communities to have trust and confidence in regulated health practitioners.

This charter is our commitment to you. It is the standard of service you can expect from us.

Fair and respectful	Transparent	Responsive	Empathic	Accountable
We will treat you fairly and with respect. **We will listen to you.**	**We will be clear about what is/isn't possible and share everything we can.**	**We will act in a timely way.** **We will keep you informed about what is going on, what to expect and when.**	**We will respect your point of view and try to understand your situation.**	**We will offer an explanation and apology when a mistake is made.** **We will encourage your feedback so we can continually improve.**

When you contact us for information, we will:

- generally respond to your phone call or email within 5 business days
- avoid handing you from person to person
- only refer you to a formal process, such as FOI, where an informal one isn't possible
- give an explanation if we are unable to complete your request or if we can't provide information to you.

When you seek or renew registration, we will:

- provide a time estimate for your application to be processed
- contact you if we need more information from you
- finalise your application within 10 business days, once we have everything we need, unless your application is complex or needs to be referred to a Board.

When you raise a concern* about a practitioner, we will:

- talk to you about the concern and listen to your experience
- recognise that your concern is important to you and that the experience may be challenging
- tell you what to expect and when
- update you as things progress, or a change occurs
- provide reasons which explain the decision that has been made.

When you have a concern raised about you, we will:

- call to tell you that we have received a concern
- recognise that being the subject of a concern may be confronting and that the experience may be challenging
- tell you what to expect and when
- update you as things progress, or a change occurs
- provide reasons which explain the decision that has been made.

When there are changes to your registration, we will:

- update the online public register within 1 business day of changes being finalised
- establish a monitoring plan for you within 30 business days of the decision, if restrictions are imposed on your registration.

When you make an administrative complaint about Ahpra, we will:

- acknowledge and try to resolve your complaint within 2 business days
- if more complex, respond within 20 business days
- provide information about how to raise your concern with the National Health Practitioner Ombudsman (NHPO) if we are unable to resolve your complaint.

There may be times when our ability to carry out this charter is limited by the Health Practitioner Regulation National Law, most commonly with the amount of information we can provide.

Learn more at **www.ahpra.gov.au** or call **1300 419 495**

*Note that in NSW, Ahpra does not normally manage concerns.

Communicating

We actively engage with people by phone, through our website, social media, and by letter and email. Since COVID-19 we see people face-to-face less often.

We consult extensively. We talk and listen to practitioners, members of the public, governments, professional associations, community groups and the media.

The Ahpra website was viewed more than 29 million times.[1] The most frequently visited section was 'Registration' with more than 13 million unique page views, then 'Online services' with more than 2 million unique views. The *Register of practitioners* was the most popular individual page with almost 8 million unique views, followed by the home page with more than 4.5 million unique views.

We published 617 news items, including 37 media releases.

We responded to 481 media enquiries.

Our national Customer Service team answered an average of 766 telephone calls and responded to 278 web enquiries each business day. Compared with the previous year, calls were down by 9% and web enquiries were up by 24%. Almost one-third of callers opted to use the call-back service, meaning they were able to retain their place in the queue without waiting on hold.

We published 18 episodes of our *Taking care* podcast. The theme that guided this year was 'The patient voice: Opportunities for safer healthcare'. We had more than 23,500 listens (up 11% from last year), with an average of 65 per day (up 19%).

We published 61 National Board newsletters, with an average open rate of 63.2%.

Our social media posts were seen more than 3 million times and received 135,109 interactions (likes, shares and comments). We increased our audience across all platforms, with 106,453 LinkedIn followers, 77,715 Facebook interactions (likes, comments, views, shares and clicks), 11,416 Twitter followers and 2,798 Instagram followers.

1 Web statistics include staff working remotely as well as external visitors.

Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025

We made significant progress in the second year of implementing this strategy.

Health Strategy Group

The Aboriginal and Torres Strait Islander Health Strategy Group identified the need to change its *Terms of reference*. Key proposals include partnering with the National Health Leadership Forum – a self-determining external group of Aboriginal and Torres Strait Islander health bodies – a membership change, and delineating operational activity from strategic.

Increased participation

The Aboriginal and Torres Strait Islander Health Strategy Unit was established in August with a new identified National Director role, affirming our commitment to supporting Indigenous leadership and knowledge.

The National Boards committed to funding the recruitment of seven identified roles across Ahpra to lead key project deliverables. Targeted recruitment campaigns also resulted in the appointment of 13 Aboriginal and Torres Strait Islander Board and committee members.

Embedding cultural safety

A working group provided feedback on embedding cultural safety into 24 key documents, including profession guidelines, accreditation standards, policies and strategies.

Cultural safety plans were developed for each area of Ahpra, focusing on implementing the goals of the Strategy and embedding learnings from Moong-moong-gak cultural safety training into the daily practice of staff. This helps share accountability and act on our commitment to culturally safe practice.

Employment strategy

Progress was made in the priority area of attracting and recruiting Aboriginal and Torres Strait Islander candidates. Recruitment, selection and appointment procedures were updated, and a new policy was implemented that allows the application of special measures provisions within various anti-discrimination laws. Relationships were established with Indigenous recruitment agencies and job boards and seven identified roles were created.

Reconciliation Action Plan (RAP)

All commitments are on track to deliver Ahpra's first Innovate-level RAP. There was a significant increase in engagement with Aboriginal and Torres Strait Islander stakeholders and an increased expenditure with Indigenous businesses. Ahpra partnered with Supply Nation to change the way purchases are made and formalised Aboriginal and Torres Strait Islander businesses as preferred suppliers.

Moong-moong-gak cultural safety training

The Moong-moong-gak cultural safety training includes eight hours of online self-paced learning and an eight-hour face-to-face workshop.

The challenge over the past 12 months was upholding the integrity of the delivery of the training while managing the impact of COVID-19 restrictions and travel limitations. The success of the training is largely attributed to the adaptability and flexibility of the suppliers, PwC Indigenous Consulting, working in partnership with Ahpra.

The impact of the training can be captured in the feedback received.

'Being an immigrant, I am no stranger to racism, but hearing the experiences of our facilitators and their families was confronting. Still, it emphasised why all of us must be aware of the history of Aboriginal and Torres Strait Islander Peoples and how we can be allies. Statutory Appointments identified some immediate changes that can be made to Board and committee application forms.'

Staff member

'The training was an amazing and insightful experience. The personal reflections of the facilitators added to my sense of urgency, and I heard a clear message to do more than feel angry and guilty about the racism against First Nations people and disappointment with my school curriculum. I will pay greater attention to ensuring Finance and Risk eliminates systemic racism from our systems and processes.'

Staff member

Consulting advisory groups

Professions Reference Group

Chaired by Mr Nello Marino from the Australian Podiatry Association, the Professions Reference Group (PRG) met six times. It brings together professional associations for each of the regulated health professions. It provided feedback on the revised Regulatory Principles for Ahpra, the new-look *Register of practitioners*, the use of the title 'surgeon', the review of the regulation of registered health practitioners in cosmetic surgery, and the partnership for patient safety (our joint project with the Australian Commission on Safety and Quality in Health Care).

Ahpra updated PRG members on our COVID-19 surge workforce response, the start of the Notifier Support Service, the health consumer complaints process, the proposed legislative amendments to the National Law, updates on our accreditation work, and fee setting in the National Scheme.

Community Advisory Council

Ahpra worked with the then Community Reference Group (CRG) to amplify the voice of the community, and revise the CRG's terms of reference to take a more proactive involvement in the National Scheme and ensure a diverse and inclusive membership. As a result, the CRG was renamed the Community Advisory Council (CAC).

Four new members were recruited in December and there are now two members who identify as Aboriginal and/or Torres Strait Islander. Ms Patricia Hall was appointed Chair starting 1 January, sharing a transition arrangement with Mr Mark Bodycoat as co-Chair until June. Mr Bodycoat had chaired the CRG since its inception in 2013.

The CAC provided important advice on our work to enhance the *Register of practitioners*, the review by governments of use of the title 'surgeon' by medical practitioners, regulation of health practitioners in cosmetic surgery, Ahpra's revised privacy policy, and the *Code of conduct*. Members also represented the views of the community and consumers on many reference and working groups.

'The members of the CAC are very committed people. They are generous with their time and with their knowledge and expertise, and they have unshakeable commitments to the scheme and to making ongoing improvements in its functioning, and to ensuring that the community voice continues to be heard in all of that. The staff who support it are genuinely dedicated to making its work relevant and effective.'

Mr Mark Bodycoat, Retiring Chair, Community Advisory Council

Working with governments

Ahpra maintains a strong working relationship with the Australian, state and territory health departments, primarily through its Jurisdictional Advisory Committee.

National Law amendments

In February, Health Ministers agreed to progress amendments that would strengthen public protection, improve registration processes and strengthen the governance of the National Scheme. The Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 was introduced into the Queensland Parliament by the Honourable Yvette D'Ath, Minister for Health and Ambulance Services on 11 May.

Inquiries and reviews

- Ahpra and the National Boards actively engaged with the Senate Community Affairs References Committee at the 'Senate Inquiry into the administration of registration and notifications by Ahpra and related entities', including appearing before the Committee on several occasions and responding to multiple requests for information. The Committee delivered its final report in April. Ahpra already had work underway about several of the recommendations. We work hard to be transparent and we value public scrutiny.
- Ahpra and the Medical Board of Australia commissioned an independent review of the regulation of health practitioners in cosmetic surgery. It aimed to improve understanding of barriers preventing consumers, practitioners or their employees raising concerns about unsafe practice or unsatisfactory outcomes.

Contributing internationally

As a World Health Organization (WHO) Collaborating Centre for Health Workforce Regulation, Ahpra works in partnership to strengthen the capacity and skills of regulators in the Western Pacific Region of WHO. In February, Ahpra was redesignated as a WHO Collaborating Centre for a further four years.

Ahpra leads the Western Pacific Regional Network of Health Workforce Regulators, with members from approximately 20 countries. We held three regional network webinars on important health workforce regulation topics.

More information is on our website at www.ahpra.gov.au/About-Ahpra/Our-engagement-activities/WHO-collaboration.

Organisation

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
- National Director Health Strategy Unit
- 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
- National Business Coordinator Information Technology

Leading, directing and managing

Agency Management Committee

Ahpra's governing body meets up to 11 times per year. The Committee publishes a communique of meetings that summarises issues discussed and decisions made. It has established four committees:

- **Accreditation Committee** provides independent and expert advice on accreditation governance, reform, accountability and transparency issues, and a whole-of-scheme perspective on the performance of the accreditation functions.
- **Finance, Audit and Risk Management Committee** oversees risk and provides advice to the Agency Management Committee on the effectiveness of the corporate assurance framework and risk management, financial strategy, sustainability and internal audit functions. The Committee also oversees the external audit process.
- **Regulatory Performance Committee** makes 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** helps the Agency Management Committee effectively discharge its functions by providing governance oversight of strategy and performance in relation to people, capability and culture.

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 Liz Davenport
  Chief Financial 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.

Table 41. Staff, 30 June

Directorate	Full-time equivalent staff
Regulatory Operations	772
Strategy and Policy	227
Information Technology	104
People and Culture	44
Finance and Risk	43
Office of the CEO	2
Total	**1,192**

Directorates

- **Regulatory Operations** carries out Ahpra's core regulatory functions of 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, wherever possible, resolve other matters more quickly.
- **Strategy and Policy**'s purpose is to protect the public through effective and responsive strategy, policy, engagement and regulatory governance. With a multiprofession focus, it works in partnership with National Boards, accreditation authorities and stakeholders 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** is 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.

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 (to 25 Feb), Mr Timothy Bowen (from 14 Jun), and Mr David Clements was acting state manager
- Northern Territory: Ms Helen Egan (to 29 Oct), Ms Claudia Manu-Preston (from 24 Jan), and Mrs Karen Banks and Ms Diane Walsh were acting territory managers
- Queensland: Ms Heather Edwards
- South Australia: Ms Sheryle Pike (to 9 Jul), Mr Patrick Maher (from 5 Jul)
- Tasmania: Mr David Clements
- Victoria: Dr Clarissa Martin PhD (to 19 Nov), Ms Joe Goddard-Williams (from 9 May), and Mr Anthony McEachran, Mr Luka Dujmovic and Mr Patrick Maher were acting state managers
- Western Australia: Mrs Karen Banks (to 10 Dec), Ms Jodie Holbrook (from 13 Jun), and Mr Richard Smirk was acting state manager.

Financial management

Ahpra and the National Boards work in partnership to ensure the scheme operates efficiently and effectively and is sustainable.

The financial statements describe the performance in more detail, including the net result and equity position for each National Board.

Financial overview

Key financial information for the past five years is summarised in Table 42. Income and expenses have steadily increased since 2017/18. Accounting for other economic flows, the comprehensive result for 2021/22 of $14.9 million is a decrease from $17.3 million in 2020/21.

The changes to each year's net result reflect growing practitioner numbers, increase in business operations and improvements to support the scheme's public safety objectives.

Fluctuations in net cash flows reflect the timing and any changes in registration renewals, grants, employee and vendor payments and interest receipts.

Table 42. Financial summary, 2018–22 ($million)

Five-year financial summary	2022	2021	2020	2019	2018
Revenue from government grants	4.1	4.6	1.7		1.6
Income from operating activities	245.6	230.6	218.8	203.2	183.2
Total income from transactions	**249.7**	**235.2**	**220.4**	**203.2**	**184.8**
Total expenses from transactions	232.0	217.8	213.8	209.0	196.6
Other economic flows included in net result	(2.8)	(0.9)			
Comprehensive result for the year	**14.9**	**17.3**	**6.7**	**(5.8)**	**(11.8)**
Net cash flow from operating activities	37.4	37.7	24.4	20.0	2.7
Collections on behalf of government agencies	41.1	39.3	37.1	34.3	31.3
Total assets	**303.5**	**284.8**	**266.4**	**208.1**	**196.4**
Total liabilities	**201.8**	**197.9**	**196.9**	**145.3**	**113.4**

Financial performance

A favourable yet lower comprehensive result was due to higher revenue and income being offset by increased expenses, investment in technology enhancements, Ahpra's transformation program and loss on revaluation of financial assets.

