Annual report 2019/20

Ten years of your National Scheme
for safer healthcare

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

Ahpra & National Boards

The regulated health workforce in 2019/20

801,659 registered health practitioners

1 in 15 people employed in Australia is a registered health practitioner

Figure 1. Age of registered health practitioners

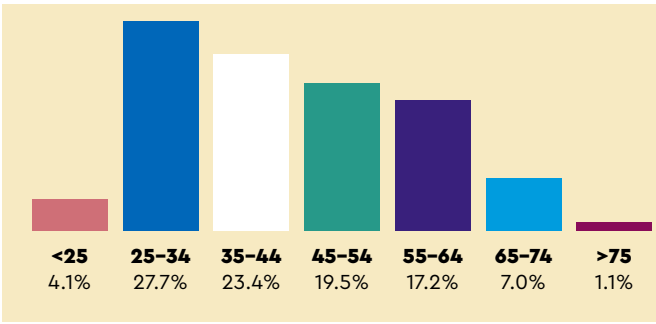
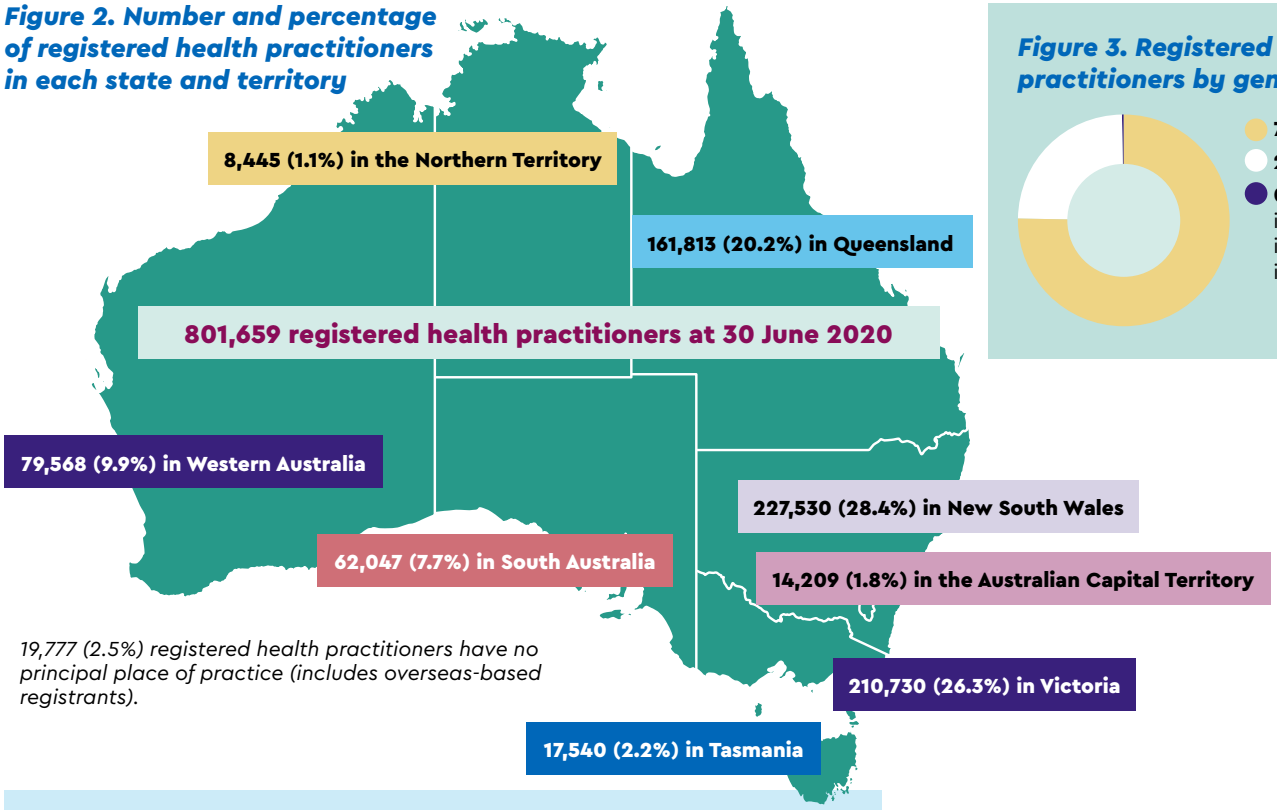


Figure 2. Number and percentage of registered health practitioners in each state and territory



19,777 (2.5%) registered health practitioners have no principal place of practice (includes overseas-based registrants).

Figure 3. Registered health practitioners by gender

Figure 4. Relative size of registered health professions

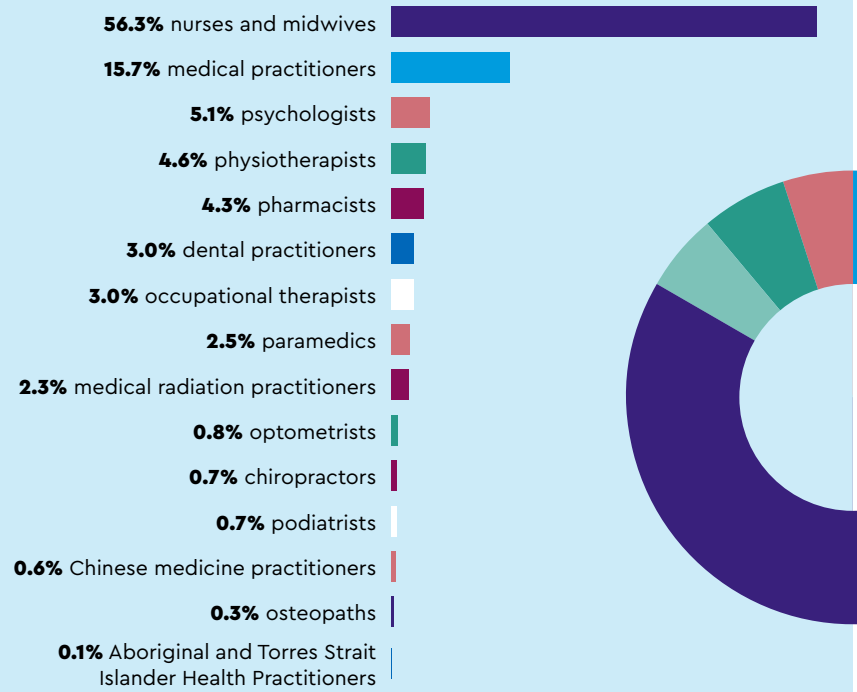
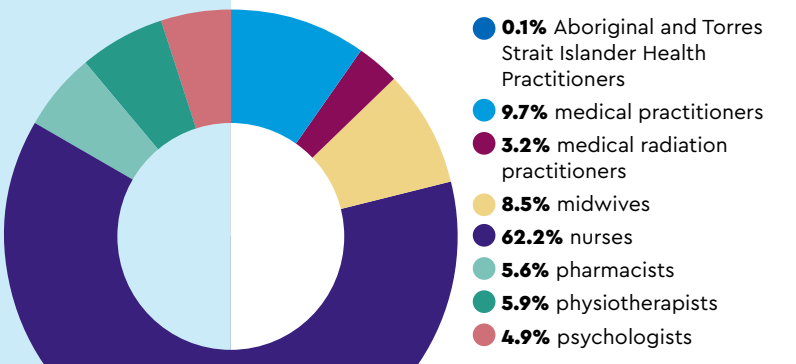


Figure 5. Pandemic sub-register composition



About us

Our mission

To protect the public by regulating health practitioners efficiently and effectively to facilitate access to safer healthcare.

Our vision

We are recognised as a leading risk-based regulator enabling a competent and flexible health workforce to meet the current and future needs of the Australian community.

The Australian Health Practitioner Regulation Agency (Ahpra) is the national organisation responsible for implementing the National Registration and Accreditation Scheme (the National Scheme) across Australia. The Agency Management Committee is the governing board for Ahpra.

Ahpra works in partnership with 15 National Boards to ensure the community has access to a safe health workforce across all professions registered under the National Scheme. Together, we protect the public by regulating health professionals who practise in Australia. Public safety is always our number one 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).

In 2020/21 we start a new five-year strategy. See page 94.

What we do

Ahpra has five core regulatory functions.

Professional standards

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

Registration

In partnership with the National Boards, 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.

Accreditation

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

How we do it

- We support the National Boards in their primary role of protecting the public.
- We support the National Boards in developing registration standards, codes and guidelines.
- We publish an online national *Register of practitioners* so that important information about individual health practitioners is available to the public: www.ahpra.gov.au/registration/registers-of-practitioners.
- We manage registration and renewal processes for local and overseas-qualified health practitioners, and manage student registration.
- We manage notifications about the professional conduct, performance or health of registered health practitioners on behalf of the National Boards, except in New South Wales (NSW) and Queensland (Qld) where we only manage notifications that are referred to us.
- We work with health complaints entities (HCEs) to make sure the appropriate organisation deals with the community's concerns about health practitioners.
- We provide advice to the Ministerial Council about the administration of the National Scheme.

Our regulatory principles

Eight regulatory principles underpin our work and guide our decision-making in the public interest. These principles foster a responsive, risk-based approach to regulation. These principles are:

- protect the public
- take timely and necessary action
- administer the National Law
- ensure registrants are qualified
- work with stakeholders
- uphold professional standards
- identify and respond to risk
- use appropriate regulatory force.

More information about us can be found on our website www.ahpra.gov.au. Board websites can also be accessed from Ahpra's homepage.

Anyone needing advice on how to make a complaint can call Ahpra on 1300 419 495 or visit www.ahpra.gov.au/about-ahpra/contact-us#Makeanotification for information.

For definitions of words and phrases in this report, refer to Common abbreviations and acronyms *and the* Glossary.

Unless stated otherwise, this report provides Ahpra data.

The 2019/20 data include practitioners registered on the temporary pandemic sub-register created in response to the COVID-19 pandemic. This has led to a larger than usual annual increase in the number of practitioners for those professions that are part of the sub-register, which is especially evident for the smaller professions. It also affects some percentages about practitioner numbers – for instance the percentage of practitioners aged over 65 is higher than usual this year, as retired practitioners were among those recruited to the sub-register.

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

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

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

In 2019/20

Registration

801,659 registered health practitioners[1] in Australia, across 16 professions[2]

99.4% of registrants renewed their registration online

81,437 new applications for registration received

12.5% decrease since last year

2,713 applications for registration refused because they did not meet suitability/eligibility requirements (3.3% of all new applications)

57,222 (7.7%) more registrants than last year

includes 35,099 registrants on the pandemic sub-register

77,677 domestic and international criminal history checks made

7,637 health practitioners identify as Aboriginal and/or Torres Strait Islander

193,800 students studying to be health practitioners through an approved program of study or clinical training program

Accreditation

The National Scheme accredits over 850 approved programs of study delivered by more than 130 education providers

1. This number includes those on the pandemic sub-register.
2. In 2019/20, 15 National Boards regulated 16 professions. The Nursing and Midwifery Board of Australia regulates two professions – nursing and midwifery.

Notifications

13,006 practitioners had a notification made about them nationally; this is an increase of 4.5% from 2018/19[1]

10,236 notifications about practitioners were received by Ahpra[2]

9.6% increase in notifications received by Ahpra

1.6% of all registered health practitioners were the subject of a notification[1]

Immediate action was taken 580 times to restrict or suspend the registration of a practitioner[2]

The top three reasons for a notification were:

- clinical care (43.5%)
- medication-related issues (9.9%)
- communication (7.2%)

30.5% of the notifications that were closed had action taken on them, with around half referred to a health complaints entity or another body

Compliance

2,629 practitioners were monitored by Ahpra for health, performance and/or conduct during the year

Legal actions

132 matters were determined by tribunals

100% resulted in disciplinary action

11 successful prosecutions

584 advertising-related complaints received

412 new offence complaints received about title protection

420 closed following investigation

106 appeals lodged in tribunals about Board decisions

Of the 73 appeals that were finalised:

- 10 resulted in no change to the Board's decision
- 33 resulted in the appeal being withdrawn
- 19 resulted in the decision being amended or substituted for a new decision
- 11 were dismissed on administrative grounds

1. Includes data provided by the Health Professional Councils Authority (HPCA) for New South Wales (NSW) and the Office of the Health Ombudsman (OHO) for Queensland (based on available data from these entities at time of publication).
2. This refers to notifications managed by Ahpra (excludes data from HPCA and OHO). For information on how complaints about health practitioners are lodged and managed in Australia, see page 14.

Contents

Tables

Figures

Introduction

In 2020 we marked 10 years of national health practitioner regulation in Australia and the establishment of the National Registration and Accreditation Scheme, Ahpra and the National Boards. No one could have predicted that this important milestone would occur in the middle of a pandemic that has turned our lives upside down. The COVID-19 pandemic left us with no choice about the need to engage, navigate, adapt and respond quickly.

2020 has shown us all how much we rely on health practitioners at the frontline to keep us all safe. Ahpra and National Boards have worked closely with accreditation authorities, governments and our partners to ensure we play our part fully in supporting these health practitioners and the wider health system response to COVID-19.

In particular, we have worked to ensure that our health services could access the qualified and experienced health practitioners they need. We quickly established a pandemic sub-register to respond to surge workforce needs across the health system which saw more than 35,000 health practitioners return to registration. We also worked with National Boards to streamline our regulatory requirements and processes wherever possible, while still ensuring patient safety. Acknowledging that students are the registered practitioners of the future, accreditation authorities, National Boards and Ahpra moved quickly to clarify how existing accreditation standards enabled flexibility in the ways clinical education requirements could be achieved for students. We ensured national agreement to principles for clinical education during the pandemic.

Our annual report highlights the impact of COVID-19 on our regulatory work and how we have adapted. Ahpra became a virtual organisation within weeks. Board meetings were held on digital meeting platforms and all Ahpra staff started to work from home, many for the first time. Having well-established relationships with our stakeholders, we worked hard to keep registered health practitioners, governments and other stakeholders updated about our work and other developments.

In a big, busy year other achievements and activities also stand out.

There are now 801,659 registered health practitioners in Australia, across 16 professions.

We continued to improve our timelines for registering new practitioners including an extensive campaign to ensure around 39,000 new graduate applications for registration were managed smoothly.

New and modernised accreditation agreements with external accreditation authorities came into effect and National Boards established new terms of reference for accreditation committees.

The number of notifications Ahpra received increased by 9.6% on the previous year. Although we reduced the average time to complete notifications, there was an increase in the number of open notifications. The timeliness of our notifications process is an ongoing focus.

We implemented changes to the National Law for reporting of mandatory notifications by treating practitioners and carried out an extensive education campaign.

We initiated an independent review of reforms to our management of sexual boundary notifications, and this year, for the first time, we also report on this important area of our work.

Our work towards eliminating racism from the health system continued, in particular through partnerships with Aboriginal and Torres Strait Islander health experts and representatives. It's an ambitious and important goal that requires commitment and hard work from multiple agencies and individuals across the National Scheme. We deeply appreciate the commitment and work of our Aboriginal and Torres Strait Islander Health Strategy Group.

In its 10th year the value of the National Registration and Accreditation Scheme has been demonstrated, particularly as we have been able to respond to the uncertainties and new challenges of COVID-19. In a year where we had to quickly make unprecedented changes, National Board and committee members, accreditation authorities and Ahpra staff have worked exceptionally well in an environment of great uncertainty. For this we are deeply grateful, and we sincerely thank everyone for their efforts. We will continue to keep learning and adapting.

Ultimately, our purpose is to ensure safe and professional registered health practitioners for all Australians. At the end of an extraordinary year, we acknowledge and thank all health practitioners who have responded with such professionalism and commitment to keep us all safe and recognise the students who are our health practitioners of the future.

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

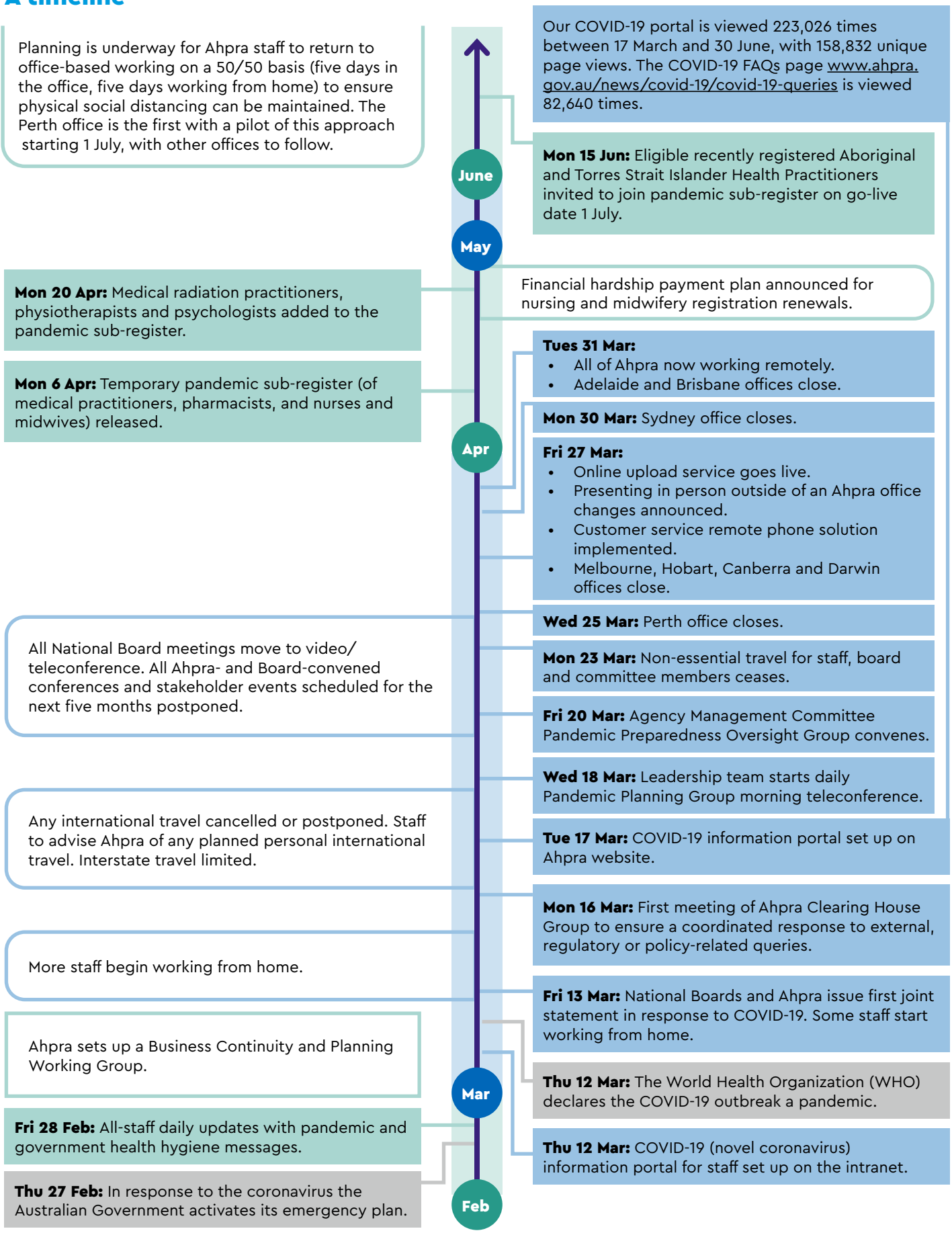
Co-convenor, Forum of National Registration and Accreditation Chairs

Chair, Pharmacy Board of Australia

COVID-19

As with so many organisations and people, COVID-19 arrived and has fundamentally affected the way we work.

A timeline



Managing a crisis

After the Australian Government activated its emergency response plan for COVID-19, in early March, Ahpra implemented its Business Continuity Plan to ensure we were well prepared to support the Australian health sector and safeguard the essential services of health practitioner regulation in Australia.

In just four weeks we transformed our organisation. Eight state and territory offices closed and all Ahpra employees were working from home with the key functions all completely upheld. All Boards moved to virtual meetings.

Ahpra and National Boards worked to regulate practitioners in light of a pandemic and the likelihood of a nationwide need for a surge health workforce. A coordinated response was essential to overseeing this work and to help jurisdictions in meeting the unique challenge.

Jurisdictions began health service planning to ensure the Australian health system had enough resources including personnel, hospital beds, and emergency and intensive care services, for what could happen in the coming days, weeks and months.

Ahpra responded to lead and oversee the scheme's emergent and unique responses to COVID-19. Two groups were set up: a Pandemic Preparedness Oversight Group with Agency Management Committee members and National Board Chairs to provide governance oversight, and a Regulatory Policy Clearing House Group. This ensured timely and appropriate regulatory policy decisions were made and communicated to all stakeholders.

To support systematic workforce contingency planning and regulatory responses across the Australian health system continuing, Ahpra convened a working group of officers from health departments across Australia to inform our response to meeting health workforce needs.

Providing information online

Ahpra set up a dedicated section of its website for COVID-19 information on 19 March. It was promoted at the top of all webpages and all National Board websites linked to it.

The COVID-19 portal was segmented into relevant topics, including National Board and profession-specific information, workforce resources and FAQs. The Nursing and Midwifery Board of Australia, as the National Board regulating the largest COVID-19 priority workforce profession, also had a dedicated COVID-19 webpage.

National Boards sent a total of 91 COVID-19 email updates directly to different practitioner groups. These were also published in the news section of individual Board websites and linked from the Ahpra website COVID-19 portal. We also emailed public health messages to registered health practitioners on behalf of governments.

Between 17 March and 30 June, the COVID-19 portal received over 158,000 unique page views. The updates page attracted over 115,000 (unique) views, the FAQs page over 82,000, and the pandemic sub-register over 60,000. The most popular day was 2 April, the day all 15 National Boards emailed registrants, with over 20,000 page views.

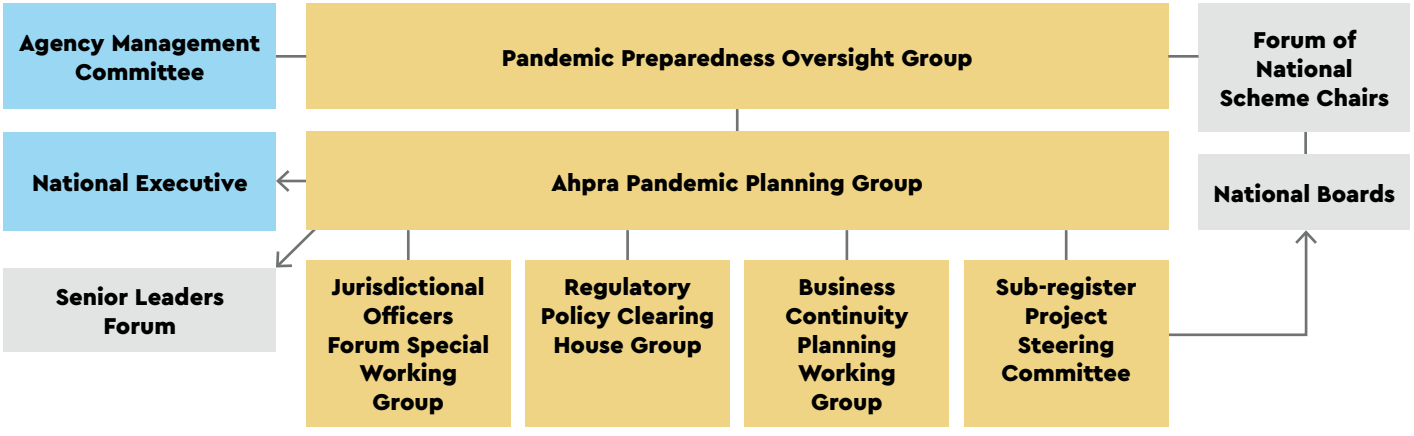
'The start of the pandemic was also very close to the start of nursing renewals, which is our busiest time of year. It was an interesting challenge to try to set up working-from-home capabilities for the entire Customer Service team and switch everyone to working from home.

'There were times when we were working with just one small laptop and some were using a TV screen as a second monitor! We had to learn to contact our team leaders via chat and all of this with around 2,000 contacts per day.

'The workload was high and the team did their best to answer as many of the calls as they could, while encouraging one another and maintaining their positivity.'

Ahpra Customer Experience Manager

Figure 6. Governance framework for our pandemic response



Increasing the health workforce: the pandemic sub-register

The pandemic response sub-register was established following the request from Australia's Health Ministers to enable more health practitioners' quick return to practice.

On 1 April we announced the new sub-register to fast-track the return of experienced and qualified health practitioners to the workforce to help in the response to the COVID-19 pandemic.

Figure 7. Social media posts about the sub-register

More than 40,000 doctors, nurses, midwives and pharmacists who had previously held general or specialist registration and had left the *Register of practitioners* or moved to non-practising registration in the past three years and met other specific criteria were placed on the sub-register. This approach was similar to action being taken in other countries whose health systems were also affected by the pandemic.

The sub-register was launched on 6 April and will operate for up to 12 months. Only those practitioners who are properly qualified, competent and suitable have been returned to this temporary register. There is no obligation for anyone added to the sub-register to practise or remain on it, and they can opt out at any time. In the first two weeks 10,000 practitioners opted out.

The sub-register was a huge feat to design, develop and implement rapidly. The process included identifying eligible practitioners, designing a way to distinguish those on the sub-register and ensuring there was a simple opt-out.

On 20 April, some 5,000 physiotherapists, psychologists and radiographers were added to the sub-register. Like the first phase, it operated on an opt-out basis.

We strongly encouraged those who were not comfortable being part of the sub-register to opt out, especially anyone who had a health issue that prevented them from practising safely or who was unable to practise. Sub-registrants were also advised that they were required to have appropriate professional indemnity insurance if they wished to return to practice.

In June, Aboriginal and Torres Strait Islander Health Practitioners who met the criteria were invited to join the sub-register.

The news of the sub-register generated a huge number of calls and enquiries. Many practitioners were interested in seeing if they could 'do their bit' to help.

We worked closely with government and health services to monitor the need for additional health practitioners as the pandemic progressed. We encouraged practitioners who had capacity to go to their state and territory health department website to express interest in joining the COVID-19 surge workforce if it was required.

At 30 June, 35,077 practitioners remained on the sub-register.

Effects on our regulatory work

As COVID-19 cases escalated and spread across the world in March, Ahpra and National Boards moved quickly to carry out all our regulatory functions in a completely virtual environment.

While maintaining registration standards to keep the public safe, we developed flexible regulatory approaches to respond to the needs of practitioners and health service delivery during a pandemic. The changes reflected the Boards' existing policy and standards framework while recognising the unprecedented new environment in which health practitioners were now practising. We also introduced new policies to help create more workforce capacity. We applied the overriding principle that the Boards and Ahpra were prepared to be flexible in approaches to COVID-19, although public safety remains our first priority.

In some cases, National Boards introduced safe modifications when practitioners could not meet the usual National Board requirements. For example, many practitioners' plans for continuing professional development (CPD) were disrupted and National Boards clarified that, while they encouraged practitioners to continue CPD relevant to their practice where possible, they did not want CPD requirements to take practitioners away from clinical care or cause additional concerns to practitioners already under extra pressure.

If a practitioner can't meet the CPD standard because of the COVID-19 pandemic, then generally National Boards indicated they wouldn't take action for the registration period during which the COVID-19 emergency is in force. Similarly, where needed, some additional flexibility was introduced for interns and other practitioners doing supervised practice.

In other cases, our existing regulatory framework was already flexible enough and we only needed to explain how it applied in the context of a pandemic. Telehealth became a key modality to help maintain access to services and reduce the risk of community transmission of the novel coronavirus that causes COVID-19 while providing protection for patients and health practitioners. To support the safe and effective use of telehealth by registered health practitioners, we developed *Telehealth guidance for practitioners* – with responses to frequently asked questions, for all National Scheme professions. See www.ahpra.gov.au/News/COVID-19/Workforce-resources/Telehealth-guidance-for-practitioners. The National Scheme's title protection model of regulation means that Boards do not prescribe what individual practitioners can and cannot do. In this context, the Medical Board of Australia provided additional guidance to respond to queries about medical practitioners working outside their usual scope of practice.

In the education and training context, outcome-based accreditation standards already provided significant flexibility to education providers. Accreditation authorities individually and collectively clarified how the standards could accommodate changes made to program delivery. National Boards, accreditation authorities, Ahpra and the Commonwealth Departments of Health and Education developed joint national principles for clinical education. These are available at www.ahpra.gov.au/news/covid-19/national-principles-for-clinical-education-during-covid-19.

Through all of this, National Boards and Ahpra drew on the strength of the partnerships and collaboration in the National Scheme. We recognised that by working together, and encouraging practitioners to draw on existing regulatory frameworks and their inherent professional judgement, we could support safe responses to COVID-19.

When COVID hit

The COVID-19 pandemic meant many practitioners and community members were looking for answers during a national health crisis.

Early on, our Customer Service team (CST) was inundated with calls and web enquiries about our regulatory response. Enquiries were varied, ranging from questions about the pandemic sub-register to the supply of personal protective equipment and protocols surrounding the use of telehealth. A high volume of calls came from previously registered health practitioners and members of the public wanting to know how they could quickly re-register to practise again or help in general with the COVID-19 healthcare efforts.

While working to meet the large volume of enquiries, CST members were also dealing with the transition to working remotely due to Ahpra offices closing. To help respond to queries, a Regulatory Policy Clearing House Group was established to provide accurate and up-to-date information as quickly as possible. CST kept the Clearing House informed about the types of enquiries coming in so website resources, including FAQs, could be developed and updated as required.

Many practitioners and community members also turned to social media with their enquiries and comments. Examples of the types of queries received were questions about guidelines for safe practice and the effect of COVID-19 restrictions on a practitioner's practice. Many of the people who contacted us expressed feelings of worry and anxiety, so our responses needed to be empathetic. The Clearing House Group coordinated responses to external, regulatory and policy-related queries to answer these enquiries promptly.

Figure 8. Social media posts during the pandemic

As communities went into lockdown, there was a significant increase in user activity and engagement with our social media platforms, particularly on Facebook and with our newly established Instagram platform. We noticed a shifting expectation in audiences who became more comfortable with less formal content. In response, we began releasing new content and sharing COVID-19 related posts from government sources to support our stakeholders and followers. One example of this type of engagement was our statement condemning racism in healthcare, which achieved significant engagement and was seen over 40,000 times.

'When COVID-19 first started we had practitioners across Australia contacting us asking for help and advice on what to do. People contacting CST were scared and emotional and looking to Ahpra for support. Within a short time we knew exactly what to say and what the plan was. It was an amazing turnaround.'

Customer Service team leader

'When COVID struck, we pushed up our sleeves and got to work on responding to the deluge of comments and enquiries we received on social media.

'There were many enquiries from people who were frustrated about being unable to complete their applications for registration due to English language tests not being available or due to previous test results not meeting regulatory requirements for competency.

'For many of these people meeting the English language standards was the last hurdle to applying for registration, so it was essential for us to respond with empathy and compassion.'

Ahpra Communications Adviser (Online)

Figure 9. Banner in Ahpra offices in March

Progress towards our strategic outcomes

Examples of our work are provided for each outcome.

Reducing risk of harm to the public

Ahpra has worked with National Boards to embed our risk-based approach to notifications to progressively improve regulatory effectiveness and notifier and practitioner experience. We have continued to develop and implement our risk framework with a focus on patient and public safety. The information we receive in a notification is our starting point and tells us about the notifier's concerns. As part of how we assess a notification we also consider information about the types of activities the practitioner does, the practice setting and patients and consumers the practitioner works with, and what we know about the practitioner's registration history.

Our risk approach is also focused on reducing the chances of similar events or concerns occurring again. So, we ask practitioners about the things they have done to manage the risks and we want to understand what health services or practices have done to respond to the concerns raised. When the concerns are serious, or more needs to be done to protect the public, Boards take regulatory action including imposing conditions or restrictions to manage risk. A number of national notification assessment committees have been established during this year, to support early assessment and response to risk.

Trust is fundamental to our work as a regulator. We received over 1,858 responses to our post-notifications surveys, 60% of which were from practitioners. This feedback from notifiers and practitioners helps us improve our notifications processes. We also received over 8,000 responses to our community surveys of health practitioners and members of the community about their awareness and understanding of our work, and their levels of trust and confidence in us.

Assuring that health practitioners are trained and qualified

Registration examinations

The Pharmacy Board of Australia's registration examination (written and oral) provides assurance that pharmacy graduates during internship (interns), and pharmacists who are returning to practice after an absence, are competent to practise. The Board and the Australian Pharmacy Council jointly developed the Intern Year Blueprint (IYB) as part of the Board's long-standing work program on intern assessment quality improvement. The IYB provides a direct link between learning objectives and assessment methods. The Board is working on a revised assessment process to implement the most appropriate and effective assessment for each competency that pharmacists must meet to practise.

Following a review of the current arrangements, the Chinese Medicine Board of Australia is developing new written and clinical regulatory examinations that are consistent, reliable and valid to assess internationally qualified Chinese medicine applicants. The Board has partnered with education providers and individual subject matter experts to develop and implement the regulatory examinations.

Assessment process for internationally qualified nurses and midwives

The Nursing and Midwifery Board of Australia (NMBA) and Ahpra have reformed the process for internationally qualified nurses and midwives (IQNMs) wanting to apply for registration in Australia. The new process is evidence-based and ensures that all nurses and midwives are required to meet the same standards, no matter where they gained their qualifications.

IQNMs can now use an online self-check tool for their qualifications and in most cases to receive immediate advice on how it compares to an NMBA-approved program of study, as well as what steps they'll need to take to be eligible to apply for registration.

All IQNMs who continue towards registration in Australia now complete an interactive orientation program to support their transition to our healthcare context. IQNMs who hold relevant, but not substantially equivalent, qualifications (and who meet the mandatory registration standards) are assessed according to an outcomes-based model, which consists of a multiple-choice question exam and objective structured clinical exam.

Increased public confidence in the regulation of health practitioners

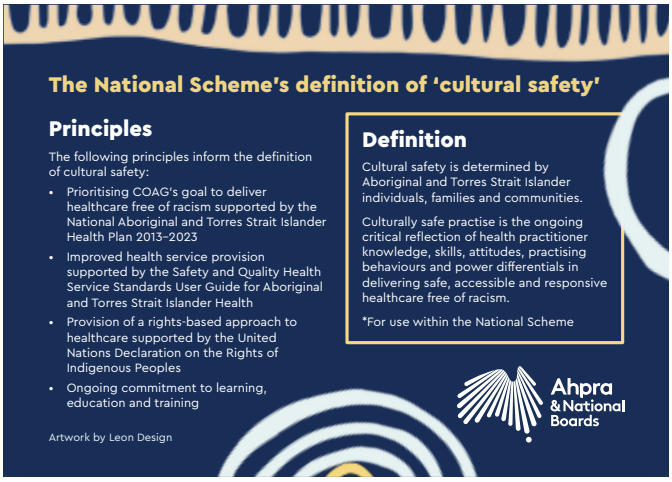
Addressing racism

We all have a part to play in ensuring culturally safe healthcare and addressing the gap in health outcomes for Aboriginal and Torres Strait Islander Peoples.

Implementing cultural safety is as much about individual practice as it is about changing systemic and institutional responses, whether that be practice standards, policy or legislation.

Our work on doing our part to eliminate racism from the health system continues through the *Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025*. Focusing on embedding cultural safety and increasing participation of, and access by, Aboriginal and Torres Strait Islander Peoples in the National Scheme, the strategy was launched in February. It was developed in partnership with Aboriginal and Torres Strait Islander health experts and representatives from the National Scheme through our Aboriginal and Torres Strait Islander Health Strategy Group.

The National Boards set the national standards that all registered health practitioners must meet to become and remain registered. The Boards are progressively integrating cultural safety requirements into these standards, meaning that the community can be clear about what they can expect from their practitioner. It also means that if a practitioner fails to provide culturally safe care, a Board may take regulatory action.



Increased public benefit from the use of our data

Ahpra collects unique national data about the registered health professions. These data can be de-identified and used for a range of approved purposes that can benefit the public.

Examples include contributing to the evidence base for the regulatory standards, codes and guidelines set by National Boards; building an evidence base for regulatory approaches, such as audits of advertising compliance to establish a baseline level of compliance and help to target interventions; and highlighting issues for professions/cohorts of practitioners to reinforce Boards' expectations of professional practice. We also supply public information to health services about their registered practitioner employees through our Practitioner Information Exchange (PIE) and data extract subscription services. This helps employers to stay current with public information from the national register.

Our data can also be used to inform workforce policy, planning and initiatives. For example, we have provided data securely for use in public benefit activities, such as SafeScript and National Real Time Prescription Monitoring. We are supporting health workforce planning by providing national health workforce surveys to practitioners when they renew their registration. We use data to inform health workforce initiatives most recently about the numbers of registrants who could potentially support a surge workforce during the COVID-19 pandemic.

Our data are also used for approved research purposes. When our data are used for research purposes these are often published as research outcomes in academic journals. Our data also support innovation and learning. We are exploring how to give feedback to accreditation authorities and education providers about any issues emerging in notifications about practitioners in the early years post-graduation. And we are part of an international collaboration exploring how new data analytic approaches and technologies can support regulatory decision-making and enhance the effectiveness of our regulatory work.

A healthy workforce

Supporting practitioners

Practitioner health is vitally important not only for the individual's wellbeing but also for quality patient care.

The Medical Board of Australia funds a national network of doctors' health services that provide health advisory and referral services for doctors and medical students. Doctors' Health Services Pty Ltd (DrHS) (known as DRS4DRS) was established in 2016 as a subsidiary of the Australian Medical Association and is run independently from the Board to enable doctors across Australia to access confidential advice and support 24/7.

Nurse and Midwife Support funded by the Nursing and Midwifery Board of Australia also started in 2016. This initiative ensures that nurses, midwives and nursing and midwifery students anywhere in Australia can access confidential advice and referral on issues about their health. The service provides education, advice and referral and raises awareness about health issues for nurses, midwives, students, education providers, employers and concerned others. It is independently run and operated by Turning Point (part of Eastern Health in Victoria) allowing practitioners to access free and confidential advice 24/7.

Nurse & Midwife Support DRS4DRS

Following the success of these services, the Dental Board of Australia started developing a national 24/7 telephone and online service to support all dental practitioners and students. The development of Dental Practitioner Support was fast-tracked during the COVID-19 pandemic to give support, advice and assistance at a time of uncertainty and change surrounding providing dental care. The project team was able to complete the first phase of the service (telehealth and website) within 12 weeks, allowing the service to be launched on 6 July 2020.

Dental Practitioner Support

A podcast for *Taking care*

Ahpra launched its podcast series this year, with new episodes released regularly. Focused on topics that are relevant to both patients and practitioners, each episode features a conversation with one or more health practitioners. The goal of this series is to share knowledge and interesting facts and observations in a way that is easier to access for busy people.

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

The Agency Management Committee, appointed by the Ministerial Council, oversees Ahpra's work.

Fifteen National Boards are responsible for the regulation of 16 health professions. The Boards' responsibilities include setting standards that practitioners must meet to be registered, making policy decisions, and investigating complaints and concerns raised about registered health practitioners. Ahpra has a Health Profession Agreement with each Board that outlines how each Board and Ahpra work together.

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 at www.ahpra.gov.au/notifications. However, if their complaint is about a registered health practitioner or student in NSW or Queensland, the process is different.

New South Wales

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

The National Boards have no role in handling notifications in NSW. Ahpra has a limited role in accepting mandatory notifications and referring them to the HCCC.

For more information, visit the HPCA website www.hpca.nsw.gov.au or the HCCC website www.hccc.nsw.gov.au.

Queensland

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

For more information, visit the OHO website www.oho.qld.gov.au.

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

Other complaint organisations

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, and/or
- an improvement for a hospital, clinic, pharmacy or community health service.

HCEs in each state and territory are:

Australian Capital Territory ACT Human Rights Commission

New South Wales Health Care Complaints Commission

Northern Territory Health and Community Services Complaints Commission

Queensland Office of the Health Ombudsman

South Australia Health and Community Services Complaints Commission

Tasmania Health Complaints Commissioner

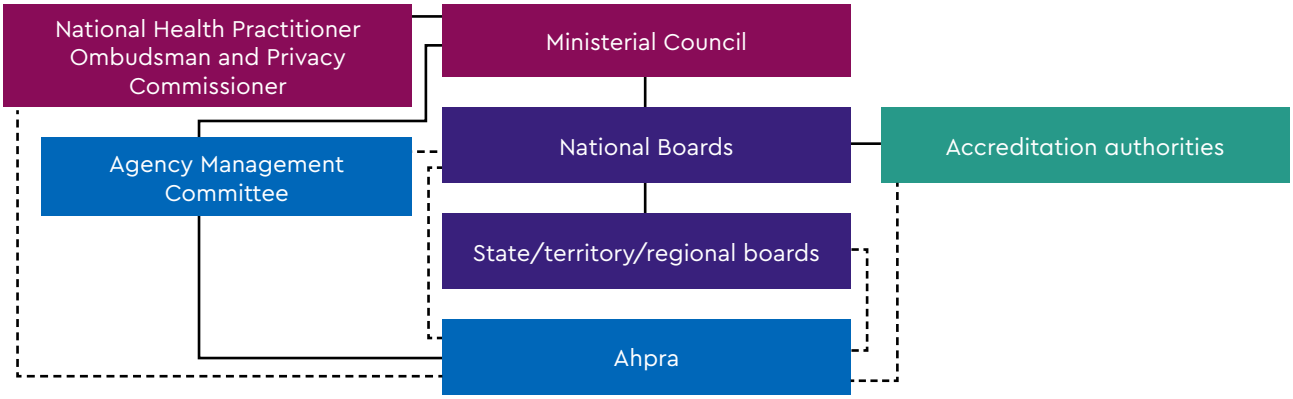
Victoria Health Complaints Commissioner

Western Australia Health and Disability Services Complaints Office.

Independent ombudsman

The National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) 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 10. Who's who in the National Scheme



Agency Management Committee

The Agency Management Committee is appointed by the Ministerial Council. It ensures that Ahpra performs its functions in a proper, effective and efficient way. It is responsible for determining and agreeing Ahpra policies, setting the strategic direction for the National Scheme and assuring its performance.

For more information, visit www.ahpra.gov.au/about-ahpra/who-we-are/agency-management-committee.

Members of the Agency Management Committee during 2019/20


Ms Gill Callister PSM (Chair)


Dr Peggy Brown AO


Adjunct Professor Karen Crawshaw PSM


Ms Philippa Smith AM


Ms Jenny Taing OAM


Ms Barbara Yeoh AM


Dr Susan Young

National Boards for the regulated health professions

The National Boards work with the support of Ahpra to ensure safe, quality healthcare across Australia. All Chairs are registered health practitioners in their profession.


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


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


Dr Wayne Minter AM, Chair, Chiropractic Board of Australia


Dr Murray Thomas, Chair, Dental Board of Australia


Dr Anne Tonkin, Chair, Medical Board of Australia


Mr Mark Marcenko, Chair, Medical Radiation Practice Board of Australia


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


Ms Julie Brayshaw, Chair, Occupational Therapy Board of Australia


Mr Ian Bluntish, Chair, Optometry Board of Australia


Dr Nikole Grbin, Chair, Osteopathy Board of Australia


Professor Stephen Gough ASM, Chair, Paramedicine Board of Australia


Mr Brett Simmonds, Chair, Pharmacy Board of Australia


Ms Kim Gibson, Chair, Physiotherapy Board of Australia


Associate Professor Cylie Williams, Chair, Podiatry Board of Australia


Ms Rachel Phillips, Chair, Psychology Board of Australia

Aboriginal and Torres Strait Islander Health Practitioners

From the Chair

Issues this year

The Aboriginal and Torres Strait Islander Health Practice Board has made steady progress on its strategic objectives during 2019/20. Those objectives include telling the Aboriginal and Torres Strait Islander Health Practitioner story to governments and the wider community so that Aboriginal and Torres Strait Islander Health Practitioners can be understood and used to their full capabilities as registered health practitioners.

By making sure a registered health practitioner is qualified and competent to carry out the work they do in their everyday practice, whether that is through individually sought or employer-led training and education, there is much we can do to promote a better understanding of the role of Aboriginal and Torres Strait Islander Health Practitioners in the broader health workforce.

In keeping with the objectives of the National Law, the Board does not define what a registered practitioner can or cannot do in their everyday practice (their chosen scope of practice) but rather, leaves that up to the individual and/or employer.

Regulatory response to COVID-19

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

New standards, codes or guidelines

The Board published five revised registration standards on 1 December 2019:

- *Professional indemnity insurance arrangements*
- *Continuing professional development* (and *CPD guidelines*)
- *Recency of practice*
- *English language skills*
- *Aboriginal and Torres Strait Islander*.

Several supporting documents have also been published to help explain the registration standards, codes and guidelines.

The Board is contributing to the work to revise its *Code of conduct*, which is shared with 11 other health professions regulated in the National Scheme.

Accreditation

The Aboriginal and Torres Strait Islander Health Practice Accreditation Committee (ATSIHPAC) is a committee of the Board. ATSIHPAC continues to do a fine job monitoring and reporting to the Board on the accredited programs of study. Its job is made more challenging by the geographic spread of our approved programs of study and the Board is very appreciative of ATSIHPAC's diligent work in this vital area.

The Board looks forward to the implementation of the revised accreditation standards from 1 July 2020. The revised standards expand the eligibility criteria for programs of study to seek accreditation for courses leading to registration for practitioners.

Stakeholder engagement

The Board conducts extensive visits and engagements when it meets four times a year. It is always good to visit services and to see the very broad ways that Aboriginal and Torres Strait Islander Health Practitioners work, helping to provide culturally safe care across the breadth of the health system. We hope to return to our normal visiting schedule when safe to do so after the COVID-19 pandemic eases.

Ms Renee Owen, Chair

Aboriginal and Torres Strait Islander Health Practice Board

Board members

- **Ms Renee Owen (practitioner) (Chair)**
- Mr Bruce Brown (community)
- Ms Karrina DeMasi (community) (Deputy Chair)
- Ms Celia Harnas (practitioner)
- Ms Veronica (Bonny) King (practitioner)
- Ms Margaret McCallum (community)
- Mr David Nicholls (practitioner)
- Ms Leanne Quirino (practitioner)
- Ms Kim Schellnegger (practitioner)

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

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Snapshot of the profession

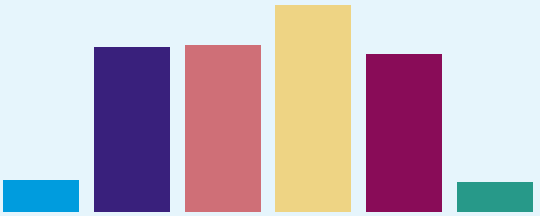
812 Aboriginal and Torres Strait Islander Health Practitioners

- → **Up 17.7%** from 2018/19
- → **0.1%** of all registered health practitioners

100% identified as Aboriginal and/or Torres Strait Islander

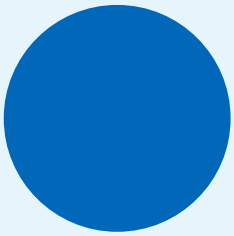
77.6% female; **22.4%** male

Figure 11. Age



4.2%	21.7%	22.0%	27.3%	20.8%	3.9%
< 25	25–34	35–44	45–54	55–64	65–74

Figure 12. Audit outcomes



- **100.0%** fully compliant
- **0.0%** compliant (through education)
- **0.0%** non-compliant
- **0.0%** no audit action required

Regulating the profession

Notifications

8 notifications lodged with Ahpra

- → **6** registered Aboriginal and Torres Strait Islander Health Practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.7%** of the profession

Figure 13. Sources of notifications

- **50.0%** patient, relative or member of the public
- **25.0%** other practitioner
- **12.5%** HCE
- **12.5%** employer

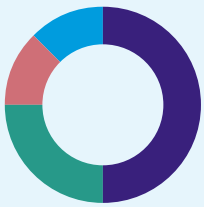
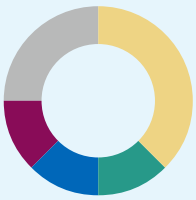


Figure 14. Most common types of complaint



- **37.5%** breach of non-offence provision – National Law
- **12.5%** clinical care
- **12.5%** offence against other law
- **12.5%** conflict of interest
- **25%** other

No immediate action taken

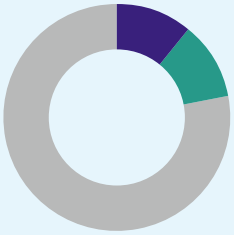
1 mandatory notification received

- → about professional standards

Figure 15. Notifications closed

9 notifications closed

- **11.1%** referred to another body or retained by a health complaints entity
- **11.1%** received a caution or reprimand
- **77.8%** no further action



Monitoring

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

4 cases being monitored at 30 June:

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

Criminal offence complaints

1 criminal offence complaint made

- → about title protection

2 were closed

Referrals to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

No appeals

Visit the Board's website at www.atsihealthpracticeboard.gov.au for more information and to download data tables.

Chinese medicine practitioners

From the Chair

Regulatory response to COVID-19

COVID-19 proved to be a national public health crisis that evolved rapidly and challenged all Australians. The Chinese Medicine Board of Australia worked with Ahpra to provide an overlay of emergency regulation over the existing practitioner regulation framework.

Policy updates

Needling and acupuncture

The Board worked with the Chinese Medicine Council of NSW to provide registered Chinese medicine practitioners with access to the educational resource on safe needling on the thorax to prevent pneumothorax. The education resource was developed by the Council following several notifications associated with pneumothorax in recent years.

In March, the Board published a statement on the use of unregistered assistants to remove acupuncture needles from patients. The removal of acupuncture needles from patients is an integral component of the professional service provided by the registered practitioner. This task should not be delegated to an unregistered assistant.

New professional capabilities

In December, the Board released *Professional capabilities for Chinese medicine practitioners*. These capabilities identify the knowledge, skills and professional attributes required to safely and competently practise as an acupuncturist, and/or a Chinese herbal medicine practitioner, and/or a Chinese herbal dispenser in Australia. They describe the threshold level of professional capability required for both initial and continuing registration.

Accreditation

The Chinese Medicine Accreditation Committee carries out accreditation functions for Chinese medicine in the National Scheme. Following public consultation, the accreditation committee's proposed 2019 *Accreditation standards for registered Chinese medicine practitioners* were approved in late 2019 by the Board, to be in effect as of June 2020.

The new accreditation standards will replace the current (2013) accreditation standards.

Our accreditation committee, together with the Accreditation Councils and committees for all professions regulated within the National Scheme, has adopted the collective position of the Health Professions Accreditation Collaborative Forum with respect to accredited programs and the impact of COVID-19.

Stakeholder engagement

Reference Group

The Chinese Medicine Reference Group's purpose is to enhance a common understanding of the National Scheme from the differing perspectives of stakeholders. The fourth meeting was held in Sydney in October. The meeting included informative updates from a range of stakeholders including Ahpra's Community Reference Group, which supported the Board's activities to reach rural and remote practitioners, and the Therapeutic Goods Administration representative who spoke about the progress of reforms to the complementary medicine regulatory framework.

Practitioner forums

The Board held practitioner forums in NSW and Queensland before the end of 2019 and an online forum for practitioners in Cairns in February. Due to COVID-19, we had to cancel several other planned forums. Alternative arrangements on digital platforms are being developed.

Meeting with national associations

In April, the Board met with representatives from the six national professional associations:

- Australian Acupuncture and Chinese Medicine Association (AACMA)
- Chinese Medicine and Acupuncture Society of Australia Ltd (CMASA)
- Chinese Medicine Industry Council (CMIC)
- Federation of Chinese Medicine and Acupuncture Societies of Australia (FCMA)
- Australian Natural Therapists Association (ANTA)
- Australian Traditional Medicine Society (ATMS).

There was robust discussion on several profession-specific issues with a major focus on the impact of COVID-19 on the profession. The Board published a communiqué following the meeting.

Other news

The Board welcomed Ms Stephanie Campbell as a community member for her first term, which started in November.

The Board announced that registration fees have been frozen at $579 for another consecutive year.

Distinguished Professor Charlie C. Xue, Chair

Chinese Medicine Board

Board members

- **Distinguished Professor Charlie C. Xue (practitioner) (Chair)**
- Ms Christine Berle (practitioner)
- Mr David Brereton (community)
- Ms Stephanie Campbell (community) (from 22 Nov)
- Dr Liang Zhong Chen PhD (practitioner)
- Dr David Graham PhD (community) (Deputy Chair)
- Dr Di Wen Lai (practitioner)
- Mr Roderick Martin (practitioner)
- Mrs Bing Tian (practitioner)

Ms Debra Gillick was the Executive Officer, Chinese Medicine to April and Ms Sangeetha Masilamani from April.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Visit the Board's website at www.chinesemedicineboard.gov.au *for more information and to download data tables.*

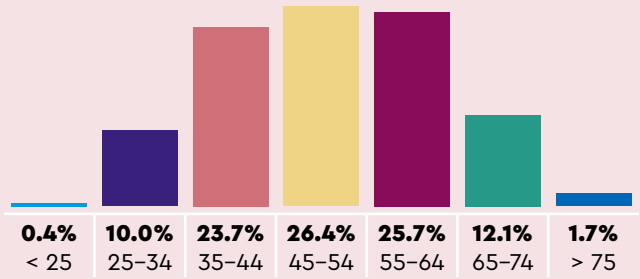
Snapshot of the profession

4,921 Chinese medicine practitioners
- → **Up 0.6%** from 2018/19
- → **0.6%** of all registered health practitioners

0.4% identified as Aboriginal and/or Torres Strait Islander

57.0% female; **43.0%** male

Figure 16. Age



0.4%	10.0%	23.7%	26.4%	25.7%	12.1%	1.7%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 17. Audit outcomes

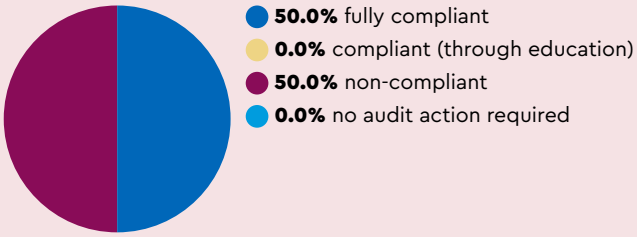


Figure 18. Divisions

97.9%	Registered as an acupuncturist
64.0%	Registered as Chinese herbal medicine practitioner
21.8%	Registered as a Chinese herbal dispenser

37.0%	Registered in one division
42.5%	Registered in two divisions
20.6%	Registered in three divisions

Regulating the profession

Notifications

38 notifications lodged with Ahpra
- → **66** Chinese medicine practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.3%** of the profession

Figure 19. Sources of notifications

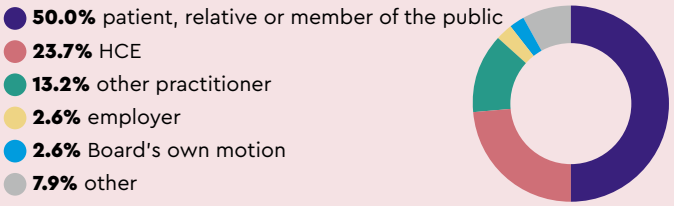
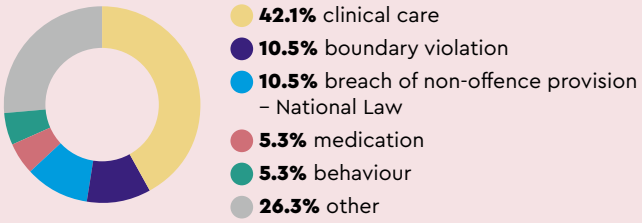


Figure 20. Most common types of complaint

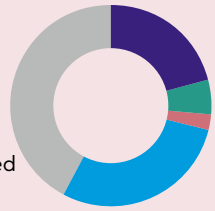


2 immediate actions taken

4 mandatory notifications received
- → **all** about professional standards

Figure 21. Notifications closed

38 notifications closed
- **21.1%** conditions imposed on registration or an undertaking accepted
- **5.3%** received a caution or reprimand
- **2.6%** registration suspended or cancelled
- **28.9%** referred to another body or retained by a health complaints entity
- **42.1%** no further action



Monitoring

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

818 cases being monitored at 30 June:
- → **2** for conduct
- → **4** for performance
- → **4** for prohibited practitioner/student
- → **808** for suitability/eligibility for registration

Criminal offence complaints

16 criminal offence complaints made
- → **11** about title protection
- → **1** about practice protection
- → **4** about advertising breaches

15 were closed

Referrals to an adjudication body

1 matter decided by a tribunal

No matters decided by a panel

No appeals

National Scheme thanks long-term Chinese Medicine Board Chair

The Chinese Medicine Board and Ahpra acknowledge and thank Distinguished Professor Charlie Xue for his dedication to the profession as Board Chair since Chinese medicine joined the National Scheme in 2011. For the past nine years, Distinguished Professor Xue has made outstanding contributions to the regulation of Chinese medicine. Under his leadership, national standards for Chinese medicine have been developed and the profession has grown to nearly 5,000 practitioners. Charlie finishes his role as Chair in December 2020.

Chiropractors

From the Chair

Throughout the past year, the Chiropractic Board of Australia has continued its commitment to ensuring the public has access to safe and competent health services from registered chiropractors. We have engaged with practitioners and stakeholder groups to ensure the expectations and requirements of the Board and the National Law are being met by the profession.

Regulatory response to COVID-19

During the pandemic, the Board worked with Ahpra to provide information to the profession, including answers to common questions and regular updates. We communicated directly with chiropractors through the release of several e-bulletins and regular newsletters.

To keep informed about the impact of the pandemic on the profession, the Board received regular updates from its stakeholders and regulatory partners including professional associations, the Chiropractic Council of NSW and the Council on Chiropractic Education Australasia.

Advertising

Together with the other 14 National Boards and Ahpra, the Board carried out public consultation on the *Guidelines for advertising a regulated health service*. We continued to work with Ahpra to ensure chiropractors understood and complied with their professional and legal advertising obligations.

Standards and guidelines

Following Ministerial approval, the Board implemented the revised *Registration standard: continuing professional development* (CPD), which came into effect on 1 December 2019. As part of this implementation we released *Guidelines: continuing professional development* and other guidance material.

Chiropractors were part of multi-profession focus groups who reviewed guidance material designed to help practitioners understand the requirements of the revised CPD registration standard. The material included updated FAQs, fact sheets and a CPD portfolio template.

Interim policy on spinal manipulation

In July 2019, the Board made a submission to the review of chiropractic spinal care on children under 12 years. The independent review was carried out by Safer Care Victoria. The recommendations from the review are being considered by Ministers. The Board will communicate further with the profession at the end of the review process.

Stakeholder engagement

In August, the Board presented at Chiropractic Australia's national conference in the Gold Coast and in October presented at the Australian Chiropractors Association annual conference in Melbourne.

The Board held two information forums during February and March in Melbourne and Perth, and postponed the remaining planned forums due to the pandemic. These forums provided chiropractors with important information about regulatory matters, including the revised CPD registration standard and advertising. They also gave chiropractors an opportunity to engage with the Board.

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 of the Board and the National Law.

Dr Wayne Minter AM, Chair

Chiropractic Board

Board members

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

Ms Miriam Bourke was the Executive Officer, Chiropractic from July to September and Ms Kirsten Hibberd from September.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

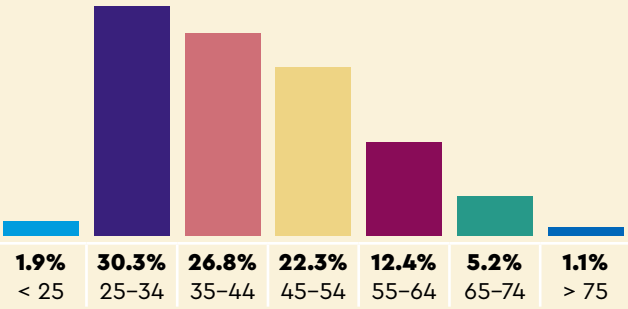
Snapshot of the profession

5,777 chiropractors
- → **Up 4.1%** from 2018/19
- → **0.7%** of all registered health practitioners

0.4% identified as Aboriginal and/or Torres Strait Islander

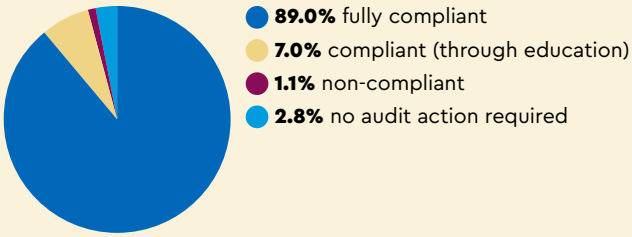
40.7% female; **59.3%** male

Figure 22. Age



1.9%	30.3%	26.8%	22.3%	12.4%	5.2%	1.1%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 23. Audit outcomes



Regulating the profession

Notifications

92 notifications lodged with Ahpra
- → **137** chiropractors Australia-wide, including HPCA and OHO data, had notifications made about them
- → **2.4%** of the profession

Figure 24. Sources of notifications

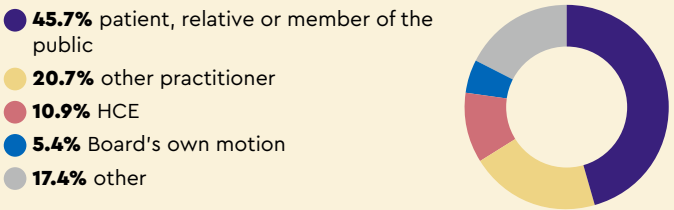
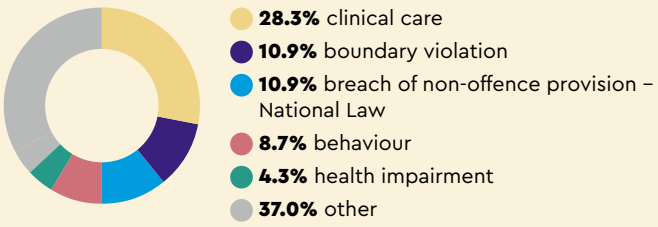


Figure 25. Most common types of complaint

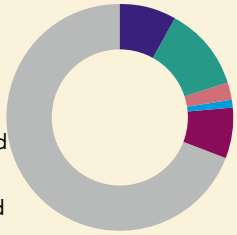


4 immediate actions taken

8 mandatory notifications received
- → **5** were about professional standards

Figure 26. Notifications closed

84 notifications closed
- **8.3%** conditions imposed on registration or an undertaking accepted
- **11.9%** received a caution or reprimand
- **2.4%** registration suspended or cancelled
- **1.2%** fined
- **7.1%** referred to another body or retained by a health complaints entity
- **69.0%** no further action



Monitoring

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

39 cases being monitored at 30 June:
- → **14** for conduct
- → **1** for health reasons
- → **9** for performance
- → **6** for prohibited practitioner/student
- → **9** for suitability/eligibility for registration

Criminal offence complaints

15 criminal offence complaints made
- → **5** about title protection
- → **1** about practice protection
- → **9** about advertising breaches

20 were closed

Referrals to an adjudication body

3 matters decided by a tribunal

No matters decided by a panel

1 appeal

Visit the Board's website at www.chiropracticboard.gov.au for more information and to download data tables.

Dental practitioners

From the Chair

Protecting the public from harm is paramount for the Dental Board of Australia in its role of regulating the dental profession. We support practitioners to remain fit to practise by:

- setting and enforcing national standards
- taking initiatives to maintain and enhance practitioners' professional skills and knowledge.

This summary highlights some of the Board's initiatives in 2019/20.

Highlights this year

The year has seen the Board review several standards and guidelines and the development of a flagship initiative – a national health and wellbeing support service.

Dental Practitioner Support

Dental Practitioner Support, which is starting on 6 July 2020, is a national service and the first 24/7 free and confidential telephone and online service for all dental practitioners and students.

Regulatory response to COVID-19

A significant focus in the first part of 2020 was our response to the COVID-19 pandemic and support for practitioners to continue to comply with their regulatory obligations in a rapidly changing environment.

The Board released several COVID-19 updates to practitioners by email, explaining the evolving advice about the restrictions to dental practice issued by the Australian Health Protection Principal Committee and how Ahpra and the Board would respond to the challenges of COVID-19.

It also developed and published a series of FAQs on matters such as registration, professional indemnity insurance, financial hardship and registration fees, continuing professional development and other issues.

Due to the COVID-19 pandemic, the Board has readily adapted to fully remote meetings, working groups and committees since March.

Stakeholder engagement

The COVID-19 Dental Stakeholder Liaison Group was first convened within an environment where COVID-19 was posing extraordinary challenges to the health system. Membership includes representatives from over 10 organisations, including professional associations, other regulators, accreditation authorities, private and public sectors and the education sector.

Having facilitated greater stakeholder collaboration and communication, the function of the group was expanded as the membership acknowledged the ongoing benefits and opportunities of continuing the forum for engagement around professional and consumer challenges and issues.

Accreditation

On 1 July 2019 a new five-year accreditation agreement came into effect. The Australian Dental Council (ADC) continues as the Board's accrediting authority. The ADC also carried out a review of the accreditation standards. The new standards will come into effect 1 January 2021. The Board has also worked closely with the ADC to monitor the effects of COVID-19 on approved programs of study.

Standards, guidelines and codes

The revised *Scope of practice registration standard*, in effect from 1 July 2020, was approved by the Ministerial Council in November 2019. A 'Know your scope' online hub launched by the Board in May has information and resources to support dental practitioners' understanding of their obligations under the revised standard, including:

- webinar recordings of Q&A sessions and a stakeholder presentation
- FAQs
- a reflective practice tool
- a podcast
- links to relevant state and territory legislation.

In 2019, the Board carried out a review of the *Guidelines for dental records*. Following extensive consultation, the Board decided to retire these guidelines as the *Code of conduct* contains adequate guidance about health record management. A fact sheet and self-reflective tool have been developed and will be published before the guidelines are retired in the second half of 2020.

Together with four other Boards, the Board consulted on and approved new *Guidelines for registered health practitioners and students in relation to blood-borne viruses*, which were coming into effect 6 July 2020. The Board's guidelines are for practitioners and students who perform exposure-prone procedures and for registered health practitioners who are treating registered health practitioners or students living with a blood-borne virus who themselves perform exposure-prone procedures. The Board holds the view that most dental practitioners working in clinical practice will perform exposure-prone procedures.

Dr Murray Thomas (Chair)

Dental Board

Board members

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

Ms Rachel Griffiths was the Executive Officer, Dental, July to November and Ms Luisa Interligi from November.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

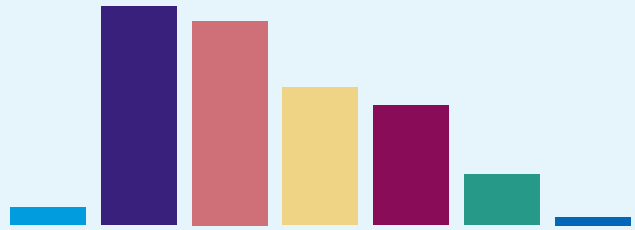
Snapshot of the profession

24,406 dental practitioners
- → **Up 2.8%** from 2018/19
- → **3.0%** of all registered health practitioners

0.5% identified as Aboriginal and/or Torres Strait Islander

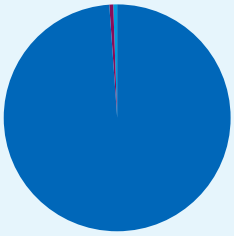
52.6% female; **47.4%** male

Figure 27. Age



2.3%	28.9%	27.0%	18.2%	15.8%	6.7%	1.1%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

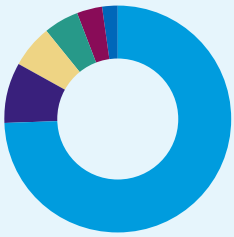
Figure 28. Audit outcomes



- **98.9%** fully compliant
- **0.0%** compliant (through education)
- **0.7%** non-compliant
- **0.4%** no audit action required

Figure 29. Divisions

- **74.6%** dentists
- **8.6%** oral health therapists
- **6.0%** dental hygienists
- **5.2%** dental prosthetists
- **3.4%** dental therapists
- **2.2%** registered in multiple divisions



Regulating the profession

Notifications

784 notifications lodged with Ahpra
- → **1,010** registered dental practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **4.1%** of the profession

Figure 30. Sources of notifications

- **49.4%** patient, relative or member of the public
- **31.9%** HCE
- **7.7%** other practitioner
- **1.8%** employer
- **1.5%** Board's own motion
- **7.8%** other

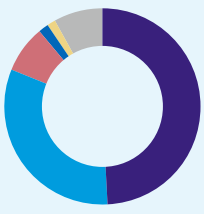
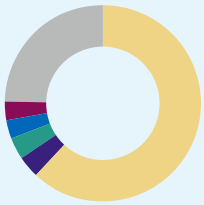


Figure 31. Most common types of complaint



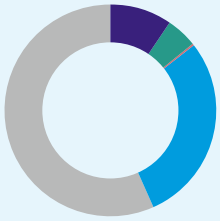
- **62.0%** clinical care
- **3.6%** breach of non-offence provision – National Law
- **3.6%** health impairment
- **3.3%** communication
- **2.9%** behaviour
- **24.6%** other

36 immediate actions taken

32 mandatory notifications received
- → **21** were about professional standards

Figure 32. Notifications closed

730 notifications closed
- **9.5%** conditions imposed on registration or an undertaking accepted
- **4.7%** received a caution or reprimand
- **0.5%** registration suspended or cancelled
- **28.9%** referred to another body or retained by a health complaints entity
- **56.4%** no further action



Monitoring

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

137 cases being monitored at 30 June:
- → **7** for conduct
- → **15** for health reasons
- → **71** for performance
- → **7** for prohibited practitioner/student
- → **37** for suitability/eligibility for registration

Criminal offence complaints

80 criminal offence complaints made
- → **30** about title protection
- → **8** about practice protection
- → **42** about advertising breaches

68 were closed

Referrals to an adjudication body

4 matters decided by a tribunal

3 matters decided by a panel

3 appeals

Visit the Board's website at www.dentalboard.gov.au for more information and to download data tables.

Medical practitioners

From the Chair

Issues this year

The COVID-19 pandemic has had an enormous impact on the medical profession during the latter part of 2019/20 and this is likely to continue. The Medical Board of Australia has made a number of pragmatic decisions to ease the administrative burden for practitioners and the health system, while maintaining patient safety.

The Board is very proud to have successfully run the first Medical Training Survey during 2019/20. This was a collaborative effort with a lot of support from doctors in training, their employers and supervisors.

We progressed work on the Professional Performance Framework, consulted on a number of guidelines and worked in partnership with Ahpra to improve the notifications experience for notifiers and practitioners.

Regulatory response to COVID-19

As we faced the enormous public health challenge of COVID-19, the Board recognised that doctors would have an important role in supporting the health system and dealing with sick and anxious patients. The Board made a series of decisions to boost the medical workforce and ease administrative demands on health services, while maintaining public safety. These responses included:

- relaxing requirements for medical practitioners to meet the continuing professional development (CPD) registration standard for 2020
- easing the general registration requirements for interns, by reducing timeframes and relaxing accredited term requirements if an individual's internship was disrupted directly as a result of COVID-19
- making registration requirements for international medical graduates (IMGs) more flexible, by reducing requirements for change of circumstances applications and not requiring IMGs to demonstrate progression towards general or specialist registration if they could not sit an Australian Medical Council (AMC) or college examination or assessment
- clarifying the conditions under which IMGs with limited registration can practise telehealth
- in partnership with Ahpra, establishing the pandemic response sub-register that enabled recently retired practitioners to automatically return to the *Register of practitioners* and therefore to practise
- providing advice that, if a notification was received, the Board would consider the circumstances in which the doctor was practising, particularly if affected by COVID-19
- clarifying 'scope of practice' and confirming that the Board does not restrict practitioners' practice.

Policy and project updates

Medical Training Survey

The Board and Ahpra ran the first Medical Training Survey (MTS) during the 2019 renewal period. Nearly 10,000 doctors in training took part in the MTS, creating the first national, comprehensive picture of medical training in Australia.

The MTS results provide an evidence base that educators, employers and stakeholders across the health sector can use to improve the culture of medicine and further strengthen medical training.

Trainee responses are presented in a series of static reports and the data are also accessible through an online reporting tool, available on the MTS website at www.medicaltrainingsurvey.gov.au.

The survey results found that, in general, trainees rate their training, clinical supervision and teaching very highly. About 75% of trainees work more than 40 hours a week, but many value the training opportunities this provides. Most trainees would recommend their current training post and nearly all intend to continue with their training program. There are opportunities to improve trainee access to health and wellbeing support programs, and bullying and harassment remain prevalent.

More than one in three trainees report having experienced or witnessed bullying, harassment and/or discrimination. Only one-third of those who reported experiencing it, reported it.

There is work to do to better support Aboriginal and/or Torres Strait Islander specialist trainees and improve their experience of medical training. Survey findings show Aboriginal and/or Torres Strait Islander trainees are nearly twice as likely to have experienced and witnessed bullying, harassment and discrimination in the last 12 months.

The Board and Ahpra are grateful for the support and contributions of many doctors in training and other stakeholders. The MTS has been a team effort. We will continue to run the MTS and hope that participation rates continue to increase as doctors in training gain confidence in the survey.

Professional Performance Framework

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

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

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

CPD registration standard

The Board consulted on a revised registration standard for continuing professional development (CPD). The standard is built on existing arrangements and proposed strengthened CPD requirements based on evidence. The standard proposed that medical practitioners:

- complete a minimum of 50 hours of CPD each year that includes a mix of:
  - at least 25% on activities that review performance
  - at least 25% on activities that measure outcomes
  - at least 25% on educational activities
- have a CPD home and participate in its CPD program
- do CPD that is relevant to their scope of practice
- base the CPD on a personal professional development plan.