The National Scheme revenue and income for the full financial year to 30 June was $249.7 million, an increase of $14.5 million from 2020/21. The growth was due to an increase in regulatory income and investment income, offset by a decline in Commonwealth grant funding to meet the COVID-19 health workforce response.

Fees are set by each National Board to meet the full costs of regulation for each profession. Six National Boards froze their registration renewal fees, seven Boards increased fees by 2.5% or 3.0% in line with inflation, and two Boards reduced their fees.

Grant funding from the Commonwealth Department of Health provided a further $2.6 million in support 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 $232.0 million in 2021/22, an increase of $14.3 million from 2020/21 due to expected increases in wage inflation and workforce growth, additional costs of growing business operations, our digital transformation program and partial resumption of travel and office-based working.

A change to investment policy was implemented in 2021/22 and as term deposits matured, investments were made in low-risk managed funds with the Victorian Funds Management Corporation to achieve improved return on financial assets in the medium term. Short-term revaluation losses on the unit funds were realised in response to economic decline in the market value of the units held.

Financial position

The financial statements disclose income and expenditure by each National Board and the equity balances held at year end. The amounts held are assessed against equity targets, based on independently developed actuarial models.

Equity

Equity increased by $14.4 million to $101.7 million in 2021/22. Equity is held by each National Board in accordance with an agreed framework and 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 also includes funding for strategic projects delayed due to restrictions or other consequences of COVID-19 in recent years. These projects have been committed to by Boards to support effective and efficient regulatory functions.

Assets

The financial assets of $242.2 million includes $116.4 million in registration fees paid in advance for all professions.

Non-financial assets include IT intangible assets that increased to $17.0 million from $9.4 million in 2020/21. Property lease assets have been consumed, reducing to $44.2 million in 2021/22 as scheduled.

Capital investment was higher than in 2020/21. Property right-of-use assets increased $2.6 million with a new lease for the Western Australian office. Intangible asset investments for cyber security, data platform and transformation program increased the work in progress to $12.2 million as at 30 June 2022.

Liabilities

Employee benefits provisions increased in line with additional resourcing to meet demands of business growth and investment initiatives, long service, wage inflation and an increase to the superannuation guarantee. There is a slight offset resulting from the economic impact of applying an increased discount rate that reduces the present value of long service leave and excess annual leave liability.

The year ahead

The expected financial performance in 2022/23 is for a small operating deficit to occur, as expenditure is increased to meet growth in operational demands and investment in transformation programs. Break-even results are forecast in the forward years consistent with our five-year financial plan that aims to adequately fund the required workforce, support and systems from continued increases to the scheme's regulatory income.

Risk management

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*.

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 the National Boards, seeks to manage risks in ways that allow us to meet the objectives of the National Scheme strategy. During 2021/22, the National Scheme managed its risks within the following risk themes:

- regulatory effectiveness and partnerships
- business transformation outcomes and financial sustainability
- delivering actions to eliminate racism for Aboriginal and Torres Strait Islander Peoples within healthcare
- removing barriers to access for identified communities
- public confidence/trust
- cyber security/emerging technologies
- people and culture
- health practitioner workforce sustainability.

The corporate assurance and risk management processes are integrated with the strategic and business planning processes and come from many sources within the organisation.

Ahpra's internal audit function forms part of the review process, provides assurance on the risk management process, and advises the Finance, Audit and Risk Management committee (FARMC) accordingly.

Insurance policies are in place to mitigate the risk of financial losses arising from an (insured) event.

Quality assurance activities confirm the implementation of our work by doing the right things the right way. We review organisational systems and processes to help us identify and mitigate risks by applying the right controls. Quality assurance complements risk management activities by taking proactive and preventive action to reduce risks and drive continuous improvement.

Corporate legal compliance

In addition to regular reporting to FARMC, we have undertaken the following tasks to improve governance and compliance:

- implementing Ahpra's whole-of-organisation legislative compliance program, with reporting to be presented to FARMC in late 2022
- reviewing Ahpra's *Public interest disclosure (whistleblower) policy* and drafting an accompanying procedure to assist Ahpra public interest disclosure (PID) officers to meet their obligations in each state and territory
- cataloguing and reviewing all Ahpra corporate policies and the National Law to assess Ahpra and the National Boards' risk of regulatory capture
- working with Ahpra's Procurement team to draft a *Modern slavery policy* to ensure Ahpra's supply chain is compliant with Commonwealth anti-slavery legislation
- refreshing Ahpra's *Procedure to respond to a breach of privacy* to assist staff to identify risks and quickly and easily report privacy breaches.

Ahpra's *Public interest disclosure policy* is for the use of Ahpra staff as well as members of the public and is published on the Ahpra website (www.ahpra.gov.au/About-Ahpra/Complaints/Whistleblower-policy). Twenty-one referrals were received by Ahpra's whistleblower hotline provider, Deloitte, and another two were sent directly to Ahpra. Of the 21 referrals submitted to Deloitte, ten were made by a single person and nine were complaints regarding vaccine mandates. After an assessment, one referral was found to meet the criteria of a public interest disclosure. This matter related to conduct arising in Victoria and was referred to the Independent Broad-based Anti-corruption Commission (IBAC). IBAC considered the disclosure and decided that the matter did not warrant investigation.

Freedom of information requests

Ahpra received:

- **286** valid applications for access to documents under the *Freedom of Information Act 1982* (FOI Act)
- **21** applications for internal review of an FOI decision.

The National Health Practitioner Privacy Commissioner (NHPPC) notified Ahpra that:

- **12** applications for external review of an Ahpra FOI decision had been made
- **7** external review applications had been closed.

The NHPPC provided notice that Ahpra's FOI decision had been affirmed in one matter. In another matter, the NHPPC notified Ahpra that it had varied Ahpra's access decision to provide an applicant with additional details within redacted documents. Ahpra was advised that two applicants had withdrawn their applications for external review and three matters were discontinued by the NHPPC.

Two applications were made to a responsible tribunal for a review of FOI decisions. These applications were made after the NHPPC had already made a decision.

During the year, 326 FOI applications were finalised. Outcomes are shown in Table 43. At 30 June, 25 FOI matters were open and had not been finalised.

Evidentiary certificates

Ahpra issued 129 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 140 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.

Table 43. Finalised FOI applications

Application outcome	Number
Granted in full	31
Granted in part	147
Access refused	68
Withdrawn	80
Internal review	21
External review (NHPPC)	7
External review (Tribunal)	0

Table 44 describes the nature of the documents sought by FOI applicants.

Table 44. Documents sought by FOI applicants

Document type	Number of FOI applications
Notifications/complaints	258
Registration applications and decisions	20
Policy procedure, guidelines	10
Statistics and general data	8
Monitoring and compliance of registration restrictions	6
Criminal offences	5
Finances	1
Request to correct a record	1
Other	17

Administrative complaints

When – and why – people complain about us

When people raise concerns about Ahpra and the National Boards, we aim to listen, to respond 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. They are divided into three types:

- **Stage 1** (straightforward) complaints are handled by the Ahpra area that receives them.
- **Stage 2** (complex) complaints are managed by a National Complaints team.
- **Stage 3** complaints are investigated or reviewed externally by the National Health Practitioner Ombudsman (NHPO).

We received fewer complaints from health practitioners, employers and the public, and more complaints about public campaigns.

Table 45 outlines who raised complaints. We saw 50 fewer concerns raised from health practitioners compared to 2020/21. We also saw fewer complaints from members of the public (34, compared with 74 in 2020/21) and employers (down from 14 to 9).

There was a significant increase in complaints about a public campaign: 160, up from 48 previously.

Table 45. Source of administrative complaints

Who made the complaint?	Number
Health practitioner (applicant)	348
Notifier	165
Public campaign	160
Health practitioner (notification)	76
Health practitioner (other)	52
Member of the public	34
Employer	9
Non-government organisation	6
Education provider	2
Member of Parliament	1
Total	**853**

Public campaign complaints

The increase in overall complaints can be attributed to a substantial increase in the number of public campaign complaints, which increased by 233%. Public campaign complaints accounted for 18.7% of all complaints received.

A public campaign complaint is made about our regulatory role by individuals who are not a party to a regulatory action and do not have a personal relationship with the subject of the regulatory actions. Often this involves submitting a complaint after being made aware of the matter, usually through traditional or social media. This year we received public campaign complaints about statements made by Ahpra and the National Boards about the COVID-19 vaccination program and regulatory action taken against specific health practitioners.

Issues raised

We received 853 complaints about 1,239 issues – a complaint may include more than one issue.

Table 46 includes all issues raised. Table 47 shows more detail about the main issues raised for each profession.

Table 46. Administrative complaints by issue

Issues raised	Number
Process/policy	254
Dissatisfied with regulatory outcome	249
Communication	227
Delay	172
COVID-19	160
Fees	45
Privacy breach	11
Other	121
Total	**1,239**

Registration issues

In the 374 complaints received about registration, process and policies were raised 165 times, communication was raised 147 times, perceived delay in our management of applications was raised 102 times, and other issues (including accessibility and technical problems) were raised 71 times.

Notifications issues

In the 285 complaints received about notifications, dissatisfaction with the outcome was raised 183 times, communication 100 times, policies or processes 73 times, and the time taken to finalise a notification 55 times.

Resolving complaints

We responded to 838 complaints. When we receive a complaint, we look carefully at 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.

Table 48 outlines the actions we took to resolve complaints this year. We may take more than one action to address a complaint.

Table 47. Stage 1 and 2 administrative complaints, by profession and main issue raised

Board	Complaints received	Stage 1	Stage 2	Area of issue: Registration	Notifications	Customer service interactions	Compliance	Legal	IT/website issues	Other
Aboriginal and Torres Strait Islander Health Practice	**0**									
Chinese medicine	**13**	8	5	6	2	1			1	3
Chiropractic	**5**	2	3	4	1					
Dental practice	**35**	10	25	11	22	3				
Medical practice	**417**	209	208	86	188	9	13		13	140
Medical radiation practice	**6**	5	1	5						1
Nursing and midwifery	**182**	72	110	129	28	13	8		3	20
Occupational therapy	**19**	11	8	16	3					1
Optometry	**2**	2		1						1
Osteopathy	**0**									
Paramedicine	**17**	4	13	13	3	1	2			
Pharmacy	**28**	17	11	23	4					2
Physiotherapy	**23**	13	10	16	1	1				6
Podiatry	**2**	1	1	1	1					
Psychology	**104**	34	70	63	32	4	2	2	1	6
Total	**853**	**388**	**465**	**374**	**285**	**32**	**25**	**2**	**18**	**180**

Table 48. Action taken on the issues raised

Action taken to resolve issues	Number
Provided further explanation to complainant	563
Offered apology	211
Provided an update on progress of regulatory matter	132
Noted feedback about a process or policy	103
Offered a refund	8
Corrected an error	7
Arranged for a regulatory matter to be reconsidered	3
Other	117

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, 102 complaints were handed to us to resolve directly.

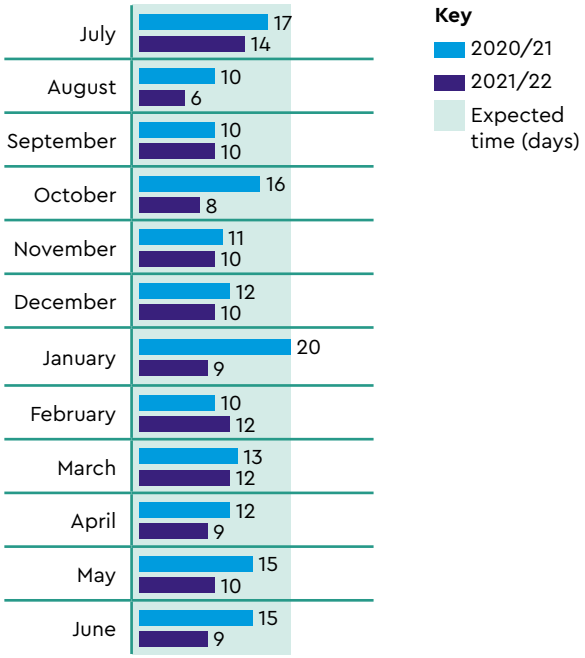
We responded to 76 enquiries received from the NHPO seeking preliminary information about a complaint. We also provided documents and other information in response to 17 notices of investigation from the NHPO.

A complaint can be reported more than once if a person complains to both Ahpra and the NHPO.

Performance

We aim to respond to complaints within 20 business days. Figure 87 shows that our average time to respond was usually faster than the expected timeframes.

Figure 87. Time to finalise complaints (days)



Financial statements for the year ended 30 June 2022

Australian Health Practitioner Regulation Agency

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 Act 2009 (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 2022 and financial position of the Australian Health Practitioner Regulation Agency as at 30 June 2022.