The Board will finalise the registration standard in the next year and submit it to the Ministerial Council for approval.

Health checks for late career practitioners

The Board's Clinical Advice Committee progressed work on what should be involved in pragmatic and effective health checks for late career practitioners (doctors aged 70 years and older). The committee reported to the Board during the year. The Board will develop a registration standard, taking into consideration the committee's recommendations and will consult widely on the standard.

New and revised guidelines

Guidelines for advertising regulated health services

Together with the other 14 National Boards, the Medical Board consulted on revised *Guidelines for advertising regulated health services*. The guidelines were developed to explain the advertising requirements in the National Law and to help advertisers (including registered health practitioners) meet these requirements and advertise responsibly. The review aimed to make sure the guidelines are as contemporary, relevant and effective as possible.

The guidelines were approved and will be published and implemented during 2020/21.

Guidelines for mandatory notifications

Changes to the mandatory notification provisions in the National Law came into effect during the year. To support practitioners to better understand their obligations, the 15 National Boards consulted on revised *Guidelines for mandatory notifications*.

Ahpra and the Board also developed and delivered educational resources to support the changes to the legislation. We are grateful for the support of many stakeholders who helped us publicise the changes and dispel many of the myths about mandatory reporting.

The new guidelines came into effect during the year.

Guidelines for registered health practitioners and students in relation to blood-borne viruses

The Board consulted on *Guidelines for registered health practitioners and students in relation to blood-borne viruses*. The guidelines were published, coming into effect on 6 July 2020.

Consultation on revised *Good practice guidelines for the specialist international medical graduate assessment process*

These good practice guidelines aim primarily to support specialist colleges as they assess specialist IMGs. The guidelines were revised after a Deloitte Access Economics review of the performance of the specialist medical colleges in their assessment of specialist IMGs.

Stakeholder engagement

Newsletters

The Board published nine regular editions of the *Medical Board update* in 2019/20 and two newsletters dedicated to the Board's response to COVID-19.

Media

The Board receives regular media requests for comment on a range of issues. During the year there was interest in mandatory reporting, the MTS and the Professional Performance Framework.

We also receive requests for comment about individual practitioners, but the information we can provide is limited by law.

Meetings with stakeholders

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

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

During the year, the Board held a forum with key stakeholders about the results of the MTS.

For the sixth consecutive year we also met with representatives of the AMA to discuss initiatives introduced to improve the notifications process.

Internal engagement

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

Other news

Notifications process

Managing notifications (complaints) will always be fraught and we know that those involved are unlikely to be happy with the process. Notifiers tend to believe that the Board is on the doctor's side while doctors tend to feel that the Board and Ahpra are on the notifier's side.

These responses are understandable, but we aim to be impartial, fair and transparent. We also want to deal with notifications as quickly as possible.

The Board worked with Ahpra to further fine-tune our risk-based approach. We have established processes to deal with lower risk matters more quickly and less formally, with more communication with notifiers and practitioners. This has been supported by the Board's national Notifications Committee: Assessment.

The work of the Sexual Boundaries Notifications Committee has also continued, with increased numbers of notifications. During the year, we commissioned Professor Ron Paterson to review the effectiveness of implementing the recommendations in the *Independent review of the use of chaperones to protect patients in Australia*. The report, published in July 2020, can be viewed at www.ahpra.gov.au/news/2020-07-30-chaperone-report-three-years-on.

Accreditation

The Australian Medical Council (AMC) is the accreditation authority for the medical profession. The AMC develops accreditation standards that are approved by the Board and against which they assess medical schools and specialist colleges. The AMC also reviews and accredits authorities that accredit intern training programs.

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

The AMC also monitors medical schools, specialist colleges and authorities that accredit intern training programs and provides monitoring reports to the Board.

Dr Anne Tonkin, Chair

Medical Board

Board members

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

Dr Joanne Katsoris is the Executive Officer, Medical.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Snapshot of the profession

125,641 medical practitioners

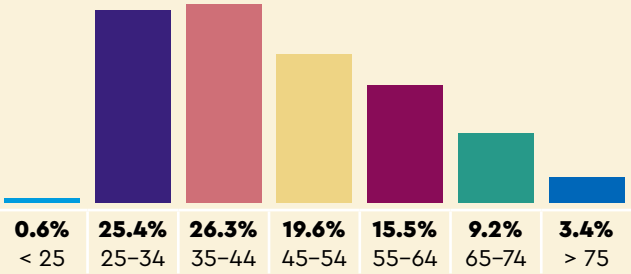
→ **Up 5.6%** from 2018/19

→ **15.7%** of all registered health practitioners

0.4% identified as Aboriginal and/or Torres Strait Islander

43.8% female; **56.2%** male

Figure 33. Age

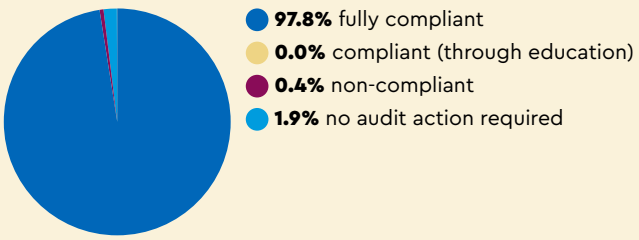


0.6%	25.4%	26.3%	19.6%	15.5%	9.2%	3.4%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 34. Specialties

75,889	medical practitioners with specialties
192	addiction medicine
5,604	anaesthesia
600	dermatology
2,736	emergency medicine
28,359	general practice
1,036	intensive care medicine
355	medical administration
2,215	obstetrics and gynaecology
330	occupational and environmental medicine
1,079	ophthalmology
3,312	paediatrics and child health
335	pain medicine
411	palliative medicine
2,304	pathology
11,900	physician
4,220	psychiatry
450	public health medicine
431	radiation oncology
2,786	radiology
583	rehabilitation medicine
139	sexual health medicine
143	sport and exercise medicine
6,369	surgery

Figure 35. Audit outcomes



Regulating the profession

Notifications

5,745 notifications lodged with Ahpra

- → **7,254** registered medical practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **5.8%** of the profession

Figure 36. Sources of notifications

- **58.9%** patient, relative or member of the public
- **21.8%** HCE
- **7.5%** other practitioner
- **2.1%** employer
- **1.6%** Board's own motion
- **8.0%** other

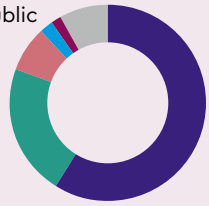
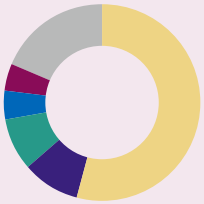


Figure 37. Most common types of complaint



- **54.2%** clinical care
- **9.6%** medication
- **8.5%** communication
- **4.8%** documentation
- **4.4%** behaviour
- **18.5%** other

209 immediate actions taken

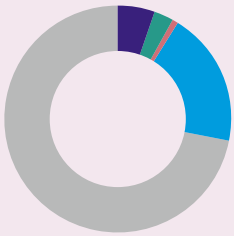
325 mandatory notifications received

- → **186** about professional standards

Figure 38. Notifications closed

5,498 notifications closed

- **5.5%** conditions imposed on registration or an undertaking accepted
- **2.8%** received a caution or reprimand
- **0.6%** registration suspended or cancelled
- **0.1%** fined
- **19.2%** referred to another body or retained by a health complaints entity
- **71.7%** no further action



Monitoring

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

1,118 cases being monitored at 30 June:

- → **104** for conduct
- → **174** for health reasons
- → **237** for performance
- → **100** for prohibited practitioner/student
- → **503** for suitability/eligibility for registration

Criminal offence complaints

162 criminal offence complaints made

- → **96** about title protection
- → **1** about practice protection
- → **62** about advertising breaches
- → **2** directing or inciting unprofessional conduct/ professional misconduct
- → **1** other offence

176 were closed

Referrals to an adjudication body

61 matters decided by a tribunal

11 matters decided by a panel

54 appeals

Visit the Board's website at www.medicalboard.gov.au for more information and to download data tables.

Medical radiation practitioners

From the Chair

Issues this year

For the Medical Radiation Practice Board of Australia, by far the greatest challenge of 2019/20 has been our response to the COVID-19 pandemic. However, we progressed our consideration of some intersecting issues, including digital and machine learning in medical radiation practice, conflict and violence in healthcare facilities, inequality in healthcare, and decision models for practitioners.

Regulatory response to COVID-19

Following a request from Australia's Health Ministers to enable more qualified and experienced diagnostic radiographers to quickly return to practice, on 20 April 2020 over 1,100 diagnostic radiographers who had left the *Register of practitioners* or moved to non-practising registration in the past three years were added to the pandemic response sub-register.

While practitioners have been added to the sub-register we have been mindful of the impact for practitioners whose work hours have been reduced and the uncertainty this has created for them. We applaud the professionalism and collaborative spirit of a large number of practitioners who have offered their support to public health services in dealing with the pandemic.

The Board modified supervised practice arrangements to allow more flexible arrangements in response to the COVID-19 pandemic, noting the increased pressure on clinical training centres. The changes allow supervised practitioners to move through the program more quickly while still ensuring that they meet the standards of practice necessary for general registration.

Accreditation

The Board approved revised *Accreditation standards: medical radiation practice*, which came into effect on 1 March.

The Board also approved new terms of reference for the Medical Radiation Practice Accreditation Committee aligning them with the arrangements for other accreditation entities.

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

Policy and project updates

Revised professional capabilities

In late 2019 the Board released revised *Professional capabilities for medical radiation practice* following a 12-month consultation. The new professional capabilities started on 1 March and introduced some changes including:

- strengthened requirements for recognising and responding to the deteriorating patient
- obligations for a practitioner to alert other health practitioners involved in the care of a patient when urgent or unexpected findings are identified
- the introduction of new minimum capabilities for ultrasound (US) and magnetic resonance imaging (MRI)
- improved practitioner capabilities when using scheduled medicines
- an obligation to practise in a culturally safe way, particularly with respect to Aboriginal and Torres Strait Islander Peoples.

Videos developed to support practice

In June the Board released the first two videos in a planned series of videos to help practitioners to give safe care. The first video focuses on taking appropriate and timely action when urgent or unexpected findings are identified (*See something, say something*) and the second video focuses on recognising and responding to the deteriorating patient (*Deteriorating patient*).

Stakeholder engagement

In the second half of 2019 the Board sent representatives to some industry collaborations. A conference on revised accreditation standards and professional capabilities was planned for mid-March but due to COVID-19 it was cancelled. However, the changed arrangements for interaction since then have given us an opportunity to engage with stakeholders through different digital mediums.

Supporting the use of scheduled medicines

The *Professional capabilities for medical radiation practice* enable safe practice in emerging areas of practice, including the use of scheduled medicines. Recently, in Queensland, nuclear medicine technologists were given authority to use and administer medications necessary for some examinations.

Mr Mark Marcenko, Chair

Medical Radiation Practice Board

Board members

- **Mr Mark Marcenko (practitioner) (Chair)**
- Mr Richard Bialkowski (community)
- Ms Joan Burns (community)
- Ms Donisha Duff (community)
- Dr Susan Gould PhD (community)
- Mr James Green (practitioner)
- Mr Christopher Hicks (practitioner)
- Mr Brendan McKernan (practitioner)
- Ms Cara Miller (practitioner)
- Ms Tracy Vitucci (practitioner)
- Mr Roger Weckert (practitioner)
- Dr Caroline Wright PhD (practitioner)

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

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

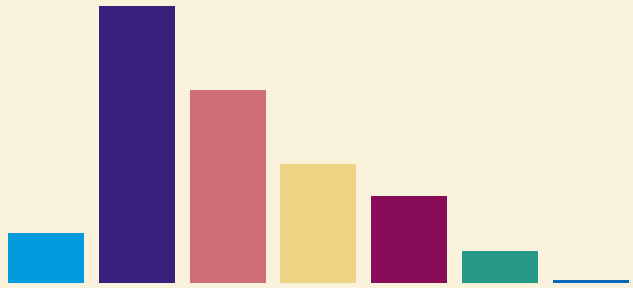
Snapshot of the profession

18,243 medical radiation practitioners
- → **Up 9.4%** from 2018/19
- → **2.3%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

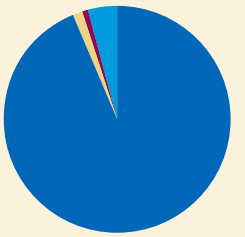
68.2% female; **31.8%** male

Figure 39. Age



6.5%	36.5%	25.4%	15.7%	11.5%	4.1%	0.3%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 40. Audit outcomes



- **93.8%** fully compliant
- **1.3%** compliant (through education)
- **0.9%** non-compliant
- **4.0%** no audit action required

Figure 41. Divisions

14,454	diagnostic radiographers
16	diagnostic radiographers and nuclear medicine technologists
2	diagnostic radiographers and radiation therapists
1,216	nuclear medicine technologists
2,555	radiation therapists

Regulating the profession

Notifications

31 notifications lodged with Ahpra
- → **35** registered medical radiation practitioners Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.2%** of the profession

Figure 42. Sources of notifications

- **19.3%** patient, relative or member of the public
- **9.7%** employer
- **9.7%** other practitioner
- **6.5%** HCE
- **6.5%** Board's own motion
- **48.4%** other

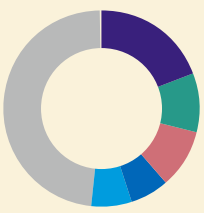
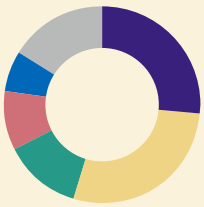


Figure 43. Most common types of complaint



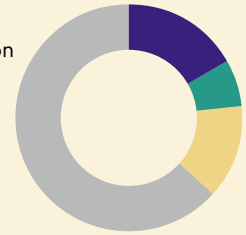
- **29.0%** health impairment
- **25.8%** clinical care
- **12.9%** behaviour
- **9.7%** breach of non-offence provision – National Law
- **6.5%** boundary violation
- **16.1%** other

2 immediate actions taken

6 mandatory notifications received
- → **none** were about professional standards

Figure 44. Notifications closed

30 notifications closed
- **16.7%** conditions imposed on registration or an undertaking accepted
- **6.7%** received a caution or reprimand
- **13.3%** referred to another body or retained by a health complaints entity
- **63.3%** no further action



Monitoring

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

41 cases being monitored at 30 June:
- → **3** for conduct
- → **9** for health reasons
- → **1** for performance
- → **3** for prohibited practitioner/student
- → **25** for suitability/eligibility for registration

Criminal offence complaints

3 criminal offence complaints made
- → **3** about title protection

None were closed

Referrals to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

No appeal

Visit the Board's website at www.medicalradiationpracticeboard.gov.au for more information and to download data tables.

Nurses and midwives

From the Chair

New international assessment

The Nursing and Midwifery Board of Australia (NMBA) launched its new model of assessment for internationally qualified nurses and midwives (IQNMs) this year. The process includes a self-check tool which enables IQNMs interested in applying for registration in Australia to have their qualifications assessed and receive advice about next steps towards applying for registration.

IQNMs who proceed to applying for registration have access to an interactive orientation package, including aspects of cultural safety education, to support them working in Australia. The orientation will support IQNMs to transition to the Australian healthcare context. The cultural safety aspects of the package were developed in partnership with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives.

Decision-making framework

NMBA's new *Decision-making framework for nursing and midwifery* (DMF) took effect in February.

The DMF supports decision-making about nursing or midwifery practice and delegation of nursing or midwifery care. We encourage all nurses and midwives, managers and employers to use the DMF in practice. The DMF is particularly helpful for making decisions in clinical practice about delegation from registered nurses and midwives to enrolled nurses and other health workers.

We also released DMF summaries for the professions of nursing and midwifery. These one-page summaries guide nurses and midwives step-by-step through making a safe decision in practice.

The DMF was developed from an evidence-based review of the previous *National framework for the development of decision-making tools for nursing and midwifery practice*.

Engaging students

In May, the NMBA sent its e-newsletter to students of nursing and midwifery for the first time, alongside their registered colleagues who receive the newsletter throughout the year.

We had previously done qualitative engagement research with students and recent graduates of nursing and midwifery approved programs of study through focus groups across the country in 2018. The aim of this research was to benchmark students' understanding of their future professional responsibilities and identify areas for improvement in communications between students and new graduates and the NMBA.

The outcomes of this research indicated strong interest from student nurses and midwives for direct communication with their Board, including receiving e-newsletters. New graduates also indicated a desire for further support in their transition from study to complex practice environments.

We are trialling sending our monthly e-newsletter to nursing and midwifery students for the purpose of directly engaging students with their future professional requirements, supporting their transition to practice and establishing an early positive relationship with the National Scheme. As part of this trial, a new section of the newsletter was developed specifically for students and new graduates.

We will develop further guidance and support for students and new graduates, to be communicated through the e-newsletter, throughout 2020 and beyond. The NMBA will evaluate the impact of this initiative against the 2018 benchmark.

Supporting the professions during COVID-19

The NMBA is supporting nurses, midwives and employers through the COVID-19 pandemic by adapting its policies and processes, as well as developing new guidance for practitioners.

Registration renewal

The annual renewal of registration for nurses and midwives fell during the pandemic (April–May). We developed a payment plan to support nurses and midwives who were experiencing financial hardship to be able to renew their registration.

Continuing professional development

We encouraged nurses and midwives to meet their continuing professional development (CPD) requirements for the 2019/20 registration period and advised that COVID-19 training and research could count towards CPD hours. However, to further support the professions during the pandemic, the NMBA committed to not take action against any nurse or midwife who declared at annual renewal that they had been unable to complete the required CPD hours.

Other policy/guidance

We also developed specific COVID-19 policy guidance for the professions, including on issues such as scope of practice, education, accreditation and clinical placements. The NMBA and Ahpra worked with government and the Commonwealth and state and territory Chief Nursing and Midwifery Officers to provide coordinated updates to nurses and midwives during the pandemic.

Pandemic sub-register

To ensure adequate numbers of experienced and qualified health practitioners were available to respond to the COVID-19 pandemic, a pandemic response sub-register was launched by Ahpra and National Boards on 6 April. This sub-register enabled nurses and midwives who had recently been registered with the NMBA to practise in the short-term (for up to 12 months) if they met certain criteria such as being able to get professional indemnity insurance and having no changes to their criminal history since they were last registered.

Registered nurse accreditation standards

In October, the NMBA approved the new *Registered nurse accreditation standards*, which programs of study must meet to become an NMBA-approved program leading to registration. The new standards were developed and widely consulted on by the NMBA's independent accrediting authority, the Australian Nursing and Midwifery Accreditation Council (ANMAC). The new standards ensure that future registered nurses have the knowledge, skills and capability to provide safe and effective nursing care.

ANMAC reviews its standards every five years and the review sought to ensure the standards could meet contemporary workforce requirements and emerging trends such as an ageing population, a significant increase in chronic disease and co-morbidities, and the diverse needs of multicultural Australians. Regular critical appraisal of the standards is required to support the next generation of registered nurses to be well equipped to provide healthcare and meet future workforce challenges. The new standards are contemporary, evidence-based and aligned with the NMBA *Registered nurse standards for practice*.

Associate Professor Lynette Cusack, Chair

National Scheme thanks long-term NMBA Chair

The NMBA and Ahpra wish to thank Associate Professor Lynette Cusack for her leadership as Chair of the NMBA for the past six years and as a member since 2009. In that time, Associate Professor Cusack has overseen the development of national standards for Australia's 400,000-plus nurses and midwives, including leading the NMBA in partnership with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives to include cultural safety requirements in the NMBA codes of conduct. Lynette finishes her role as Chair in October 2020.

Nursing and Midwifery Board

Board members

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

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

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Snapshot of the nursing profession

415,433 nurses

- → **Up 8.3%** from 2018/19
- → **51.8%** of all registered health practitioners
- → **29,736** also hold registration in midwifery

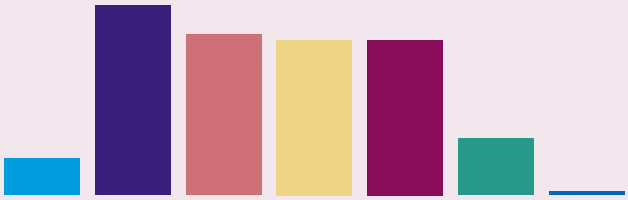
The number of dual registered nurses and midwives is up **7.3%** from last year

1.3% of nurses and midwives identified as Aboriginal and/or Torres Strait Islander

Nurses, including dual registered, **88.5%** female, **11.5%** male

Nurse-only registered, **87.8%** female; **12.1%** male

Figure 45. Age



4.8%	**25.1%**	**21.2%**	**20.5%**	**20.5%**	**7.5%**	**0.5%**
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 46. Divisions, dual registration and endorsements

Nurses by division

415,433	total
73,310	enrolled nurses
9,371	enrolled nurses and registered nurses
332,752	registered nurses

Nurses and midwives

29,736	total
110	enrolled nurses and midwives
80	enrolled nurses and registered nurses and midwives
29,546	registered nurses and midwives

Nurses with endorsements

3,306	total
2,069	nurse practitioners
1,237	scheduled medicines

Regulating the nursing profession

Notifications

1,872 notifications lodged with Ahpra

- **2,266** registered nurses Australia-wide, including HPCA and OHO data, had notifications made about them
- **0.5%** of the profession

Figure 47. Sources of notifications

- **26.5%** employer
- **26.0%** patient, relative or member of the public
- **14.9%** other practitioner
- **6.5%** HCE
- **3.2%** Board's own motion
- **23.0%** other

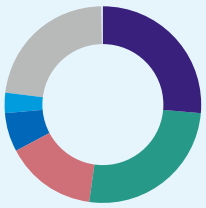
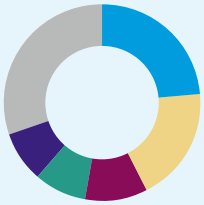


Figure 48. Most common types of complaint



- **23.6%** clinical care
- **18.9%** health impairment
- **10.5%** behaviour
- **8.5%** medication
- **8.3%** offence against other law
- **30.1%** other

209 immediate actions taken

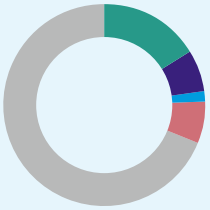
533 mandatory notifications received

- **294** were about professional standards

Figure 49. Notifications closed

1,624 notifications closed

- **16.3%** conditions imposed on registration or an undertaking accepted
- **6.7%** received a caution or reprimand
- **1.5%** registration suspended or cancelled
- **6.9%** referred to another body or retained by a health complaints entity
- **68.7%** no further action



Monitoring

1,011 practitioners monitored for health, performance and/or conduct during the year

1,404 cases being monitored at 30 June:

- **80** for conduct
- **239** for health reasons
- **130** for performance
- **197** for prohibited practitioner/student
- **758** for suitability/eligibility for registration

Criminal offence complaints

82 criminal offence complaints made

- **61** about title protection
- **1** about practice protection
- **16** about advertising breaches
- **4** directing or inciting unprofessional conduct/ professional misconduct

81 were closed

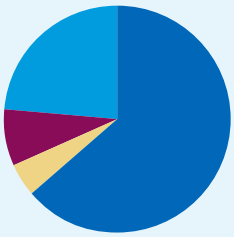
Referrals to an adjudication body

41 matters decided by a tribunal

5 matters decided by a panel

21 appeals by nurses, **4** by dual registered nurses and midwives

Figure 50. Audit outcomes for nurses and midwives



- **63.8%** fully compliant
- **4.6%** compliant (through education)
- **8.0%** non-compliant
- **23.6 %** no audit action required

Snapshot of the midwifery profession

36,045 midwives

- → **Up 7.8%** from 2018/19
- → **4.5%** of all registered health practitioners
- → **6,309** hold registration as midwife only, **0.8%** of all registered health practitioners

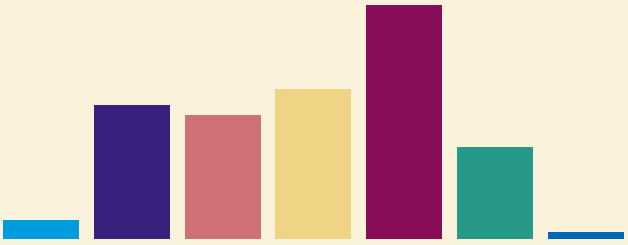
The number of practitioners who are registered as a midwife only is up **10.2%** from last year

1.3% of midwives and nurses identified as Aboriginal and/or Torres Strait Islander

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

Midwife-only registered **99.7%** female; **0.3%** male

Figure 51. Age



2.5%	17.6%	16.3%	19.8%	30.9%	12.1%	0.8%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 52. Endorsements

Midwives with endorsements

629	total
1	midwife practitioner
628	scheduled medicines

Regulating the midwifery profession

Notifications

85 notifications lodged with Ahpra

- → **122** registered midwives Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.3%** of the profession

Figure 53. Sources of notifications

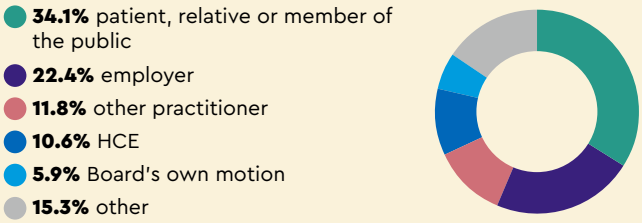
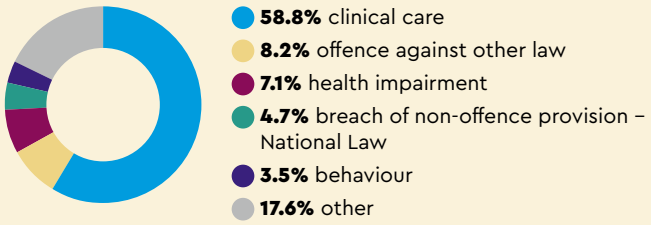


Figure 54. Most common types of complaint



8 immediate actions taken

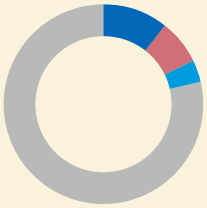
23 mandatory notifications received

- → **11** were about professional standards

Figure 55. Notifications closed

56 notifications closed

- **10.7%** conditions imposed on registration or an undertaking accepted
- **7.1%** received a caution or reprimand
- **3.6%** referred to another body or retained by a health complaints entity
- **78.6%** no further action



Monitoring

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

31 cases being monitored at 30 June:

- → **2** for conduct
- → **2** for health reasons
- → **7** for performance
- → **1** for prohibited practitioner/student
- → **19** for suitability/eligibility for registration

Criminal offence complaints

9 criminal offence complaints made

- → **8** about title protection
- → **1** about advertising breaches

8 were closed

Referrals to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

No appeals by midwives, **4** by dual registered nurses and midwives

Visit the NMBA's website at www.nursingmidwiferyboard.gov.au for more information and to download data tables.

Occupational therapists

From the Chair

Regulatory response to COVID-19

Since March the Occupational Therapy Board of Australia's work has included responding to COVID-19 from a regulatory perspective. The Board has been working with Ahpra to provide up-to-date information on COVID-19 to practitioners including answering common questions. The Board has recognised the adaptability and responsiveness of the profession in managing and working through the COVID-19 pandemic.

Competency standards

The Board developed the *Australian occupational therapy competency standards*, which have been in effect since 1 January 2019.

These competency standards focus on four conceptual areas of occupational therapy practice: professionalism, knowledge and learning, occupational therapy process and practice, and communication. They specifically acknowledge the need for occupational therapists to enhance their cultural responsiveness and capabilities for practice with Aboriginal and Torres Strait Islander Peoples.

Through the year the Board has developed and published some case studies to help registered occupational therapists understand how the competency standards might apply to various occupational therapy roles. Consistent with the emphasis in the competency standards, the Board remains committed to working with Indigenous Allied Health Australia to enhance and improve culturally safe occupational therapy practice with Aboriginal and Torres Strait Islander Peoples and communities.

Revised registration standards

Following a scheduled review and wide-ranging consultation, the Board, along with five other National Boards, has revised the registration standards for:

- continuing professional development (CPD)
- recency of practice (RoP)
- professional indemnity insurance (PII) arrangements.

The registration standards apply to registered occupational therapists and applicants at initial registration (except for the CPD standard, which does not apply at initial registration).

The Ministerial Council approved each of the revised registration standards on 30 June 2019 and the revised standards took effect on 1 December 2019.

Accreditation

During the year the Board approved five programs of study delivered by three education providers. There are now 42 occupational therapy programs of study across 22 education providers.

The Board works closely with the Occupational Therapy Council of Australia Ltd (OTC), which has been assigned the accreditation function to assess and monitor occupational therapy programs of study offered by Australian education providers. Programs are assessed and monitored against the revised *Accreditation standards for Australian entry-level occupational therapy education programs* (December 2018) that came into effect on 1 January 2020.

Stakeholder engagement

The Board continued to collaborate with key stakeholders on matters of mutual interest. Thanks to the National Scheme's Combined Meeting in February, we met with representatives of the Occupational Therapy Council of Australia Ltd (OTC), the Occupational Therapy Council of New South Wales and the Occupational Therapy Board of New Zealand (OTBNZ).

The Board also published two documents outlining the role and responsibilities of occupational therapy stakeholders. These documents aim to provide guidance on the functions and responsibilities of each of the organisations involved in the regulation of occupational therapists and the accreditation of occupational therapy programs of study.

As part of the Occupational Therapy Australia (OTA) 28th National Conference and Exhibition, the Board held a forum on 10 July 2019 that all registered occupational therapists in NSW were invited to attend. The Board Chair hosted the Forum together with members of the Occupational Therapy Council of New South Wales and gave updates on the Board's regulatory activities.

International collaboration

Members of the Board co-presented at the Council on Licensure, Enforcement and Regulation (CLEAR) Annual Conference in Minneapolis, USA on 20 September 2019 with representatives from the OTBNZ. The presentation focused on the development of professional competencies within the regulatory context and included a discussion about the development and implementation of cultural competencies specific to the Australian and New Zealand practice environments.

Engaging with students and graduates

The Board successfully engaged with students and soon-to-be graduates by hosting its fourth annual national webinar. It provided information about the Board, Ahpra and the registration requirements, followed by a Q&A session. The webinar gave us a valuable opportunity to engage with graduates and share information about their obligations on becoming registered.

Ms Julie Brayshaw, Chair

Occupational Therapy Board

Board members

- **Ms Julie Brayshaw (practitioner) (Chair)**
- Mr James Carmichael (practitioner)
- Ms Sally Cunningham (practitioner)
- Mrs Rachael Kay (practitioner)
- Ms Roxane Marcelle-Shaw (community)
- Dr Areti Metuamate PhD (community)
- Miss Jennifer Morris (community)
- Mrs Terina Saunders (practitioner)
- Dr Justin Scanlan PhD (practitioner)

Ms Amel Toubani was the Executive Officer, Occupational Therapy from July to October and Ms Vathani Shivanandan from November.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Snapshot of the profession

23,997 occupational therapists
- → **Up 7.1%** from 2018/19
- → **3.0%** of all registered health practitioners

0.6% identified as Aboriginal and/or Torres Strait Islander

90.6% female; **9.4%** male

Figure 56. Age

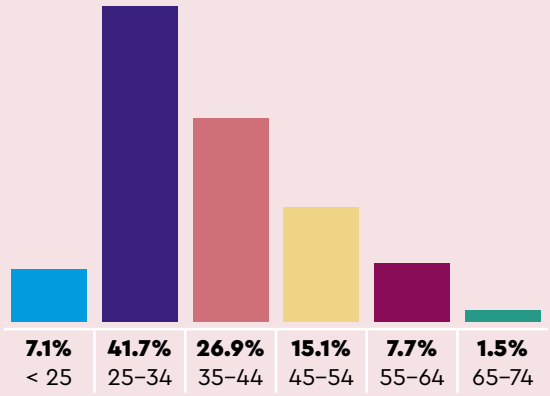


Figure 57. Audit outcomes

- **0.0%** fully compliant
- **0.0%** compliant (through education)
- **0.0%** non-compliant
- **100.0%** no audit action required

Regulating the profession

Notifications

53 notifications lodged with Ahpra
- → **81** registered occupational therapists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.3%** of the profession

Figure 58. Sources of notifications

- **56.6%** patient, relative or member of the public
- **9.4%** employer
- **9.4%** other practitioner
- **7.5%** HCE
- **17.0%** other

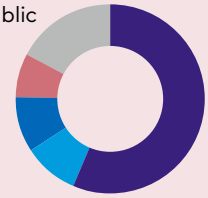
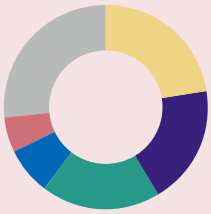


Figure 59. Most common types of complaint



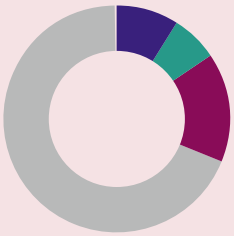
- **22.6%** clinical care
- **18.9%** health impairment
- **18.9%** documentation
- **7.5%** boundary violation
- **5.7%** behaviour
- **26.4%** other

No immediate action taken

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

Figure 60. Notifications closed

45 notifications closed
- **8.9%** conditions imposed on registration or an undertaking accepted
- **6.7%** received a caution or reprimand
- **15.6%** referred to another body or retained by a health complaints entity
- **68.9%** no further action



Monitoring

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

79 cases being monitored at 30 June:
- → **1** for conduct
- → **4** for health reasons
- → **1** for performance
- → **73** for suitability/eligibility for registration

Criminal offence complaints

7 criminal offence complaints made
- → **6** about title protection
- → **1** about advertising breaches

8 were closed

Referrals to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

No appeals

Visit the Board's website at www.occupationaltherapyboard.gov.au for more information and to download data tables.

Optometrists

From the Chair

Issues this year

The last quarter of 2019/20 has been a challenging time for registered optometrists in the face of restrictions arising from COVID-19. The Optometry Board of Australia worked with other National Boards and Ahpra to support health practitioners during the pandemic. Regulatory approaches were modified to accommodate exceptional circumstances. The Board also encouraged practitioners to become familiar with the revised CPD registration standard.

Regulatory response to COVID-19

The impact of the pandemic gave rise to issues such as the completion of clinical placements by final-year students. The Board is grateful for the alternative teaching strategies and equivalent learning experiences deployed by optometry schools at universities and the collaborative assessments provided by the Board's accreditation body, Optometry Council of Australia and New Zealand (OCANZ).

We encouraged practitioners to continue to complete available continuing professional development (CPD) while recognising the difficulty in meeting CPD requirements as a result of withdrawn or denied leave requests, conference cancellations and the reprioritisation necessary to meet workforce needs. The Board issued an assurance that it will not take action if practitioners cannot meet the CPD registration standard due to the pandemic.

The CPD registration standard requires practitioners to complete cardiopulmonary resuscitation (CPR) training every three years. However, these courses have been postponed by private providers as the CPR component has to be done in person. The Board asked that this training be completed when there is no longer an unnecessary risk involved.

The Board also issued a recommendation that optometry practices implement a system of phone triage for their patients, to prioritise patients requiring urgent eye and vision care rather than routine examinations.

Revised CPD standard

On 30 June, the Ministerial Council approved the Board's revised *Continuing professional development registration standard*, which will come into effect on 1 December 2020.

A longer lead-up time was approved so that optometrists have 18 months to adjust to the new requirements, which move from a points system to hours. We published advance copies of the registration standard and supporting documents on the Board's website.

The revised registration standard allows greater flexibility in choices of learning activities. We published an updated fact sheet to provide greater clarity for applicants seeking limited registration for postgraduate training and/or supervised practice.

Return to practice

In response to an identified need by practitioners who would like to plan a lengthy break from practice, we published return-to-practice explanatory materials.

Stakeholder engagement

The Board convened the annual meeting of the Optometry Regulatory Reference Group in October.

We welcomed Mr Andrew Brown, Queensland Health Ombudsman, and the Chair of the Optometrists and Dispensing Opticians Board New Zealand (ODOB NZ) at our February Board meeting.

The Board and members of its committees participated in the National Scheme's Combined Meeting in February, nearly a decade after the scheme's establishment.

Accreditation

The Board has approved its accreditation agreement's second year of funding with OCANZ. The agreement's contemporary framework addresses accreditation issues such as cultural safety, safety and quality and reducing regulatory burden, and aims to strengthen accountability and transparency of accreditation.

On the Board's recommendation, Ahpra, as the contracting entity, entered into a one-year contract extension with Optometry Australia for the provision of CPD accreditation services for a final term until 30 November 2020. From 1 December 2020, the revised CPD registration standard will start and CPD courses will no longer be accredited by the Board.

Other news

The Board supports the National Scheme's *Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025* released in early 2020.

The Board commissioned Ahpra to conduct a review of complaints during 2010–17 about optometrists and in 2019 confirmed that the vast majority of optometrists in Australia provide safe and effective care, with the profession drawing fewer complaints than the average for all regulated health professions.

The Board also released an information guide to help the public know what to expect when visiting a registered optometrist or optician.

Mr Ian Bluntish, Chair

Snapshot of the profession

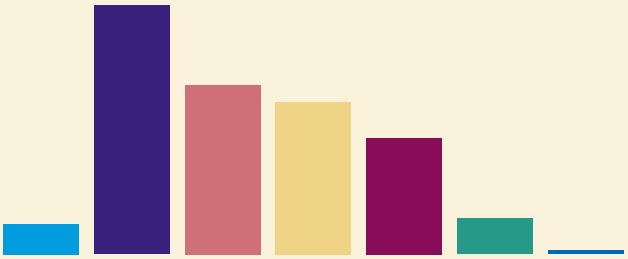
6,043 optometrists

- → **Up 4.5%** from 2018/19
- → **0.8%** of all registered health practitioners

0.2% identified as Aboriginal and/or Torres Strait Islander

55.9% female; **44.1%** male

Figure 61. Age



4.0%	32.9%	22.4%	20.1%	15.4%	4.7%	0.5%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 62. Audit outcomes

- **0.0%** fully compliant
- **100.0%** compliant (through education)
- **0.0%** non-compliant
- **0.0%** no audit action required

Optometry Board

Board members

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

Ms Valerie Cheong is the Executive Officer, Optometry.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Regulating the profession

Notifications

41 notifications lodged with Ahpra

- → **55** registered optometrists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.9%** of the profession

Figure 63. Sources of notifications

- **63.4%** patient, relative or member of the public
- **14.6%** HCE
- **4.9%** Board's own motion
- **2.4%** other practitioner
- **14.6%** other

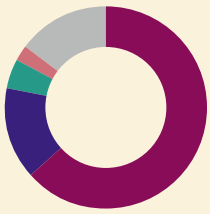
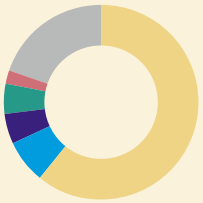


Figure 64. Most common types of complaint



- **61.0%** clinical care
- **7.3%** offence against other law
- **4.9%** communication
- **4.9%** breach of non-offence provision – National Law
- **2.4%** behaviour
- **19.5%** other

1 immediate action taken

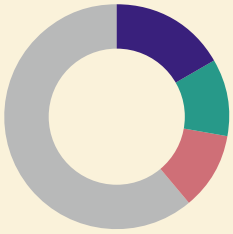
2 mandatory notifications received

- → **1** about professional standards

Figure 65. Notifications closed

36 notifications closed

- **16.7%** conditions imposed on registration or an undertaking accepted
- **11.1%** received a caution or reprimand
- **11.1%** referred to another body or retained by a health complaints entity
- **61.1%** no further action



Monitoring

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

9 cases being monitored at 30 June:

- → **4** for conduct
- → **2** for performance
- → **3** for suitability/eligibility for registration

Criminal offence complaints

6 criminal offence complaints made

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

4 were closed

Referrals to an adjudication body

No matters decided by a tribunal

2 matters decided by a panel

No appeals

Visit the Board's website at www.optometryboard.gov.au for more information and to download data tables.

Osteopaths

From the Chair

Issues this year

Enhancing communications has been a focus for the Osteopathy Board of Australia this year, including social media, video and use of virtual platforms, to reach groups such as students and stakeholders, as well as our regular newsletters. Our newsletters continue to have a high open rate. This communications groundwork was important when registrants needed quick messaging about COVID-19.

Regulatory response to COVID-19

From March, the Board has contacted registrants directly by newsletters and email with information about the impact of COVID-19 and the regulatory response for osteopaths. Osteopaths generally work in private clinics and have been able to work through the pandemic during the period covered by the annual report. Specific osteopathy questions relating to this type of practice, plus the common questions, are on a consolidated COVID-19 resources webpage.

For practitioners who have been unable to work during this time or do CPD, there have been some extensions of regulatory requirements.

International Osteopathic Health Week 2020 was scheduled to be celebrated in April, but due to the worldwide situation relating to COVID-19 the Board, in line with other osteopathy bodies and organisations, postponed the event until a later date.

Policy updates

The revised *Capabilities for osteopathic practice* (2019) took effect on 1 December 2019. We have developed FAQs about the transition period to give information on the upcoming change to osteopaths, educators and supervisors/supervisees.

We also published a video, *Getting to know your revised osteopathy capabilities*, and a range of other supporting documents.

Standards and guidelines

The Board carried out joint public consultation with other National Boards on the:

- proposed *Supervised practice framework*
- review of the *Guidelines for advertising a regulated health service*
- review of the *Guidelines for mandatory notifications*.

This year, the Board was involved in the release of the following guidelines with other Boards:

- *Mandatory notifications about registered health practitioners*
- *Mandatory notifications about registered students*.

The Board jointly published a new guide to help registered health practitioners understand and meet their obligations when using social media.

Accreditation

Following the release of the *Capabilities for osteopathic practice* in 2019 the Board has asked the Australian Osteopathic Accreditation Council (AOAC) to conduct a project to review the Accreditation standards for osteopathic courses in Australia. Work is well underway and consultation is about to start.

Stakeholder engagement

Local

The Board continued registrant forums in Perth in August and Hobart in November to engage with registrants and hear about the issues that are of most interest regarding regulation. As part of the forum, senior Ahpra staff from the state offices in those cities presented and were on hand to answer questions. Forums in 2020 in the other capital cities have been postponed due to COVID-19 and the inability to meet face to face.

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

During the National Scheme's Combined Meeting in February, the Board met with the Chair of the AOAC, President of the Osteopathy Council of NSW, and the Chair and Registrar of the Osteopathic Council of New Zealand to discuss issues of mutual interest.

International

The Executive Officer and I attended the annual Osteopathic International Alliance (OIA) meeting in Frankfurt, Germany, in October. The conference focused on osteopathy regulation, education, research and association leadership. The conference also focused on the three collaborative projects with the World Health Organization and their associated taskforces on benchmarks in practice, update on the global profession (global survey), and a glossary of osteopathic terms.

Dr Nikole Grbin, Chair

Osteopathy Board

Board members

- **Dr Nikole Grbin (practitioner) (Chair)**
- Dr Pamela Dennis (practitioner)
- Ms Judith Dikstein (community)
- Ms Julia Duffy (community)
- Mr Joshua Hatten (community)
- Dr Katherine Locke (practitioner)
- Dr Paul Orrock PhD (practitioner)
- Dr Patricia Thomas (practitioner)
- Dr Andrew Yaksich (practitioner)

Dr Cathy Woodward PhD is the Executive Officer, Osteopathy.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

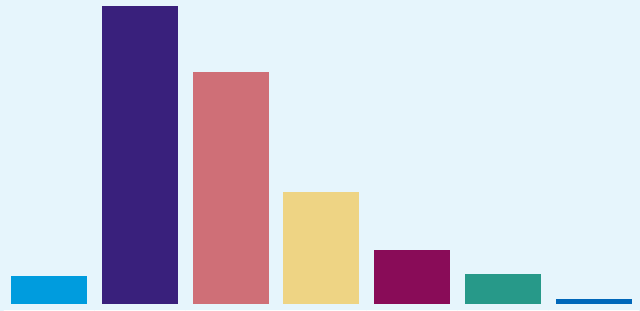
Snapshot of the profession

2,753 osteopaths
- → **Up 8.1%** from 2018/19
- → **0.3%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

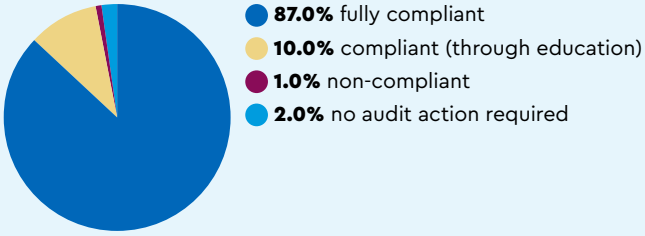
54.3% female; **45.7%** male

Figure 66. Age



3.6%	39.3%	30.6%	14.8%	7.1%	3.9%	0.6%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 67. Audit outcomes



Regulating the profession

Notifications

21 notifications lodged with Ahpra
- → **29** registered osteopaths Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.1%** of the profession

Figure 68. Sources of notifications

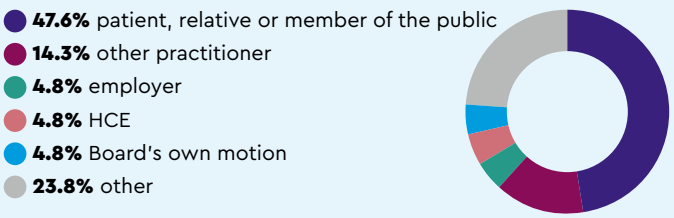
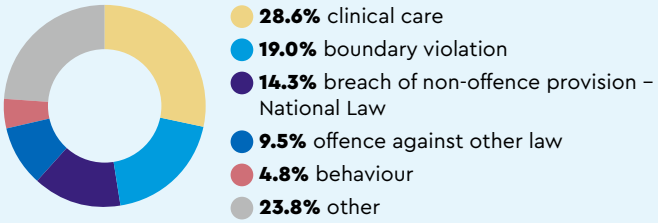


Figure 69. Most common types of complaint

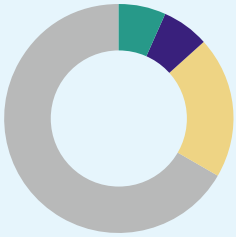


2 immediate actions taken

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

Figure 70. Notifications closed

15 notifications closed
- **6.7%** conditions imposed on registration or an undertaking accepted
- **6.7%** received a caution or reprimand
- **20.0%** referred to another body or retained by a health complaints entity
- **66.7%** no further action



Monitoring

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

8 cases being monitored at 30 June:
- → **1** for conduct
- → **3** for prohibited practitioner/student
- → **4** for suitability/eligibility for registration

Criminal offence complaints

7 criminal offence complaints made
- → **5** about title protection
- → **2** about advertising breaches

13 were closed

Referrals to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

No appeals

Visit the Board's website at www.osteopathyboard.gov.au for more information and to download data tables.

Paramedics

From the Chair

Issues this year

The regulation of paramedicine started on 1 December 2018 and the Paramedicine Board of Australia's work to further implement the regulation of the profession continued into the 2019/20 year. Overall, the transition of the profession to regulation has continued to be a relatively smooth process despite the large numbers of applications received. There are now almost 20,000 registered paramedics in the National Scheme and by 30 November 2019 over 17,000 had renewed their registration for the first time.

Regulatory response to COVID-19

To meet the challenges faced due to this national health emergency, the Board agreed that its regulatory approaches could be modified to accommodate these exceptional circumstances, provided public safety was not compromised. We provided streamlined and pragmatic approaches on CPD, recency of practice and English language proficiency to support the workforce challenge. The Board also worked to streamline the conditions and reporting obligations on some practitioners to better enable them and their employers to meet the workforce demands within the pandemic environment.

The support of Ahpra staff to expedite applications where possible was important in responding to the pandemic and was much appreciated by the Board.

Policy updates

As provided for in the *English language skills registration standard*, we approved additional tests that met the requirements of the Board for the demonstration of English language skills. Currently, there is no paramedicine-specific occupational English test (OET), and therefore the Board agreed that an equivalent pass of the OET for any other registered health profession will meet the Board's requirements.

The Board continued to work closely with the Nursing and Midwifery Board of Australia on matters relating to dual qualified nurse-paramedics and together we released an updated fact sheet for dual registered practitioners. This provides extra clarity about staying connected with the professions when maintaining recency of practice.

Guidelines

To support the implementation of the *Communicable Diseases Network Australia guidelines* that were approved by the Australian Health Ministers' Advisory Council, the Board, together with the Dental, Medical, Nursing and Midwifery and Podiatry Boards, approved *Guidelines for registered health practitioners and students in relation to blood-borne viruses*. These support safe practice for paramedics, who may have to perform exposure-prone procedures on patients in an emergency setting.

We also joined in with other Boards in approving common guidelines for mandatory reporting that took into account the changes in legislation that took effect on 1 March 2020.

Stakeholder engagement

The Board continued its approach of engaging with and supporting the profession in joining the National Scheme. We produced a range of supportive material about some of our registration standards and met routinely with key stakeholders. The COVID-19 pandemic affected the Board's program of engagement activities, but we hope to reinvigorate this program later in 2020.

National entry-level competency assessment

Subsequent to some substantial work, an agreement was reached on a national entry-level competence assessment for paramedics to be conducted by a consortium of universities across Australia. The assessment was developed to give applicants for registration or renewal of registration an opportunity to support their application, when required, with a demonstration of their competence as a paramedic.

The foundation work done by Edith Cowan University, Flinders University, La Trobe University, University of the Sunshine Coast and Western Sydney University, which formed the consortium to develop and provide the competence assessment, was greatly appreciated by the Board. All consortium members provide entry-to-practice paramedicine programs at their respective university, are registered by the Tertiary Education Quality and Standards Agency and have extensive experience in assessing an individual's capability to practise paramedicine safely and competently.

On behalf of the Board, I thank everyone who has contributed to the regulation of paramedics during 2019/20. Board members, Ahpra, the profession, employers and government have all played a critical role in embedding the regulation of paramedicine as a health profession under the National Law.

Professor Stephen Gough ASM, Chair

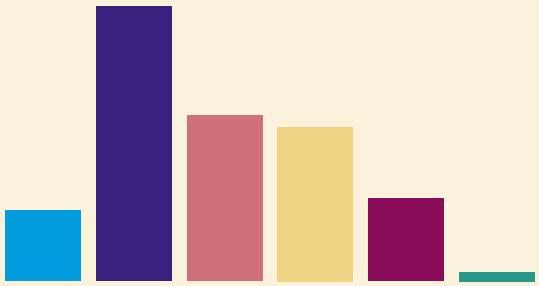
Snapshot of the profession

19,838 paramedics
- → **Up 14.5%** from 2018/19
- → **2.5%** of all registered health practitioners

1.6% identified as Aboriginal and/or Torres Strait Islander

44.4% female; **55.6%** male

Figure 71. Age



9.3%	36.3%	21.9%	20.4%	10.9%	1.2%
< 25	25–34	35–44	45–54	55–64	65–74

Paramedicine Board

Board members

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

Mr Paul Fisher is the Executive Officer, Paramedicine.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Regulating the profession

Notifications

112 notifications lodged with Ahpra
- → **152** registered paramedics Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.8%** of the profession

Figure 72. Sources of notifications

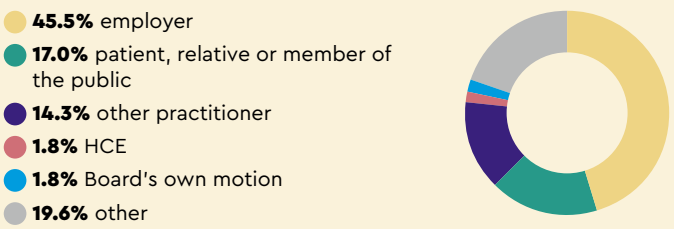
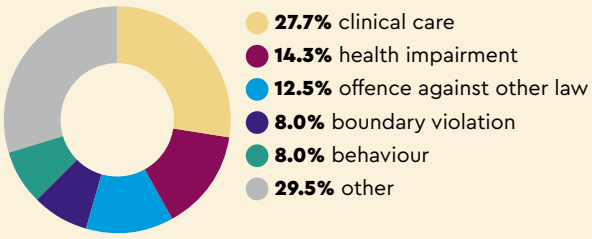


Figure 73. Most common types of complaint

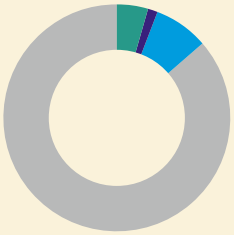


17 immediate actions taken

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

Figure 74. Notifications closed

65 notifications closed
- **4.6%** conditions imposed on registration or an undertaking accepted
- **1.5%** received a caution or reprimand
- **7.7%** referred to another body or retained by a health complaints entity
- **86.2%** no further action



Monitoring

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

168 cases being monitored at 30 June:
- → **5** for conduct
- → **12** for health reasons
- → **1** for performance
- → **11** for prohibited practitioner/student
- → **139** for suitability/eligibility for registration

Criminal offence complaints

26 criminal offence complaints made
- → **24** about title protection
- → **1** about advertising breaches
- → **1** directing or inciting unprofessional conduct/professional misconduct

24 were closed

Referrals to an adjudication body

No matters decided by a tribunal

No matters decided by a panel

4 appeals

Visit the Board's website at www.paramedicineboard.gov.au for more information and to download data tables.

Pharmacists

From the Chair

Issues this year

Position statement on pharmacist prescribing

This year, the Pharmacy Board of Australia released its position statement on pharmacist prescribing. This followed an extensive work program during the last two years to explore the competence of pharmacists in Australia to prescribe under the models of non-medical prescribing defined by the Health Professionals Prescribing Pathway (HPPP). Our work included competency mapping and broad stakeholder engagement by hosting a forum and releasing a discussion paper on pharmacist prescribing.

The Board concluded that under the National Law it has no regulatory barriers in place for pharmacists to be able to prescribe in two of those models of care within a collaborative healthcare environment, via a structured prescribing arrangement or under supervision. The Board also confirmed its view that autonomous prescribing by pharmacists requires additional regulation through an endorsement for scheduled medicines.

The work to explore pharmacist prescribing did not result in any regulatory proposals. However, it will assist stakeholders, including government and the public, to further explore how qualified and competent pharmacists might further contribute to the delivery of health services to the public.

The statement includes several important considerations that would inform the development of any pharmacist prescribing models in the future. The Board continues to engage with stakeholders about the outcomes in the position statement.

Pharmacy intern experience survey report

The Board published the final report of the *Pharmacy internship experience survey*, a large-scale survey of recent pharmacy interns and preceptors across Australia.

The survey was an opportunity for interns and preceptors to provide feedback on their own experiences. This enabled the Board to explore their views on the quality of and degree of consistency in the internship experience, and to identify opportunities to improve the experience as well as the supervised practice process for future interns and preceptors.

The results included positive feedback about internship experiences, as well as areas for improvement. We will address these issues through development of new content for our *Intern pharmacist and preceptor guide*, and through ongoing engagement with stakeholders to identify how best to provide additional support to interns and preceptors to facilitate good learning outcomes across all internships.

The report will also inform the Board's review of its *Registration standard: supervised practice arrangements*, starting next year.

Internship assessment

The Board continued its collaboration with the Australian Pharmacy Council, through the Intern Year Blueprint Implementation Working Group, to develop a strategy to revise the intern assessment process. This contributes to the Board's long-standing intern-assessment quality improvement work program. This work will continue next year.

Regulatory response to COVID-19

In response to the COVID-19 pandemic, the Board provided guidance to pharmacists about meeting the Board's regulatory requirements during this challenging and demanding period. Given the impact of the pandemic on pharmacists providing increased services to the public, the Board announced the following responses:

- general registration was granted to over 1,900 pharmacists who had held general registration and left the *Register of practitioners* or moved to non-practising registration in the past three years, enabling them to return to practice
- the Board would not take action if the pandemic affected pharmacists' ability to complete the minimum annual CPD requirement for renewal of registration
- a reduction in the total number of intern supervised practice hours required for general registration and advice on modifications to the arrangements for supervision of interns
- a revised schedule of intern registration examinations, including the delivery of oral examinations using an online platform given the need for social distancing.

The Board worked collaboratively with Ahpra, the Australian Pharmacy Council, interns, preceptors and examiners to enact these measures.

Accreditation

The Board approved the *Accreditation standards for pharmacy programs in Australia and New Zealand, 2020* developed by the Australian Pharmacy Council. The Board provided funding for this work.

The revised accreditation standards will continue to support the provision of degree programs and intern training programs but will also enable education providers to develop and deliver programs which integrate degree and intern training programs.

Mr Brett Simmonds, Chair

Visit the Board's website at www.pharmacyboard.gov.au for more information and to download data tables.

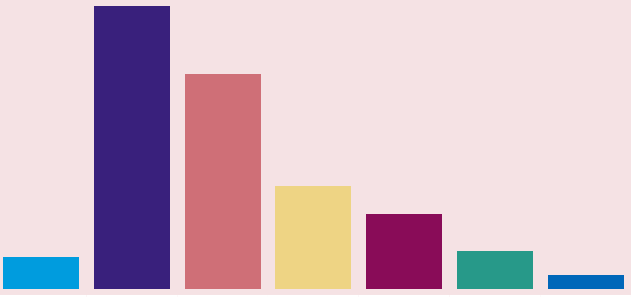
Snapshot of the profession

34,512 pharmacists
- → **Up 8.0%** from 2018/19
- → **4.3%** of all registered health practitioners

0.3% identified as Aboriginal and/or Torres Strait Islander

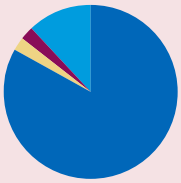
62.7% female; **37.3%** male

Figure 75. Age



4.2%	37.3%	28.4%	13.6%	9.8%	4.9%	1.8%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 76. Audit outcomes



- **83.3%** fully compliant
- **2.4%** compliant (through education)
- **2.4%** non-compliant
- **11.9%** no audit action required

Pharmacy Board

Board members

- **Mr Brett Simmonds (practitioner) (Chair)**
- Mrs Elise Apolloni (practitioner)
- Ms Melissa Cadzow (community)
- Dr Alice Gilbert PhD (practitioner)
- Ms Joy Hewitt (practitioner)
- Mr Mark Kirschbaum (practitioner)
- Ms Hannah Mann (practitioner)
- Dr Suzanne Martin (veterinarian) (community)
- Mr Cameron Phillips (practitioner)
- Dr Rodney Wellard PhD (community)
- Mr Rodney Wellington (community)
- Mr Laurence (Ben) Wilkins (practitioner)

Mr Joe Brizzi is the Executive Officer, Pharmacy.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Regulating the profession

Notifications

448 notifications lodged with Ahpra
- → **649** registered pharmacists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.9%** of the profession

Figure 77. Sources of notifications

- **58.5%** patient, relative or member of the public
- **13.4%** other practitioner
- **7.1%** HCE
- **6.7%** Board's own motion
- **2.9%** employer
- **11.4%** other

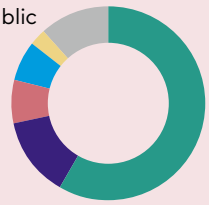
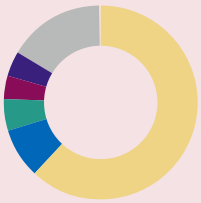


Figure 78. Most common types of complaint



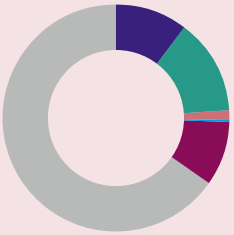
- **62.1%** medication
- **8.3%** communication
- **5.4%** clinical care
- **4.0%** health impairment
- **4.0%** behaviour
- **16.3%** other

48 immediate actions taken

46 mandatory notifications received
- → **36** about professional standards

Figure 79. Notifications closed

336 notifications closed
- **10.4%** conditions imposed on registration or an undertaking accepted
- **13.7%** received a caution or reprimand
- **1.2%** registration suspended or cancelled
- **0.3%** registration surrendered
- **9.2%** referred to another body or retained by a health complaints entity
- **65.2%** no further action



Monitoring

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

125 cases being monitored at 30 June:
- → **18** for conduct
- → **18** for health reasons
- → **24** for performance
- → **23** for prohibited practitioner/student
- → **42** for suitability/eligibility for registration

Criminal offence complaints

13 criminal offence complaints made
- → **10** about title protection
- → **3** about advertising breaches

8 were closed

Referrals to an adjudication body

8 matters decided by a tribunal

No matters decided by a panel

6 appeals

Physiotherapists

From the Chair

Issues this year

The work of the Physiotherapy Board of Australia built on its initiatives from last year and was informed by an extensive program of stakeholder engagement.

Regulatory response to COVID-19

The Board has been meeting online each month since the COVID-19 pandemic started in March. We have been responding to the needs of the profession, healthcare services and the public by modifying our regulatory approach to support the profession through the pandemic and contribute to the national response.

Since March, the Board has made a series of pragmatic decisions to temporarily modify regulatory requirements. These changes include taking a more flexible approach to CPD requirements. With other Boards, we adopted *National principles for clinical education through the COVID-19 pandemic* to support students to continue their studies and graduate.

The Board encouraged registered physiotherapists to continue to do CPD in 2020. However, the Board will not take action at renewal this year about practitioners who cannot meet the CPD standard as a result of the pandemic.

Pandemic response sub-register

Another significant development is the inclusion of physiotherapy among a small number of priority health professions on the pandemic sub-register. On 20 April, over 2,000 physiotherapists who have held registration in the past three years were added to the sub-register and those with capacity to help were encouraged to return to practice. This is particularly important for intensive care patients requiring COVID-related physiotherapy, as well as for others in healthcare facilities (including aged care) and the community who need physiotherapy for injuries, rehabilitation or chronic conditions.

Telehealth

Telehealth has emerged as an important change to patient care during COVID-19 with many practitioners offering telephone or online consultations to support their patients. The overall uptake and feedback have been positive for both patients and practitioners, with many third-party funders agreeing to include physiotherapy via telehealth as a subsidised service. This sets up the ability to provide greater access to physiotherapy during the pandemic and beyond.

Stakeholder engagement

As part of its strategic objectives, the Board strengthened its relationships with its key stakeholders, including the Australian Physiotherapy Association and its appointed accreditation authority, the Australian Physiotherapy Council, as well as the Council of Physiotherapy Deans of Australia and New Zealand (CPDANZ). These partnerships were particularly valuable during the COVID-19 preparedness response as we worked together to consider the workforce, public safety and clinical education implications.

Each year the Board organises local presentations with different states and jurisdictions to interact and engage with practitioners. A successful stakeholder engagement event was held in Brisbane. Unfortunately, a planned event in partnership with NSW Physiotherapy Council had to be deferred due to the pandemic. We are considering greater use of virtual platforms for future stakeholder events and webinars.

Policy updates

Physiotherapy is participating in and has contributed to several multi-professional policy reviews, which include a revised supervised practice framework, code of conduct, mandatory reporting guidelines, telehealth guidance and the agreed definition of cultural safety.

Strategic projects

Prescribing initiative

The Board is doing work in the area of prescribing to form a view on whether it will progress with an endorsement for prescribing for physiotherapists. We commissioned a literature review and exploration report on the success of physiotherapy prescribing in other jurisdictions and the implications for the Australian context. The Board will develop a better understanding of prescribing as work continues.

Limited registration initiative

The Board committed in its regulatory plan for 2019/20 to improving its understanding of the characteristics of physiotherapy registrants holding limited registration for supervised practice (LRSP). The Board has a particular interest in those working in aged care settings given the vulnerability of the patient population.

The project has given us a better understanding of the characteristics, work settings and periods of supervised practice, and has prompted the implementation of recommendations that can strengthen regulatory mechanisms to ensure public protection.

Ms Kim Gibson, Chair

Physiotherapy Board

Board members

- **Ms Kim Gibson (practitioner) (Chair)**
- Ms Sally Adamson (practitioner)
- Mrs Janet Blake (community)
- Mr David Cross (practitioner)
- Mrs Lynette Green (community)
- Dr Paula Harding PhD (practitioner)
- Ms Cherie Hearn (practitioner)
- Mr Peter Kerr AM (community)
- Emeritus Professor Sheila Lennon (practitioner)
- Mr Lachlan Mortimer (practitioner)
- Ms Elizabeth Trickett (practitioner)
- Ms Katherine Waterford (community)

Ms Jill Humphreys was the Executive Officer, Physiotherapy, from July to September, Ms Paula Bateson from September to January, and Ms Alison Abud from February.

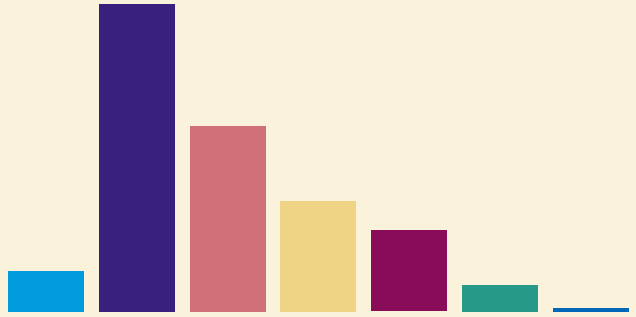
Snapshot of the profession

37,113 physiotherapists
- → **Up 9.8%** from 2018/19
- → **4.6%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

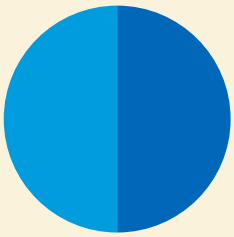
65.6% female; **34.4%** male

Figure 80. Age



5.4%	40.7%	24.5%	14.6%	10.7%	3.5%	0.5%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 81. Audit outcomes



- **50.0%** fully compliant
- **0.0%** compliant (through education)
- **0.0%** non-compliant
- **50.0%** no audit action required

Regulating the profession

Notifications

125 notifications lodged with Ahpra
- → **176** registered physiotherapists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **0.5%** of the profession

Figure 82. Sources of notifications

- **58.4%** patient, relative or member of the public
- **13.6%** other practitioner
- **11.2%** HCE
- **5.6%** employer
- **3.2%** Board's own motion
- **8.0%** other

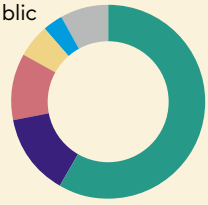
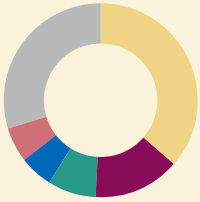


Figure 83. Most common types of complaint



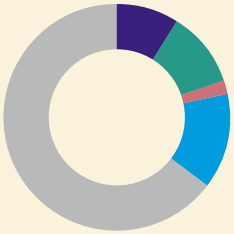
- **36.8%** clinical care
- **14.4%** boundary violation
- **8.0%** documentation
- **5.6%** offence against other law
- **5.6%** communication
- **29.6%** other

11 immediate actions taken

14 mandatory notifications received
- → **8** were about professional standards

Figure 84. Notifications closed

101 notifications closed
- **8.9%** conditions imposed on registration or an undertaking accepted
- **10.9%** received a caution or reprimand
- **2.0%** registration suspended or cancelled
- **13.9%** referred to another body or retained by a health complaints entity
- **64.4%** no further action



Monitoring

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

56 cases being monitored at 30 June:
- → **12** for conduct
- → **2** for health reasons
- → **4** for performance
- → **5** for prohibited practitioner/student
- → **33** for suitability/eligibility for registration

Criminal offence complaints

35 criminal offence complaints made
- → **23** about title protection
- → **12** about advertising breaches

33 were closed

Referrals to an adjudication body

4 matters decided by a tribunal

No matters decided by a panel

1 appeal

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Visit the Board's website at www.physiotherapyboard.gov.au for more information and to download data tables.

Podiatrists

From the Chair

In a year largely dominated by the COVID-19 pandemic, the Podiatry Board of Australia continued to build on initiatives from the previous year.

Regulatory response to COVID-19

We temporarily modified some of our regulatory requirements to provide flexibility for podiatrists and podiatric surgeons whose practice was affected when restrictions were introduced to slow the spread of coronavirus, the virus that causes COVID-19. Our responses included providing an extension for practitioners working towards endorsement for scheduled medicines to complete their supervised practice and a flexible approach to continuing professional development (CPD).

The professionalism of practitioners who adapted (and in some cases halted) their practice to comply with the relevant health directions contributed to containing the spread of the virus in Australia while ensuring safe access to urgent and essential podiatry care when needed.

Endorsement for scheduled medicines

The Board worked with Ahpra to identify where practitioners may need further guidance to support their understanding of our requirements for endorsement for scheduled medicines and to streamline our processes. As part of this work we published an example of a portfolio of evidence.

Cross-professional work

One of the strengths of the National Scheme is the opportunity to collaborate with other National Boards on the development of regulatory policy.

The Board and four other National Boards consulted on and approved *Guidelines for registered health practitioners and students in relation to blood-borne viruses*, which were to come into effect on 6 July 2020.

Together with other National Boards and Ahpra, we also reviewed and consulted on multi-profession guidelines for mandatory notifications, guidelines for advertising a regulated health service, and a supervised practice framework.

Accreditation

The Podiatry Accreditation Committee started performing the accreditation functions for the podiatry profession on 1 July 2019, supported by Ahpra. The Board thanks the committee for its commitment and hard work in a challenging first year that was significantly affected by COVID-19.

The committee began developing professional capabilities and accreditation standards for the podiatry profession, which will involve wide-ranging consultation in the coming year.

Stakeholder engagement

The Board has an ongoing program of stakeholder engagement that includes regular meetings with stakeholders including the Australian Podiatry Association, the Podiatry Council of New South Wales and the Podiatry Accreditation Committee.

We also met with stakeholders in Perth, including Podiatry WA, the Australian Association of Podiatric Surgeons and the Australasian College of Podiatric Surgeons. In February we met with representatives of the Podiatrists Board of New Zealand and the Health Ombudsman of Queensland, at the National Scheme's Combined Meeting in Melbourne.

A member of the Aboriginal and Torres Strait Islander Health Practice Board attended one of our board meetings to provide us with some insight into the Aboriginal and Torres Strait Islander Health Practice profession and the work of Aboriginal and Torres Strait Islander Health Practitioners, including their important cultural liaison role in the health workforce.

Assessing authority for skilled migration

In November, the Board was approved as the skilled migration assessing authority for podiatrists under the Australian Government's Skilled Migration Program. Information about what is accepted as evidence of a suitable skills assessment for immigration purposes is published on the *Assessment for migration* page of our website.

Other news

The Board welcomed new community member Mrs Maria Cosmidis, who was appointed in November to fill a vacancy. She attended her first board meeting in December.

Associate Professor Cylie Williams, Chair

Podiatry Board

Board members

- **Associate Professor Cylie Williams (practitioner) (Chair)**
- Dr Paul Bennett PhD (practitioner)
- Mrs Maria Cosmidis (community) (from 22 November)
- Dr Janice Davies PhD (community)
- Miss Julia Kurowski (practitioner)
- Dr Kristy Robson PhD (practitioner)
- Ms Shellee Smith (community)
- Mrs Kathryn Storer (practitioner)
- Mr Andrew van Essen (practitioner)

Ms Jenny Collis is the Executive Officer, Podiatry.

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Snapshot of the profession

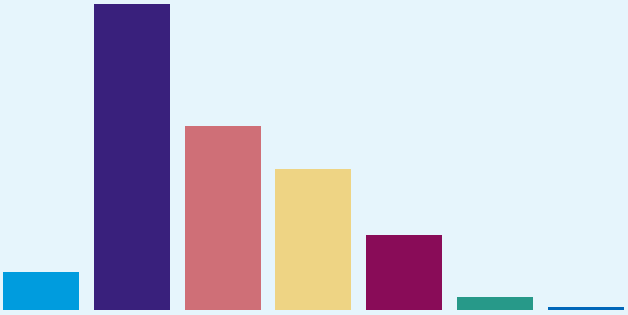
'Podiatrists' includes podiatric surgeons in this report, unless otherwise stated.

5,608 podiatrists
- → **Up 4.6%** from 2018/19
- → **0.7%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

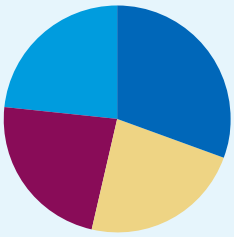
59.2% female; **40.8%** male

Figure 85. Age



5.0%	40.4%	24.3%	18.6%	9.8%	1.7%	0.3%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 86. Audit outcomes



- **30.8%** fully compliant
- **23.1%** compliant (through education)
- **23.1%** non-compliant
- **23.1%** no audit action required

Figure 87. Registration type

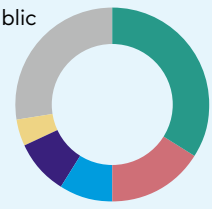
5,429	general
143	non-practising
36	general and specialist

Regulating the profession

Notifications

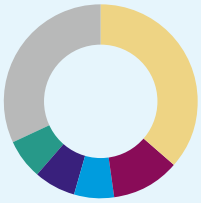
44 notifications lodged with Ahpra
- → **73** registered podiatrists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **1.3%** of the profession

Figure 88. Sources of notifications



- **34.1%** patient, relative or member of the public
- **15.9%** HCE
- **9.1%** Board's own motion
- **9.1%** other practitioner
- **4.5%** employer
- **27.3%** other

Figure 89. Most common types of complaint



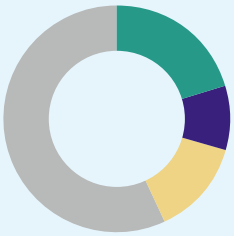
- **36.4%** clinical care
- **11.4%** communication
- **6.8%** documentation
- **6.8%** boundary violation
- **6.8%** confidentiality
- **31.8%** other

1 immediate action taken

2 mandatory notifications received
- → **both** were about professional standards

Figure 90. Notifications closed

44 notifications closed
- **20.5%** conditions imposed on registration or an undertaking accepted
- **9.1%** received a caution or reprimand
- **13.6%** referred to another body or retained by a health complaints entity
- **56.8%** no further action



Monitoring

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

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

Criminal offence complaints

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

4 were closed

Referrals to an adjudication body

1 matter decided by a tribunal

No matters decided by a panel

No appeals

Visit the Board's website at www.podiatryboard.gov.au for more information and to download data tables.