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

25 August 2022

Martin Fletcher

Chief Executive Officer

25 August 2022

Elizabeth Davenport FCPA

Chief Financial Officer

25 August 2022

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 2022 • 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 2022 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 3 of Schedule 3 to the *Health Practitioner Regulation National Law Act* 2009 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* 2009, 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
9 September 2022

Sanchu Chummar
as delegate for the Auditor-General of Victoria

Australian Health Practitioner Regulation Agency

Statement of comprehensive income for the year ended 30 June 2022

Continuing operations	Note	2022 $'000	2021 $'000
Revenue and income from transactions			
Registration and application fee	*A1.1*	235,607	222,369
Investment income	*A2*	4,065	2,589
Grant revenue	*A3*	2,591	4,581
Other income and revenue	*A4*	7,422	5,638
Total revenue and income from transactions		**249,685**	**235,177**
Expenses from transactions			
Employee costs	*B1.1*	151,081	141,160
Board and committee sitting fees		5,734	5,881
Legal and notification costs		12,945	12,854
Accreditation expenses		9,592	9,893
Other operating expenses	*B2*	39,869	34,320
Depreciation and amortisation	*C4.1*	12,071	12,804
Finance costs – leases	*E1.2*	736	837
Total expenses from transactions		**232,028**	**217,749**
Net result from transactions		**17,657**	**17,428**
Other economic flows included in net result			
Net (loss) on non-financial assets	C4.2	(78)	(63)
Net (loss) on financial instruments at fair value	B3	(4,277)	(479)
Other gain from other economic flows	B3	1,572	453
Total other economic flows included in net result		**(2,783)**	**(89)**
Net result for the year		**14,874**	**17,339**
Other comprehensive income		0	0
Comprehensive result for the year		**14,874**	**17,339**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency

Statement of financial position as at 30 June 2022

	Note	2022 $'000	2021 $'000
Financial assets			
Cash and cash equivalents	*E2*	5,683	10,661
Receivables	*D1*	5,016	2,990
Prepayments	*D3*	3,728	2,871
Investments and other financial assets	*C1*	227,818	209,500
Total financial assets		**242,245**	**226,022**
Non-financial assets			
Property, plant and equipment	*C2*	44,247	49,347
Intangible assets	*C3*	17,025	9,396
Total non-financial assets		**61,272**	**58,743**
Total assets		**303,517**	**284,765**
Liabilities			
Payables and accruals	*D2*	10,931	10,808
Contract liabilities	*A1.2*	117,295	109,538
Employee benefits	*B1.2*	29,511	28,382
Lease liability	*E1*	43,293	48,230
Other provisions	*D4*	754	948
Total liabilities		**201,784**	**197,906**
Net assets		**101,733**	**86,859**
Equity			
Contributed capital	*G7*	43,895	43,895
Accumulated surplus	*G7*	57,838	42,964
Total equity		**101,733**	**86,859**
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 2022

	Note	Contributed capital $'000	Accumulated surplus $'000	Total equity $'000
Balance at 1 July 2020		**43,895**	**25,625**	**69,520**
Net result for the year		0	17,339	**17,339**
Balance at 30 June 2021		**43,895**	**42,964**	**86,859**
Net result for the year		0	14,874	**14,874**
Balance at 30 June 2022	*G7*	**43,895**	**57,838**	**101,733**

This statement should be read in conjunction with the accompanying notes.

Statement of cash flows for the year ended 30 June 2022

	Note	2022 $'000	2021 $'000
Cash flows from operating activities			
Receipts			
Receipts relating to regulatory fees		242,434	229,426
Receipts from government grant	*A3*	3,521	0
Goods and Services Tax (GST) recovered from the Australian Taxation Office (ATO)		7,509	5,755
Other receipts		6,255	5,529
Interest received		3,069	2,089
Total receipts		**262,788**	**242,799**
Payments			
Payments to suppliers, employees and others		(224,686)	(204,258)
Interest paid		(736)	(837)
Total payments		**(225,422)**	**(205,095)**
Net cash flows from operating activities	*E2*	**37,366**	**37,704**
Cash flows from investing activities			
Payments for plant and equipment, intangibles and work-in-progress		(12,289)	(5,907)
Purchase of investments and other financial assets		(243,000)	(108,000)
Proceeds of investments		220,500	78,000
Receipts for equipment disposal	*C4.2*	0	44
Net cash flows used in investing activities		**(34,789)**	**(35,863)**
Cash flows from financing activities			
Repayment of principal portion of lease liabilities		(7,554)	(6,993)
Net cash flows used in financing activities		**(7,554)**	**(6,993)**
Net increase in cash and cash equivalents		**(4,977)**	**(5,152)**
Cash and cash equivalents at the beginning of the year		10,661	15,812
Total cash and cash equivalents at end of the year	*E2*	**5,683**	**10,661**

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:

- assessing whether there is an enforceable contract with sufficiently specific performance obligations to recognise revenue or income (refer to *Note A1* and *A3*)
- 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 intangible assets initial recognition and impairment (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 is in 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.

Regulatory fees do not constitute a supply and are therefore exempt from GST. 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 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 Australian Accounting Standards 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 2022 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. There were no changes in accounting policies in preparing the financial statements.

These financial statements were authorised to be issued by the Agency Management Committee on 25 August 2022.

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.

Structure

A1. Registration and application fees

A2. Investment income

A3. Grant revenue

A4. Other income and revenue

Judgement required

Ahpra has made judgement assessing whether there is an enforceable contract with specific performance obligations to recognise revenue or income.

Revenue and income is recognised to the extent that it is probable that the economic benefits will flow to Ahpra and it can be reliably measured. Revenue and income over which Ahpra does not have control is disclosed as administered revenue and income (see *Note G8*).

Note A1: Registration and application fees

Ahpra collects registration fees and in return provides eligible registrants rights to practise and provide suitable healthcare to the public. Ahpra has determined it has an enforceable contract with sufficiently specific performance obligations to recognise registration fees in accordance with AASB 15 *Revenue from Contracts with Customers*.

AASB 15 recognition exemption permits accounting for short-term licences or low-value licences with two options:

- recognise the revenue associated with those licences at the point in time the licence is issued, or
- on a straight-line basis over the licence term or another systematic basis.

When a person pays a registration fee, the fee is recognised over the term of the registration.

When a person pays an application fee, the fee is recognised at the point in time the fee is received.

Registrations are payable periodically in advance. Only the portion of registration fees that are attributable to the current financial year are recognised as revenue. Consideration received in advance of recognising the associated revenue from registrants is recorded as a contract liability.

A1.1: Registration and application fee revenue

	2022 $'000	2021 $'000
Registration fees	218,343	206,989
Application fees	17,264	15,380
Total registration and application fee revenue	**235,607**	**222,369**

A1.2 Contract liabilities

Contract liabilities	Note	2022 $'000	2021 $'000
Registration fees received in advance			
Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA)		50	51
Chinese Medicine Board of Australia (CMBA)		713	714
Chiropractic Board of Australia (ChiroBA)		1,083	1,055
Dental Board of Australia (DBA)		5,365	5,109
Medical Board of Australia (MBA)		21,782	20,200
Medical Radiation Practice Board of Australia (MRPBA)		1,236	1,188
Nursing and Midwifery Board of Australia (NMBA)		66,602	62,197
Occupational Therapy Board of Australia (OTBA)		1,202	1,097
Optometry Board of Australia (OptomBA)		769	716
Osteopathy Board of Australia (OsteoBA)		458	414
Paramedicine Board of Australia (ParaBA)		2,257	2,233
Pharmacy Board of Australia (PharmBA)		4,943	4,668
Physiotherapy Board of Australia (PhysioBA)		2,031	1,860
Podiatry Board of Australia (PodBA)		802	790
Psychology Board of Australia (PsyBA)		7,072	7,246
Total registration fees received in advance		**116,365**	**109,538**
Other contract liabilities			
Government grant received in advance	*A3*	930	0
Total contract liabilities		**117,295**	**109,538**
Represented by			
Current liabilities		117,295	109,538

Registration fee received in advance	2022 $'000	2021 $'000
Opening balance	**109,538**	**107,062**
Add: registration fee received during the year	225,170	209,465
Less: Revenue recognised from performance obligations satisfied	(218,343)	(206,989)
Total payments received for performance obligations yet to be completed	**116,365**	**109,538**

Note A2: Investment income

Interest income is accrued by reference to the principal of a financial asset at the effective interest rate when earned.

Distribution from investment in managed funds is recognised as income when the right to receive payment is established. It represents the income arising from Ahpra's investments in managed funds consistent with Ahpra's investment policy.

Net unrealised gains and losses on the revaluation of investments do not form part of income from transactions, but are reported as other economic flows in the net result.

	2022 $'000	2021 $'000
Interest on term deposits	2,009	2,589
Distribution from investments in managed fund	2,056	0
Total investment income	**4,065**	**2,589**

Note A3: Grant revenue

Revenue 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 2021/22, a $3.521 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 obligations.

Grant revenue is recognised when the relevant services are provided and performance obligations are met. In 2021/22, Ahpra has recognised a $2.591 million grant received as revenue with remaining $0.930 million as contract liabilities (*Note A1*).

Other contract liabilities – government grant received in advance	2022 $'000	2021 $'000
Opening balance	**0**	**4,581**
Add: Grant consideration for sufficiently specific performance obligations received during the year	3,521	0
Less: Revenue recognised from performance obligations satisfied	(2,591)	(4,581)
Total payments received for performance obligations yet to be completed	**930**	**0**
Represented by		
Current liabilities	930	0
	930	**0**

Note A4: Other income and revenue

Other income and revenue includes legal fee recoveries, fees received for examinations and revenue from providing the practitioner information service to external parties.

Legal fee recoveries and fines are recognised when an invoice is issued, which establishes the entitlement to payment.

Practitioner Information Exchange and examinations are recognised when invoices are issued and services are received by customers.

	2022 $'000	2021 $'000
Accreditation	654	295
Certificate of registration status	254	216
Legal fee recoveries and fines	1,182	1,692
Examinations	3,443	1,704
Practitioner Information Exchange (PIE)	1,323	1,123
Application for registrar program	281	294
Other	285	314
Total other income	**7,422**	**5,638**

Note B: The cost of delivering services

Introduction

This section provides an account of the expenses incurred by Ahpra in delivering services.

Structure

B1. Employee benefits

B2. Other operating expenses

B2. Other economic flows

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. The discount rates used are referencing to Reserve Bank of Australia's 10-year semi-annual coupon bonds, which is 3.693% in 2022 and was 1.491% in 2021.

Expenses from transactions are recognised in the *Statement of comprehensive income* when they are incurred.

Expenses from transactions	Note	2022 $'000	2021 $'000
Employee costs	*B1.1*	149,509	141,161
Board and committee sitting fees		5,734	5,881
Legal and notification costs		12,945	12,854
Accreditation expenses		9,592	9,893
Other operating expenses	*B2*	39,906	34,862

Board and committee sitting fees

Board and committee sitting fees include costs related to meetings held by Agency Management Committee, as well as those national, state and regional board 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 costs.

B1.1 Employee costs

	Note	2022 $'000	2021 $'000
Salaries and related on-costs		118,407	111,628
Leave entitlements		13,789	12,734
Superannuation expenses	*B1.3*	12,823	11,258
Termination benefits		487	250
Contractors		4,841	4,044
Staff development and amenities		734	1,247
Total employee costs		**151,081**	**141,161**

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	2022 $'000	2021 $'000
Annual leave		
Unconditional and expected to be settled within 12 months	9,088	8,028
Unconditional and expected to be settled after 12 months	2,546	2,825
Long service leave		
Unconditional and expected to be settled within 12 months	1,776	1,696
Unconditional and expected to be settled after 12 months	8,552	8,555
Provision for on-costs		
Unconditional and expected to be settled within 12 months	1,747	1,468
Unconditional and expected to be settled after 12 months	1,782	1,695
Total current provisions for employee benefits and on-costs	**25,491**	**24,267**
Non-current employee benefits provisions		
Conditional long service leave entitlements expected to be settled after 12 months	3,113	3,322
On-costs	907	793
Total non-current provisions for employee benefits and on-costs	**4,020**	**4,115**
Total provisions for employee benefits and on-costs	**29,511**	**28,382**

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	**10,853**	**13,573**	**3,956**	**28,382**
Additional provisions recognised	10,241	3,457	480	**14,178**
Reductions arising from payments	(9,343)	(1,745)	0	**(11,088)**
Reductions resulting from settlement without cost	0	(489)	0	**(489)**
Effect of changes in the discount rate	(117)	(1,355)	0	**(1,472)**
Carrying amount at the end of the year	**11,634**	**13,441**	**4,436**	**29,511**
Current	11,634	10,328	3,529	**25,491**
Non-current	0	3,113	907	**4,020**
Total	**11,634**	**13,441**	**4,436**	**29,511**

(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.

Contributions to defined contribution and defined benefits superannuation plans are expensed when incurred.

Superannuation contributions paid or payable for the reporting period are included as part of staffing 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	2022 $'000	2021 $'000	2022 $'000	2021 $'000
Defined benefit plans:				
Southern State Superannuation Scheme	215	221	1	1
Qsuper	107	110	0	0
Other (5 funds)	98	109	1	7
Defined contribution plans:				
Australian Super	4,811	4,016	0	0
First State accumulation	575	521	0	0
HESTA	509	437	0	0
VicSuper	421	385	0	0
QSuper accumulation	578	472	0	0
UniSuper	548	441	0	0
Sunsuper	510	483	0	0
Other (about 200 funds)	4,398	3,994	51	66
Total	**12,770**	**11,189**	**53**	**74**

Note B2. Other operating expenses

	Note	2022 $'000	2021 $'000
Bank charges and merchant fees		1,289	1,129
Criminal history checks		1,318	1,199
External contract services		2,327	504
Funding for intern training accreditation authorities (section 52)		936	925
Health programs		3,044	3,808
Insurance		1,128	908
Internal audit fees		282	310
National Health Practitioner Ombudsman and Privacy Commissioner Office		2,640	2,570
Office of the Health Ombudsman (OHO, in Queensland)	*G8*	4,451	4,532
Printing, postage and publications		917	1,006
Property expenses		2,695	2,569
Strategic and project consultant costs		2,991	2,323
Systems and communications		11,719	9,941
Travel and accommodation		1,603	1,033
Other		2,529	1,563
Total other operating expenses		**39,869**	**34,320**

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.

National Health Practitioner Ombudsman and Privacy Commissioner Office

The National Health Practitioner Ombudsman (NHPO) investigates complaints, facilitates resolutions and makes recommendations to improve the regulation of Australia's registered health practitioners. The NHPO is funded by registration fees paid by health practitioners. The Health Chief Executives Forum (HCEF) approves the budget request from the NHPO each year and directs Ahpra to pay the approved funds.

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 are accounted as depreciation of right-of-use assets and interest on leases (*Note E1.2*). Variable lease payments, such as rates and outgoings, that do not depend on an index or a rate and which are not in substance fixed, are recognised in the period they occur as property expenses.

Strategic and project costs

Strategic and project costs relate to strategic project consultant 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*.

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 to attend scheduled board and committee meetings.

Others

Expenses to administer exams, advertisements, external audit fees, membership and affiliations, recruitment costs and venue hire are reported as other expenses.

Note B3. Other economic flows

Other economic flows are changes in the value of an asset or liability that do not result from transactions.

Net gain/(loss) on financial instruments at fair value includes:

- realised and unrealised gains and losses from revaluations of financial instruments at fair value
- disposals of financial assets
- bad and doubtful debts impairments and reversals of impairment.