Psychologists

From the Chair

Strategic projects

The Psychology Board of Australia's education and training reform project is a multi-year initiative aimed at reducing the regulatory burden and complexity of psychology training. We completed the first phase of the project last year when we announced the retirement of the 4+2 internship program as a pathway to general registration.

This year the Board has started the second phase of reform: reviewing the competencies required for both general psychologists and endorsed psychologists.

The focus of phase two is to improve the alignment of psychology training and competency development with registration for general and endorsed psychologists, and to maximise the area of practice endorsement framework as a regulatory mechanism for the benefit of the public.

The Board is committed to ensuring that both general and endorsed psychologists can demonstrate the professional competencies to ensure safe, responsive, accessible and effective practice. The regulation of psychologists needs to be responsive to client and industry needs.

Clients should be able to easily find and access psychologists who have expertise that matches their needs, and psychologists need to have clear ways to explain to their clients the services they can provide. We need to help the community and the profession to better understand the competencies of a general psychologist and the meaning and purpose of area of practice endorsement.

Unfortunately the COVID-19 pandemic delayed some of our planned face-to-face consultation activities this year. However the Board remains committed to finding ways of ensuring the views of psychologists, educators, government and the community are heard as we continue to progress this important piece of work.

While the pandemic delayed these consultation activities, we remain committed to finding ways of ensuring these views are heard as we continue our education and training reform, our major initiative for the year and beyond.

Regulatory response to COVID-19

In addition to the cross-professional regulatory measures that Ahpra and the National Boards put in place in response to the pandemic, the Board temporarily modified some of the regulatory requirements for 4+2 and 5+1 interns so that they could continue professional training while still maintaining client safety.

These included allowing interns to work fewer than the minimum hours required per week and to complete direct observation tasks via video. The Board also supported interns to complete the national psychology exam in a safe and timely manner via online proctoring, in which interns sat the exam via the internet from their home or workplace, rather than at a testing centre.

We further supported psychologists to gain or maintain Board approval as a supervisor by allowing both initial training and refresher training to be completed online.

Over 1,700 eligible psychologists were added to the pandemic sub-register in April.

Standards and guidelines

A revised *Registration standard for area of practice endorsements* was approved by Health Ministers and came into effect on 1 December 2019, along with new *Guidelines for area of practice endorsements*.

The revised documents bring the Board's endorsement qualification requirements in line with the new *Accreditation standards for psychology programs*. Other changes have been made to reduce the regulatory burden on registrars and their supervisors, including slightly reduced supervised practice hours, less frequent progress reports and greater flexibility in supervision arrangements.

The Board also published new *Guidelines for the national psychology exam* on 19 July 2019. Following a public consultation, the guidelines were amended to permanently exempt higher degree students from being required to sit the exam.

The Board also sought to improve the clarity and simplicity of information provided to exam candidates by revising the policy content in the guidelines and removing operational information and publishing it in a new manual for candidates.

Focus on regional boards

This year the Board, in conjunction with Ahpra, ran recruitment campaigns to appoint a number of practitioner and community members to vacancies on the New South Wales, Queensland, Victoria/ACT/Tasmania and Northern Territory/South Australia/Western Australia regional boards.

These four regional boards of the Psychology Board of Australia play an important role in regulatory decision-making for psychologists. They perform functions that are delegated by the National Board in regulatory matters related to registration and health, performance and conduct. They also bring a local perspective to regulatory decision-making.

We look forward to working with both our new and reappointed members in 2020/21.

Ms Rachel Phillips, Chair

Visit the Board's website at www.psychologyboard.gov.au for more information and to download data tables.

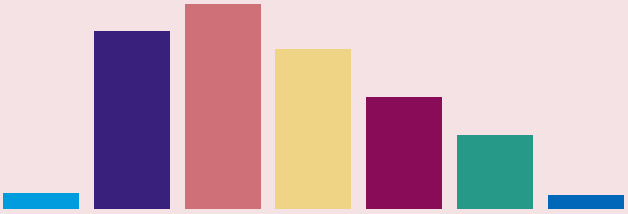
Snapshot of the profession

40,517 psychologists
- → **Up 7.2%** from 2018/19
- → **5.1%** of all registered health practitioners

0.7% identified as Aboriginal and/or Torres Strait Islander

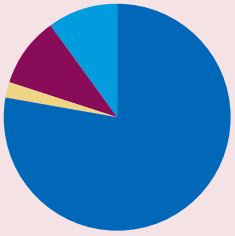
80.0% female; **20.0%** male

Figure 91. Age



2.0%	23.5%	27.1%	21.1%	14.7%	9.7%	1.8%
< 25	25–34	35–44	45–54	55–64	65–74	> 75

Figure 92. Audit outcomes



- **78.0%** fully compliant
- **2.0%** compliant (through education)
- **10.0%** non-compliant
- **10.0%** no audit action required

Psychology Board

Board members

- **Ms Rachel Phillips (Chair) (practitioner)**
- Ms Mary Brennan (community)
- Ms Rebecca Campbell (practitioner)
- Ms Marion Hale (community)
- Ms Vanessa Hamilton (practitioner)
- Mr Peter Hooker (community)
- Dr Melissa Hughes (PsychD) (practitioner)
- Mr Christopher Joseph (community)
- Mr Timothy Ridgway (practitioner)
- Professor Jennifer Scott (practitioner)
- Associate Professor Jennifer Thornton (practitioner)
- Professor Kathryn von Treuer (practitioner)

Ms Angela Smith is the Executive Officer, Psychology

See Appendices 1 and 3 for committees and members.

See Appendices 5 and 6 for Board consultations and approved registration standards, codes and guidelines.

Regulating the profession

Notifications

737 notifications lodged with Ahpra
- → **895** registered psychologists Australia-wide, including HPCA and OHO data, had notifications made about them
- → **2.2%** of the profession

Figure 93. Sources of notifications

- **65.8%** patient, relative or member of the public
- **13.8%** other practitioner
- **7.6%** HCE
- **4.2%** employer
- **1.9%** Board's own motion
- **6.6%** other

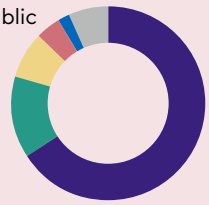
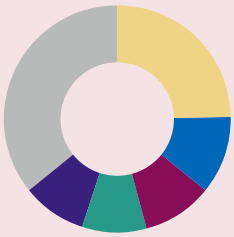


Figure 94. Most common types of complaint



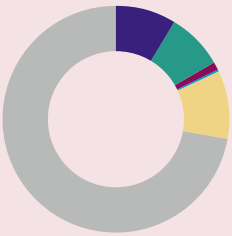
- **25.0%** clinical care
- **10.9%** communication
- **10.0%** confidentiality
- **9.4%** documentation
- **9.1%** boundary violation
- **35.7%** other

30 immediate actions taken

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

Figure 95. Notifications closed

580 notifications closed
- **8.8%** conditions imposed on registration or an undertaking accepted
- **7.9%** received a caution or reprimand
- **1.2%** registration suspended or cancelled
- **0.2%** fined
- **0.2%** registration surrendered
- **9.7%** referred to another body or retained by a health complaints entity
- **72.1%** no further action



Monitoring

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

161 cases being monitored at 30 June:
- → **28** for conduct
- → **13** for health reasons
- → **40** for performance
- → **18** for prohibited practitioner/student
- → **62** for suitability/eligibility for registration

Criminal offence complaints

132 criminal offence complaints made
- → **124** about title protection
- → **1** about practice protection
- → **7** about advertising breaches

130 were closed

Referrals to an adjudication body

9 matters decided by a tribunal

4 matters decided by a panel

12 appeals

Supporting the Boards

Appointments

National Board members are appointed by the Ministerial Council and state, territory and regional board members by the relevant Minister for Health in each jurisdiction. The regulatory work of the National Scheme is not possible without the right people serving on boards and committees. Ahpra provided administrative support for 493 statutory appointments (see Table 1), which included National Boards; National Board committees and panels (including advisory assessor panels and list of approved persons for panels); and state, territory and regional boards and committees.

Table 1. Statutory appointments in 2019/20

National Boards	8
National Board committees and panels	235
State, territory and regional boards	51
State, territory and regional committees	199
Total	**493**

The data cover all appointments made within the financial year.

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

Payment to Board Chairs

Board members are entitled to remuneration, including travelling and subsistence allowances, as the Ministerial Council determines. In addition to sitting fees for scheduled Board and committee meetings, Chairs may also be remunerated for the additional work required to carry out their role. To increase transparency and accountability, the Agency Management Committee, with the support of all Chairs, has agreed to voluntarily disclose payment arrangements to Chairs.

Table 2. Payments to Board Chairs[1]

Range	Number of Chairs	2019/20 payments $
$0–$20,000	2	16,430
$20,001–$40,000	1	21,419
$40,001–$60,000	5	242,036
$60,001–$80,000	3	207,405
$80,000 plus	5	482,996
Total	**16**	**970,286**

1. Payments to Chairs, including the Agency Management Committee, under the Ministerially approved remuneration framework.

Supporting good governance

Structural changes led to the formation of a national regulatory governance team within Ahpra. The team provides national leadership in strategic governance, regulatory advice, and executive and administrative support that ensures good regulatory governance between National Boards, Ahpra and accreditation authorities.

Tools and activities to support effective and efficient board processes and the integrity of decision-making under the National Law include:

- the Board members' manual to assist members in understanding their duties and discharging their regulatory responsibilities, and which outlines policy, procedural and administrative arrangements for calling, conducting and managing meetings
- ensuring Board and committee members have access to the right information at the right time, enabled by:
  - standard formats for Board and committee documents and meeting papers
  - consistent procedural arrangements for secretariat and meeting management processes
  - using a secure, reliable electronic meeting document-delivery platform, supporting over 750 Board and committee members and staff users
- developing, providing and overseeing the orientation and ongoing professional development program for Board and committee members.

All new National Board members are given an orientation to the National Scheme and to the Board(s) to which they have been appointed, usually before they attend their first meeting. This full-day session includes an overview of the National Scheme, its legislative and governance frameworks, the interplay between the entities in the scheme and the role of regulatory boards in that environment. It is complemented by further Board-specific orientation activities and briefings.

With the help of external provider Effective Governance, we developed a customised two-day professional development program, *Governance and decision-making in the National Scheme*, which is offered to members within six to 12 months of their appointment. Ahpra staff are also invited to attend to further strengthen our collaboration and partnership.

In 2019/20, 39 National Board members participated in the program.

As part of our response to the COVID-19 pandemic, all Board and committee meetings have been conducted online since mid-March. It is likely that virtual meetings will continue well into the next reporting period. Beyond that, virtual meetings will likely become part of a suite of options for managing business as usual. To support Chairs and members, we provided resource kits, tip sheets and one-on-one training on the virtual technology platform.

Accreditation – assuring quality of education and qualifications

Accreditation

Snapshot

- **Over 193,000 students** studying to be health practitioners through an approved program of study or clinical training program
- **The National Scheme accredits over 850 approved programs of study** delivered by more than 130 education providers through the work of accreditation authorities
- **Over $10 million** of National Board funding contributions to accreditation authorities
- **National principles for clinical experience** are designed to assist education providers, accreditation authorities and other stakeholders to navigate the impact of COVID-19 on student placements.

Accreditation provides a framework for assuring that individuals seeking registration are suitably trained, qualified and competent to practise as health practitioners in Australia. This is a crucial quality assurance and risk management mechanism for the National Scheme.

National Boards work closely with their accreditation authorities to effectively implement the National Scheme. Accreditation authorities and National Boards have separate but complementary functions under the National Law, which specifies these functions. For example, the National Law provides that an accreditation authority accredits a program of study and the relevant National Board approves the program of study for the purposes of registration.

If the accreditation authority is an external council, the council works with the National Board to deliver specified accreditation functions under a formal agreement with Ahpra on the Board's behalf. If the accreditation authority is a committee, the committee works with the National Board according to the committee's terms of reference. Ahpra publishes the accreditation agreements and terms of reference. See www.ahpra.gov.au/accreditation/accreditation-authorities for a complete list of accreditation authorities by Board and the published agreements and terms of reference.

Approved programs

Ahpra publishes an online searchable database of approved programs of study that lists qualifications for general registration, specialist registration or endorsement of registration. See www.ahpra.gov.au/accreditation/approved-programs-of-study.

'The COVID-19 pandemic had a profound impact on the education sector. Accreditation authorities, National Boards and Ahpra received an initial avalanche and then waves of queries from education providers, governments, students and other stakeholders about the implications for program delivery, graduates and workforce sustainability. Combining our resources and expertise we were able to respond rapidly to these questions, and provide individual and shared messages to clarify the situation.'

National Director, Policy and Accreditation

Accreditation systems review

In February, the then COAG Health Council announced its response to the final report of *Australia's health workforce: strengthening the education foundation, independent review of accreditation systems within the National Scheme*, informed by further consultation undertaken by the Australian Health Ministers' Advisory Council (AHMAC). Ministers accepted (either in full, in part or in principle) many of the recommendations in the final review report but did not accept the governance model recommendations. Ministers decided to direct Ahpra to establish an independent accreditation committee with broad stakeholder membership to provide advice to National Scheme bodies on relevant accreditation reforms, working within the existing governance of the National Scheme. See the link to their communiqué at www.coaghealthcouncil.gov.au/Projects/Accreditation-Systems-Review.

Advisory committee

The Accreditation Advisory Committee has been established by the Agency Management Committee to oversee the management of agreements for the performance of the accreditation functions, including financial and reporting matters; providing oversight of accreditation governance, accountability and transparency issues; and provide a whole-of-scheme perspective on accreditation.

The committee met five times during 2019/20. A major focus of its work was the reporting model for the new accreditation agreements and terms of reference established in mid-2019. After the COVID-19 pandemic emerged, the committee also considered effects on education providers and accreditation processes, including approaches by National Scheme bodies to monitor impacts of substantial changes to program delivery and scheduled clinical placements, and to manage associated risks.

The committee will continue to monitor ongoing impacts of the pandemic. The committee issues a communiqué after each meeting to keep stakeholders informed about its work. See www.ahpra.gov.au/about-ahpra/who-we-are/agency-management-committee/accreditation-advisory-committee.

Developing standards

Ahpra's procedures for developing accreditation standards are an important governance mechanism. They set out issues that:

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

The procedures are published on the Procedures page www.ahpra.gov.au/publications/procedures. During the year, Ahpra completed reviewing and updating these procedures, and will publish the revised version early in 2020/21.

Accreditation funding

Each year, the National Boards contribute funding to accreditation authorities. For more information see www.ahpra.gov.au/accreditation/accreditation-authorities.

Table 3. National Board funding contributions to accreditation

Board	2019/20 $'000[1]	2018/19 $'000[1]
ATSIHPBA	149	165[2]
CMBA	93	140[2]
ChiroBA	192	184
DBA	447	497
MBA	3,648	3,643
MRPBA	196	269[2]
NMBA	2,832[2]	2,799[2]
OTBA	0	140[3]
OptomBA	323	314
OsteoBA	186	181
ParaBA	199[2]	18[4]
PharmBA	595	777[2]
PhysioBA	325	270
PodBA	201[2]	237[2]
PsyBA	1,013	988
Total	**10,399**	**10,622**

1. These are actual amounts. Requirements of the accounting standards may result in differences between these and the amounts stated in our financial statements.
2. These amounts include funding for the review of accreditation standards.
3. These amounts are solely to fund the accreditation standards review.
4. The Paramedicine Accreditation Committee started exercising accreditation functions in April 2019.

New agreements and terms of reference

By 30 June 2019, Ahpra had signed new accreditation agreements with the 10 external accreditation authorities to apply until 30 June 2024. Early in 2019/20, National Boards established new terms of reference for accreditation committees, which mirror the key aspects of the agreements. See www.ahpra.gov.au/accreditation/accreditation-authorities/accreditation-agreements.

Accreditation committees

Five National Boards exercise accreditation functions through a committee established by the Board:

- Aboriginal and Torres Strait Islander Health Practice Accreditation Committee (ATSIHPAC)
- Chinese Medicine Accreditation Committee (CMAC)
- Medical Radiation Practice Accreditation Committee (MRPAC)
- Paramedicine Accreditation Committee (ParaAC)
- Podiatry Accreditation Committee (PodAC).

This year, Ahpra continued to support the accreditation committees to:

- assess and accredit programs of study
- monitor approved programs of study
- develop and/or review accreditation standards (ParaAC and PodAC)
- develop consistent guidelines for accreditation of education and training programs in these professions.

At 30 June, these accreditation committees have accredited and approved:

- ATSIHPAC – 15 programs of study, with one accreditation assessment in progress
- CMAC – 10 programs of study
- MRPAC – 25 programs of study
- PodAC – 15 programs of study, with two accreditation assessments in progress.

The ParaAC is monitoring 26 Board-approved programs (under s. 310) until accreditation assessments can start against the newly developed paramedicine accreditation standards.

Policy, standards and process

Ahpra's role in supporting the accreditation committees provides an opportunity for multi-profession approaches to the accreditation function.

We supported the accreditation committees to apply a risk-based approach to their monitoring activities. The National Law supports a flexible, risk-based model. Ahpra works with the committees to tailor the methods and frequency of activities to monitor education providers' compliance with the accreditation standards based on specific issues and risk profiles.

We supported the committees to review their accreditation processes and develop and consult on guidelines for accreditation of education and training programs in their professions. The guidelines provide detailed information about the approach the committees use to assess, accredit and monitor education and training programs in their respective professions, and are complemented by profession-specific information (such as approaches to establishing assessment teams) where necessary.

We also continued to support collaboration between the accreditation committees to implement a consistent cross-profession process and tools for annual data collection for more than 45 education providers delivering more than 90 approved programs across the five professions.

New and revised standards

Ahpra supported the Paramedicine Accreditation Committee to develop new accreditation standards and started a project with the Podiatry Accreditation Committee to review and revise accreditation standards for podiatry, podiatric surgery and endorsement for scheduled medicines. The project team worked in collaboration with the two committees to draft accreditation standards that are consistent with the standards for 11 other professions, that reflect current and emerging trends in education and practice, and that address the relevant objectives and requirements of the National Law.

Wide-ranging consultation on the draft accreditation standards for paramedicine began in late 2019 and the project was due to be completed in August 2020 when the National Board was expected to approve the new standards.

The project with the Podiatry Accreditation Committee also covers the professional capabilities for podiatry, podiatric surgery and endorsement for scheduled medicines, as these form an important part of the accreditation standards. Wide-ranging consultation on the draft accreditation standards and professional capabilities will begin in late 2020 and the project will be completed in mid-2021.

Collaborative forum

The accreditation committees, with Ahpra, participated in the Health Professions Accreditation Collaborative Forum (HPACF). This participation reflects the HPACF's multi-profession and multi-entity nature and its consideration of issues affecting all accreditation entities.

'The initial onset of COVID-19 and its impact on our work was frantic – coordinating responses and activities for five accreditation authorities – was a challenge, and at times stressful, but with the collective talent and dedication of the Accreditation team, and the accreditation committees, we were able to respond to the crisis with a measured and reasoned approach.'

Accreditation team manager

COVID's effect on the future health workforce

Students build the capabilities they need to practise safely and competently as a registered health practitioner through clinical education experiences, including student placements in a range of health services and settings.

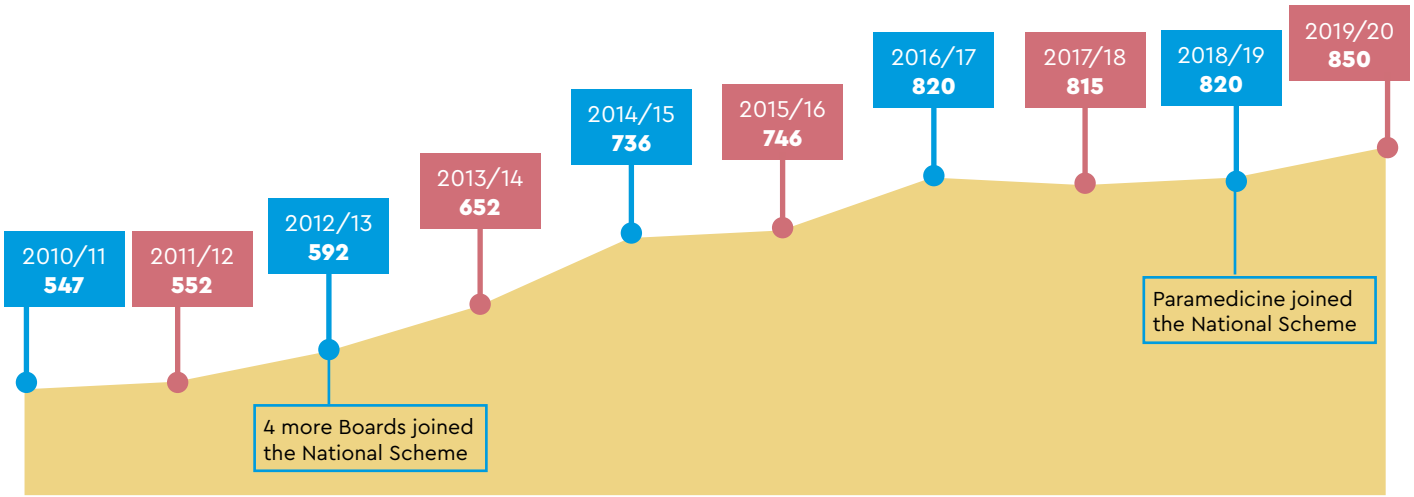
Australia's future health workforce is dependent on current students maintaining access to a range of opportunities to build these capabilities. Their timely graduation and registration is critical to workforce sustainability.

To comply with social distancing requirements, in the early stages of the COVID-19 pandemic many universities and education providers moved quickly to close campuses and move to online course delivery. Simultaneously, some health services cancelled clinical placements while public health restrictions prevented others taking place. Ahpra received a high volume of questions from education providers and health services about the impacts of the pandemic on clinical education, students expecting to graduate in 2020 and the future health workforce supply.

Accreditation authorities, National Boards and Ahpra had to move quickly to clarify how our existing accreditation standards enabled flexibility in the ways clinical education requirements could be achieved. We did this through a unique multi-sector collaboration to protect Australia's future health workforce. This approach enabled many students to continue their studies and graduate to become health practitioners during the COVID-19 pandemic.

The Australian Government, through the health and education portfolios, Ahpra, National Boards and accreditation authorities, issued national principles for clinical education to encourage and support student placements to continue where this is safe and possible. See www.ahpra.gov.au/news/covid-19/national-principles-for-clinical-education-during-covid-19.

Figure 96. Number of accredited courses, year by year, since the National Scheme began



Registration – who is on the register

Registration

Snapshot

- **A new pandemic response sub-register** was rapidly launched to meet the surge workforce needs of Australia's healthcare system in response to the COVID-19 pandemic
- **801,659 health practitioners across all 16 professions were registered,** including the practitioners on the pandemic response sub-register (up 7.7% from 2018/19); without the inclusion of practitioners on the pandemic response sub-register, 769,430 health practitioners across all professions were registered (up 3.4% from 2018/19)
- **There was a 12.5% decrease in new applications for registration – 81,437 received,** this was largely due to the increased number of registration applications for the new profession of paramedicine in 2018/19
- **The time to decide the outcome of an application was reduced:**
  - median time of four days (eight days in 2018/19)
  - average of 19 days (24 days in 2018/19)
- **We finalised 82,520 applications for registration**
- **38,938 new applications were from new graduates**, including nearly 22,000 applying for registration as a nurse[1]
- **We completed 2,099 audits of compliance with registration standards**
- **99.4% of all eligible practitioners renewed their registration online**

Register of practitioners

Our online *Register of practitioners* (see www.ahpra.gov.au/registration/registers-of-practitioners) has accurate, up-to-date information about the registration status of all registered health practitioners in Australia. As decisions are made about a practitioner's registration/renewal or disciplinary proceedings, the register is updated to inform the public of the current status of individual practitioners and any restrictions placed upon their registration.

Tribunal decisions (see www.ahpra.gov.au/publications/tribunal-decisions) that result in the cancellation of a practitioner's registration due to impairment, performance or conduct issues result in the individual appearing on a *Register of cancelled practitioners* (see www.ahpra.gov.au/Registration/registers-of-practitioners/cancelled-health-practitioners).

In 2018, National Boards decided to publish links to adverse tribunal (disciplinary) decisions and court outcomes on a practitioner's record on the national register. This decision was in line with a recommendation made by Professor Paterson in the *Independent review of the use of chaperones to protect patients in Australia*. Links are included for all adverse disciplinary decisions and court outcomes relating to a registered practitioner if the decision is already public and the name of the practitioner has not been suppressed by the court or tribunal.

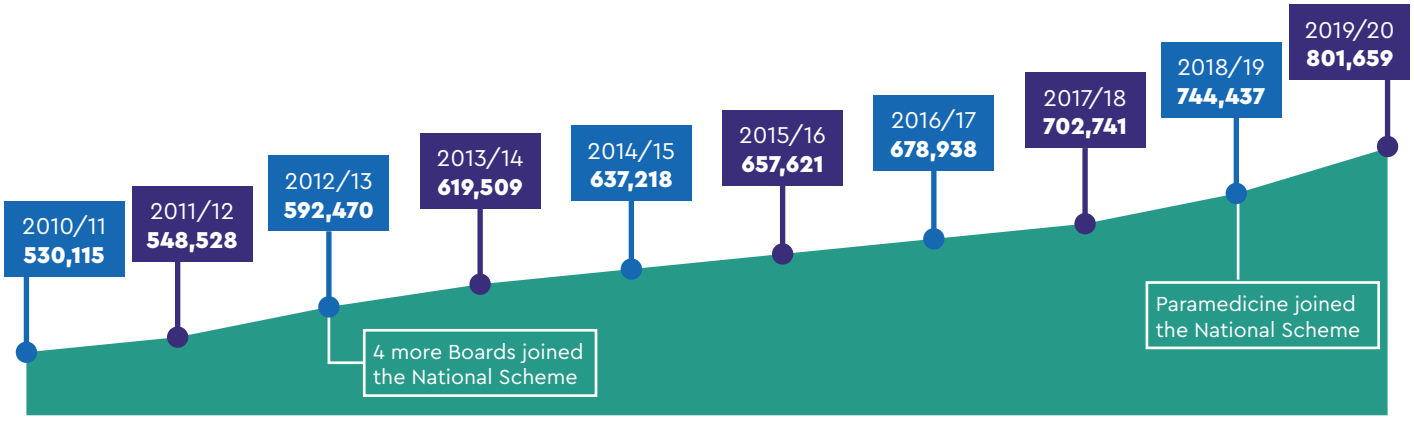
Registered practitioners

The number of registered health practitioners grew by 7.7% this year, to 801,659 (see Table 4). This is an increase compared to the 5.9% growth experienced in 2018/19.

The higher growth this year is due to the inclusion of 35,099 health practitioners on the COVID-19 pandemic response sub-register launched on 6 April. To understand the impact of the sub-register on registration trends, Table 4A shows the number of health practitioners by profession, excluding practitioners on the pandemic response sub-register, and noting that some health practitioners are registered in more than one health profession. Without the practitioners on the pandemic response sub-register, 769,430 health practitioners across all professions were registered at 30 June. This is an annual increase of 3.4% and consistent with trends since the scheme began in July 2010 (see Figure 97).

Of the registrant base, 98.1% hold some form of practising registration. There are 77,755 dental practitioners, medical practitioners and podiatrists who hold specialist registration in an approved specialty (9.7% of total registrants). In addition, 23,039 practitioners hold endorsement to extend their scope of practice in a particular area because they have an additional qualification that is approved by the National Board (2.9% of total registrants). For more information, visit Ahpra's website, choose the relevant National Board, then click the 'Registration' tab.

Figure 97. Registration numbers, year by year, since the National Scheme began



1 In 2018/19 we incorrectly reported 36,468 new applications were from new graduates. The correct number is 38,468.

Table 4. Registered practitioners by profession and principal place of practice, at 30 June 2020[1]

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]	Total 2019/20[1]	Total 2018/19	% change 2018/19–2019/20
Aboriginal and Torres Strait Islander Health Practitioner	2	179	220	149	69	4	29	160		**812**	**690**	**17.7%**
Chinese medicine practitioner	74	1,989	13	896	195	44	1,325	258	127	**4,921**	**4,892**	**0.6%**
Chiropractor	68	1,886	30	921	371	62	1,543	706	190	**5,777**	**5,550**	**4.1%**
Dental practitioner	441	7,272	162	4,980	2,024	395	5,741	2,791	600	**24,406**	**23,730**	**2.8%**
Medical practitioner	2,365	38,003	1,455	25,320	8,898	2,661	31,229	12,627	3,083	**125,641**	**118,996**	**5.6%**
Medical radiation practitioner	325	6,025	142	3,736	1,399	373	4,423	1,548	272	**18,243**	**16,683**	**9.4%**
Midwife	196	1,506	98	1,395	744	54	1,608	496	212	**6,309**	**5,727**	**10.2%**
Nurse	6,797	112,094	4,580	84,573	34,943	10,005	110,488	40,335	11,618	**415,433**	**383,509**	**8.3%**
Nurse and midwife[3]	545	8,300	500	6,187	2,015	678	8,149	3,063	299	**29,736**	**27,707**	**7.3%**
Occupational therapist	398	6,643	199	4,759	1,858	341	6,179	3,271	349	**23,997**	**22,412**	**7.1%**
Optometrist	98	2,001	39	1,209	371	111	1,604	457	153	**6,043**	**5,781**	**4.5%**
Osteopath	46	607	6	240	43	50	1,640	70	51	**2,753**	**2,546**	**8.1%**
Paramedic	287	5,089	197	5,188	1,338	509	5,751	1,233	246	**19,838**	**17,323**	**14.5%**
Pharmacist	683	10,335	287	6,899	2,412	860	8,821	3,641	574	**34,512**	**31,955**	**8.0%**
Physiotherapist	734	10,850	225	7,044	2,909	568	9,198	4,277	1,308	**37,113**	**33,792**	**9.8%**
Podiatrist[4]	73	1,565	27	985	501	115	1,778	492	72	**5,608**	**5,361**	**4.6%**
Psychologist	1,077	13,186	265	7,332	1,957	710	11,224	4,143	623	**40,517**	**37,783**	**7.2%**
Total 2019/20	**14,209**	**227,530**	**8,445**	**161,813**	**62,047**	**17,540**	**210,730**	**79,568**	**19,777**	**801,659**		**7.7%**
Total 2018/19	**13,045**	**212,207**	**7,899**	**149,516**	**57,784**	**16,202**	**194,693**	**73,647**	**19,444**		**744,437**	

1. 2019/20 data include practitioners registered on the temporary pandemic sub-register created in response to the COVID-19 pandemic.
2. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
3. Registrants who hold dual registration as both a nurse and a midwife.
4. Throughout this report, the term 'podiatrist' refers to both podiatrists and podiatric surgeons unless otherwise specified.

Table 4A. Registered practitioners by profession and principal place of practice (excluding pandemic response registrants), at 30 June 2020

Profession	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[1]	Total 2019/20	Total 2018/19	% change 2018/19–2019/20
Aboriginal and Torres Strait Islander Health Practitioner	2	174	218	146	68	4	28	151		**791**	**690**	**14.6%**
Chinese medicine practitioner	74	1,989	13	896	195	44	1,325	258	127	**4,921**	**4,892**	**0.6%**
Chiropractor	68	1,886	30	921	371	62	1,543	706	190	**5,777**	**5,550**	**4.1%**
Dental practitioner	441	7,272	162	4,980	2,024	395	5,741	2,791	600	**24,406**	**23,730**	**2.8%**
Medical practitioner	2,304	36,998	1,427	24,636	8,629	2,582	30,427	12,170	3,076	**122,249**	**118,996**	**2.7%**
Medical radiation practitioner	302	5,662	132	3,519	1,312	353	4,147	1,436	271	**17,134**	**16,683**	**2.7%**
Midwife	195	1,484	91	1,376	721	52	1,582	480	212	**6,193**	**5,727**	**8.1%**
Nurse	6,500	106,897	4,408	80,691	33,132	9,562	105,312	38,338	11,614	**396,454**	**383,509**	**3.4%**
Nurse and midwife[2]	490	7,415	460	5,580	1,743	615	7,490	2,794	294	**26,881**	**27,707**	**-3.0%**
Occupational therapist	398	6,643	199	4,759	1,858	341	6,179	3,271	349	**23,997**	**22,412**	**7.1%**
Optometrist	98	2,001	39	1,209	371	111	1,604	457	153	**6,043**	**5,781**	**4.5%**
Osteopath	46	607	6	240	43	50	1,640	70	51	**2,753**	**2,546**	**8.1%**
Paramedic	287	5,089	197	5,188	1,338	509	5,751	1,233	246	**19,838**	**17,323**	**14.5%**
Pharmacist	645	9,685	277	6,465	2,275	813	8,379	3,447	573	**32,559**	**31,955**	**1.9%**
Physiotherapist	699	10,192	210	6,667	2,755	537	8,688	3,988	1,305	**35,041**	**33,792**	**3.7%**
Podiatrist[3]	73	1,565	27	985	501	115	1,778	492	72	**5,608**	**5,361**	**4.6%**
Psychologist	1,027	12,552	255	7,025	1,864	660	10,802	3,977	623	**38,785**	**37,783**	**2.7%**
Total 2019/20	**13,649**	**218,111**	**8,151**	**155,283**	**59,200**	**16,805**	**202,416**	**76,059**	**19,756**	**769,430**		**3.4%**
Total 2018/19	**13,045**	**212,207**	**7,899**	**149,516**	**57,784**	**16,202**	**194,693**	**73,647**	**19,444**		**744,437**	

1. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
2. Registrants who hold dual registration as both a nurse and a midwife.
3. Throughout this report, the term 'podiatrist' refers to both podiatrists and podiatric surgeons unless otherwise specified

Aboriginal and Torres Strait Islander health workforce

Ahpra and the National Boards are committed to closing the gap in health outcomes between Aboriginal and Torres Strait Islander Peoples and other Australians. To help support workforce policy and planning, Ahpra and the National Boards facilitate the collection of data on the number of registered health practitioners who identify as Aboriginal and/or Torres Strait Islander.

This year, Aboriginal and/or Torres Strait Islander participation across the regulated health professions was 1.0% (see Table 5), which is the same as last year but well short of the 3.3% Aboriginal and Torres Strait Islander representation in the general population. Increasing participation in the registered health workforce is one of the goals of the *Aboriginal and Torres Strait Islander health and cultural safety strategy* (www.ahpra.gov.au/about-ahpra/aboriginal-and-torres-strait-islander-health-strategy).

All registrants in the Aboriginal and Torres Strait Islander Health Practice profession identified as being Aboriginal and/or Torres Strait Islander (it is a requirement for registration in that profession). The profession with the second highest representation was paramedicine, which had 1.6% of their workforce identifying as Aboriginal and/or Torres Strait Islander, followed by nursing and midwifery with 1.3%.

To find out more about the work Ahpra and the National Boards are doing to support health equity for all Australians, see pages 12–13 and 98.

Student registration

Under the National Law, a National Board must decide whether students who are enrolled in an approved program of study or doing clinical training should be registered. A student does not need to apply for registration, as education providers are responsible for arranging the registration of all their students with Ahpra. The student register is not public. All National Boards have decided to register students, except for the Psychology Board of Australia, which requires provisional registration. See Table 6.

The accuracy of the student registration information Ahpra receives depends on the quality of data supplied to us by education providers. We continue to work with more than 130 education providers to improve the exchange of information and identify the status of students to ensure that information is accurate, particularly about students who may have completed or ceased their study.