	2022 $'000	2021 $'000
Net gain/(loss) on financial instruments at fair value		
Net (loss) arising from revaluation of financial assets at fair value through profit and loss	(4,318)	0
Doubtful debts recoveries/write-off	41	(479)
Total net (loss)/gain on financial instruments at fair value	**(4,277)**	**(479)**
Other gain/(loss) from other economic flows		
Net gain arising from revaluation of leave liability	1,572	453
Total other gain from other economic flows	**1,572**	**453**
Total (loss)/gain from other economic flows	**(2,705)**	**(26)**

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 we used in the delivery of services.

Structure

C1. Investments

C2. Property, plant and equipment (PPE)

C3. Intangible assets

C4. Depreciation, amortisation and impairment

Judgement required

The assets included in this section are carried at cost less accumulated depreciation and impairment, except for the managed investment scheme, which is carried at fair value. Judgement has been applied in assessing the useful lives of plant and equipment.

Note C1: Investments

Ahpra manages its investments and other financial assets in accordance with the investment policy approved by the Agency Management Committee.

Investments include both term deposits, which Ahpra has the positive intent and ability to hold to maturity at fixed or repricing interest rates, and managed funds.

Investments are recognised when Ahpra enters into a contract to purchase the investment. They are initially measured at fair value, net of transaction costs.

Term deposits are classified as current with original maturity dates of three to 12 months, while term deposits with original dates in excess of 12 months are classified as non-current. Investments in managed funds are classified between current and non-current based on Ahpra's intention at balance date with respect to the timing of disposal of each asset.

	2022 $'000	2021 $'000
Current		
Bank term deposits maturing less than 90 days	28,000	27,500
Bank term deposits maturing more than 90 days but less than 1 year	63,000	93,000
Total current investments	**91,000**	**120,500**
Non-current		
Bank term deposits maturing greater than 1 year	56,000	89,000
Managed investment schemes	80,818	0
Total non-current investments	**136,818**	**89,000**
Total investments and other financial assets	**227,818**	**209,500**

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 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**
Additions	2,635	1,433[1]	33	1,007	19	**5,127**
Disposals/write-offs	(1,385)	(186)	(108)	(464)	(233)	**(2,376)**
Balance at 30 June 2022	**58,111**	**16,298**	**1,468**	**9,238**	**387**	**85,502**
Accumulated depreciation						
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)**
Depreciation charge during the year	(7,577)	(1,176)	(176)	(971)	(61)	**(9,961)**
Disposals/write-offs	1,216	166	101	464	163	**2,110**
Balance at 30 June 2022	**(21,601)**	**(10,467)**	**(897)**	**(8,054)**	**(236)**	**(41,255)**
Net book value						
At 30 June 2021	**41,621**	**5,594**	**721**	**1,148**	**263**	**49,347**
At 30 June 2022	**36,510**	**5,831**	**571**	**1,184**	**151**	**44,247**

1. This includes 1,367K completed projects transferred in from work-in-progress. 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:

- 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; and
- 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.

The right-of-use asset is subsequently measured at cost less accumulated depreciation and impairment. It 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 two 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 remeasurements of the lease liability.

During 2021/22, Ahpra signed up to a new 10-year lease for the Western Australian office and moved into the premises in June 2022. As a result, a right-of-use asset is added at $2.552 million.

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 2020	20,395	1,837	**22,232**
Additions	0	4,322	**4,322**
Disposals/write-offs	0	(274)	**(274)**
Transfer to additions	1,988	(2,802)	**(814)**
Balance at 30 June 2021	**22,383**	**3,083**	**25,466**
Additions	0	11,148	**11,148**
Disposals/write-offs	(1,482)	(42)	**(1,524)**
Completed projects	614	(1,981)	**(1,367)**[1]
Balance at 30 June 2022	**21,515**	**12,208**	**33,723**
Accumulated amortisation			
Balance at 30 June 2020	(13,920)	0	**(13,920)**
Amortisation charge during the year	(2,150)	0	**(2,150)**
Disposals/write-offs	0	0	**0**
Balance at 30 June 2021	**(16,070)**	**0**	**(16,070)**
Amortisation charge during the year	(2,110)	0	**(2,110)**
Disposals/write-offs	1,482	0	**1,482**
Balance at 30 June 2022	**(16,698)**	**0**	**(16,698)**
Net book value			
At 30 June 2021	**6,313**	**3,083**	**9,396**
At 30 June 2022	**4,817**	**12,208**	**17,025**

1. This includes 1,367K completed projects transferred out to leasehold improvement assets.

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.

Leasehold improvements are depreciated over the shorter of the remaining term of the lease or their estimated useful lives. 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 year are included in the table below:

	2022		2021	
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

Note C4.1: Depreciation and amortisation charged for the reporting period

	2022 $'000	2021 $'000
Depreciation		
Leasehold improvements	1,176	1,099
Furniture and fittings	176	179
Computer equipment	971	1,561
Office equipment	61	59
Right-of-use assets	7,577	7,756
Amortisation		
Computer software	2,110	2,150
Total depreciation and amortisation	**12,071**	**12,804**

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. Any difference is written off as an expense (other operating expenses – other).

The net gain or loss arising from the sale of non-financial assets is included as revenue (other income and revenue) 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.

Written-down value of non-financial assets written off	2022 $'000	2021 $'000
Right-of-use assets	169	46
Computer equipment	0	54
Office equipment	0	1
Leasehold improvement	20	6
Total written-down value of non-financial assets written off	**189**	**107**
Net gain/(loss) on disposal of non-financial assets	**2022 $'000**	**2021 $'000**
Proceeds from disposal of non-financial assets		
Computer equipment	0	44
Total proceeds from disposal	**0**	**44**
Less: written down value of assets disposed		
Right-of-use assets	0	(46)
Computer equipment	0	(54)
Office equipment	(70)	(1)
Furniture and fittings	(8)	0
Leasehold improvement	0	(6)
Net gain/(loss) on disposal	**(78)**	**(63)**

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.

Structure

D1: Receivables

D2: Payables and accruals

D3: Prepayments

D4: Other provisions

Judgement required

Judgement is exercised in estimating the provision for expected credit losses.

Significant judgement and estimate 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.

Note D1: Receivables

	Note	2022 $'000	2021 $'000
Contractual			
Trade receivables		3,454	2,580
Credit loss allowance	*F2*	(1,813)	(1,854)
Accrued investment income		2,449	1,589
Statutory			
GST receivable		926	675
Total receivables		**5,016**	**2,990**
Represented by:			
Current receivables		5,016	2,990
		5,016	**2,990**

Movement in the credit loss allowance for contractual receivables	2022 $'000	2021 $'000
Balance at beginning of year	1,854	1,375
Increase in allowance recognised in net result for the year	342	610
Reversal of provision of receivables written off during the year	(383)	(131)
Balance at end of year	**1,813**	**1,854**

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 to collect the contractual cash flows and thereafter subsequently 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, statutory receivables 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

	2022 $'000	2021 $'000
Contractual		
Trade creditors	2,951	2,310
Accrued expenses	7,335	8,030
Statutory		
Payroll tax and other payables	645	468
Total payables and accruals	**10,931**	**10,808**
Represented by:		
Current payables	10,769	10,646
Non-current payables	162	162
	10,931	**10,808**

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: Pre-payments

Prepayments 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

	2022 $'000	2021 $'000
Current provisions		
Make-good provisions	0	194
Total current provisions	**0**	**194**
Non-current provisions		
Make-good provisions	754	754
Total non-current provisions	**754**	**754**
Total other provisions	**754**	**948**

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 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 an 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.

The make-good provision is recognised in accordance with the lease agreement over the offices' leases.

Reconciliation of movements in provisions

	Make good $'000	Total $'000
Opening balance at 30 June 2021	**948**	**948**
Additional provisions recognised	0	**0**
Reductions arising from payments	(5)	**(5)**
Reductions due to reversal of provision not required	(189)	**(189)**
Closing balance at 30 June 2022	**754**	**754**
Current	0	**0**
Non-current	754	**754**
Total	**754**	**754**

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.

Structure

E1. Leases

E2. Cash flow information and balances

E3. Commitments

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 assessing the lease term when there is an option to extend or terminate leases.

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 of various properties for office operations in each state and territory. The lease contracts are typically made for fixed periods of three 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.

E1.1 Right-of-use assets

Right-of-use assets are presented in *Note C2.1*.

E1.2 Other presentation of leases in financial statements

The following amounts are recognised in the *Statement of comprehensive income* relating to leases:

	2022 $'000	2021 $'000
Interest expense on lease liabilities	736	837
Variable lease payments, not included in the measurement of lease liabilities	1,576	1,577
Total amount recognised in the *Statement of comprehensive income*	**2,312**	**2,414**

The following amounts are recognised in the *Statement of cash flows* relating to leases:

	2022 $'000	2021 $'000
Interest paid	736	837
Repayment of principal portion of lease liabilities	7,554	6,993
Total cash outflow for leases	**8,290**	**7,830**

The following amounts are recognised as lease liabilities in the *Statement of financial position* at 30 June:

Lease liabilities	2022 $'000	2021 $'000
Current	7,681	7,576
Non-current	35,612	40,654
Total lease liabilities recognised in the *Statement of financial position*[1]	**43,293**	**48,230**

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 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 five-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 that is within the control of the lessee.

1 Lease liabilities reported include lease liabilities of $3.389 million from lease fit-out incentives and $39.904 million from lease accounting implementation, both to be amortised over 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, or if there are changes to in-substance fixed payments. 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:	2022 $'000	2021 $'000
Less than one year	8,401	8,275
One to five years	30,203	33,062
More than five years	7,653	9,980
Total undiscounted lease liabilities as at 30 June	**46,257**	**51,317**

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.

	2022 $'000	2021 $'000
Cash and cash equivalents, at bank	5,683	10,661
Total cash and cash equivalents	**5,683**	**10,661**

Reconciliation of net result for the period to cash flow from operating activities

	2022 $'000	2021 $'000
Net result for the year	**14,874**	**17,339**
Non-cash movements		
Depreciation and amortisation	12,071	12,804
Loss on disposal of non-financial assets	78	63
Loss on revaluation of financial assets	4,318	0
Distribution income from managed funds reinvested	(2,057)	0
Write-off work in progress/assets	42	0
Credit loss allowance	(384)	(131)
Movements in assets and liabilities		
Decrease/(increase) in receivables	277	(479)
(Increase) in prepayments	(857)	(558)
Increase in contract liabilities	7,757	2,476
Increase in payables and accruals	123	4,023
Increase in employee benefits	1,129	3,088
(Decrease) in other provisions	(5)	(921)
Net cash flows from operating activities	**37,366**	**37,704**

Note E3: Commitments

Commitments for future expenditure include operating commitments arising from non-cancellable contractual or statutory obligations. Ahpra's contractual obligations are with Information Technology (IT) and Enterprise Resource Planning (ERP) platform providers. 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 as at 30 June 2022.

Nominal amounts	Not later than 1 year $'000	1–5 years $'000	5+ years $'000	Total $'000
Non-cancellable				
2022				
Other commitments payable (inclusive of GST)	3,014	3,835	0	**6,849**
Less: GST recoverable	(274)	(349)	0	**(623)**
Total commitments (exclusive of GST)	**2,740**	**3,486**	**0**	**6,226**
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**

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*.

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 interest income on term deposit investment.

Financial assets at fair value through profit and loss

Financial assets in this category are held by Ahpra to achieve its objective by collecting both:

- the distributions, based on the earnings from the fund's assets over the period and may include income from share dividends, rent from property or interest from cash investments less any costs, and
- capital growth from the revaluation of the units held in the managed fund investment.

Ahpra recognises the following financial asset at fair value through profit and loss:

- managed fund investment.

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.

The effective interest method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense in net result over the relevant period. The effective interest is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

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.

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.

Ahpra is exposed to credit risk in relation to the investment managed by Victoria Funds Management Corporation (VFMC) that is designated at fair value through profit and loss. The maximum exposure at the end of the reporting period is the carrying amount of the investments. VFMC trades only with recognised credit-worthy third parties and cash balances are maintained with Westpac Banking Corporation which has an AA- credit rating.

Ahpra term deposits investments are in line with the investment policy and maintained with banks with credit ratings of AA- or above. Ahpra does not have more than 40% of term deposits with one individual bank.

Ahpra monitors the credit risk by actively assessing the rating quality and liquidity of counterparties. Except as otherwise detailed in the table at right, 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.

Credit quality of contractual financial assets[a]

2022	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	5,683	0	**5,683**
Term deposit investments	147,000	0	**147,000**
Accrued investment income	0	2,449	**2,449**
Statutory receivables (with no impairment loss recognised)	926	0	**926**
Financial assets with loss allowance measured at lifetime expected credit loss:			
Contractual receivables applying the simplified approach for impairment	0	1,641	**1,641**
Total financial assets	**153,609**	**4,090**	**157,699**

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**
Term deposit 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**

(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 2022	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%	5–15%	15–50%	11–60%	17–94%	
Contractual receivables	36	1,134	225	305	1,754	**3,454**
Loss allowance	**0**	**(15)**	**(43)**	**(155)**	**(1,600)**	**(1,813)**

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)**

1 Standard & Poor's rate AA-. Moody's Investors Service rate Aa3. Fitch ratings A+.

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 2022 under AASB 9 *Financial instruments*.

(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 flow 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.

The maximum exposure to liquidity risk is the total carrying amount of the financial liabilities as shown below.

These tables disclose the maturity analysis of Ahpra's financial liabilities:

2022 payables[a]	Carrying amount $'000	Maturity dates				
		Less than 1 month $'000	1–3 months $'000	3–12 months $'000	1–5 years $'000	More than 5 years $'000
Trade creditors	2,951	2,723	16	50	0	162
Accrued expenses	7,335	7,335	0	0	0	0
Lease liabilities[b]	42,867	0	0	7,603	27,699	7,565
Total	**53,153**	**10,058**	**16**	**7,653**	**27,699**	**7,727**

2021 payables[a]	Carrying amount $'000	Maturity dates				
		Less than 1 month $'000	1–3 months $'000	3–12 months $'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**

(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) Performance risk exposure

Ahpra is exposed to fluctuations in the performance of the underlying financial assets held with VFMC in their capital stable fund. The fund closely monitors performance within the risk tolerance set out for the fund and manages the following risks through diversification of its investment portfolio. The fund's risk tolerances are aligned to Ahpra's investment policy tolerances.