Table 5. Health practitioners who identified as being Aboriginal and/or Torres Strait Islander, 2014 to 2019

Profession[1]	2014 registrants	%	2015 registrants	%	2016 registrants	%	2017 registrants	%	2018 registrants	%	2019 registrants	%
Aboriginal and Torres Strait Islander Health Practitioner[2]	322	100.0%	514	100.0%	549	100.0%	584	100.0%	647	100.0%	670	100.0%
Chinese medicine practitioner	17	0.4%	17	0.3%	17	0.3%	25	0.5%	23	0.4%	23	0.4%
Chiropractor	17	0.4%	19	0.4%	19	0.4%	15	0.3%	21	0.4%	21	0.4%
Dental practitioner	68	0.3%	73	0.3%	79	0.4%	98	0.4%	108	0.5%	121	0.5%
Medical practitioner	283	0.3%	302	0.3%	348	0.3%	399	0.4%	467	0.4%	519	0.4%
Medical radiation practitioner	49	0.3%	64	0.4%	60	0.4%	80	0.5%	95	0.6%	114	0.7%
Nurse and midwife	3,196	0.9%	3,428	1.0%	3,740	1.0%	4,136	1.1%	4,707	1.2%	5,094	1.3%
Occupational therapist	67	0.4%	76	0.4%	77	0.4%	89	0.4%	111	0.5%	137	0.6%
Optometrist	5	0.1%	16	0.3%	13	0.3%	11	0.2%	7	0.1%	12	0.2%
Osteopath	11	0.6%	16	0.8%	15	0.7%	17	0.7%	16	0.7%	18	0.7%
Paramedic											287	1.6%
Pharmacist	59	0.2%	68	0.2%	73	0.2%	79	0.3%	80	0.3%	98	0.3%
Physiotherapist	123	0.5%	142	0.5%	157	0.5%	191	0.6%	213	0.7%	239	0.7%
Podiatrist	66	1.5%	30	0.7%	35	0.7%	30	0.6%	30	0.6%	38	0.7%
Psychologist	142	0.5%	167	0.5%	192	0.6%	199	0.6%	218	0.6%	246	0.7%
Total and percentage of overall health workforce[3]	**4,425**	**0.7%**	**4,932**	**0.8%**	**5,374**	**0.8%**	**5,953**	**0.9%**	**6,743**	**1.0%**	**7,637**	**1.0%**

Source: National Health Workforce Data Set (NHWDS) medical practitioners data 2014–19, NHWDS nursing and midwifery data 2014–19, NHWDS allied health data 2014–19

1. Data shown in this table represent those practitioners who identified themselves as being born in Australia and Aboriginal and/or Torres Strait Islander in a workforce survey conducted at the time of renewal of registration.
2. The Aboriginal and Torres Strait Islander Health Practitioners number in Table 5 is different from Table 4 due to the point in time at which the data were extracted.
3. The workforce survey has very high response rates, making it a good source of information on the participation of Aboriginal and Torres Strait Islanders in the health workforce. However, accuracy is not guaranteed due to the survey's voluntary nature. A small number of these practitioners will hold dual registration and may be counted twice.

Table 6. Student registration numbers in 2019/20

Students by profession[1]	Approved program of study[2] students by expected completion date	Clinical training[3] students by expected completion date	Total 2019/20[4]	Total 2018/19
Aboriginal and Torres Strait Islander Health Practice	476	72	**548**	**396**
Chinese medicine	1,556		**1,556**	**1,434**
Chiropractic	2,136	11	**2,147**	**2,346**
Dental	4,416		**4,416**	**4,204**
Medical	22,062	353	**22,415**	**22,540**
Medical radiation practice	5,341	329	**5,670**	**4,906**
Midwifery[5]	4,135		**4,135**	**4,065**
Nursing[5]	111,123	623	**111,746**	**104,137**
Occupational therapy	9,843		**9,843**	**9,361**
Optometry	1,645	101	**1,746**	**2,142**
Osteopathy	1,885		**1,885**	**1,843**
Paramedicine[5]	9,026		**9,026**	**7,920**
Pharmacy	7,137	10	**7,147**	**6,820**
Physiotherapy	9,950	217	**10,167**	**9,188**
Podiatry	1,353		**1,353**	**1,355**
Total 2019/20	**192,084[6]**	**1,716**	**193,800**	
Total 2018/19	**180,889**	**1,768**		**182,657**

1. Student figures are based on the number of students reported as undertaking an approved program of study/clinical training program within the relevant financial year (accurate at 1 July 2020 and does not account for fluctuations throughout the financial year). 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. Approved programs of study refer to those students enrolled in a course that has been approved by a National Board and that leads to a qualification for registration. These courses can be found on our website: www.ahpra.gov.au/accreditation/approved-programs-of-study.
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, the 2019/20 data should not be objectively compared to those of previous years.
5. To avoid double-counting, there were 3,730 students undertaking an approved double degree involving more than one profession (nursing/midwifery and nursing/paramedicine) that have only been assigned to a single profession (nursing [1,992]/midwifery [186] and nursing [1,469]/paramedicine [83]).
6. 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.

New applications

Ahpra receives applications for registration on behalf of the National Boards. Before a practitioner can practise and use a title protected under the National Law, applicants must provide evidence that they are eligible to hold registration, and registration must be granted. The health practitioners on the pandemic response sub-register were not required to make a new application for registration as they were returned to the register automatically if they met the specified criteria and did not opt out.[1]

This year, Ahpra received 81,437 applications, down 12.5% from 2018/19. We anticipated this reduction because, in the previous year, a large number of applicants applied for registration in the new nationally regulated health profession of paramedicine. In nearly all professions the number of new applications for registration increased this year. Of all practitioners applying for registration, 91.8% (74,792 applicants) sought practising registration. As a percentage of all applications received, there was a 4.4% increase in practitioners applying for non-practising registration when compared with last year (see 'Registration type' in the *Glossary*).

Ahpra made improvements to how people can apply for registration and now accepts online applications from:

- new graduates
- practitioners holding general registration who are applying for non-practising registration
- practitioners applying under the *Trans-Tasman Mutual Recognition Act 1997*.

Online applications not only improve the applicant experience, they also reduce the amount of manual data entry by staff to capture application details and contribute to improved timeliness of assessment processes.

Outcomes for applications finalised

In partnership with the National Boards, we consider every application for registration carefully and assess it against requirements for registration set by each Board. Only those practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. Where appropriate to protect the public, and in accordance with the regulatory principles of the National Scheme, National Boards may decide to impose conditions on a practitioner's registration or refuse the application entirely.

There were 82,520 decisions made about applications for registration. Of these, 5.2% resulted in conditions being imposed on a practitioner's registration, or a refusal of registration, in the public interest. See Table 8.

New assessment for internationally qualified nurses and midwives

In March, the assessment of internationally qualified nurses and midwives (IQNM) changed according to the new model approved by the Nursing and Midwifery Board of Australia described on pages 12 and 30. The new process allows a nurse or midwife to determine, through a self-assessment process before lodging their application for registration, whether they may be eligible for registration.

The new model streamlines the IQNM registration application process. One of the main changes is that some candidates will be required to pass a multiple-choice examination and a behavioural component in the form of an objective structured clinical examination (OSCE), before applying for registration. These changes may result in the number of unsuccessful applications for registration received from IQNMs reducing.

The new assessment model and its implementation has been a significant piece of work over several years involving Ahpra staff and the Nursing and Midwifery Board of Australia working together.

1 Except Aboriginal and Torres Strait Islander Health Practitioners who opted in.

Examinations

Ahpra holds examinations to support the registration requirements of the Pharmacy Board of Australia, the Psychology Board of Australia and the Medical Radiation Practice Board of Australia. The examinations held were:

Pharmacy Board of Australia

Ahpra administered the oral examination (practice) in October, February and June. Examiners assessed 1,777 candidates (pharmacy interns). Another 63 oral exam sessions were held throughout the year for practitioners holding limited or general registration with conditions on their registration requiring the completion of an examination in practice, or law and ethics.

Due to COVID-19, significant changes were made to the delivery of the exams in June. The exams are normally held face-to-face with examiner pharmacists in locations in each state and territory. With less than eight weeks' lead time, the Pharmacy Board of Australia and Ahpra developed a model that enabled the exams to be held using virtual technology with everyone participating from home or their own location. Over the course of two days, 210 exam sessions were held.

Psychology Board of Australia

A total of 873 candidates sat the national psychology examination. This exam is held quarterly at test centres in each capital city. Due to COVID-19, the exam in the last quarter was held via online supervision with each candidate being responsible for sourcing a suitable location to sit the exam.

Medical Radiation Practice Board of Australia

In total 53 candidates sat the national medical radiation practice examination. This exam is held quarterly at test centres in each capital city. The exam in the last quarter was held via online supervision with each candidate being responsible for sourcing a suitable location to sit the exam.

Criminal history checks

Ahpra received the results of 77,677 domestic and international criminal record checks of practitioners and/or applicants for registration this year, a decrease of 19.2% since 2018/19 (see Table 7). A reduction was anticipated because, in the previous year, there was a large number of applicants applying for registration in paramedicine.

Overall, 4.0% of the results indicated that the applicant had a disclosable court outcome. All disclosable court outcomes are assessed in accordance with the *Criminal history registration standard*, which is common across all 15 National Boards. See www.ahpra.gov.au/registration/registration-standards/criminal-history.

Usually an applicant is granted registration if they meet all other registration requirements and the nature of an individual's disclosable court outcome has little relevance to their ability to practise safely and competently. However, registration may be refused, or regulatory action may be taken to restrict registration, if an applicant's criminal history indicates this is necessary to protect the public. This year, having considered a disclosable court outcome:

- one applicant had conditions imposed on their registration; compliance with the conditions is subject to ongoing monitoring by Ahpra
- one applicant was refused registration based on their disclosable court outcome.

How we check criminal history

Under the National Law, applicants for initial registration must undergo criminal history checks. Applicants seeking registration must disclose any criminal history information when they apply for registration, and practitioners renewing their registration are required to disclose if there has been a change to their criminal history status in the preceding 12 months.

International applicants seeking registration in Australia and certain registered health practitioners, including those registered under Trans-Tasman Mutual Recognition arrangements, need to obtain an independent international criminal history check from an Ahpra-approved supplier, who will provide the report to the applicant as well as directly to us. A check is required when an applicant or practitioner declares an international criminal history and/or has lived, or been primarily based, in any country other than Australia for six consecutive months or more, when aged 18 years or over. Ahpra may also seek a report from a police commissioner or an entity in a jurisdiction outside Australia that has access to records about the criminal history of people in that jurisdiction. Criminal history reports are one part of our assessment of an applicant's suitability to hold registration.

To check the criminal history of local applicants, Ahpra has an agreement with the Australian Criminal Intelligence Commission (ACIC) to conduct criminal history checks through their National Police Checking Service Support System (NSS).

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

Table 7. Domestic and international criminal history checks, and disclosable court outcomes, by state or territory

State/territory[1]	2019/20		2018/19	
	Number of criminal history checks[2]	Number of disclosable court outcomes	Number of criminal history checks[2]	Number of disclosable court outcomes
ACT	1,345	41	1,616	72
NSW	20,559	851	24,936	1,389
NT	836	43	1,060	79
QLD	13,736	632	18,762	1,088
SA	5,511	287	6,517	425
TAS[3]	1,344	330	1,769	619
VIC	19,526	493	24,346	792
WA	7,194	414	8,340	638
No PPP[4]	7,626	40	8,778	42
Total 2019/20	**77,677**	**3,131**		
Total 2018/19			**96,124**	**5,144**

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.

Renewing registration

Once on the register, health practitioners must apply to renew their registration each year. When applying to renew registration, practitioners are required to make a series of declarations and, in particular, to disclose to the Board if there are any issues which may affect their continued eligibility or suitability for registration (known as adverse disclosures).

There are three main annual renewal periods, with limited and provisional registration falling outside these times:

- nurses and midwives by 31 May
- medical practitioners by 30 September
- other health practitioners by 30 November.

Ahpra renewed registration for 693,751 practitioners across Australia. As with new applications for registration, National Boards may impose conditions on a practitioner's registration or refuse renewal entirely.

Online renewal was once again widely accepted, with 99.4% of all eligible practitioners renewing their registration online (29,476 more practitioners renewed online in comparison to last year). Online renewals as a percentage of all renewals increased by 0.2%. This is attributed to both renewal campaign improvements and the take-up by new graduates who engage with online registration processes when they are first registered.

Table 8. Applications finalised in 2019/20, by profession and outcome

Profession	Register	Register with conditions	Refuse application[1]	Withdrawn[2]	Total 2019/20	Total 2018/19
Aboriginal and Torres Strait Islander Health Practitioner	205	1		32	**238**	**144**
Chinese medicine practitioner	464	41	24	80	**609**	**640**
Chiropractor	429	6	2	15	**452**	**394**
Dental practitioner	1,617	23	12	64	**1,716**	**1,635**
Medical practitioner	16,439	277	26	772	**17,514**	**16,999**
Medical radiation practitioner	1,474	20	18	109	**1,621**	**1,529**
Midwife	1,819	22	14	200	**2,055**	**1,878**
Nurse	32,343	792	2,579	2,558	**38,272**	**35,588**
Occupational therapist	2,430	80	7	60	**2,577**	**2,461**
Optometrist	393	3		7	**403**	**392**
Osteopath	317	4		9	**330**	**274**
Paramedic	3,027	173	17	265	**3,482**	**17,430**
Pharmacist	3,419	56	3	110	**3,588**	**3,396**
Physiotherapist	3,295	29	7	183	**3,514**	**3,602**
Podiatrist	446	4		14	**464**	**436**
Psychologist	5,424	43	4	214	**5,685**	**5,344**
Total 2019/20	**73,541**	**1,574**	**2,713**	**4,692**	**82,520**	
Total 2018/19	**83,048**	**1,157**	**4,214**	**3,723**		**92,142**

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.

End-of-year new graduate campaign

The peak registration period for new graduates qualifying at the end of a calendar year is from 1 October to 31 March annually. During that period, we received 29,094 new graduate applications for registration (a significant 12.5% increase from the previous year). Of the new graduate applications received, 97.7% were made online.

To assist end-of-year new graduates to register, we initiated a communication campaign and identified appropriate pathways for key stakeholders to escalate urgent matters. We refreshed website information and developed fact sheets to help applicants understand the assessment process and avoid common mistakes. As the Australian Criminal Intelligence Commission strengthened its requirements for certifying identity documents, we developed communication materials to help new graduates and other stakeholders to understand the new requirements. These identity documents must be submitted correctly for us to conduct the required criminal history checks to satisfy eligibility requirements.

There have been some significant improvements to the average time taken to decide the outcome of an application from a graduate when compared to the previous year. The average time taken to decide the application, typically on receipt of a graduate list from education providers confirming qualification, was reduced to 10 days (down from 19 days in 2018/19). The average time to decide the outcome of the application from the date *received* by Ahpra was also reduced to 42 days (down from 61 days in 2018/19).

These improvements were the result of using dedicated staff during the new graduate campaign period and changing processes to support prompt communications with applicants to follow up any outstanding information needed to complete the application.

Ahpra also conducted the first ever 'applicant experience' survey of end-of-year new graduates, with 24,212 graduates invited to participate in the voluntary survey and a participation rate of 15.8% (3,834 respondents). Overall the feedback was positive with almost 80% of respondents satisfied with how their application was managed.

Most respondents commented favourably on the timeliness of their assessment, felt they were generally well informed about their application status, had positive interactions with our Customer Service team and found the process and website easy to understand. Those who reported a less positive experience have provided valuable feedback on areas we can improve, for example communication processes, which have been incorporated into the planning approach for the 2020/21 new graduate campaign.

Renewals process improvements

During the nursing and midwifery renewal campaign, we made improvements to our application forms to help explain to practitioners when an adverse disclosure needs to be made. We also implemented a triage system to review adverse disclosures received from practitioners. This allowed us to identify high-risk applications needing further assessment, in contrast to low-risk applications that could be renewed without delay.

This year we will continue the work to help practitioners understand what they do and don't need to tell us and why.

Practitioner Information Exchange

Practitioner Information Exchange (PIE) is a secure web-based system providing information to employers about the registration of the health practitioners they employ, including any restrictions that a Board might have placed on their registration.

As governments have embarked on a digital transformation, we have seen a significant increase in government agencies accessing PIE services. These range from large-scale customisations of PIE to support initiatives such as National Real Time Prescription Monitoring, to smaller projects supporting the validation of health practitioner credentials.

This year, there were 127 subscribers to the PIE service from government departments, public and private hospitals, healthcare businesses, pharmaceutical companies, medical insurers, and nursing and aged care agencies. For more information on PIE, see www.ahpra.gov.au/registration/employer-services/practitioner-information-exchange.

Practitioner audits

Auditing compliance

Ahpra conducts regular audits of compliance with registration standards by health practitioners, on behalf of the National Boards. Audits provide assurance that practitioners understand the registration standards for their profession and are meeting these obligations.

On a random schedule, Ahpra completed 2,099 audits of practitioners across all professions, excluding paramedics due to their relatively recent inclusion in the National Scheme. Of the completed audits, 91.0% of practitioners were found to be in full compliance with the registration standards being audited.

Since we began conducting audits in 2012, most practitioners audited have been found to comply with registration standards. About 3.1% of those audited elected to surrender their registration, failed to renew their registration or changed their registration type to non-practising. Analysis of the circumstances of those practitioners demonstrates two clear groups: practitioners residing overseas, and those no longer practising but maintaining registration.

We analysed the audit outcomes to better understand why non-compliance occurs. In some professions, practitioners were not always fully aware of specific requirements for continuing professional development. This continues to be addressed through increased communication about what is required to comply with professional development standards.

How our audit process works

Registered practitioners are required to comply with a range of national registration standards. Each time a practitioner applies to renew their registration they must make a declaration that they have met the standards for their profession. Our auditing provides additional assurance to the public, Boards and practitioners that the requirements of the National Law are understood and that practitioners are compliant with their Board's standards. During an audit, a practitioner is required to provide evidence to support the declarations made in the previous year's renewal of registration.

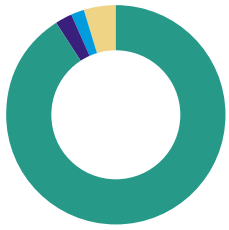
The standards that may be audited are:

- 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 with the audit standards.

Practitioners who are found to have not quite met the registration standard, but 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)'. This contingent represented 2.5% of completed audits. See Figure 98.

Figure 98. Audit outcomes for 2019/20



- **91.0%** compliant: fully compliant with the registration standards
- **2.5%** compliant (education): compliant through education in one or more standards
- **1.9%** non-compliant: non-compliant with one or more standards
- **4.6%** no audit action required by the National Board: 3.1% of practitioners changed their registration type to non-practising, elected to surrender their registration or failed to renew their registration; 1.1% of practitioners were referred to a co-regulatory jurisdiction to manage the matter due to suspected non-compliance in a jurisdiction where a National Board does not have power to take action outside an application for registration or renewal of registration; and 0.4% related to Board decisions to grant exemptions, in extenuating circumstances.

Non-compliance with 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 of the intended action and gives them an opportunity to respond before a decision is made.

Of the practitioners found to be non-compliant, 74.4% of cases resulted in some form of regulatory action being taken (such as cautions and imposition of conditions). For 25.6%, the result was no further action. In these matters, further information was received from the practitioner that identified that there was no risk to the public that would warrant regulatory action being taken.

COVID-19's effect on registration

Like most Australian organisations, the sudden restrictions on people movement and social distancing requirements had a significant effect on Ahpra. There are over 300 people in the Registration team alone and it took two weeks to set up all staff to work from home effectively. This was a considerable achievement allowing us to provide seamless customer service, maintain productivity and, where required, introduce necessary process changes.

Setting up the pandemic sub-register

Ahpra established a short-term pandemic response sub-register to fast track the return to the workforce of experienced and qualified health practitioners. The sub-register enabled doctors, nurses, midwives and pharmacists who had previously held general or specialist registration and left the *Register of practitioners* or moved to non-practising registration in the past three years to return to practice. Only those who were properly qualified, competent and suitable were returned to the register.

The sub-register was launched on 6 April and will remain in place for up to 12 months. Over 40,000 practitioners who met the criteria were contacted to alert them that they would be added to the sub-register. There was no obligation for anyone added to practise or remain on it. Practitioners can opt out at any time, for any reason.

On 16 April, further health professions were added to prepare for any surge in workforce demand resulting from COVID-19. Around 5,000 physiotherapists, psychologists and diagnostic radiographers were added from 20 April.

A third phase has begun with 180 Aboriginal and Torres Strait Islander Health Practitioners contacted and given the opportunity to opt in (as opposed to opt out). At 30 June, 20 practitioners had registered their interest and were joining the sub-register on 1 July 2020.

Enabling an online upload service

Due to the pandemic our state and territory offices were temporarily closed to the public. As a result, it was essential to find a way to help people lodge their applications online, and make sure Ahpra staff working from home could receive and process application forms electronically.

From 27 March, applicants and registered health practitioners were given access to an online upload service that allows them to submit applications and other forms with supporting documents. This significantly reduced hardcopy submissions, enabling practitioners to join the healthcare workforce sooner by reducing the time required to mail and process information. Applicants, registered health practitioners and external stakeholders were advised of the availability of the online upload service via Ahpra and National Board websites, social media posts and emails to major stakeholders.

Changes to presenting requirement

When we closed the Ahpra offices in each state and territory in late March, we were not sure how many eligible applicants arrived in Australia before our borders were closed. It was important to introduce interim measures quickly to replace the requirement for people to attend in person at an Ahpra office to have their identity verified.

We worked with health service providers to find a solution. To enable people to join the workforce quickly, overseas applicants who hold current in-principle approval of registration are now able to present in person at their intended place of employment in Australia rather than to an Ahpra office to have their identity verified and identity documents certified by a registered health practitioner. That practitioner or other employee at the intended place of employment then submits a copy of the documents to Ahpra via email for final assessment.

> *'It was like déjà vu in our 10th year of the scheme – the pulling together and collective wisdom of senior staff to get the pandemic sub-register up and running was like the first weeks in 2010, meetings every day and then into the weekend – but we have got a lot faster and there was a real feeling that this was ours to own.'*
>
> National Director, Registration

Changes to arrivals of overseas graduates

Australia closed its borders on 20 March and this development appears to have contributed to a noticeable difference in the number of new registration applications received from overseas-qualified applicants. From 1 April to 30 June, Ahpra received 12.8% fewer applications (852) from overseas applicants with a medical qualification, in comparison to 977 applications in the same period last year.

The border restrictions have also prevented some overseas applicants holding current in-principle approval of registration to present in person at their intended place of employment to have their identity verified. As a result, from 1 April to 30 June, there was a 45.4% reduction in the number of finalised registration approvals (295) of overseas applicants with a medical qualification, in comparison to 540 approvals in the same period last year.

Countering these changes, in the same period we saw a 22.7% increase in the number of requests from international medical graduates (IMGs) with limited or provisional registration, working in Australia, to change their circumstances. A request for a change in circumstances is typically made when the IMG seeks a change to their approved employment and/or supervision arrangements. For the duration of the pandemic, the Medical Board of Australia has streamlined the process to enable IMGs who are working in hospitals to be redeployed more easily without a formal application to the Board. This change was made to ensure that IMGs are quickly available to work in the areas where the Australian health system needs them.

Nursing renewals and financial hardship

During the 2020 renewal period, nurses and midwives who self-assessed as meeting the following criteria were eligible to submit a financial hardship application:

- experiencing financial hardship, and
- not currently employed or able to work because of caring responsibilities or illness, and/or
- waiting for the outcome of an eligibility assessment for income support payments or other COVID-19 supplements from the Australian Government.

If financial hardship was determined, the nurse or midwife became eligible to pay the applicable registration fee in two instalments: the first at the time of making the application and the second within three months of the start of the registration period.

Approximately 180 financial hardship applications were received during the renewal period. A similar approach will be offered to other professions for registration renewal.

Notifications – when someone has a concern

Notifications

When someone becomes concerned about a registered health practitioner or student, they can let us know. Because they are notifying us, this is called *making a notification*.

Any person or entity can notify us when they have a concern about a registered health practitioner. Each year, National Boards and Ahpra work to improve the way we manage notifications.

We aim to continuously improve:

- the time that it takes us to manage notifications overall
- the experience of individuals who are involved in a notification
- the quality of our regulatory decision-making.

During 2019/20, Ahpra continued to carry out significant structural and process reforms. We:

- introduced a new risk-assessment approach across all professions in our scheme
- recruited clinical advisors across all professions in our scheme
- initiated an independent review of our management of sexual boundary notifications, to review progress after three years since a review into the practice of using chaperone restrictions
- implemented changes to the National Law about mandatory notifications and conducted a campaign to improve understanding of obligations among registered health practitioners
- started implementing COAG Health Council's *Policy direction 2019–1: Paramountcy of public protection when administering the National Scheme*
- published Ahpra's *Regulatory guide* to clearly and transparently explain our regulatory decision-making
- started acting on the recommendations of an independent review by the National Health Practitioner Ombudsman and Privacy Commissioner of the confidentiality safeguards for people making notifications
- engaged independent experts to advise us on ways our management of notifications could be linked to behavioural insights
- surveyed notifiers and practitioners about their experiences of our notifications process to inform and track improvements
- continued to improve our use of data during the notifications process.

What is a notification?

In the National Scheme, an individual or entity can notify us of their concern about a registered health practitioner or student. Increasingly, we contact people soon after they make a notification to ensure they have told us everything they think is important, to explain what we do and to help them to decide if they are in the right place for the concern they have raised.

Ahpra manages notifications in partnership with the National Boards (see Figure 100). Most of the notifications we receive about an individual practitioner's health, performance or conduct are managed through Part 8 of the National Law. Decisions made in response to a notification can affect a practitioner's registration.

When we receive a complaint about title protection, unlawful claims as to registration, restricted acts and advertising of regulated health services, these are treated differently under the National Law. Ahpra can prosecute individuals who commit any of the offences described in the National Law. For information about offences, see pages 85–87.

When a notification is made about a practitioner, we carry out a risk assessment about the practitioner. Our risk assessment includes:

- assessing the circumstances of the notification in relation to the practitioner's setting, context of practice and the relevant National Board's standards, codes and guidelines
- assessing historical regulatory data about the practitioner
- considering a range of 'risk controls' or protections, implemented by others, that operate to prevent harm to the public.

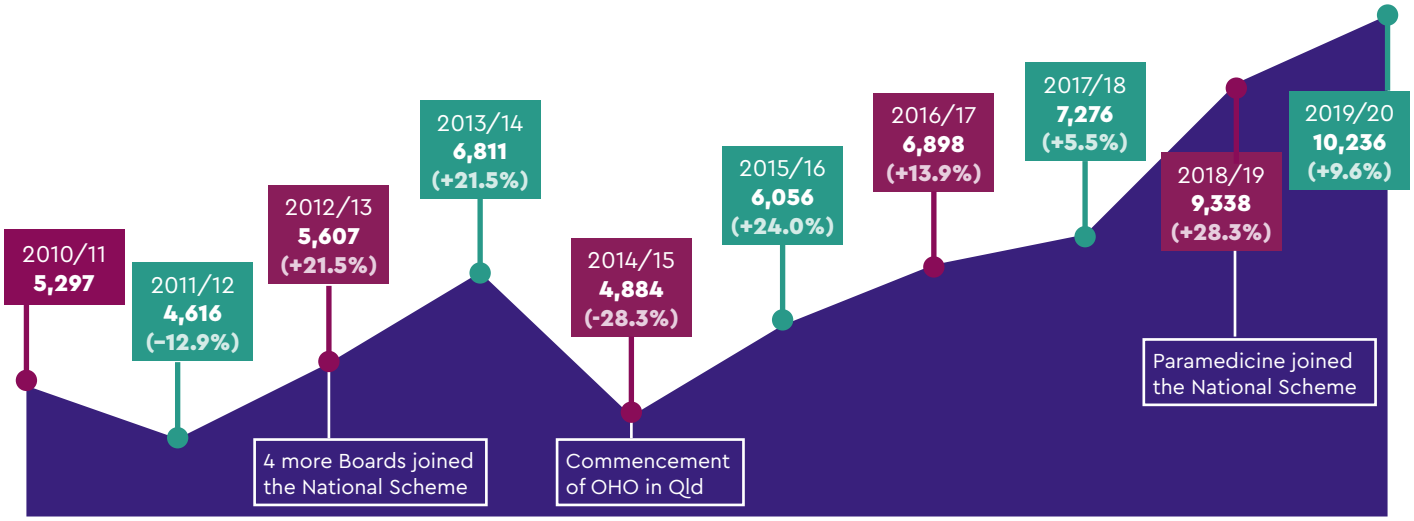
When this assessment indicates that there is a potential risk to the public, higher than the inherent risk associated with health practice, a National Board can act.

Snapshot

Compared to 2018/19, we:

- → **received 9.6% more** notifications
- → **received 4.0% fewer** (46 notifications) mandatory notifications
- → **received a similar percentage** (51.6% in 2019/20 and 52.3% in 2018/19) of notifications from patients, their families and friends, and other members of the public
- → **took immediate action 580 times** to protect public health or safety, which is 51.0% (196) more than in 2018/19 (noting that this higher rate of immediate action taken was more in line with longer term trends following a one-off decline in 2018/19)
- → **closed 70.2% of notifications following an assessment**; these notifications did not require an investigation beyond this assessment; this is up from 68.1% in 2018/19
- → **closed 3.5% more notifications**
- → **saw an increase** in the number of open investigations, health assessments and performance assessments by 16.6%
- → **saw an increase** in the proportion of notifications that have been open for longer than 12 months from 13.7% to 15.4%
- → **reduced the average time taken** to complete notifications overall by 5.3%
- → **reduced the average age** of open notifications by 7.5%
- → **received 1,858 responses** to our post-notification surveys, 60.0% of which were from practitioners.

Figure 99. Total notifications received by Ahpra, year by year, with percentage increase/decrease, since the National Scheme began



About our data

Ahpra does not manage all notifications made about health practitioners in Australia and our data reflect this. We report on only those notifications received and managed by Ahpra and the National Boards, unless otherwise stated.

The notification process is different in NSW and Queensland:

- In NSW, Ahpra does not manage notifications. They are managed by 15 health professions councils supported by the Health Professional Councils Authority (HPCA) and the Health Care Complaints Commission (HCCC).
- In Queensland, the Office of the Health Ombudsman (OHO) receives all complaints about health practitioners. It decides whether it will keep a complaint or refer it to a National Board and Ahpra to manage.

Wherever possible in the tables in this report, HPCA and OHO data are given in separate columns. These data are verified by the HPCA and OHO (correct at time of publication). Please refer to their annual reports on their websites, as data may have been subsequently reconciled.

Ahpra and OHO are committed to improving data sharing for annual reporting. This collaboration has resulted in increased representation of Queensland-related work throughout our notifications dataset. We thank the team at OHO for their ongoing collaboration.

As part of our continuous improvement, we refine our data collection and reporting each year. This means that data may not directly correlate across annual reports. For instance, since 2015/16, notifications data are based on the practitioner's principal place of practice (PPP). This is different to previous years, when data were captured based on the jurisdiction where a notification was received and managed.

For more information on how health complaints are managed in Australia, see page 14.

The 2019/20 data include practitioners registered on the temporary pandemic sub-register created in response to the COVID-19 pandemic. This affects some percentages.

Figure 100. How Ahpra and the National Boards manage complaints about health practitioners

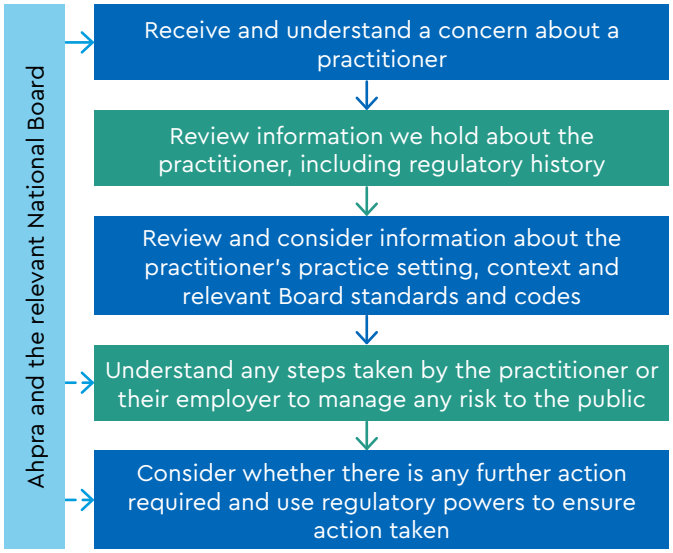


Figure 101. Who makes a complaint?

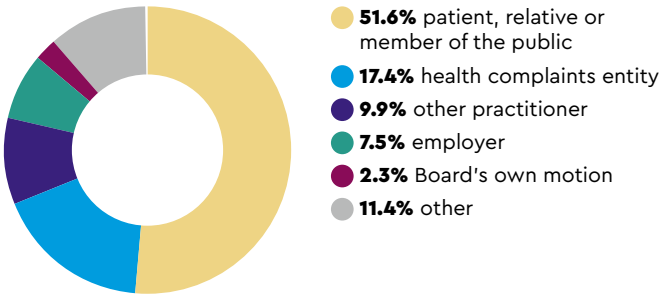
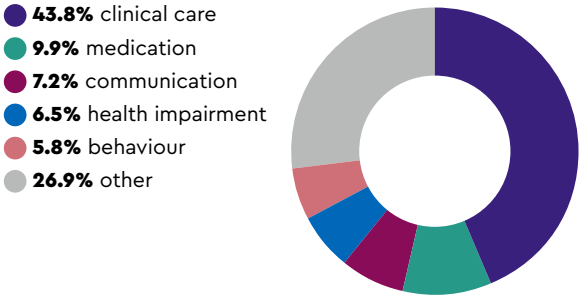


Figure 102. The most common types of complaint



Anyone can notify us of a concern they have about a registered practitioner's health, performance or conduct.

We receive most notifications (51.6%) from patients, their families and friends, and other members of the public.

We receive notifications (17.4%) from health practitioners and employers.

Registered health practitioners and employers have mandatory notification obligations. Mandatory notifications made up 10.8% of notifications received.

Employers and health practitioners can also make voluntary notifications about registered health practitioners.

Standards of clinical care continue to be the primary issue notified. The proportion of notifications that were made about this issue decreased by 2.5%. See Figure 102.

We receive notifications about students who are enrolled in programs of study that lead to eligibility for registration as a practitioner. Usually, these notifications are made by education providers or places at which students do clinical training because the student has an impairment and may place the public at substantial risk of harm. A National Board also receives notifications about students who have been charged with or convicted or found guilty of an offence punishable by 12 months' imprisonment or more. The number of notifications we received about students decreased. The proportion of the notifications that resulted in conditions or undertakings affecting the student's registration decreased by 3.7% compared to last year. See Tables 12 and 13 on page 73.

How we manage notifications

Every notification we receive is important. They provide us with a person's experience of engaging with a registered practitioner. Combined, these notifications provide a rich data set or *intelligence* about issues arising in practice.

We assess every notification we receive. A record is made of the notification that remains permanently in our database. We use each new notification to trigger a risk assessment of the practitioner who is the subject of the notification. The practitioner's regulatory history can be an important factor in assessing whether there is a current risk to the public to manage.

Our risk assessment starts with a review of the concerns raised in the notification. Clinical advice is incorporated into the risk assessment for every notification. We usually clarify those concerns through a conversation with the notifier (the person who made the notification).

We consider practice information, the practice setting of the practitioner and the relevant National Board's standards, codes and guidelines.

We also look back at the practitioner's regulatory history with us or under a former state-based scheme. Registration history, and any notification and compliance with any previous regulatory requirements, is considered to understand whether there have been previous issues. This helps us to analyse and consider risks to patient and public safety.

In nearly all cases, early on we discuss the concerns raised with the practitioner who has had a notification made about them. Letting them know about, and respond to, the concern can be an important step in supporting professional practice into the future. Health practitioners, like other professionals, can use the feedback received in a complaint to improve their practice.

We use our discussion with the practitioner to consider their:

- prior participation in any complaint resolution process with the notifier
- response to, and actions taken since, any issues and concerns were raised by the notifier
- reflections on the experience reported to us by the notifier.

Often notifications can be closed after this assessment without the need for regulatory action. This is particularly the case if a practitioner or their employer has already taken action to address the concerns or the practitioner has not been the subject of earlier concerns and does not have any significant regulatory history.

If we need more information, we can ask for it from the notifier or the practitioner. If we need information from another source, for example, a hospital or other health service, we will generally investigate.

We won't usually need to investigate if our initial discussions:

- provide us with all the information that a Board requires to make an informed decision
- identify that a practitioner has met a reasonable standard of practice
- prompted a practitioner to make reasonable adjustments to their practice to address the concerns
- do not raise an issue that requires investigation.

At any time, when we identify that a practitioner poses a serious risk or there is a strong public interest in limiting a practitioner's right to practise, a Board is able to take interim action quickly to protect the public. See Figure 103 for an outline of the notification process.

When does a National Board act?

We recognise the practice of healthcare is not risk-free. Practice in any of our regulated professions carries risk. That is why the professions are regulated.

Ahpra and the National Boards' regulatory activities work in tandem with the steps taken by health services and health practitioners to ensure patient and public safety. We support safe, professional practice to minimise the potential of harm to the public.

A National Board's registration standards set out the minimum requirements for entry into a profession. These standards ensure that individuals who become registered have appropriate training to perform in a regulated health profession safely.

A National Board's codes and guidelines set out what is expected of practitioners when practising their profession. They describe the safe, professional practice that we expect from health practitioners.

When concerns are raised about the conduct or professional standards of practice of an individual practitioner, or possible impairment, a National Board considers whether a regulatory response is required. Ahpra's *Regulatory guide* explains how we manage notifications about a practitioner's performance, conduct or health and is available at www.ahpra.gov.au/Publications/Corporate-publications. Regulatory actions supplement the actions taken by employers and practitioners every day. They are usually only taken when a National Board considers that there is a gap in risk controls put in place by a practitioner and their employer to ensure patient safety.