Foreign currency risk

Foreign currency risk is the risk that the fair value of a financial instrument will fluctuate because of changes in foreign exchange rates. Ahpra is exposed to foreign currency risk through its investment with VFMC capital stable fund.

Equity price risk

Equity price risk is the risk that the fair value of a financial instrument will fluctuate because of changes in market prices. Such factors may include changes in performance of the economies, markets and securities in which the VFMC invests. Ahpra is exposed to equity price risk through its investment with VFMC capital stable fund.

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

2022	Weighted average interest rate	Non-interest bearing $'000	Floating interest rate $'000	Fixed interest rate $'000	Total $'000
Financial assets					
Cash and cash equivalents	0.79%	0	5,683	0	**5,683**
Investments in term deposits	1.28%	0	11,000	136,000	**147,000**
Investments in managed fund	0.00%	85,136	0	0	**85,136**
Receivables	0.00%	3,454	0	0	**3,454**
Accrued income	0.00%	2,449	0	0	**2,449**
Total financial assets		**91,039**	**16,683**	**136,000**	**243,722**
Financial liabilities					
Payables [a]	0.00%	2,951	0	0	**2,951**
Accrued expenses	0.00%	7,335	0	0	**7,335**
Lease liabilities [b]	1.28–4.05%	0	0	39,904	**39,904**
Total financial liabilities		**10,286**	**0**	**39,904**	**50,190**

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 in term deposits	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**

(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 of $3,551K.

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 +2.00% and -0.05% (2021: +0.25% and -0.25%) in market interest rates (AUD) from year-end rates of 1.28% and 0.79% due to historical low interest rates throughout the year and the Reserve Bank of Australia's intention to manage inflation.

The following table discloses the impact on net operating result and equity for each category of financial instrument held by Ahpra at year end. Investments that have a fixed rate of return over the next 12 months are assessed as not subject to the market interest rates shift. Investments that 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.

2022 financial assets	Carrying amount $'000	At +2% $'000 Surplus	At +2% $'000 Equity	At −0.05% $'000 Surplus	At −0.05% $'000 Equity
Cash and cash equivalents	5,683	114	114	(3)	(3)
Investments	147,000	1,056	1,056	(26)	(26)
		1,170	**1,170**	**(29)**	**(29)**

2021 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	10,661	27	27	(5)	(5)
Investments	209,500	189	189	(37)	(37)
		216	**216**	**(42)**	**(42)**

F2.1: Fair value determination

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

In determining fair values, a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, known as the fair value hierarchy. The levels are 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's managed fund investments are facilitated by VFMC in its Capital Stable Fund using Level 2 valuation. It has quoted market and redemption price. The net asset value (NAV) is directly observed and is the net value of the fund's assets less its liabilities, divided by the number of units outstanding. VFMC considers the valuation techniques and inputs used in valuing these funds as part of its due diligence prior to investment, to ensure they are reasonable and appropriate, and therefore the NAV of these funds may be used as an input into measuring their fair value.

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.

The following 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 2022 $'000	Fair value 2022 $'000	Carrying amount 2021 $'000	Fair value 2021 $'000
Contractual financial assets					
Cash and cash equivalents		5,683	5,683	10,661	10,661
Investments – bank term deposits		147,000	147,000	209,500	209,500
Investments – managed fund		80,818	80,818	0	0
Receivables	*D1*	1,641	1,641	726	726
Accrued income		2,449	2,449	1,589	1,589
Total contractual financial assets		**237,591**	**237,591**	**222,476**	**222,476**
Contractual financial liabilities					
Payables	*D2*	2,951	2,951	2,310	2,310
Accrued expenses		7,335	7,335	8,030	8,030
Lease liabilities		39,904	39,904	44,041	44,041
Total contractual financial liabilities		**50,190**	**50,190**	**54,381**	**54,381**

Note F3: Contingent assets and liabilities

Contingent assets	2022 $'000	2021 $'000
Legal proceedings and disputes	0	0

No claim for damages was lodged during the year.

Contingent liabilities	2022 $'000	2021 $'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 policies

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 Ministers in the table below were members of the Ministerial Council (formally known as the Australian Health Workforce Ministerial Council) during the year 1 July 2021 to 30 June 2022, unless otherwise noted.

Amounts relating to responsible ministers' remuneration are reported in the financial statements of the relevant minister's jurisdiction.

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 (to May 2022)	Minister for Health Minister Assisting the Prime Minister for the Public Service and Cabinet	Commonwealth
The Hon Mark Butler MP (from June 2022)	Minister for Health and Aged Care	Commonwealth
The Hon Bradley Hazzard MP	Minister for Health	New South Wales
The Hon Natasha Fyles MLA	Chief Minister Minister for Health Minister for Alcohol Policy Minister for Defence Minister for Major Projects	Northern Territory
The Hon Yvette D'Ath MP	Minister for Health and Ambulance Services	Queensland
The Hon Stephen Wade MLC (to March 2022)	Minister for Health and Wellbeing	South Australia
The Hon Chris Picton MP (from March 2022)	Minister for Health and Wellbeing	South Australia
The Hon Jeremy Rockliff MP	Premier Minister for Health Minister for Mental Health and Wellbeing Minister for Tourism Minister for Trade	Tasmania
The Hon Martin Foley MP (to June 2022)	Minister for Health Minister for Ambulance Services Minister for Equality	Victoria
The Hon Mary-Anne Thomas MP (from June 2022)	Minister for Health Minister for Ambulance Services	Victoria
The Hon Roger Cook MLA (to December 2021)	Deputy Premier Minister for Health; Medical Research; State Development, Jobs and Trade; Science	Western Australia
The Hon Amber-Jade Sanderson MLA (from December 2021)	Minister for Health; Mental Health	Western Australia

(b) Agency Management Committee members

	Period
Ms Gill Callister PSM, Chair	1/7/2021–30/6/2022
Dr Peggy Brown AO	1/7/2021–19/7/2021
Adjunct Professor Karen Crawshaw PSM	1/7/2021–30/6/2022
Ms Jenny Taing OAM	1/7/2021–30/6/2022
Ms Barbara Yeoh AM	1/7/2021–30/6/2022
Dr Susan Young	1/7/2021–30/6/2022
Professor Arie Freiberg AM	1/7/2021–30/6/2022
Mr Lynton Norris	1/7/2021–30/6/2022
Mr Jeffrey Moffet	1/7/2021–30/6/2022

(c) Chief Executive Officer and National Executive team

- Chief Executive Officer, Mr Martin Fletcher
- Executive Director, Regulatory Operations, Ms Kym Ayscough
- Executive Director, Strategy and Policy, Mr Chris Robertson
- Executive Director, People and Culture, Mr Mark Edwards
- Chief Information Officer, Mr Clarence Yap
- Chief Financial Officer, Ms Liz Davenport

(d) Remuneration of KMP

Other than the responsible ministers, the remuneration for KMP is disclosed as follows.

	2022 $	2021 $
Short-term employee benefits	2,126,833	2,099,367
Long-term employee benefits	23,818	52,811
Post-employment benefits	162,060	152,475
Total	**2,312,711**	**2,304,653**

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 2021/22.

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 2021 to 30 June 2022.

The aggregate compensation made to the CEO and National Executive team is set out below:

	2022 $	2021 $
Short-term employee benefits	2,041,853	1,991,107
Long-term employee benefits	23,818	52,811
Post-employment benefits	153,562	142,589
Total	**2,219,233**	**2,186,507**
Total number of executives	6	6
Total annualised employee equivalents	6	6

Note G3: Remuneration of external auditor for the audit of thefinancial statements

	2022 $'000	2021 $'000
Victorian Auditor-General's Office	164	160
Total	**164**	**160**

Note G4: Australian Accounting Standards issued that are not yet effective

The following table outlines the accounting pronouncements that have been issued but are not effective for 2021/22, which may result in potential impacts 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. AASB 2020–6 *Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-current – Deferral of Effective Date* was issued in August 2020 and defers the effective date to annual reporting periods beginning on or after 1 January 2023 instead of 1 January 2022, with earlier application permitted.	*1 January 2023*	The standard is not expected to have a significant impact on Ahpra.

Note G5: Changes in accounting policies

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

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 income and total expenses transacted and attributed to each National Board are shown in the table below.

	2022					2021		
National Board	Revenue $'000	Expenses $'000	Net result from transactions $'000	Other comprehensive loss $'000	Net result $'000	Revenue $'000	Expenses $'000	Net result $'000
ATSIHPBA	623	(627)	(4)	4	**0**	607	607	**0**
CMBA	2,004	(1,631)	373	(137)	**236**	2,031	1,615	**416**
ChiroBA	2,828	(1,920)	908	(143)	**765**	2,940	1,740	**1,200**
DBA	13,399	(12,679)	720	(132)	**588**	12,556	12,487	**69**
MBA	87,392	(85,408)	1,984	(258)	**1,726**	82,597	81,041	**1,556**
MRPBA	3,517	(3,879)	(362)	(58)	**(420)**	3,285	3,546	**(261)**
NMBA	83,674	(75,397)	8,277	(1,173)	**7,104**	76,404	69,148	**7,256**
OTBA	3,266	(3,545)	(279)	(85)	**(364)**	2,879	3,126	**(247)**
OptomBA	1,942	(1,866)	76	(42)	**34**	1,950	1,711	**239**
OsteoBA	1,179	(876)	303	(37)	**266**	1,082	887	**195**
ParaBA	6,331	(4,299)	2,032	(189)	**1,843**	5,751	3,645	**2,106**
PharmBA	13,362	(12,291)	1,071	(122)	**949**	12,627	11,331	**1,296**
PhysioBA	5,294	(5,177)	117	(72)	**45**	4,887	4,903	**(16)**
PodBA	2,141	(1,847)	294	(78)	**216**	2,028	1,681	**347**
PsyBA	19,023	(16,876)	2,147	(261)	**1,886**	18,648	15,465	**3,183**
Other	3,710	(3,710)	0	0	**0**	4,905	4,905	**0**
Total	**249,685**	**(232,028)**	**17,657**	**(2,783)**	**14,874**	**235,177**	**217,838**	**17,339**

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 revenue, 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	2021/22 net result	2021/22 net result funded from equity	Accumulated surplus/(deficit) to 30 June 2022	Equity at 30 June 2022	Accumulated surplus/(deficit) to 30 June 2021	Equity at 30 June 2021
ATSIHPBA	276	0	0	(276)	**0**	(276)	**0**
CMBA	1,293	236	0	5,764	**7,057**	5,528	**6,821**
ChiroBA	1,164	765	0	5,951	**7,115**	5,186	**6,350**
DBA	3,120	588	0	2,020	**5,140**	1,432	**4,552**
MBA	12,257	1,726	0	4,293	**16,550**	2,567	**14,824**
MRPBA	2,218	0	(420)	633	**2,851**	1,053	**3,271**
NMBA	12,816	7,104	0	9,466	**22,282**	2,362	**15,178**
OTBA	3,574	0	(364)	724	**4,298**	1,088	**4,662**
OptomBA	1,061	34	0	879	**1,940**	845	**1,906**
OsteoBA	996	266	0	818	**1,814**	552	**1,548**
ParaBA	0	1,843	0	9,047	**9,047**	7,204	**7,204**
PharmBA	2,716	949	0	2,139	**4,855**	1,190	**3,906**
PhysioBA	2,728	45	0	502	**3,230**	457	**3,185**
PodBA	420	216	0	3,461	**3,881**	3,245	**3,665**
PsyBA	2,194	1,886	0	9,479	**11,673**	7,593	**9,787**
Other	(2,938)	0	0	2,938	**0**	2,938	**0**
Total	**43,895**	**15,658**	**(784)**	**57,838**	**101,733**	**42,964**	**86,859**

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 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 the following table.

Summary of HPCA fee collected and payable

National Board	2022 $'000	2021 $'000
ATSIHPBA	9	8
CMBA	361	381
ChiroBA	470	449
DBA	4,285	4,132
MBA	17,475	16,432
MRPBA	218	212
NMBA	10,831	10,617
OTBA	276	262
OptomBA	260	256
OsteoBA	177	217
ParaBA	735	718
PharmBA	3,343	3,164
PhysioBA	543	517
PodBA	282	275
PsyBA	1,848	1,713
Total	**41,113**	**39,353**

Office of the Health Ombudsman (OHO) Queensland

The Office of the Health Ombudsman (OHO) is funded for each activity it undertakes in relation to complaints about registered health practitioners at a unit rate agreed between Ahpra and OHO. The Queensland Health Minister informs Ahpra and the National Boards of the amount to be paid to the OHO. This payment is included in the *Statement of comprehensive income* as an expense. In 2021/22, Ahpra was required to pay $4.20 million (2020/21: $4.24 million) to OHO under these arrangements.

A further $0.40 million (2020/21: $0.93 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 $4.20 million. Along with the final 2020/21 reconciliation adjustment $0.151 million credit processed in 2021/22, total reported expenses in 2021/22 is $4.45 million. The breakdown of the payment and accrual is shown in the following table.

National Board	Minister's determination for 2022 $'000	QCAT accrual for 2022 $'000	Reconciliation adjustment for 2021 $'000	Reported total 2022 $'000	Reported total 2021 $'000
ATSIHPBA	0	1	0	**1**	**(1)**
CMBA	83	(49)	12	**46**	**31**
ChiroBA	134	(72)	14	**76**	**(17)**
DBA	64	128	16	**208**	**130**
MBA	2,010	(118)	(130)	**1,762**	**2,085**
MRPBA	2	8	(18)	**(8)**	**36**
NMBA	1,192	156	(76)	**1,272**	**1,608**
OTBA	4	1	0	**5**	**4**
OptomBA	3	1	(3)	**1**	**6**
OsteoBA	20	25	9	**54**	**67**
ParaBA	172	62	21	**255**	**89**
PharmBA	176	146	18	**340**	**118**
PhysioBA	25	11	(33)	**3**	**175**
PodBA	3	2	(9)	**(4)**	**17**
PsyBA	316	96	28	**440**	**184**
Total	**4,204**	**398**	**(151)**	**4,451**	**4,532**

Appendices

The National Scheme exists to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and innovation in the education of, and service delivery by, health practitioners.

This section comprises:

- **Appendix 1:** Structure of the National Boards
- **Appendix 2:** Meetings of Boards and committees
- **Appendix 3:** State, territory and regional board, committee, panel and group members
- **Appendix 4:** Attendance at Agency Management Committee and its subcommittee meetings
- **Appendix 5:** National Board consultations
- **Appendix 6:** Registration and professional standards, codes and guidelines

I come from a culturally diverse background and my experience in disability, healthcare, aged care and community services provides me with deeper insights into the importance of inclusive, accessible and culturally safe mainstream services for all.

National Board member

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 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	Dental Notifications Committee: Assessment Immediate Action Committee Notification and Compliance Committee 1 Notification and Compliance Committee 2 Registration and Compliance Committee	N/A	N/A	N/A
MBA	Finance Committee Notifications Committee: Assessment • Standing Committee • Regular Committee National Special Issues Committees • Sexual boundaries and family violence • COVID-19	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 National Special Issues Committee (from 1 Apr)	N/A	All states and territories	Immediate Action Committee (excluding NSW) When required: Notifications Committee (excluding NSW) Registration Committee
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
OTBA	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 Continuous Improvement 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 & Vic NT, SA & WA	NSW Qld	N/A

1 As part of the Multi-Profession Immediate Action Committee. See pages 147–148.

Appendix 2: Meetings of Boards and committees

This table shows 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 the meetings listed as either state/territory board or state/territory committee, along with most 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	9	8	**17**			**0**	**17**
CMBA	15	40	**55**			**0**	**55**
ChiroBA	15	42	**57**			**0**	**57**
DBA	13	96	**109**			**0**	**109**
MBA	15	366	**381**	117	455	**572**	**953**
MRPBA	13	36	**49**			**0**	**49**
NMBA[1]	18	182	**200**	98	318	**416**	**616**
OTBA	16	27	**43**			**0**	**43**
OptomBA	15	23	**38**			**0**	**38**
OsteoBA	12	15	**27**			**0**	**27**
ParaBA	14	76	**90**			**0**	**90**
PharmBA	15	111	**126**			**0**	**126**
PhysioBA	12	41	**53**			**0**	**53**
PodBA	13	29	**42**			**0**	**42**
PsyBA	14	112	**126**	56		**56**	**182**
Total	**209**	**1,204**	**1,413**	**271**	**773**	**1,044**	**2,457**

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 2021/22 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

Professor Brian Jolly (community), Chair

Dr Liming (Henry) Liang (practitioner)

Adjunct Professor Chi Eung Danforn Lim (practitioner), Deputy Chair

Dr Yu-Ting Sun PhD (practitioner)

Mr Brett Vaughan (practitioner)

Policy, Planning and Communications Committee

Ms Sophy Athan (community), Chair

Mr David Brereton (community)

Mr Luke Hubbard (practitioner)

Mr Roderick Martin (practitioner), Deputy Chair

Ms Glenys Savage (practitioner)

Dr Yun Shen PhD (practitioner)

Ms Dina Tsiopelas (practitioner)

1 The NMBA changed its approach to the assessment of notifications in 2021/22, which resulted in a change to the number of meetings.

Registration and Notifications Committee

Mr David Brereton (community), Chair, to 31 Dec

Ms Bing Tian (practitioner), Chair, from 1 Jan

Ms Stephanie Campbell (community), Deputy Chair

Ms Christina Lam (community)

Ms Jacinta Ryan (practitioner)

Dr Johannah Shergis PhD (practitioner)

Ms Dina Tsiopelas (practitioner)

Chinese Medicine Reference Group

Individual practitioner members

Mr Yu Tat (Augustus) Chan

Dr Kevin Ryan

Dr Carol Chungfeng Wang

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, to 30 Sep

Dr Ailsa Wood (practitioner), Chair, from 1 Oct

Ms Kim Barker (community)

Mr Frank Ederle (community)

Ms Anne Burgess AM (community)

Dr Abbey Chilcott (practitioner), Deputy Chair

Dr Wayne Minter AM (practitioner)

Mrs Colleen Papadopoulos (community)

Mr Ken Riddiford (community)

Dr Michael Shobbrook AM (practitioner)

Dr Arcady Turczynowicz (practitioner)

Ms Alison von Bibra (community)

Dental Board of Australia: National committee members

Immediate Action Committee

Mrs Brydget Barker-Hudson (community), Chair

Dr Rachel Martin (practitioner), Chair

Dr Robert McCray (practitioner), Chair

Mr Leigh Gorringe (practitioner)

Professor Lesleyanne Hawthorne (community)

Ms Jill Huck (community)

Dr Quentin Rahaus (practitioner)

Dr Ainslie Waldron (community)

Notifications Committee: Assessment

Dr Werner Bischof (practitioner), Chair

Dr Ioan Jones (practitioner), Chair

Professor Robert Love (practitioner), Chair

Dr Erna Melton (practitioner), Chair

Dr Kerrie O'Rourke (practitioner), Chair

Dr Simon Shanahan (practitioner), Chair, to 25 Nov

Ms Jill Huck (community)

Mrs Brydget Barker-Hudson (community)

Professor Craig Zimitat (community)

Dr Ainslie Waldron (community)

Notification and Compliance Committee

Dr Ioan Jones (practitioner), Chair

Professor Robert Love (practitioner), Chair

Dr Rachel Martin (practitioner), Chair

Dr Simon Shanahan (practitioner), Chair, to 25 Nov

Mrs Brydget Barker-Hudson (community)

Professor Lesleyanne Hawthorne (community)

Dr Lena Lejmanoski (practitioner)

Mrs Jane Oates (practitioner)

Mr Nikolas Peacock (practitioner)

Mr Stuart Unwin (community)

Dr Satya Madhavi Vegunta (practitioner)

Professor Craig Zimitat (community)

Registration and Compliance Committee

Dr Werner Bischof (practitioner), Chair

Ms Jill Huck (community)

Dr Kerrie O'Rourke (practitioner)

Dr Philippa Sawyer (practitioner)

Dr Ainslie Waldron (community)

Associate Professor Janet Wallace (practitioner), Deputy Chair

Medical Board of Australia: State and territory board, national committee and group members

Australian Capital Territory Board

Professor Peter Warfe CSC (practitioner), Chair

Mrs Gulnara Abbasova (community)

Dr Emma Adams (practitioner)

Dr Iain Dunlop (practitioner)

Ms Catherine (Kate) Gauthier (community)

Associate Professor Boon Lim (practitioner)

Associate Professor Rodney Petersen (practitioner)

Mr Aasish Ponna (community)

Dr Louise Stone (practitioner)

New South Wales Board

Dr Sergio Diez Alvarez (practitioner), Chair

Dr Costa Boyages (practitioner)

Dr Jennifer Davidson (practitioner)

Dr Maria (Tessa) Ho (practitioner)

Associate Professor Gabriel Lau (practitioner)

Dr Amanda Mead PhD (community)

Professor Abdullah Omari (practitioner)

Ms Jebby Phillips (community)

Ms Annette Ruhotas Morgan (community)

Professor Allan Spigelman (practitioner)

Ms Amanda Wilson (community)

Northern Territory Board

Dr Hemanshu (Hemi) Patel (practitioner), Chair

Mrs Lea Aitken (community)

Mrs Julia Christensen (community)

Dr Henry Duncan (practitioner)

Ms Annette Flaherty (community)

Dr Sarah Giles (practitioner)

Dr Verushka Krigovsky (practitioner)

Associate Professor Dianne Stephens OAM (practitioner)

Dr John Zorbas (practitioner)

Queensland Board

Dr Philip Richardson (practitioner), Chair

Dr Mohamed Hashim (Hash) Abdeen (practitioner)

Dr Cameron Bardsley (practitioner)

Dr Anelisa Dazzi Chequer De Souza (practitioner)

Mr Timothy Cole (community)

Dr Caron Forde (practitioner)

Ms Christine Gee (community)

Dr Genevieve Goulding (practitioner)

Professor Harry McConnell (practitioner)

Dr Gordon McGurk PhD (community)

Professor Eleanor Milligan (community)

Ms Megan O'Shannessy (community)

Dr Morgan Windsor (practitioner)

South Australia Board

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 Board

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 Brooke Sheldon (practitioner)

Dr Benoj Varghese (practitioner)

Associate Professor Stuart Walker (practitioner)

Ms Joan Wylie (community)

Victoria Board

Dr Debra O'Brien (practitioner), Chair

Mrs Jennifer Barr (community)

Professor George Braitberg (practitioner)

Ms Jane (Meredith) Carter (community)

Dr Nicola Cunningham (practitioner)

Ms Jacqueline Gibson (community)

Dr Susan Gould PhD (community)

Associate Professor Vinay Lakra (practitioner)

Associate Professor Jenepher (Jenny) Martin (practitioner)

Dr Pamela Montgomery PhD (community)

Dr Abhishek (Abhi) Verma (practitioner)

Dr Ruth Vine (practitioner)

Western Australia Board

Professor Mark Edwards (practitioner), Chair

Professor Constantine (Con) Michael AO (practitioner)

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)

Dr Katinka Morton (practitioner)

Mr Liam Roche (community)

Dr Ruth Shean AO (community)

Non-Board members appointed to national, state or territory committees

ACT

Ms Vicki Brown (community)

Mr Robert Little (community)

Qld

Dr Oluwaseun (Wole) Akosile (practitioner)

Ms Lisa Coffey (community)

Dr Jacqueline Evans (practitioner)

Professor Harry McConnell (practitioner)

Mr Geoff Rowe (community)

Dr Samuel Stevens (practitioner)

Dr Susan Young EdD (community)

SA

Mr Paul Laris (community)

Tas

Ms Leigh Mackey (community)

WA

Dr Steven Patchett (practitioner)

COVID-19 National Special Issues Committee (from 1 May)

Dr Anne Tonkin (practitioner), Chair

Mrs Lea Aitken (community)

Dr Kerrie Bradbury (practitioner)

Mr Timothy Cole (community)

Dr George Eskander (practitioner)

Dr Caron Forde (practitioner)

Ms Christine Gee (community)

Ms Jacqueline Gibson (community)

Dr Samuel Goodwin (practitioner)

Dr Maria (Tessa) Ho (practitioner)

Ms Kate Ireland (community)

Ms Eileen Jerga AM (community)

Ms Meneesha Michalka (community)

Dr Debra O'Brien (practitioner), Deputy Chair

Mr Aasish Ponna (community)

Dr Benoj Varghese (practitioner)

Associate Professor Mary White (practitioner)

CPD Implementation Group (from 14 Sep)

Dr Anne Tonkin (practitioner), Chair

Associate Professor Stephen Adelstein (practitioner)

Dr Richard Doherty (practitioner)

Dr Kym Jenkins (practitioner)

Dr Joanne Katsoris (practitioner)

Professor Katherine (Kate) Leslie (practitioner)

Professor Robyn Langham (practitioner)

Mr Philip Pigou (community)

Dr Vijay Roach (practitioner)

Dr Hamza Vayani (community)

Medical Training Survey Advisory Group (to 14 Feb)

Associate Professor Stephen Adelstein (practitioner), Chair

Dr Mohamed Hashim (Hash) Abdeen (practitioner)

Ms Christine Brill (community)

Dr Dean Choong (practitioner)

Dr Jeanette Conley (practitioner)

Ms Helen Craig (community)

Dr Megan Crawford (practitioner)

Dr James Edwards (practitioner)

Dr Kym Jenkins (practitioner)

Dr Joanne Katsoris (practitioner)

Ms Sophie Keen (practitioner)

Professor Robyn Langham (practitioner)

Mr John McGurk (community)

Dr David Mountain (practitioner)

Ms Nicole Newton (community)

Dr Susan O'Dwyer (practitioner)

Dr Annette Pantle (practitioner)

Dr Andrew Singer (practitioner)

Professor Richard Tarala (practitioner)

Dr Artiene Tatian (practitioner)

Professor Susan Wearne (practitioner)

Dr Christopher (Chris) Wilson (practitioner)

Ms Fearn (Michelle) Wright (community)

Dr John Zorbas (practitioner)

Medical Training Survey Consultative Forum (from 27 Apr)

Associate Professor Stephen Adelstein (practitioner), Chair

Dr Monica Barolits-McCabe (practitioner)

Dr Claire Blizard (practitioner)

Dr Michael Bonning (practitioner)

Professor Stuart Carney (practitioner)

Dr Ava Carter (practitioner)

Dr Jeanette Conley (practitioner)

Dr Megan Crawford (practitioner)

Dr Sally Cross (practitioner)

Ms Jasmine Davis (community)

Dr Daniel Heredia (practitioner)

Associate Professor Louis Irving (community)

Dr Joanne Katsoris (practitioner)

Ms Nicole Newton (community)

Dr Helen Parsons (practitioner)

Dr Mary Pinder (practitioner)

Ms Kellie Porter (community)

Dr Helena Qian (practitioner)

Dr Greg Sweetman (practitioner)

Dr Hannah Szewczyk (practitioner)

Ms Theanne Walters (community)

Dr Daniel Wilson (practitioner)

Ms Fearn (Michelle) Wright (community)

Dr John Zorbas (practitioner)

Medical Training Survey Steering Committee

Associate Professor Stephen Adelstein (practitioner), Chair

Dr Daniel Heredia (practitioner)
Dr Sanjay Hettige (practitioner)
Dr Charles Jenkinson (practitioner)
Dr Joanne Katsoris (practitioner)
Professor Anthony Lawler (community)
Ms Saoirse McDonough (community)
Ms Nicole Newton (community)
Ms Kirsty White (community)
Ms Fearn (Michelle) Wright (community)
Ms Bernadette Thomson (community)