Most practitioners try to do the right thing, be accountable and rectify problems when they arise. When a practitioner's own response to problems is not enough, others play a part in assessing and responding to risks. Employers and system regulators play a part in thinking about how to minimise the likelihood of similar risks arising with the practitioner, or a different practitioner. A National Board takes these attitudes, behaviours and actions of practitioners and any employer organisations into account when determining whether it needs to act as the regulator.

If the National Board proposes to act, we will write to the practitioner with the details of the proposed action and invite the practitioner to make a submission to the National Board about the proposed action. This is part of procedural fairness and is known as the 'show cause process'.

When another entity such as a police service is investigating a practitioner, or has charged a practitioner with a criminal offence, a National Board may wait for the conclusion of those proceedings before it makes a final decision about a practitioner. This would not prevent a National Board taking interim action to protect the public in the meantime, for instance suspending a practitioner's registration, until the criminal proceedings have finished.

Communicating with notifiers and practitioners about a Board's decision

In 2018, changes to the National Law enabled us to provide more information to a notifier when we close a notification. The *Common protocol – Informing notifiers about the reasons for National Board decisions* explains what we do and is available on each National Board website (as an example, see www.medicalboard.gov.au/codes-guidelines-policies).

Because we know this is important for notifiers who have raised their concern with us, we work hard to clearly explain the reasons for the decision. In the past two years, feedback from notifiers whose matter involved an investigation shows a steady increase in satisfaction with our explanation of the reasons for the decision.

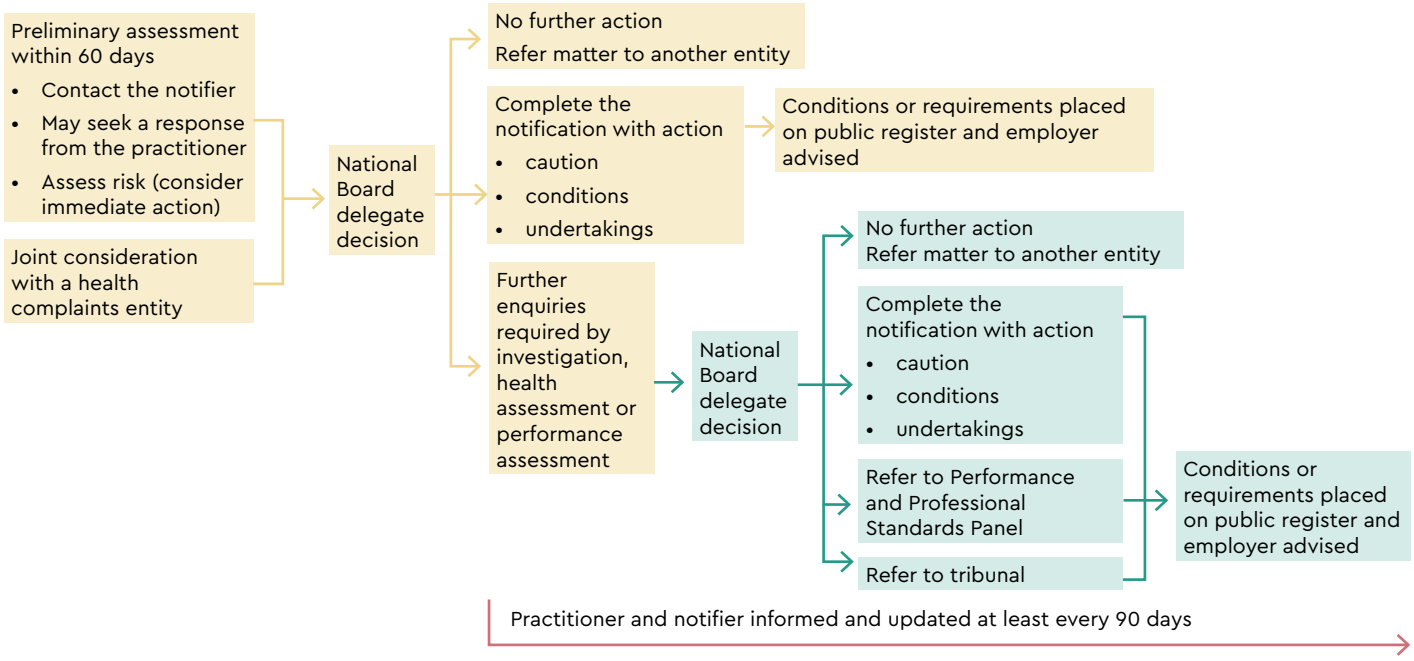
Calling practitioners and notifiers before sending the final outcomes letter also helps us to explain the reasons for the decision and the actions along the way. Even when a National Board decides to take no further action, the practitioner may have taken steps to reflect, learn or improve their practice. This can be important for the notifier to hear, as many people make a notification to prevent a similar experience for others in the future. Feedback from notifiers and practitioners about these telephone calls has been very positive.

Informing employer entities of regulatory action

In 2018, changes to the National Law broadened the nature of the practice information that a practitioner is required to tell us if requested to do so. It includes requirements to inform us of being self-employed; or working as an employee or contractor; or working in a voluntary or honorary capacity. To help practitioners meet their obligations, the *Guideline: informing a National Board about where you practise* is available on each National Board website (as an example, see www.medicalboard.gov.au/codes-guidelines-policies).

These changes require us to inform a broader range of places where a practitioner practises of regulatory action taken.

Figure 103. The notifications process



Improving the notification process

Each year, we make changes to our notification process to improve its timeliness, quality and experience.

Our new risk-assessment approach was implemented across all professions

We've expanded the set of information that we consider when deciding how to approach a practitioner who is the subject of a notification. We evaluate a practitioner's overall regulatory history when a notification prompts us to risk-assess the practitioner. We consider practice context and setting information.

Our work as a regulator supports and takes account of the professionalism of individual practitioners and clinical governance protections that support safety and quality in healthcare. How an individual practitioner, or an organisation they work for, responds to poor patient experiences or safety concerns can be powerful tools in preventing future risk to the public.

When we contact practitioners who are the subject of a notification, we are looking for safe, professional responses to incidents, events or experiences.

When we identify patterns of concerns, or more serious isolated concerns about an individual practitioner, the responses of their employers are taken into account.

Safe, professional responses by practitioners and their employers help us to ensure future protection of the public. Safe, professional practitioners, engaged by safe health services, benefit all patients and the broader community.

Clinical advisors available for all professions

We have recruited practitioners from all professions to join our existing clinical advisor network, including a team of medical advisors. We recognise that a strong understanding of how health services are delivered safely is vital to our work. These registered health practitioners work alongside our regulatory staff to identify concerns or issues, understand risk, interpret clinical matters and reference profession-specific guides, standards and codes. Clinical input is accessed at various times when managing a notification.

Adding these clinical advisors means we now employ clinicians for every profession covered by our scheme.

Three-year check-up since the chaperone review

We engaged Professor Ron Paterson to review the changes we have made over the past three years to manage sexual boundary notifications since his original review in 2017.

Professor Paterson found that:

- nearly all 28 recommendations of the 2017 chaperone review report have been fully implemented
- the changes made by Ahpra and the Medical Board of Australia have been wide and deep. The impact of implementing the recommendations has been profound in terms of how notifications of alleged sexual abuse are dealt with by regulators.

The report *Three years on: changes in regulatory practice since Independent review of the use of chaperones to protect patients in Australia* and Ahpra's response accepting all recommendations is available at www.ahpra.gov.au/news/2020-07-30-chaperone-report-three-years-on.

Policy direction from COAG Health Council

Ahpra started implementing COAG Health Council's *Policy direction 2019–1: Paramountcy of public protection when administering the National Scheme*. The policy direction provides a clear mandate to Ahpra and the National Boards to prioritise public protection; to protect the public and prevent harm, paying attention to the needs of vulnerable people. See *Appendix 7*.

Timeliness

We continue to aim to reduce the time to complete notifications. As a measure of the time that it takes us to manage notifications overall, we improved our timeliness:

- we reduced the average time to complete notifications by 10 days from 187 days to 177 days
- we completed the majority (71.6%) of notifications in less than six months; this is an improvement on previous years (68.2% in 2018/19 and 64.5% in 2017/18)
- the average age of open notifications also reduced from 226 to 209 days.

We saw a slight increase in:

- the proportion of notifications that have been open for longer than 12 months from 13.7% to 15.4%.

For further detail see *Outcomes and timeliness of notifications* closed on page 78.

Surveying notifiers and practitioners

Since 2016, we have been asking notifiers and practitioners to tell us about their experience of the notifications process. This year, we received 1,858 responses to our post-notifications surveys, 60% of which were from practitioners. We know that some key things matter to both notifiers and practitioners: ease of finding information, knowing who to contact, receiving regular updates and having clear reasons for decisions. We use the survey data to inform improvements we need to make and to track whether changes have actually delivered improved experiences. In addition, we interviewed a small number of notifiers and practitioners to capture an end-to-end, detailed understanding about their experience of the process.

As a result of earlier feedback from practitioners that they would have benefited greatly from hearing the voice of other practitioners who have gone through the notifications process, Ahpra launched the second first-person practitioner experience video *Putting it in perspective: a practitioner's notification experience* available at www.ahpra.gov.au/news/2019-08-20-practitioner-experience-video-two.

Equipping our people with improved IT

We made significant investments in IT hardware and software through 2019/20, to enable our notification teams to be more productive.

We developed a tool that enables us to more easily show our staff a single practitioner view of a practitioner's total regulatory history.

We have automated production of information to support efficient management and decision-making and reduce manual effort.

Changes to the mandatory notification laws

Treating practitioners are registered health practitioners who treat other health practitioners as patients. The mandatory requirements for treating health practitioners to make notifications under the National Law changed in all states and territories excluding Western Australia. These legislative amendments increase the threshold for when a treating practitioner must make a mandatory notification about another health practitioner.

The threshold for a treating practitioner to report a concern about impairment, intoxication and/or a departure from professional standards has been raised. The threshold is now reached when there is a substantial risk of harm to the public. The changes were introduced to give practitioners the confidence to seek help from a treating health practitioner if they need it to manage their own health.

To help practitioners understand the changes, we launched a public awareness campaign in advance of the changes starting on 1 March. The aim of the campaign was to provide greater clarity to treating practitioners on when they need to make a mandatory notification to ensure public safety, and to encourage practitioners to seek help for their health and wellbeing without fear they'll be the subject of an unnecessary mandatory notification. Alongside the revised guidelines, we developed and launched new resources to explain the changes. This included three new videos, case studies, expanded FAQs, a podcast and a myth-busting guide. Media stories featured in a range of publications and we ran a social media campaign across our main channels (Facebook, Twitter, Instagram and LinkedIn) to raise awareness when the changes came into effect.

The guidelines and resources are available on all National Boards' websites and the Ahpra website at www.ahpra.gov.au/notifications/mandatorynotifications.

We established a *mandatory notification information service* (hotline) so that people with mandatory reporting obligations can have de-identified discussions about potential mandatory notifications with Ahpra staff with significant experience in managing them. These calls help people to determine when a practitioner's health, conduct or performance might reach the new threshold and when it is not likely to do so.

Response to independent research on vexatious complaints

In 2018, new independent research[1] was published finding that there is more risk from people not reporting concerns than from making dubious complaints. Ahpra commissioned the research from the School of Population and Global Health, The University of Melbourne, to find out the size of the problem of vexatious complaints and identify how they can be better prevented, identified and managed. Ahpra initiated this work in line with its commitment to the Senate Affairs Reference Committee into the medical complaints process in Australia. The report found that the number of vexatious complaints dealt with in Australia and internationally is very small, less than 1%, but they have a big effect on the practitioner involved.

The Medical Board has toughened its *Code of conduct* on vexatious complaints. Other National Boards are also doing this. These clear benchmarks will enable further action against a practitioner who makes complaints purely to damage someone. Ahpra staff have received training to better recognise vexatious notifications early and work is underway on further guidance.

Review of confidentiality safeguards for notifiers

Ahpra started acting on the recommendations of the independent review by the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) of the confidentiality safeguards in place for individuals making notifications about registered health practitioners.

The *Review of confidentiality safeguards for people making notifications about health practitioners* was conducted at our request following the conviction of a general practitioner for the attempted murder of a pharmacist who had made a notification about his prescribing practices.

It examined our current management of confidential and anonymous notifications and whether there were ways to strengthen safeguards to ensure safety of notifiers. The review found that our practices for managing confidentiality and anonymity were reasonable and consistent with the practices of other regulators internationally.

Ahpra has accepted all 10 recommendations for improvements and outlined a timeline to adopt the changes. The report and Ahpra's response is available at www.ahpra.gov.au/news/2020-06-17-nhpopc.

Notifications received

This year, Ahpra received more notifications than we have ever received in a single year (see Table 9). A total of 10,236 notifications were received, 9.6% more than the number we received in 2018/19 (9,338 notifications), and 40.7% more than in 2017/18 (7,276 notifications).

The number of practitioners in each profession who have had notifications made about them is shown in Table 10.

Tables 11 and 11A show the percentage of all registered health practitioners with notifications made about them by profession, including and excluding practitioners on the pandemic response sub-register (see page 72). The larger pool of practitioners because of the creation of the pandemic response sub-register has reduced the percentage of the registrant base with notifications made about them to 1.6%.

Without the practitioners on the pandemic response sub-register, the percentage of all registered health practitioners with notifications made about them was 1.7%. For comparison, this percentage was 1.7% in 2018/19 and 1.6% in 2017/18.

These four tables include data supplied to us by the HPCA for NSW and OHO for Queensland.

During the year we received 44 notifications about students, see Tables 12 and 13.

1 Morris J, Canaway R, Bismark M (The University of Melbourne, Melbourne School of Population and Global Health, Centre for Health Policy) 2017 Summary report of a literature review prepared for the Australian Health Practitioner Regulation Agency: *Reducing, identifying and managing vexatious complaints* available at www.ahpra.gov.au/News/2018-04-16-vexatious-complaints-report.

Table 9. Notifications received in 2019/20, by profession and state or territory (includes HPCA and OHO)

Profession	Ahpra[1]									Ahpra subtotal 2019/20	HPCA[5]	OHO[6]	Total 2019/20	Total 2018/19[7]
	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]					
Aboriginal and Torres Strait Islander Health Practitioner		2	1				1	4		**8**	2		**10**	**12**
Chinese medicine practitioner		3	1	4	1		24	5		**38**	32	5	**75**	**102**
Chiropractor	2	2	2	17	10	1	38	19	1	**92**	56	14	**162**	**154**
Dental practitioner	11	12	9	231	45	10	353	93	20	**784**	501	90	**1,375**	**1,329**
Medical practitioner	130	133	69	1,558	454	133	2,495	626	147	**5,745**	2,653	1,079	**9,477**	**9,013**
Medical radiation practitioner	1			6	1		15	1	7	**31**	16		**47**	**54**
Midwife	4	1	5	15	14	2	18	19	7	**85**	51	4	**140**	**144**
Nurse	35	30	42	453	255	107	581	254	115	**1,872**	761	189	**2,822**	**2,724**
Occupational therapist	2	3	1	15	7		23	2		**53**	31	13	**97**	**111**
Optometrist	2	1		13		3	16	3	3	**41**	16	10	**67**	**76**
Osteopath				5			16			**21**	15	1	**37**	**31**
Paramedic	6	9	3	37	17	3	22	12	3	**112**	63	17	**192**	**128**
Pharmacist	3	6	3	85	44	13	216	40	38	**448**	450	30	**928**	**746**
Physiotherapist	2	2	1	34	9		53	19	5	**125**	65	21	**211**	**187**
Podiatrist	1	1		13	7		16	6		**44**	36	2	**82**	**109**
Psychologist	28	15	14	158	66	11	291	118	36	**737**	302	97	**1,136**	**938**
Total 2019/20	**227**	**220**	**151**	**2,644**	**930**	**283**	**4,178**	**1,221**	**382**	**10,236**	**5,050**	**1,572**	**16,858**	
Total 2018/19	**251**	**123**	**141**	**2,347**	**1,004**	**331**	**3,725**	**1,093**	**323**	**9,338**	**4,861**	**1,659**		**15,858**

1. Based on the state or territory of the practitioner's principal place of practice (PPP).
2. Matters managed by Ahpra where the conduct occurred outside NSW.
3. Based on the number of matters referred by the Office of the Health Ombudsman (OHO) to Ahpra and the National Boards, where the practitioner's PPP is in Qld.
4. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
5. Matters received and managed by the Health Professional Councils Authority (HPCA) in NSW.
6. Matters received and managed by OHO in Qld.
7. The total for 2018/19 includes matters managed by the HPCA and OHO.

Table 10. Number of practitioners with notifications made about them in 2019/20, by profession and state or territory (includes HPCA and OHO)

Profession[1]	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]	Total 2019/20[5]	Total 2018/19[6]
Aboriginal and Torres Strait Islander Health Practitioner		1	1					4		**6**	**12**
Chinese medicine practitioner		31	1	9	1		19	5		**66**	**85**
Chiropractor	2	44	2	31	8	1	33	16		**137**	**134**
Dental practitioner	14	348	5	283	44	8	221	86	1	**1,010**	**992**
Medical practitioner	107	2,138	56	2,114	420	119	1,772	510	18	**7,254**	**6,970**
Medical radiation practitioner	1	13		8	1		11	1		**35**	**44**
Midwife[7]	4	47	4	21	12	1	15	18		**122**	**99**
Nurse[8]	28	629	38	567	229	94	448	227	6	**2,266**	**2,271**
Occupational therapist	1	23	1	27	7		21	1		**81**	**83**
Optometrist	2	12		23		3	12	3		**55**	**66**
Osteopath		9		6			14			**29**	**30**
Paramedic	5	51	3	51	16	2	14	10		**152**	**101**
Pharmacist	5	275	3	109	46	14	154	42	1	**649**	**560**
Physiotherapist	2	51	1	50	8		47	17		**176**	**161**
Podiatrist	1	30		15	6		15	6		**73**	**96**
Psychologist	27	256	12	208	59	8	232	88	5	**895**	**741**
Total 2019/20	**199**	**3,958**	**127**	**3,522**	**857**	**250**	**3,028**	**1,034**	**31**	**13,006**	
Total 2018/19	**235**	**3,821**	**127**	**3,244**	**897**	**290**	**2,828**	**967**	**36**		**12,445**

1. Numbers for each state and profession are based on registrants whose profession has been identified and whose principal place of practice (PPP) is an Australian state or territory. Registrants whose PPP is not in Australia are represented in the 'No PPP' section.
2. NSW data include matters managed by the HPCA, as well as notifications managed by Ahpra about a practitioner with a PPP in NSW.
3. Qld data include matters managed by OHO, as well as those referred to Ahpra by OHO about a practitioner with a PPP in Qld.
4. No principal place of practice (No PPP) includes practitioners with an overseas or unknown address.
5. The total for 2019/20 includes practitioners with notifications managed by the HPCA and OHO.
6. The total for 2018/19 includes practitioners with notifications managed by the HPCA and OHO.
7. The registrant base used for midwives includes registrants with midwifery or with nursing and midwifery registration.
8. The registrant base for nurses includes registrants with nursing registration or with nursing and midwifery registration.

Table 11. Percentage of all registered health practitioners with notifications made about them in 2019/20, by profession and state or territory (includes HPCA and OHO)

Profession[1]	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]	Total 2019/20	Total 2018/19
Aboriginal and Torres Strait Islander Health Practitioner		0.6%	0.5%					2.5%		**0.7%**	**1.7%**
Chinese medicine practitioner		1.6%	7.7%	1.0%	0.5%		1.4%	1.9%		**1.3%**	**1.7%**
Chiropractor	2.9%	2.3%	6.7%	3.4%	2.2%	1.6%	2.1%	2.3%		**2.4%**	**2.4%**
Dental practitioner	3.2%	4.8%	3.1%	5.7%	2.2%	2.0%	3.8%	3.1%	0.2%	**4.1%**	**4.2%**
Medical practitioner	4.5%	5.6%	3.8%	8.3%	4.7%	4.5%	5.7%	4.0%	0.6%	**5.8%**	**5.9%**
Medical radiation practitioner	0.3%	0.2%		0.2%	0.1%		0.2%	0.1%		**0.2%**	**0.3%**
Midwife[5]	0.5%	0.5%	0.7%	0.3%	0.4%	0.1%	0.2%	0.5%	<0.1%	**0.3%**	**0.3%**
Nurse[6]	0.4%	0.5%	0.7%	0.6%	0.6%	0.9%	0.4%	0.5%	0.1%	**0.5%**	**0.6%**
Occupational therapist	0.3%	0.3%	0.5%	0.6%	0.4%		0.3%	<0.1%		**0.3%**	**0.4%**
Optometrist	2.0%	0.6%		1.9%		2.7%	0.7%	0.7%		**0.9%**	**1.1%**
Osteopath		1.5%		2.5%			0.9%			**1.1%**	**1.2%**
Paramedic	1.7%	1.0%	1.5%	1.0%	1.2%	0.4%	0.2%	0.8%		**0.8%**	**0.6%**
Pharmacist	0.7%	2.7%	1.0%	1.6%	1.9%	1.6%	1.7%	1.2%	0.2%	**1.9%**	**1.8%**
Physiotherapist	0.3%	0.5%	0.4%	0.7%	0.3%		0.5%	0.4%		**0.5%**	**0.5%**
Podiatrist	1.4%	1.9%		1.5%	1.2%		0.8%	1.2%		**1.3%**	**1.8%**
Psychologist	2.5%	1.9%	4.5%	2.8%	3.0%	1.1%	2.1%	2.1%	0.8%	**2.2%**	**2.0%**
Total 2019/20	**1.4%**	**1.7%**	**1.5%**	**2.2%**	**1.4%**	**1.4%**	**1.4%**	**1.3%**	**0.2%**	**1.6%**	
Total 2018/19	**1.8%**	**1.8%**	**1.6%**	**2.2%**	**1.6%**	**1.8%**	**1.5%**	**1.3%**	**0.2%**		**1.7%**

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

Table 11A. Percentage of all registered health practitioners (excluding pandemic response registrants) with notifications made about them in 2019/20, by profession and state or territory (includes HPCA and OHO)

Profession[1]	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]	Total 2019/20	Total 2018/19
Aboriginal and Torres Strait Islander Health Practitioner		0.6%	0.5%					2.6%		**0.8%**	**1.7%**
Chinese medicine practitioner		1.6%	7.7%	1.0%	0.5%		1.4%	1.9%		**1.3%**	**1.7%**
Chiropractor	2.9%	2.3%	6.7%	3.4%	2.2%	1.6%	2.1%	2.3%		**2.4%**	**2.4%**
Dental practitioner	3.2%	4.8%	3.1%	5.7%	2.2%	2.0%	3.8%	3.1%	0.2%	**4.1%**	**4.2%**
Medical practitioner	4.6%	5.8%	3.9%	8.6%	4.9%	4.6%	5.8%	4.2%	0.6%	**5.9%**	**5.9%**
Medical radiation practitioner	0.3%	0.2%		0.2%	0.1%		0.3%	0.1%		**0.2%**	**0.3%**
Midwife[5]	0.6%	0.5%	0.7%	0.3%	0.5%	0.1%	0.2%	0.5%	<0.1%	**0.4%**	**0.3%**
Nurse[6]	0.4%	0.6%	0.8%	0.7%	0.7%	0.9%	0.4%	0.6%	0.1%	**0.5%**	**0.6%**
Occupational therapist	0.3%	0.3%	0.5%	0.6%	0.4%		0.3%	<0.1%		**0.3%**	**0.4%**
Optometrist	2.0%	0.6%		1.9%		2.7%	0.7%	0.7%		**0.9%**	**1.1%**
Osteopath		1.5%		2.5%			0.9%			**1.1%**	**1.2%**
Paramedic	1.7%	1.0%	1.5%	1.0%	1.2%	0.4%	0.2%	0.8%		**0.8%**	**0.6%**
Pharmacist	0.8%	2.8%	1.1%	1.7%	2.0%	1.7%	1.8%	1.2%	0.2%	**2.0%**	**1.8%**
Physiotherapist	0.3%	0.5%	0.5%	0.7%	0.3%		0.5%	0.4%		**0.5%**	**0.5%**
Podiatrist	1.4%	1.9%		1.5%	1.2%		0.8%	1.2%		**1.3%**	**1.8%**
Psychologist	2.6%	2.0%	4.7%	3.0%	3.2%	1.2%	2.1%	2.2%	0.8%	**2.3%**	**2.0%**
Total 2019/20	**1.5%**	**1.8%**	**1.6%**	**2.3%**	**1.4%**	**1.5%**	**1.5%**	**1.4%**	**0.2%**	**1.7%**	
Total 2018/19	**1.8%**	**1.8%**	**1.6%**	**2.2%**	**1.6%**	**1.8%**	**1.5%**	**1.3%**	**0.2%**		**1.7%**

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

Table 12. Student notifications (mandatory and voluntary) received in 2019/20 (includes HPCA)

Profession	Ahpra[1]									Ahpra subtotal 2019/20	HPCA[3]	Total 2019/20	Total 2018/19
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]				
Aboriginal and Torres Strait Islander Health Practitioner										**0**	1	**1**	**1**
Chinese medicine practitioner										**0**		**0**	**2**
Chiropractor										**0**		**0**	**0**
Dental practitioner										**0**	3	**3**	**4**
Medical practitioner								1	6	**7**	4	**11**	**16**
Medical radiation practitioner									4	**4**		**4**	**2**
Midwife					1				1	**2**	2	**4**	**4**
Nurse					1		4	1	22	**28**	21	**49**	**56**
Occupational therapist										**0**	6	**6**	**3**
Optometrist										**0**		**0**	**0**
Osteopath									1	**1**		**1**	**0**
Paramedic										**0**	1	**1**	**3**
Pharmacist									1	**1**	4	**5**	**4**
Physiotherapist									1	**1**		**1**	**0**
Podiatrist										**0**		**0**	**0**
Psychologist										**0**		**0**	**0**
Total 2019/20	**0**	**0**	**0**	**0**	**2**	**0**	**4**	**2**	**36**	**44**	**42**	**86**	
Total 2018/19	**0**	**2**	**0**	**1**	**1**	**0**	**4**	**1**	**48**	**57**	**38**		**95**

1. Based on the 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.

Table 13. Outcomes of notifications (mandatory/voluntary) about students by stage at closure (includes HPCA)

Stage at closure		Assessment	Health or performance assessment	Investigation	Panel hearing	Tribunal hearing	Total 2019/20	Total 2018/19
No further action	**Ahpra**	28	3	10			**41**	**48**
	HPCA[1]	10	4		1		**15**	**9**
Impose conditions	**Ahpra**		1	1			**2**	**3**
	HPCA		2		4		**6**	**5**
Accept undertaking	**Ahpra**			1			**1**	**3**
	HPCA						**0**	**0**
Caution	**Ahpra**						**0**	**2**
	HPCA						**0**	**0**
Cancel registration	**Ahpra**						**0**	**0**
	HPCA						**0**	**0**
No jurisdiction	**Ahpra**						**0**	**0**
	HPCA	6	4				**10**	**3**
Refer to other entity	**Ahpra**						**0**	**1**
	HPCA						**0**	**0**
Discontinue	**Ahpra**						**0**	**0**
	HPCA	13					**13**	**14**
Counselling	**Ahpra**						**0**	**0**
	HPCA						**0**	**1**
Surrender	**Ahpra**						**0**	**0**
	HPCA						**0**	**0**
Withdrawn	**Ahpra**						**0**	**0**
	HPCA						**0**	**0**
Total 2019/20		**57**	**14**	**12**	**5**	**0**	**88**	
Total 2018/29		**50**	**18**	**14**	**7**	**0**		**89**

1. Matters managed by the HPCA in NSW.

Mandatory notifications

All registered health practitioners, their employers and education providers have mandatory reporting responsibilities under the National Law.

Table 14. Mandatory notifications received, by profession and state or territory (includes HPCA and OHO)

Profession	Ahpra[1]									Ahpra subtotal 2019/20	HPCA[5]	OHO[6]	Total 2019/20	Total 2018/19[7]
	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]					
Aboriginal and Torres Strait Islander Health Practitioner			1							**1**			**1**	**4**
Chinese medicine practitioner								4		**4**			**4**	**6**
Chiropractor	1					1	4	2		**8**	1		**9**	**12**
Dental practitioner	3			6	1	2	11	8	1	**32**	17	2	**51**	**93**
Medical practitioner	12	12	10	39	46	15	128	60	3	**325**	107	18	**450**	**470**
Medical radiation practitioner				1	1		1	1	2	**6**	6		**12**	**10**
Midwife			2	2	3	1	4	10	1	**23**	13		**36**	**21**
Nurse	12	10	17	98	98	33	160	95	10	**533**	245	21	**799**	**869**
Occupational therapist				1	2		1			**4**	4		**8**	**25**
Optometrist							1	1		**2**			**2**	**2**
Osteopath				1			1			**2**	2	1	**5**	**5**
Paramedic	3	2	2	10	8	2	8	6		**41**	27	3	**71**	**93**
Pharmacist	1	1	1	1	13	2	20	4	3	**46**	24	1	**71**	**59**
Physiotherapist	1	2		6			3	1	1	**14**	10	1	**25**	**23**
Podiatrist					1			1		**2**	3		**5**	**10**
Psychologist	4	1	2	9	3		27	17	1	**64**	30	1	**95**	**105**
Total 2019/20	**37**	**28**	**35**	**174**	**176**	**55**	**370**	**210**	**22**	**1,107**	**489**	**48**	**1,644**	
Total 2018/19	**42**	**16**	**26**	**121**	**227**	**52**	**454**	**177**	**38**	**1,153**	**596**	**58**		**1,807**

1. Based on the state and territory of the practitioner's principal place of practice (PPP).
2. Matters managed by Ahpra where the conduct occurred outside NSW.
3. Based on the number of matters referred by OHO to Ahpra and the National Boards where the practitioner's PPP is in Qld.
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 Qld.
7. The total for 2018/19 includes matters managed by the HPCA and OHO.

Table 15. Grounds for mandatory notification by profession (includes HPCA)

Profession	Standards		Impairment		Alcohol or drugs		Sexual misconduct		Total 2019/20		Total 2018/19	
	Ahpra	HPCA[1]	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA
Aboriginal and Torres Strait Islander Health Practitioner	1								**1**	**0**	**3**	**1**
Chinese medicine practitioner	4								**4**	**0**	**4**	**2**
Chiropractor	5	1	1		1		1		**8**	**1**	**7**	**5**
Dental practitioner	21	15	9	2	1		1		**32**	**17**	**56**	**37**
Medical practitioner	186	69	101	29	18		20	9	**325**	**107**	**339**	**110**
Medical radiation practitioner		3	3	3	2		1		**6**	**6**	**4**	**6**
Midwife	11	10	11	3	1				**23**	**13**	**12**	**7**
Nurse	294	163	164	68	57	2	18	12	**533**	**245**	**566**	**275**
Occupational therapist	3	2	1					2	**4**	**4**	**7**	**18**
Optometrist	1		1						**2**	**0**	**1**	**1**
Osteopath	2							2	**2**	**2**	**5**	**0**
Paramedic	21	14	9	8	5	1	6	4	**41**	**27**	**12**	**81**
Pharmacist	36	21	5	2	4		1	1	**46**	**24**	**44**	**15**
Physiotherapist	8	4	2	5			4	1	**14**	**10**	**14**	**7**
Podiatrist	2	1		2					**2**	**3**	**10**	**0**
Psychologist	38	14	15	9	3		8	7	**64**	**30**	**69**	**31**
Total 2019/20	**633**	**317**	**322**	**131**	**92**	**3**	**60**	**38**	**1,107**	**489**		
Total 2018/19	**792**	**375**	**236**	**183**	**68**	**3**	**57**	**35**			**1,153**	**596**

1. Matters managed by the HPCA in NSW.

Registered health practitioners, their employers and education providers must tell Ahpra if they have formed a reasonable belief that a registered practitioner has:

- practised the profession while intoxicated by alcohol or drugs
- engaged in sexual misconduct in the practice of the profession
- placed the public at risk of substantial harm because of an impairment, or
- placed the public at risk because of a significant departure from accepted professional standards.

Ahpra received 1,107 mandatory notifications. This is 4.0% less (46 notifications) than in 2018/19.

- 29.4% of the mandatory notifications received were about medical practitioners, the same as in 2018/19
- 48.1% of the mandatory notifications received were about nurses, down slightly from 49.1% in 2018/19
- The number of mandatory notifications related to impairment increased from 236 in 2018/19 to 322 in 2019/20.

Immediate action was considered on 291 occasions for mandatory notifications. Immediate action was taken 230 times.

The serious nature of mandatory notifications is reflected in the outcomes of closed matters. Regulatory action was taken more often in response to mandatory notifications compared to other notifications, with 35.8% of mandatory notifications completed resulting in a form of regulatory action being taken in relation to a practitioner's registration (compared to 14.0% for all notification categories). Regulatory action taken in relation to mandatory notifications is down from 38.2% in 2018/19. See Table 16.

Table 16. Outcomes of mandatory notifications closed, by profession (includes 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 2019/20	Total 2018/19
Discontinued/ proceedings withdrawn	**Ahpra**																	**0**	**0**
	HPCA			1	3	53		4	34				3	4	2		10	**114**	**191**
Changed to non-practising	**Ahpra**																	**0**	**0**
	HPCA								5									**5**	**8**
Other/no jurisdiction	**Ahpra**																	**0**	**0**
	HPCA[1]					2		1	29	1			8	1			6	**48**	**29**
Counselling	**Ahpra**																	**0**	**0**
	HPCA								17				2	6	3		1	**29**	**47**
No further action	**Ahpra**	2	3	2	37	220	3	13	295	1	3	1	16	15	7	2	33	**653**	**623**
	HPCA				4	14	4	5	110				12	3	1	1	11	**165**	**127**
Refer notification to another body	**Ahpra**					5			6	1		2	1	1				**16**	**8**
	HPCA				5	11	1		5	2					4		1	**29**	**18**
HCE to retain	**Ahpra**								2									**2**	**10**
	HPCA																	**0**	**0**
Fine registrant	**Ahpra**					1												**1**	**4**
	HPCA																	**0**	**0**
Orders – no conditions	**Ahpra**																	**0**	**0**
	HPCA																	**0**	**0**
Caution or reprimand	**Ahpra**			1		29	1	1	43					7	3	1	9	**95**	**132**
	HPCA			1		1			5									**7**	**6**
Accept undertaking	**Ahpra**					13			15					3		2	1	**34**	**44**
	HPCA																	**0**	**0**
Impose conditions	**Ahpra**				3	53	4	2	125	2			3	9	3	3	14	**221**	**192**
	HPCA[2]			2	3	8	1	5	75	1			5	2	1	1	5	**109**	**81**
Accept surrender of registration	**Ahpra**																	**0**	**2**
	HPCA					4			2								1	**7**	**11**
Suspend registration	**Ahpra**					1			2					1	1		1	**6**	**9**
	HPCA					2			6									**8**	**1**
Cancel registration/ disqualify	**Ahpra**					4			11								2	**17**	**14**
	HPCA				4	2			10	3				1	1		2	**23**	**14**
Total 2019/20	**Ahpra**	**2**	**3**	**3**	**40**	**326**	**8**	**16**	**499**	**4**	**3**	**3**	**20**	**36**	**14**	**8**	**60**	**1,045**	
	HPCA	**0**	**0**	**4**	**19**	**97**	**6**	**15**	**298**	**7**	**0**	**0**	**30**	**17**	**12**	**2**	**37**	**544**	
Total 2018/19	**Ahpra**	**3**	**5**	**11**	**38**	**265**	**4**	**14**	**554**	**8**	**1**	**2**	**5**	**48**	**16**	**5**	**59**		**1,038**
	HPCA	**0**	**1**	**4**	**29**	**106**	**3**	**15**	**260**	**16**	**2**	**0**	**61**	**13**	**2**	**1**	**20**		**533**

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

Immediate action

Interim action can be taken when serious concerns are raised about a practitioner. This action, called immediate action under the National Law, protects the public while more information is obtained, or other processes conclude.

It is an interim measure that a Board takes only in cases where:

- the Board believes there is a serious risk to the public, or
- it is otherwise in the public interest to limit a practitioner's registration while it seeks further information.

National Boards took immediate action on 580 occasions, which is 51.0% (196) more than in 2018/19. The proportion of notifications where immediate action was taken was 5.7% of the notifications received.

Although the increase in immediate action taken this year looks high, it is similar in proportion to immediate action taken as a percentage of notifications received in previous years (4.1% in 2018/19 and 5.7% in 2017/18). See Table 17 for the breakdown of immediate action taken over the last four years and Table 18 for the breakdown by profession.