NCA Standing Committee

Dr Maria (Tessa) Ho (practitioner), Chair

Mrs Lea Aitken (community)
Mr Mark Bodycoat (community), Deputy Chair
Ms Vicki Brown (community)
Dr Sergio Diez Alvarez (practitioner)
Dr Carolyn Edmonds (practitioner)
Professor Mark Edwards (practitioner)
Dr Susan Gould PhD (community)
Mr Robert Little (community)
Professor Constantine (Con) Michael AO (practitioner)
Ms Meneesha Michalka (community)
Dr Pamela Montgomery PhD (community), Deputy Chair
Dr Bruce Mugford (practitioner)
Dr Morgan Windsor (practitioner)
Ms Joan Wylie (community)

National Special Issues Committee (formerly the Sexual Boundaries Notifications Committee)

Ms Christine Gee (community), Chair

Mr Mark Bodycoat (community)
Dr Alan Duncan (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)
Ms Katherine Sullivan (community)
Dr Anne Tonkin (practitioner)
Dr Abhishek (Abhi) Verma (practitioner)
Professor Peter Warfe CSC (practitioner), Deputy Chair

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)
Dr Jon Hodge (practitioner)
Dr Joanne Katsoris (practitioner)
Ms Megan Lewis (community)
Dr Andrew Mulcahy (practitioner)
Dr Bruce Mugford (practitioner)
Dr Hemanshu (Hemi) Patel (practitioner)
Mr Philip Pigou (community)
Dr Diane Neill (practitioner)
Adjunct Associate Professor Andrew Singer AM (practitioner)
Ms Martina Stanley (community)
Dr Janaka Tennakoon (practitioner)

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)
Associate Professor Caroline Wright (practitioner)

Policy Committee

Ms Joan Burns (community), Chair

Ms Renea Hart (community)
Mr Mark Marcenko (practitioner)
Mr Travis Pearson (practitioner)
Mr Roger Weckert (practitioner)
Associate Professor Caroline Wright (practitioner)

Registration and Notifications Committee

Mr Brendan McKernan (practitioner), Chair

Mr Richard Bialkowski (community)
Mr Anthony Buxton (practitioner)
Mr James Green (practitioner)
Ms Renea Hart (community)
Ms Cara Miller (practitioner)

Supervised Practice Committee

Associate Professor Caroline Wright (practitioner), Chair

Mr Richard Bialkowski (community)
Mr Brendan McKernan (practitioner)
Ms Cara Miller (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

Mrs Sharon Bingham (practitioner) (Tas)
Ms Angela Bull (practitioner) (NT)
Ms Felicity Dalzell (practitioner) (ACT)
Ms Michelle Dillon (practitioner) (WA)
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)
Mr Jonathan Wright (practitioner) (NT)

Australian Capital Territory Board

Ms Felicity Dalzell (practitioner), Chair

Mrs Gulnara Abbasova (community)
Mrs Alison Archer (community)
Dr Marjorie Atchan PhD (practitioner)
Ms Janet (Emma) Baldock (practitioner)
Mrs Toni Bushby (practitioner)
Dr Katrina Cubit PhD (practitioner)
Ms Catherine (Kate) Gauthier (community)
Mrs Peta Harbour (practitioner)
Mr Rory Maguire (practitioner)
Professor Karen Strickland (practitioner)

New South Wales Board

Mrs Eithne Irving (practitioner), Chair

Ms Alison Barnes (practitioner)
Ms Katherine Becker (practitioner)
Mr Roderick (Rod) Cooke (community)
Mrs Maria Cosmidis (community)
Ms Adrienne Farago (community)
Mrs Susan (Sue) Greig (practitioner)
Mrs Annette (Anne) Moehead (practitioner)
Mrs Tamara (Tammy) Tedstone (practitioner)

Northern Territory Board

Ms Angela Bull (practitioner), Chair, to 6 Sep

Mr Jonathan Wright (practitioner), Chair, from 7 Nov

Mrs Leanne Chapman (practitioner)
Mrs Emma Childs (practitioner)
Ms Aislinn McIntyre (community)
Mrs Jane Napier (practitioner)
Mrs Priscilla Moore (practitioner)
Ms Alison Phillis (community)
Dr Joanne (Jo) Seiler (DBA) (practitioner)

Mrs Helen (Nell) Stonham (community)
Mr Andrew Urquhart (practitioner)

Queensland Board

Ms Michelle Garner (practitioner), Chair
Ms Jacinta Ashton (practitioner)
Ms Suzanne (Sue) Cadigan (practitioner)
Mrs Karen (Kaz) Dolci (community)
Dr Amanda Henderson PhD (practitioner)
Mr Stanley Macionis (community)
Ms Catherine Mickel (community)
Ms Helen Towler (practitioner)
Ms Wendy Zernike (practitioner)

South Australia Board

Ms Paula Medway (practitioner), Chair
Mr Mark Bodycoat (community)
Ms Elisa Gardiner (practitioner)
Mrs Michelle Hogan (practitioner)
Mrs Margaret McCallum (community)
Dr Philippa Rasmussen PhD (practitioner)
Mr Thomas Symonds (community)
Mrs Lisa Turner (practitioner)
Ms Kellie Whelan (practitioner)

Tasmania Board

Mrs Sharon Bingham (practitioner), Chair
Mrs Briony (Bebe) Brown (practitioner)
Ms Amanda (Mandi) Buchanan (practitioner)
Professor Rosalind Bull (practitioner)
Ms Hazel Bucher (practitioner)
Mrs Lucy Byrne (community)
Mr Stephen (Steve) Carey (community)
Miss Aleara Crichton-Gill (practitioner)
Ms Belinda Webster (community)

Victoria Board

Ms Amanda Singleton (practitioner), Chair
Professor Maxine Duke (practitioner)
Mr Matthew (Matt) Grace (practitioner)
Ms Helen Karagiozakis (community)
Mrs Joanne (Jo) Mapes (practitioner)
Ms Thilaka Sathananthavel (community)
Adjunct Professor Paula Stephenson (practitioner)
Mrs Brenda Waites (practitioner)
Dr Miriam Weisz OAM (Doctorate Business Administration) (community)

Western Australia Board

Ms Marie Louise MacDonald (practitioner), Chair, to 17 Mar
Ms Michelle Dillon (practitioner), Chair, from 18 Mar
Ms Justine Burg (practitioner)
Mrs Heather Gillett (practitioner)
Adjunct Associate Professor Karen Gullick (practitioner)
Mrs Linda Hadfield (community)
Dr Yvonne Hauck PhD (practitioner)
Mr Nathan Haynes (practitioner)
Mr John (Kim) Laurence (community)
Ms Margaret (Margie) Lundy (community)
Miss Kathryn Pedler (practitioner)

Accreditation Committee (Assessment of Overseas Qualified Nurses and Midwives)

Professor Denise Fassett (practitioner), Chair
Mr Ian Frank AM (community)
Ms Marie Heartfield (practitioner)
Ms Josephine McGuiness (community)
Professor Catherine Nagle (practitioner)
Ms Fiona Stoker (practitioner)
Mr Brett Vaughan (practitioner)

Finance, Governance and Communications Committee

Associate Professor Linda Starr (practitioner), Chair, from 1 Mar
Ms Melodie Heland (practitioner), Chair, to 11 Nov
Mr David Carpenter (practitioner)
Dr Jessica (Jessa) Rogers PhD (community)
Ms Catherine Schofield (practitioner)

National Special Issues Committee (from 16 Dec)

Ms Paula Medway (practitioner), Chair
Ms Michelle Garner (practitioner)
Mr Stephen (Steve) Carey (community)

Notifications Committee Midwifery

Ms Paula Medway (practitioner), Chair
Mrs Gulnara Abbasova (community)
Dr Marjorie Atchan PhD (practitioner)
Ms Amanda (Mandi) Buchanan (practitioner)
Mr Stephen (Steve) Carey (community)
Dr Amanda Henderson PhD (practitioner)
Mr Stanley Macionis (community)
Ms Amanda Singleton (practitioner)

Notifications Committee Nursing Assessment

Ms Felicity Dalzell (practitioner)
Ms Elisa Gardiner (practitioner)
Ms Michelle Garner (practitioner)
Ms Paula Medway (practitioner)
Ms Amanda Singleton (practitioner)
Associate Professor Linda Starr (practitioner)
Ms Paula Stephenson (practitioner)
Ms Helen Towler (practitioner)
Mrs Brenda Waites (practitioner)
Ms Kellie Whelan (practitioner)

Program Approval Committee

Associate Professor Linda Starr (practitioner), Chair, to 28 Feb
Mrs Jennifer Wood (practitioner), Chair, from 1 Mar
Associate Professor Catherine Chamberlain (practitioner)
Dr Christopher Helms PhD (practitioner)
Mr Max Howard (community)
Mrs Gemma Martin (community)

Registration and Notifications Committee

Ms Annette Symes (practitioner), Chair, to 28 Feb
Dr Christopher Helms PhD (practitioner), Chair, from 1 Mar
Mr David Carpenter (practitioner)
Ms Maria Ciffolilli (community)
Ms Sonja Illievska (community)
Ms Catherine Schofield (practitioner)
Associate Professor Linda Starr (practitioner)
Mrs Jennifer Wood (practitioner)

EN OSCE Examination Committee of the Nursing and Midwifery Accreditation Committee (from 13 Dec)

Dr Paul (John) Glew (EdD) (practitioner), Chair
Mrs Louise Kemme (practitioner)
Dr Alexander (Curtis) Lee PhD (practitioner)
Mrs Michelle Tolentino (practitioner)

Midwifery Examination Committee of the Nursing and Midwifery Accreditation Committee (from 19 Jul)

Ms Paula Medway (practitioner), Chair
Ms Kathryn Brundell (practitioner)
Dr Elizabeth Rigg PhD (practitioner)

RN OSCE Examination Committee of the Nursing and Midwifery Accreditation Committee

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)

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)
Ms Sally Cunningham (practitioner)
Dr Nicole Grant PhD (practitioner)
Dr Catherine McBryde PhD (practitioner)
Ms Jennifer Morris (community)

Dr Claire Pearce PhD (practitioner)

Associate Professor Justin Scanlan (practitioner), Deputy Chair

Ms Rebecca Singh (practitioner)

Ms Angela Thynne (practitioner)

Optometry Board of Australia: National committee members

Finance and Risk Committee

Mr Anthony Evans (community), Chair to 15 Dec

Mr Stuart Aamodt (practitioner), Chair, from 16 Dec

Miss Renee Slunjski (practitioner)

Associate Professor Ann Webber (practitioner)

Policy and Education Committee

Associate Professor Ann Webber (practitioner), Chair

Associate Professor Rosemary Knight (community), Alternate Chair

Dr Carla Abbott (practitioner)

Mr Benjamin Graham (community)

Associate Professor Daryl Guest (practitioner)

Ms Adrienne Farago (community)

Mr Martin Robinson (practitioner)

Miss Renee Slunjski (practitioner)

Registration and Notifications Committee

Mr Ian Bluntish (practitioner), Chair, to 11 Nov

Mrs Judith Hannan (practitioner), Chair, from 16 Dec

Mr Stuart Aamodt (practitioner)

Mrs Nancy Atkinson (practitioner)

Ms Suzanne Dunning (practitioner)

Ms Adrienne Farago (community)

Mr Benjamin Graham (community)

Mr Kenneth Ingram (practitioner)

Mr Neville Turner (practitioner)

Scheduled Medicines Advisory Committee

Associate Professor Daryl Guest (practitioner), Chair, to 11 Nov

Dr Carla Abbott (practitioner), Chair, from 16 Dec

Mr Ian Bluntish (practitioner)

Dr Michael Chilov (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

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)

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, to 31 Dec

Ms Hannah Mann (practitioner), Chair, from 1 Jan

Ms Melissa Cadzow (community)

Dr Alice Gilbert PhD (practitioner)

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

Mr Mark Kirschbaum (practitioner), Chair

Mr Laurence (Ben) Wilkins (practitioner), Chair

Ms Hannah Mann (practitioner), Chair, from 1 Jan

Ms Melissa Cadzow (community)

Dr Suzanne Martin (veterinarian) (community)

Mr Brett Simmonds (practitioner)

Mr Rodney Wellington (community)

Policies, Codes and Guidelines Committee

Mr Brett Simmonds (practitioner), Chair, to 31 Dec

Mrs Elise Apolloni (practitioner), Chair, from 1 Jan

Ms Melissa Cadzow (community)

Dr Alice Gilbert PhD (practitioner)

Ms Joy Hewitt (practitioner)

Mr Mark Kirschbaum (practitioner)

Dr Suzanne Martin (veterinarian) (community)

Dr Cameron Phillips PhD (practitioner)

Dr Janet Preuss PhD (community)

Mr Laurence (Ben) Wilkins (practitioner)

Registration and Examinations Committee

Ms Joy Hewitt (practitioner), Chair, to 11 Nov

Dr Cameron Phillips PhD (practitioner), Chair, from 1 Jan

Mrs Elise Apolloni (practitioner)

Dr Alice Gilbert PhD (practitioner)

Mr Mark Kirschbaum (practitioner)

Ms Hannah Mann (practitioner)

Dr Suzanne Martin (veterinarian) (community)

Dr Amy Page (practitioner)

Dr Janet Preuss PhD (community)

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, to 31 Mar

Ms Sally Adamson (practitioner), Chair, from 1 Apr

Mr Timothy Barnwell (practitioner)

Mrs Janet Blake (community)

Ms Maureen Capp OAM (community)

Mr David Cross (practitioner)

Mr Mark Hindson (practitioner)

Mr Peter Kerr AM (community)

Dr Margaret Potter PhD (practitioner)
Mr Allan Renouf (community)
Ms Elizabeth Soderholm (practitioner)
Mr Grant Scroggie (practitioner)

Podiatry Board of Australia: National committee members

Registration and Notifications Committee

Dr Janice Davies OAM (community), Chair, to 11 Nov

Ms Shellee Smith (community), Chair, from 1 Jan

Dr Paul Bennett PhD (practitioner)
Ms Raelene Harrison (community)
Ms Julia Kurowski (practitioner)
Dr Kristy Robson PhD (practitioner), Deputy Chair
Mr Anthony Short (practitioner)

Strategic Planning and Policy Committee

Mrs Kathryn (Kate) Storer (practitioner), Chair

Professor Andrew Taggart (community)
Mr Andrew van Essen (practitioner)
Associate Professor Cylie Williams (practitioner)

Psychology Board of Australia: Regional board and national committee members

ACT/Tas/Vic Regional Board

Dr Joel Godfredson (practitioner), Presiding Member

Associate Professor Rubina Alpitsis (practitioner)
Dr Ann Boonzaier (practitioner)
Mr Carl Buik (community)
Dr Simon Crisp (practitioner)
Associate Professor Kimberley Norris (practitioner)
Ms Vicki de Prazer (practitioner)
Ms Lisa Wardlaw-Kelly (community)
Dr Miriam Weisz OAM (Doctorate Business Administration) (community)

New South Wales Regional Board

Associate Professor Christopher Willcox (practitioner), Chair

Mr Yat Sang (Sang) Cheung (practitioner)
Mr Roderick (Rod) Cooke (community)
Ms Anna Egeressy (practitioner)
Mr Timothy Hewitt (practitioner)
Mr Robert Lagaida (community)
Ms Maralean (Maz) McCalman (community)
Ms Pauline O'Connor (community)
Ms Alison O'Neill (practitioner)
Ms Lila Vrklevski (practitioner)

NT/SA/WA Regional Board

Mr Neil McLean (practitioner), Chair, to 16 Jun

Mr Colby Pearce (practitioner), Presiding member, from 17 Jun

Ms Cathy Beaton (community)
Ms Celeste Brand (community)
Ms Carolyn Bright (practitioner)
Ms Kathryn Collins (practitioner)
Ms Jacqueline Fidler (practitioner)
Mrs Megan Lawton (community)
Ms Elizabeth Pritchard (practitioner)
Mr Adam Santa Maria (community)
Ms Claire Simmons (practitioner)
Ms Rachel Zombor (practitioner)

Queensland Regional Board

Dr Fiona Black (practitioner), Chair

Ms Kathryn Bekavac (practitioner)
Mr Robert Blin (community)
Ms Narelle Dickinson (practitioner)
Ms Julia Duffy (community)
Ms Karen Dunshea (practitioner)
Ms Ylishavai Ngateejah (practitioner)
Ms Linda Renouf (community)
Mr David Rodwell (practitioner)

Immediate Action Committee

Ms Mary Brennan (community), Chair, to 11 Nov

Dr Fiona Black (practitioner), Chair, from 1 Jan

Dr Joel Godfredson (practitioner), Chair, from 26 Nov

Mr Neil McLean (practitioner), Chair, from 26 Nov to 16 Jun

Ms Claire Simmons (practitioner), Chair, from 26 Nov to 31 Dec

Associate Professor Christopher Willcox (practitioner), Chair, from 26 Nov

Dr Ann Boonzaier (practitioner)
Ms Carolyn Bright (practitioner)
Dr Melissa Casey (practitioner)
Ms Narelle Dickinson (practitioner)
Ms Julia Duffy (community)
Dr Sally Kalek (practitioner)
Dr Elke Kellis (practitioner)
Associate Professor Michael Kiernan (practitioner)
Mr Colby Pearce (practitioner)
Ms Linda Renouf (community)
Professor Jennifer Scott (practitioner)
Mr Theodore Sharp (community)
Ms Lisa Wardlaw-Kelly (community)
Dr Miriam Weisz OAM (Doctorate Business Administration) (community)

Notifications Committee: Assessment

Dr Haydn Till (practitioner), Chair

Dr Fiona Black (practitioner)
Dr Alexander Blaszczynski (practitioner)
Ms Carolyn Bright (practitioner)
Dr Peter Cook (practitioner)
Ms Angela Marie Davis (practitioner)
Mr John Gardiner (practitioner)
Miss Jelena Kilibarda (practitioner)
Dr Rebecca Matthews (practitioner)
Mr Neil McLean (practitioner)
Dr Shirley Morrissey (practitioner)
Mr Thomas O'Neill (practitioner)
Dr Wendy Roberts (practitioner)
Ms Claire Simmons (practitioner)
Associate Professor Christopher Willcox (practitioner)
Dr Sarah Wrigley (practitioner)

Multi-Profession Immediate Action Committee

Dr Susan Gould PhD (MRPBA) (community), Chair, from 27 Sep

Dr Janice Davies OAM (PodBA) (community), Alternate Chair, to 11 Nov

Ms Julia Duffy (OsteoBA) (community), Alternate Chair, from 27 Sep

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)
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) (practitioner)
Ms Julia Kurowski (PodBA) (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)
Associate Professor Paul Orrock (OsteoBA) (practitioner)
Ms Renee Owen (ATSIHPBA) (practitioner)
Associate Professor Ian Patrick ASM (ParaBA) (practitioner)
Dr Johannah Shergis PhD (CMBA) (practitioner)
Ms Angela Thynne (OTBA) (practitioner)
Ms Bing Tian (CMBA) (practitioner)
Mr Arcady Turczynowicz (ChiroBA) (practitioner)

Associate Professor Ann Webber (OptomBA) (practitioner)

Associate Professor Cylie Williams (PodBA) (practitioner)

Mr Kenton Winsley (ATSIHPBA) (practitioner)

Dr Ailsa Wood (ChiroBA) (practitioner)

Ms Angela Wright (ParaBA) (practitioner)

Mr Andrew Yaksich (OsteoBA) (practitioner)

Multi-Profession Registration and Notifications Committee

Mr Darryl Annett (community), from 1 Feb

Ms Kim Barker (community), from 24 Feb

Mr Richard Bialkowski (community), from 1 Feb

Dr Kerrie Bradbury (practitioner), from 1 Feb

Ms Carolyn Bright (practitioner), from 1 Feb

Mr David Brereton (community), from 24 Feb

Mr Bruce Brown (community), from 1 Feb

Dr Abbey Chilcott (practitioner), from 1 Feb

Mr Keith Driscoll ASM (practitioner), from 1 Feb

Ms Julia Duffy (community), from 1 Feb

Mr Benjamin Graham (community), from 24 Feb

Mrs Judith Hannan (practitioner), from 24 Feb

Ms Raelene Harrison (community), from 1 Feb

Professor Lesleyanne Hawthorne (community), from 24 Feb

Mr Luke Hubbard (practitioner), from 24 Feb

Ms Eileen Jerga AM (community), from 1 Feb

Mr Mark Kirschbaum (practitioner), from 1 Feb

Dr Suzanne Martin (community), from 1 Feb

Mrs Margaret McCallum (community), from 1 Feb

Dr Robert McCray (practitioner), from 24 Feb

Mr Brendan McKernan (practitioner), from 1 Feb

Dr Timothy McNamara (practitioner), from 1 Feb

Ms Jennifer Morris (community), from 1 Feb

Associate Professor Paul Orrock (practitioner), from 1 Feb

Mrs Colleen Papadopoulos (community), from 24 Feb

Ms Linda Renouf (community), from 1 Feb

Dr Jessica (Jessa) Rogers (community), from 24 Feb

Associate Professor Justin Scanlan (practitioner), from 1 Feb

Mr Anthony Short (practitioner), from 1 Feb

Associate Professor Linda Starr (practitioner), from 24 Feb

Ms Elizabeth Trickett (practitioner), from 1 Feb

Ms Katherine Waterford (community), from 1 Feb

Dr Miriam Weisz OAM (Doctorate Business Administration) (community), from 1 Feb

Mrs Jennifer Wood (practitioner), from 24 Feb

Mr Howard Wren ASM (practitioner), from 1 Feb

Accreditation Committees

Aboriginal and Torres Strait Islander Health Practice Board of Australia Accreditation Committee

Professor Elaine Duffy (community), Chair, to 31 Dec

Mr David Copley (community), Chair, from 1 Jan

Mrs Candace Angelo (community)

Mr James Harris (community)

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

Ms Cristina Blefari (practitioner)

Mrs Allison Dry (practitioner)

Ms Edel Doyle (practitioner)

Ms Jillian Harris (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)

Mr Adam Stewart (practitioner)

Ms Eliza Woollett (community)

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 2021/22 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	10/11
Adjunct Professor Karen Crawshaw PSM	11/11
Emeritus Professor Arie Freiberg AM	11/11
Mr Jeffrey Moffet	9/11
Mr Lynton Norris	11/11
Ms Jenny Taing OAM	10/11
Ms Barbara Yeoh AM	11/11
Dr Susan Young	7/11
Mr Brett Simmonds	11/11
Accreditation Committee	
Professor Andrew Wilson (Chair)	4/4
Ms Alison Barnes	3/4
Dr Heather Buchan[1]	3/4
Adjunct Professor Veronica Casey AM[2]	3/4
Ms Deborah Frew	2/4
Dr Helen Gniel	3/4
Professor Brian Jolly	4/4
Mrs Kay Leatherland	3/4
Ms Narelle Mills	4/4
Mr Jeffrey Moffet	3/4
Professor Maree O'Keefe	4/4
Mr Brett Simmonds	4/4
Dr Hamza Vayani	2/4
Emeritus Professor Ian Wronski AO	4/4
Dr Susan Young	3/4
Finance, Audit and Risk Management Committee	
Ms Barbara Yeoh AM, Chair	4/4
Mr Lynton Norris	4/4
Ms Jenny Taing OAM	3/4
Mr David Balcombe	3/4
Mr Anthony Evans	3/4
Ms Kim Jones	3/4
Ms Allyson Warrington	1/1
Dr Susan O'Dwyer	2/2

Name	Number of meetings attended/ eligible to attend
People and Remuneration Committee	
Ms Gill Callister PSM, Chair	3/4
Adjunct Professor Karen Crawshaw PSM	4/4
Ms Jenny Taing OAM	4/4
Ms Susie George	4/4
Dr Wayne Minter	3/4
Dr Murray Thomas	4/4
Regulatory Performance Committee	
Dr Susan Young, Chair	3/4
Adjunct Professor Karen Crawshaw PSM	4/4
Emeritus Professor Arie Freiberg AM	4/4
Mr Ian Bluntish	2/2
Adjunct Professor Veronica Casey AM[3]	3/4
Ms Rachel Phillips	3/4
Ms Tiina-Liisa Sexton	3/4
Mr Brett Simmonds	3/4
Dr Murray Thomas	3/4
Dr Anne Tonkin	4/4

1 Conjoint Professor Anne Duggan also attended one meeting on behalf of Dr Heather Buchan.
2 Ms Catherine Schofield also attended one meeting on behalf of Adjunct Professor Veronica Casey.
3 Ms Annette Symes also attended one meeting on behalf of Adjunct Professor Veronica Casey.

Appendix 5: National Board consultations

National Board	Name of consultation	Start date	End date
ATSIHPBA, ChiroBA, CMBA, DBA, MRPBA, OptomBA, OsteoBA, OTBA, ParaBA, PharmBA, PhysioBA, PodBA	Public consultation on the review of the shared *Code of conduct*	11 May 2021	**6 July 2021**
CMBA	Public consultation on the *Guidelines on safe Chinese herbal medicine practice*	**4 January 2022**	**4 March 2022**
CMBA	Public consultation on the *Guidelines on infection prevention and control for acupuncture and related practices*	**4 January 2022**	**4 March 2022**
DBA	Public consultation on the review of the *Guidelines on infection control*	**9 September 2021**	**15 November 2021**
MRPBA	Targeted consultation: *Supervised practice arrangements for medical radiation practice*	**15 November 2021**	**28 January 2022**
PodBA	Draft revised registration standard: *Specialist registration for the podiatry specialty of podiatric surgery*	**10 May 2022**	15 July 2022

Appendix 6: Registration and professional standards, codes and guidelines

Registration standards are approved by the Ministerial Council after submission by the relevant National Board.

Codes, guidelines and professional standards are developed and approved by the relevant National Board.

Before approval there must be public consultation.

See the Board reports for updates about accreditation standards.

National Board	Registration and/or professional standard, code or guideline	Approved by	Date of approval	Effective from
ATSIHPBA, ChiroBA, CMBA, DBA, MRPBA, OptomBA, OsteoBA, OTBA, ParaBA, PharmBA, PhysioBA, PodBA	Shared *Code of conduct*	National Boards	**9 December 2021**	**29 June 2022**
ATSIHPBA, ChiroBA, CMBA, DBA, MBA, NMBA, OptomBA, OsteoBA, OTBA, ParaBA, PhysioBA, PodBA	Shared *Supervised practice framework*[1]	National Boards	23 June 2021	**1 February 2022**
MBA	Registration standard: *Continuing professional development*	Ministerial Council	**18 July 2021**	1 January 2023
MBA	Registration standard: *Endorsement of registration for acupuncture for registered medical practitioners*	Ministerial Council	**3 December 2021**	1 July 2022
OptomBA	*Guidelines for the use of scheduled medicines*	National Board	**23 September 2021**	**10 December 2021**
PodBA	*Professional capabilities for podiatric surgeons*	National Board	**28 July 2021**	**1 January 2022**
PodBA	*Professional capabilities for podiatrists*	National Board	**28 July 2021**	**1 January 2022**

1 A key regulatory document that replaced multiple guidelines; not a registration standard, code or guideline. Some exclusions apply for medical practitioners, paramedics and podiatrists.

Common abbreviations

National Board abbreviations

ATSIHPBA
Aboriginal and Torres Strait Islander Health Practice Board of Australia

ChiroBA
Chiropractic Board of Australia

CMBA
Chinese Medicine 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

OptomBA
Optometry Board of Australia

OsteoBA
Osteopathy Board of Australia

OTBA
Occupational Therapy 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
www.ahpra.gov.au

CAC
Community Advisory Council
Formerly the Community Reference Group
www.ahpra.gov.au/About-Ahpra/Our-engagement-activities/Advisory-groups/Community-Advisory-Council

HCCC
Health Care Complaints Commission (NSW)
www.hccc.nsw.gov.au

HCE
Health complaints entity
www.ahpra.gov.au/notifications/further-information/health-complaints-organisations

HCEF
Health Chief Executives Forum
Formerly the Australian Health Ministers' Advisory Council (AHMAC)
www.health.gov.au/committees-and-groups/health-chief-executives-forum-hcef

HPCA
Health Professional Councils Authority (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 (Qld)
www.oho.qld.gov.au

PRG
Professions Reference Group
www.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 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 are many 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

A 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 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

A 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.

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.

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*.

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
The 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.

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