Table 17. Immediate action taken to protect the public

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

Table 18. Immediate action cases (includes HPCA and OHO)

Profession	No action taken			Action taken[1]												Decision pending[2]			Total 2019/20			Total 2018/19	
				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
Aboriginal and Torres Strait Islander Health Practitioner																			**0**	**0**	**0**	**1**	**1**
Chinese medicine practitioner		2		2	4						5								**2**	**11**	**0**	**3**	**10**
Chiropractor	5			3	1					1	1					1			**10**	**2**	**0**	**5**	**4**
Dental practitioner	5	11	1	3	8					24	20	1	9			5			**46**	**39**	**2**	**10**	**38**
Medical practitioner	89	36	29	77	24	3	6	13		81	108	13	45			42		4	**340**	**181**	**49**	**247**	**199**
Medical radiation practitioner	1			1						1						1			**4**	**0**	**0**	**4**	**2**
Midwife	1	1	1	1						5	3		2			1			**10**	**4**	**1**	**3**	**3**
Nurse	58	39	19	97	9	3	7	7		45	101	5	60			29		1	**296**	**156**	**28**	**186**	**158**
Occupational therapist	1										3					1			**2**	**3**	**0**	**2**	**0**
Optometrist				1															**1**	**0**	**0**	**0**	**1**
Osteopath				1	1	1				1									**2**	**1**	**1**	**0**	**1**
Paramedic	4	3	4	7	2	1				3	7	1	7						**21**	**12**	**6**	**2**	**1**
Pharmacist	2	17	1	19	26		2	1		21	39		6						**50**	**83**	**1**	**28**	**68**
Physiotherapist	3	1	1	2	1			1		7	3	4	2					1	**14**	**6**	**6**	**4**	**9**
Podiatrist				1	1						1							1	**1**	**2**	**1**	**9**	**1**
Psychologist	6	3	2	13	2	1		1		12	11	1	5			2		1	**38**	**17**	**5**	**22**	**20**
Total 2019/20	**175**	**113**	**58**	**228**	**79**	**9**	**15**	**23**		**201**	**302**	**25**	**136**			**82**	**0**	**8**	**837**	**517**	**100**		
Total 2018/19	**123**	**116**		**128**	**61**		**11**	**30**		**130**	**309**		**115**			**19**	**0**					**526**	**516**

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 Qld.

Sexual boundary notifications

There is no place for sex in a practitioner-patient relationship, either in the guise of a 'consensual' sexual relationship, or in the form of sexualised comments or behaviour, or indecent or sexual assault.[1]

Most practitioners conduct themselves in accordance with National Boards' guidelines precluding sexualised contact with a patient. The small number who breach the community's trust by engaging in sexual misconduct cause significant and lasting impact on the trustworthiness of Australia's registered health professionals.

Ahpra and National Boards can refer matters about allegations of criminal behaviour to the police. Ahpra has entered into memoranda of understanding to develop clear inter-agency protocols for sharing information with the Western Australia Police Force (WAPOL) and Victoria Police (VICPOL). Less formal arrangements are in place in other states and territories. The timely exchange of information can assist National Boards to make prompt decisions to protect public safety.

Notifications are categorised as sexual boundary notifications when they include allegations about a wide range of behaviours by a practitioner that breach sexual boundaries, from making unnecessary comments about a patient's body or clothing, to criminal behaviour. For the first time this year, we are including a new table showing notifications relating to sexual boundary allegations (issues) received (see Table 19).

Of the 464 sexual boundary notifications received by Ahpra in 2019/20, 84.1% were made about practitioners in three professions: medical practitioners (45.0%), nurses (21.6%) and psychologists (17.5%). As a proportion of all notifications received about registered health practitioners in each profession this equates to 3.6% of medical practitioner notifications, 5.3% of nurse notifications and 11.0% of psychologist notifications.

Immediate action was considered on 158 occasions for sexual boundary notifications. Immediate action was taken 109 times, with 12 matters yet to be decided at 30 June. Of the immediate action taken about sexual boundary notifications, 52.3% of the action taken related to medical practitioners, 9.2% to nurses and 17.4% to psychologists.

Sexual boundary notifications resulted in a higher proportion of suspensions through immediate action (37.3% of matters) compared to all notifications (27.2% of matters). As an outcome of immediate action, National Boards imposed conditions in 22.8% of sexual boundary matters, accepted an undertaking in 8.2% of matters and after initially considering it, decided not to take immediate action in relation to 23.4% of matters.

The serious nature of sexual boundary notifications is reflected in the outcomes of closed matters. Action was taken more often in sexual boundary matters compared to other notifications with 10.9% of all sexual boundary matters resulting in a caution or reprimand (compared to 4.6% of all notifications categories), 11.5% resulting in conditions being imposed on the practitioner's registration (compared to 7.3%) and 10.9% resulting in the practitioner's registration being surrendered, suspended or cancelled (compared to 0.9%).

The higher risk profile of sexual boundary matters is also reflected in the stage of closure when compared to all notifications with 14.2% of sexual boundary matters closed after referral to a tribunal (compared to 1.6% for all notification categories), 45.3% closed following an investigation (compared to 21.7%) and 38.8% closed at the assessment stage (compared to 73.6%).

Table 19. Notifications relating to sexual boundary issues received in 2019/20, by profession and state or territory[1]

Profession	ACT	NSW[2]	NT	QLD[3]	SA	TAS	VIC	WA	No PPP[4]	Total[5]
Aboriginal and Torres Strait Islander Health Practitioner										**0**
Chinese medicine practitioner				1			4			**5**
Chiropractor	1			1	4		3	2		**11**
Dental practitioner				1	1		1	1		**4**
Medical practitioner	6	2	2	34	19	8	102	32	4	**209**
Medical radiation practitioner				1						**1**
Midwife					1		1			**2**
Nurse	3	1	2	26	11	8	34	8	7	**100**
Occupational therapist					1		2	1		**4**
Optometrist				2						**2**
Osteopath							6			**6**
Paramedic				3	8					**11**
Pharmacist				1	1	1	3			**6**
Physiotherapist		2		6	2		7	2		**19**
Podiatrist				1	1		1			**3**
Psychologist	4		2	16	9	3	29	18		**81**
Total[5]	**14**	**5**	**6**	**93**	**58**	**20**	**193**	**64**	**11**	**464**

1. Based on the state or territory of the practitioner's principal place of practice (PPP).
2. Matters managed by Ahpra where the conduct occurred outside NSW.
3. Based on the number of matters referred by the OHO to Ahpra and the National Boards, where the practitioner's PPP is in Qld.
4. No principal place of practice (No PPP) will include practitioners with an overseas or unknown address.
5. The total number of notifications in Table 19 is greater than that shown in Figure 102 due to different reporting criteria used for boundary violation issues.

1 Medical Board of Australia's *Guidelines: sexual boundaries in the doctor-patient relationship*, 2018

Assessment and investigations

Assessment

National Boards closed 70.2% of notifications following an assessment. These notifications did not require an investigation. This is up from 68.1% in 2018/19. In 92.4% of cases closed following an assessment, a National Board decided to take no further action; or decided that a complaint raised with a health complaints entity (HCE) would be retained by an HCE. In 7.4% of cases closed following an assessment, a National Board took regulatory action by: referring the notification to another body, cautioning the practitioner, imposing conditions on registration, or accepting an undertaking. In one case a practitioner surrendered their registration.

Investigation

The proportion of notifications that progressed from assessment to investigation because a National Board required more information before it could make an informed decision was 26.2%, less than in previous years (29.6% in 2018/19 and 33.1% in 2017/18). This reflects the application of our risk assessment framework which includes early consideration of the practitioner's regulatory history, nature and context of practice and any actions taken since the event notified to us occurred.

In all, 2,881 notifications about 2,271 practitioners were referred for investigation. Deciding to investigate does not indicate that an allegation made in a notification is true. We investigate a practitioner when more information is necessary to make an informed risk assessment. A decision to investigate gives us power to require individuals to provide us with information.

During an investigation, information can be gathered from sources such as:

- the person who raised their concern with the Board (the notifier)
- the practitioner being investigated
- clinical records
- other practitioners who may have been involved in the care of a patient
- witnesses (for example, family members, other patients or staff members)
- experts (who provide independent opinions) or information from professional bodies
- police reports, and/or
- information from other sources such as pharmacy records, health insurance records or Medicare Australia data.

Table 20. Closed notification outcomes

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

Outcomes and timeliness of notifications closed

We completed 3.5% more notifications than in 2018/19. This represents the highest number of closures (9,291) since the start of the National Scheme.

Of the notifications that were closed, 14.0% resulted in regulatory action about a practitioner and 16.5% were referred to another body; or to a health complaints entity for consideration of early resolution, conciliation or other complaint resolution outcome (see Tables 20 and 23).

The average time taken to complete an assessment and to close matters in assessment is shown in Table 21. Both the increase in the number of notifications received and the initial slowing of assessments as we embedded our risk assessment framework contributed to an increase in average time to complete matters at assessment. We expect this to continue to improve as the risk assessment process is further embedded.

The average time taken to close a notification is shown in Figure 104. 41.8% of all notifications were closed in less than three months. The majority (71.6%) were completed in less than six months. This is an improvement on previous years (68.2% in 2018/19 and 64.5% in 2017/18).

Table 22 shows notifications closed by profession and stage at closure and Table 23 by profession and outcome, while Table 24 contains data provided to us by the HPCA about notifications closed in NSW.

Tables 25 and 26 contain data about 5,491 notifications that are currently being managed by Ahpra and remained open at 30 June.

Table 21. Timeframes for matters in assessment

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

Figure 104. Closed notifications by average time taken to complete the matter

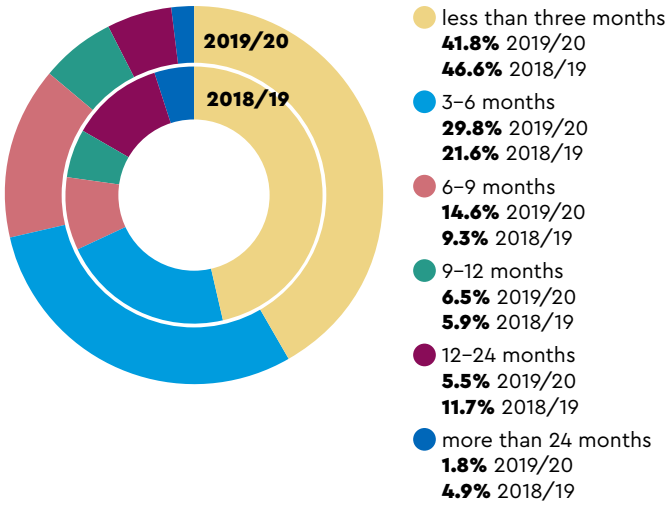


Table 22. Notifications closed in 2019/20 by profession, by stage at closure (includes HPCA)

	Assessment		Investigation		Health or performance assessment		Panel hearing		Tribunal hearing		Subtotal 2019/20		Total 2019/20	Total 2018/19
	Ahpra	HPCA[1]	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra[2]	HPCA[3]	Ahpra	HPCA		
Aboriginal and Torres Strait Islander Health Practitioner	8	2	1								**9**	**2**	**11**	**6**
Chinese medicine practitioner	26	35	10	2					2		**38**	**37**	**75**	**74**
Chiropractor	50	48	31	1		2		1	3	2	**84**	**54**	**138**	**142**
Dental practitioner	531	410	181	4	12	12	3	26	3	8	**730**	**460**	**1,190**	**1,197**
Medical practitioner	4,335	2,296	979	45	103	183	11	36	70	55	**5,498**	**2,615**	**8,113**	**7,312**
Medical radiation practitioner	19	17	9		2			1		1	**30**	**19**	**49**	**54**
Midwife	31	46	23		2	2		8		1	**56**	**57**	**113**	**149**
Nurse	951	580	502	5	124	94	5	104	42	28	**1,624**	**811**	**2,436**	**2,748**
Occupational therapist	34	30	8		3	4		1		3	**45**	**38**	**83**	**94**
Optometrist	24	24	10				2				**36**	**24**	**60**	**68**
Osteopath	8	7	7			1					**15**	**8**	**23**	**28**
Paramedic	48	46	14		3	4		6			**65**	**56**	**121**	**82**
Pharmacist	216	271	104	2	5	12		15	11	10	**336**	**310**	**646**	**753**
Physiotherapist	72	57	23	1	2			1	4	6	**101**	**65**	**166**	**153**
Podiatrist	29	35	10	1	4			3	1		**44**	**39**	**83**	**109**
Psychologist	460	296	102	10	4	16	4	16	10		**580**	**338**	**918**	**825**
Total 2019/20	**6,842**	**4,200**	**2,014**	**71**	**264**	**330**	**25**	**218**	**146[2]**	**114**	**9,291**	**4,933**	**14,224**	
Total 2018/19	**5,739**	**4,107**	**2,688**	**73**	**339**	**325**	**39**	**218**	**174**	**92**	**8,979**	**4,815**		**13,794**

1. Matters managed by the HPCA in NSW.
2. The number of cases closed at tribunal stage includes five matters that did not progress to a tribunal. Two were due to data entry errors and in three matters a Board decided not to proceed to filing in the tribunal.
3. Excludes appeals.

Table 23. Notifications closed in 2019/20, 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 2019/20[2]	Total 2018/19
Aboriginal and Torres Strait Islander Health Practitioner	7		1		1						**9**	**5**
Chinese medicine practitioner	16	3	8		2		8			1	**38**	**43**
Chiropractor	58		6	1	10	1	6		1	1	**84**	**95**
Dental practitioner	412	10	201	3	34		66		4		**730**	**733**
Medical practitioner	3,943	89	968	53	153	6	251	2	20	13	**5,498**	**4,801**
Medical radiation practitioner	19	2	2		2		5				**30**	**33**
Midwife	44	1	1		4		6				**56**	**92**
Nurse	1,115	32	80	29	108		235		5	20	**1,624**	**1,912**
Occupational therapist	31	2	5		3		4				**45**	**52**
Optometrist	22	1	3	1	4		5				**36**	**41**
Osteopath	10	2	1	1	1						**15**	**17**
Paramedic	56	3	2		1		3				**65**	**18**
Pharmacist	219	14	17	6	46		29	1	2	2	**336**	**453**
Physiotherapist	65	1	13		11		9		2		**101**	**102**
Podiatrist	25		6	2	4		7				**44**	**64**
Psychologist	418	17	39	3	46	1	48	1	3	4	**580**	**518**
Total 2019/20	**6,460**	**177**	**1,353**	**99**	**430**	**8**	**682**	**4**	**37**	**41**	**9,291**	
Total 2018/19	**6,241**	**82**	**1,074**	**112**	**663**	**8**	**716**	**6**	**45**	**32**		**8,979**

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

Table 24. Notifications closed in 2019/20, 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 2019/20	Total 2018/19
No further action[1]		13	11	120	307	8	16	239	3	5	1	20	94	7	7	74	**925**	**1,043**
No jurisdiction[2]		3	2	3	15	2	1	57	1	8		10	6	2	1	15	**126**	**98**
Discontinued	2	9	19	191	1,921	6	32	310	18	7	7	15	140	27	10	194	**2,908**	**2,816**
Withdrawn				17	68			4					11		2	13	**115**	**88**
Make a new complaint																	**0**	**0**
Refer all or part of the notification to another body		6	13	90	158	1		11	9	2			8	11	13	12	**334**	**182**
Caution				8	2			3								1	**14**	**16**
Reprimand			1	3	23			6					4				**37**	**27**
Orders – no conditions				1													**1**	**5**
Finding – no orders								1						1			**2**	**0**
Counselling/interview		6	3	10	4			29	3	2		4	23	11	3	5	**103**	**167**
Resolution/conciliation by HCCC								1					2				**3**	**2**
Fine																	**0**	**0**
Refund/payment/ withhold fee/retreat																	**0**	**1**
Conditions by consent				4	18		4	73					6			2	**107**	**108**
Order – impose conditions; would be conditions if registered			4	16	63	1	3	48	1			6	15	1	3	17	**178**	**152**
Accept surrender					22			3				1	1			4	**31**	**53**
Accept registration type change to non-practising			2		2			12									**16**	**28**
Suspend				1	17			7					1				**26**	**8**
Cancelled registration/ disqualified from registering				6	22	1	1	15	3				4	5		2	**59**	**58**
Total 2019/20	**2**	**37**	**55**	**470**	**2,642**	**19**	**57**	**819**	**38**	**24**	**8**	**56**	**315**	**65**	**39**	**339**	**4,985**	
Total 2018/19	**1**	**32**	**47**	**476**	**2,529**	**21**	**57**	**838**	**42**	**27**	**11**	**64**	**304**	**51**	**45**	**307**		**4,852**

Source: The data in this table were supplied by the HPCA. NSW legislation provides for a range of different outcomes for complaints in NSW. Some of these map to outcomes available under the National Law; others are specific to the NSW jurisdiction. Note that each notification may have more than one outcome; all outcomes have been included.

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

Table 25. Open notifications managed by Ahpra at 30 June 2020, by length of time at each stage

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 2019/20	Total 2018/19
Assessment	1,363	834	112	21	4	8	**2,342**	**1,835**
Health or performance assessment	57	55	49	17	29	3	**210**	**231**
Investigation	759	496	403	286	476	159	**2,579**	**2,160**
Panel hearing	8	2	1	1			**12**	**15**
Subtotal 2019/20	**2,187**	**1,387**	**565**	**325**	**509**	**170**	**5,143**	
Subtotal 2018/19	**2,143**	**980**	**423**	**200**	**352**	**143**		**4,241**
Tribunal hearing[1, 2]	62	33	50	38	102	63	**348**	**305**
Total 2019/20	**2,249**	**1,420**	**615**	**363**	**611**	**233**	**5,491**	
Total 2018/19	**2,185**	**1,019**	**483**	**234**	**428**	**197**		**4,546**

1. Tribunal proceedings are conducted in accordance with timetables set by the responsible tribunal in each jurisdiction.
2. There are also 10 compliance breaches before the tribunal at 30 June 2020 being managed by National Legal Service in addition to matters actioned from notifications received.

Table 26. Open notifications at 30 June 2020, by profession and state or territory (includes HPCA)

Profession	Ahpra[1]									Ahpra subtotal 2019/20[4]	HPCA[3]	Total 2019/20	Total 2018/19
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]				
Aboriginal and Torres Strait Islander Health Practitioner		2	2					1		**5**	1	**6**	**7**
Chinese medicine practitioner				3	1	1	15	3		**23**	26	**49**	**54**
Chiropractor	1		2	13	8	1	28	20	1	**74**	25	**99**	**90**
Dental practitioner	6	4	7	158	34	3	133	69	5	**419**	306	**725**	**646**
Medical practitioner	90	61	47	783	243	65	1,034	406	40	**2,769**	1,195	**3,964**	**3,790**
Medical radiation practitioner	1			4	3	1	7	1	1	**18**	2	**20**	**21**
Midwife	6	1	2	13	11	2	16	9	5	**65**	15	**80**	**57**
Nurse	28	14	19	254	168	61	355	164	44	**1,107**	352	**1,459**	**1,263**
Occupational therapist	1	2		11	4		12			**30**	8	**38**	**39**
Optometrist	1			10	1	1	10		2	**25**	3	**28**	**31**
Osteopath				1			15			**16**	11	**27**	**14**
Paramedic	7		1	21	12		15	5		**61**	32	**93**	**39**
Pharmacist	3	1	1	54	41	5	149	34	13	**301**	357	**658**	**412**
Physiotherapist		2	1	23	7	2	37	14	1	**87**	34	**121**	**97**
Podiatrist				9	3		10	4		**26**	7	**33**	**35**
Psychologist	22	6	8	101	43	8	170	103	4	**465**	94	**559**	**446**
Total 2019/20[4]	**166**	**93**	**90**	**1,458**	**579**	**150**	**2,006**	**833**	**116**	**5,491**	**2,468**	**7,959**	
Total 2018/19	**114**	**55**	**74**	**1,283**	**515**	**129**	**1,601**	**667**	**108**	**4,546**	**2,495**		**7,041**

1. Based on the 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.
4. There are also 10 compliance breaches before the tribunal at 30 June 2020 being managed by National Legal Service in addition to matters actioned from notifications received.

COVID-19's effect on notifications

Moving from office-based teams to working-from-home arrangements

The evolving COVID-19 pandemic left Ahpra, like many organisations, needing to continue to provide services where movement to and from our offices in each capital city was affected.

Fortunately, during the year we had already made significant investments in IT hardware and software to help our notification teams do their work more efficiently. We were able to build on this new resource quickly by deploying portable IT equipment to all notifications staff to enable them to work from home rather than from an office.

We equipped intake and assessment team members with 'soft-phone platforms' so they could continue to make and receive calls as if they were in the office, ensuring that members of the public could still make notifications verbally.

Conducting interviews and health assessments remotely

We have adapted the way we conduct interviews during investigations to take advantage of videoconferencing facilities.

We adjusted our scheduling of face-to-face health assessments, using telehealth services to ensure that health assessments of practitioners could continue.

'We scrambled to get organised quickly to work from home and met the challenge of COVID-19 head-on with support and constant updates from management and IT staff. Ultimately, this led to a seamless experience for notifiers and practitioners; and we also accommodated their needs in terms of timeframes for providing us with information.'

Regulatory Advisor – Notifications

Taking or defending legal action

Through its in-house legal practice (the National Legal Practice), Ahpra manages a range of regulatory litigation and associated legal services, including:

- **referrals to panels or tribunals** arising from serious notifications
- **appeals** from regulatory decisions
- **the investigation and prosecution** of criminal offences under the National Law
- **the release of information**
- the provision of **strategic legal advice**.

Referring matters to an independent tribunal

A National Board can refer a matter to a tribunal. This happens with the most serious allegations, usually when the National Board believes a practitioner has behaved in a way that constitutes professional misconduct. Only a tribunal can cancel a practitioner's registration, disqualify a person from applying for registration for a period or prohibit a person from using a specified title or providing a specified health service.

Tribunal proceedings are conducted in accordance with processes set by the responsible tribunal in each jurisdiction.

The tribunals in each state and territory are:

- New South Wales Civil and Administrative Tribunal
- Australian Capital Territory Civil and Administrative Tribunal
- Northern Territory Civil and Administrative Tribunal
- Queensland Civil and Administrative Tribunal
- South Australian Civil and Administrative Tribunal (which took over from the South Australian Health Practitioners Tribunal in August 2019)
- Tasmanian Health Practitioners Tribunal
- Victorian Civil and Administrative Tribunal
- Western Australia State Administrative Tribunal.

There were 348 notifications plus 10 compliance breaches (358 matters) open in the tribunal stage at 30 June, compared with 305 at the same time last year. Of the 141 matters closed at the tribunal stage in the year, nine matters were withdrawn or did not proceed because the practitioner was deceased or lacked capacity; or sanctions had been imposed on the practitioner because of another matter. Of the 132 matters decided by a tribunal, 100% resulted in some form of disciplinary action. See Figure 105. This shows that National Boards continue to appropriately identify the thresholds for referring a matter to a tribunal to protect the public.

Figure 105. National Board matters decided by tribunals in 2019/20

Since 2010, all practitioners who have had their registration cancelled by a court or tribunal, been disqualified from applying for registration, or prohibited from using a specified title or providing a specified health service appear on the cancelled health practitioners register. See www.ahpra.gov.au/registration/registers-of-practitioners/cancelled-health-practitioners.

We also publish summaries of tribunal outcomes at www.ahpra.gov.au/publications/tribunal-decisions.

All National Boards publish links to adverse disciplinary decisions by courts and tribunals relating to a registered health practitioner on the public *Register of practitioners*, where the decision is already public and the name of the practitioner has not been suppressed by the court or tribunal.

Referring matters to a panel to decide

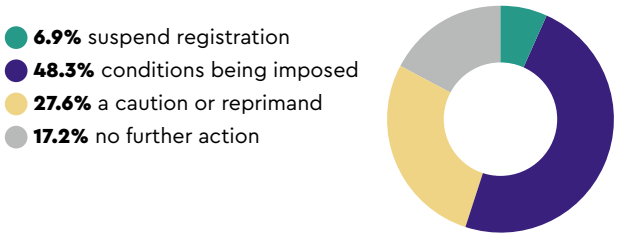
A National Board has the power to establish two types of panels depending on the type of notification:

- health panels, for issues about a practitioner's health and performance, or
- professional standards panels, for conduct and performance issues.

Under the National Law, panels must include members from the relevant health profession as well as community members. All health panels must include a medical practitioner. Each National Board has a list of approved people who may be called upon to sit on a panel.

Of the 29 National Board matters decided by panels this year, more than 80% resulted in some form of regulatory action. See Figure 106.

Figure 106. National Board matters decided by panels in 2019/20



Appeals made about regulatory decisions

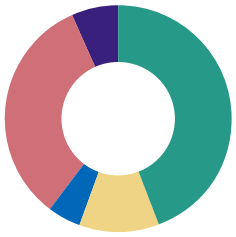
The National Law provides a mechanism of appeal to a tribunal against a decision by a National Board in certain circumstances, including decisions to:

- refuse an application for registration or endorsement of registration, or to refuse renewal of registration or renewal of an endorsement of registration
- impose or change a condition placed on registration, or to refuse to change or remove a condition imposed on registration or an undertaking given by a registrant, or
- suspend the registration of a practitioner.

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.

There were 106 appeals lodged nationally about decisions made by National Boards (see Table 27 and Figure 107). The number of appeals lodged annually has increased significantly over recent years as follows: 106 appeals in 2019/20, 62 appeals in 2018/19, and 28 appeals in 2017/18.

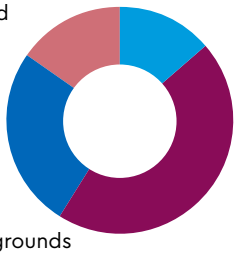
Figure 107. Appeals managed in 2019/20



- **44.3%** about a decision to impose or change a condition on a person's registration or endorsement
- **11.3%** about a decision to refuse registration, refuse renewal of registration, or refuse an endorsement on registration
- **4.7%** about a decision to refuse to change or remove a condition imposed on a person's registration, or an undertaking given by the practitioner, or the endorsement of a person's registration
- **33.0%** about a decision to suspend a person's registration
- **6.6%** about appeals against other decisions

The majority of these related to the professions with higher regulatory decision volumes, such as medical practitioners (54) and nurses (21). There were 73 appeals finalised. See Table 28 and Figure 108.

Figure 108. Appeals finalised in 2019/20



- **13.7%** had the original decision confirmed
- **45.2%** were withdrawn by the appellant and did not proceed, meaning the original decision remained in place
- **26.0%** resulted in the original decision being substituted with a new decision (11 matters) or the original decision being amended (8 matters)
- **15.1%** were dismissed on administrative grounds

There were 72 appeals not yet decided at 30 June.

More information about appeals is available in the supplementary tables published online at www.ahpra.gov.au/annualreport/2020.

Table 27. Appeals lodged in 2019/20 by profession and jurisdiction (includes HPCA)

Profession	Ahpra[1]									Ahpra subtotal 2019/20	HPCA[3]	Total 2019/20	Total 2018/19
	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP[2]				
Aboriginal and Torres Strait Islander Health Practitioner										**0**		**0**	**0**
Chinese medicine practitioner										**0**	1	**1**	**2**
Chiropractor								1		**1**		**1**	**2**
Dental practitioner		1					2			**3**	2	**5**	**3**
Medical practitioner	2	2		16	5	1	19	9		**54**	13	**67**	**40**
Medical radiation practitioner										**0**		**0**	**3**
Midwife										**0**		**0**	**0**
Nurse		2	1	1	5	2	9	1		**21**	6	**27**	**21**
Nurse and midwife					2		1	1		**4**		**4**	**2**
Occupational therapist										**0**		**0**	**1**
Optometrist										**0**		**0**	**0**
Osteopath										**0**		**0**	**0**
Paramedic	1	1					2			**4**		**4**	**0**
Pharmacist		1		2			3			**6**	6	**12**	**5**
Physiotherapist					1					**1**		**1**	**1**
Podiatrist										**0**		**0**	**0**
Psychologist	2			2	3		2	3		**12**		**12**	**6**
Total 2019/20	**5**	**7**	**1**	**21**	**16**	**3**	**38**	**15**	**0**	**106**	**28**	**134**	
Total 2018/19	**3**	**10**	**1**	**16**	**10**	**2**	**13**	**7**	**0**	**62**	**24**		**86**

1. Based on the 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.

Published court and tribunal summaries

We published 77 summaries of court and tribunal decisions about health practitioner regulation. These summaries provide practitioners with professional learning opportunities in their pursuit of safe and ethical standards of practice and behaviour, while helping patients know what to expect from a registered health practitioner under the National Law.

Some of the unacceptable conduct displayed by the practitioners in the summaries included: breaches of professional boundaries, engaging in sexual relationship with patients, accessing child exploitation materials, inappropriate prescribing, false claims as a health practitioner, practising while registration was suspended, unsatisfactory professional performance, and falsifying records to gain registration.

Table 28. Nature of decision appealed where the appeal was finalised through consent order or a contested hearing or where the appeal was withdrawn (includes HPCA)

Nature of decision appealed	Original decision confirmed		Original decision amended		Original decision substituted for a new decision		Withdrawn by appellant		Dismissed – Administrative		Total 2019/20		Total 2018/19	
	Ahpra[1]	HPCA[2]	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA	Ahpra	HPCA
Appeal against a tribunal decision	2					1			2		**4**	**1**	**3**	**0**
Decision to impose conditions on a person's registration under section 178	1		3		1		16		1		**22**	**0**	**23**	**0**
Decision to impose or change a condition on a person's registration or the endorsement of the person's registration	1	1	5	3	1	1	2	2	3	3	**12**	**10**	**5**	**14**
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	1			**2**	**1**	**5**	**0**
Decision to refuse to endorse a person's registration							1				**1**	**0**	**0**	**0**
Decision to refuse to register a person	2				1		2		1	1	**6**	**1**	**8**	**0**
Decision to refuse to renew a person's registration									1		**1**	**0**	**4**	**0**
Decision to reprimand a person											**0**	**0**	**0**	**1**
Decision to suspend a person's registration	3				7	2	11	6	2	2	**23**	**10**	**9**	**6**
Other	1										**1**	**0**	**1**	**0**
Not an appellable decision											**0**	**0**	**0**	**0**
Judicial review									1		**1**	**0**	**1**	**0**
Total 2019/20	**10**	**1**	**8**	**3**	**11**	**4**	**33**	**9**	**11**	**6**	**73**	**23**		
Total 2018/19	**6**	**3**	**4**	**0**	**3**	**4**	**37**	**10**	**9**	**4**			**59**	**21**

1. Ahpra manages appeals of registration decisions in NSW.

2. Notification matters managed by the HPCA in NSW.

Referring serious allegations to tribunals

Our National Legal Practice (NLP) continued to provide high-quality advice and service to Ahpra and National Boards. An important part of our regulatory work is in the responsible tribunals. For example, matters of note include, but are not limited to:

- findings of professional misconduct in Board referrals involving:
  - family violence offending, and other serious criminal offending
  - sexual boundary breaches, and other general boundary breaches
  - prescribing of 'peptides' or other drugs that are at risk of misuse/abuse, for non-therapeutic purposes
  - failure to comply with conditions imposed on a registration by a Board or a panel
- significant periods of disqualification in Board referrals involving:
  - mismanagement and a failure to provide safe and effective nursing and midwifery care by a manager of maternity services (10 years)
  - a practitioner who obtained registration because he or another person provided the Board with a document that was false or misleading in a material particular; made false statements about his surgical qualifications to a potential employer and the Australian Medical Council (AMC); and created a false email from the AMC verifying his surgical qualifications (eight years)
- two appeal matters that examined a National Board's power to take immediate action under:
  - section 156(1)(a), despite an acquittal in associated criminal proceedings
  - section 156(1)(e), for conduct broader than the 'example' provided for in that section.

  In both matters, the responsible tribunal confirmed the National Board's decision to take immediate action.

Ahpra's *Regulatory guide*, available at www.ahpra.gov.au/Publications/Corporate-publications is an invaluable resource for Ahpra, National Boards, stakeholders, practitioners, legal service providers and members of the public wanting to understand the regulatory process under the National Law.

Criminal offences

Snapshot

- **605 criminal offence complaints** were received – an increase of 9.8% from last year
- **602 criminal offence complaints** were considered and closed – a 25.2% increase compared with last year
- **232 open criminal offence complaints** were still under review at 30 June
- **68.1% of all new criminal offence complaints** related to alleged unlawful use of title and unlawful claims to registration
- **172 new serious-risk advertising complaints** were received; 150 were closed
- **11 prosecutions** were completed in the court for criminal offences under the National Law
- **All 11 completed prosecutions** resulted in a finding of guilt against the individual for a criminal offence

What are criminal offences under the National Law?

The National Law includes criminal offences that relate to conduct that can put individuals and the community at risk. Offences under the National Law may be committed by a person (including registered health practitioners and unregistered individuals) and/or corporate entities. See www.ahpra.gov.au/notifications/raise-a-concern/reporting-a-criminal-offence.

Types of criminal offence

Offences under the National Law predominantly relate to title protection, unlawful claims as to registration and restricted acts. Since 1 July 2019, in all states and territories other than Western Australia these are indictable offences and carry a maximum penalty of three years' imprisonment, $60,000 fine or both for an individual, or $120,000 fine for a corporate entity, per offence. In Western Australia they are summary offences and the maximum fine is $60,000 for a corporate entity, or $30,000 for an individual.

The National Law also contains offences relating to the advertising of regulated health services.

Unlawful use of protected titles

The National Law restricts the use of protected titles (sections 113, 114 and 115). It is unlawful for someone to knowingly or recklessly use a title to make someone believe they are registered in one of the 16 regulated health professions, or other practices including using a specialist title when the person does not have specialist registration or endorsement.

Unlawful claims to registrations by individuals or corporate entities

It is unlawful to knowingly or recklessly claim to be a registered health practitioner under the National Law when you do not hold registration (sections 115, 116 and 118). This can include using a title, name, initial, symbol, word or description that could be reasonably understood to indicate that an individual is a health practitioner or is qualified to practise in a health profession. The National Law also states that a person must not claim that another individual is a registered health practitioner.

A registered health practitioner must not claim to be a specialist health practitioner if they do not hold registration in the specialist category (sections 117 and 119). A breach of section 117 or 119 by a registered health practitioner does not constitute an offence but may constitute behaviour for which health, conduct or performance action may be taken.

Performing a restricted act

The National Law (sections 121, 122 and 123) restricts certain practices:

- restricted dental acts
- restricted prescription of optical appliances
- restricted spinal manipulation.

Some states have additional provisions restricting other practices, with various penalties:

- restricted birthing practices are prohibited in South Australia and Western Australia unless they are carried out by, or under the supervision of, a medical practitioner or a midwife (section 123A)
- restrictions on general anaesthesia and simple sedation apply in NSW (section 121A)
- restrictions on dispensing optical appliances without a prescription apply in South Australia (sections 74 and 75).

Unlawful advertising

Under the National Law (section 133), you may not advertise a regulated health service or a business providing a regulated health service in a way that:

- is false, misleading or deceptive or is likely to be misleading or deceptive
- offers a gift, discount or other inducement to attract a person to use the service or the business, unless the advertisement also states the terms and conditions of the offer
- uses a testimonial or purported testimonial about the service or business
- creates an unreasonable expectation of beneficial treatment, or
- directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.

A breach of the advertising provisions of the National Law is an offence and carries a maximum fine of $10,000 for a corporate entity, or $5,000 for an individual, per offence.

Concerns about unlawful advertising are managed in two ways:

- all serious-risk complaints about advertising by registered health practitioners, as well as all complaints about advertising by corporate entities and unregistered persons, are managed by the Criminal Offences Unit
- all low-to-moderate-risk advertising offences by registered health practitioners are managed under the *Advertising compliance and enforcement strategy*.

Criminal offence complaints received and closed

Ahpra recorded 605 new criminal offence complaints. This is a growth of 9.8% in comparison to criminal offence complaints received in the previous year.

Of criminal offence complaints received nationally, 68.1% related to concerns about alleged unlawful use of title and unlawful claims to registration. See Figure 109. More than half of all new offence complaints are made about people who are not registered health practitioners or companies.

This year 602 criminal offence complaints have been closed and are shown in Table 29. This is a 25.2% increase in comparison to offence complaints closed in the previous year.

At 30 June 2020, there were 232 criminal offence complaints under review, in comparison to 238 at 30 June 2019. See Figure 110.

See page 91 for low-to-moderate-risk advertising complaints managed under the *Advertising compliance and enforcement strategy*.

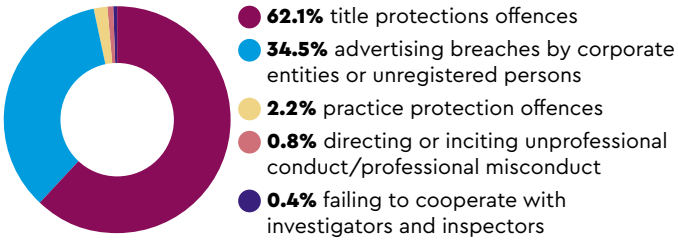
Table 29. Criminal offence complaints received and closed, by type of offence and profession[1]

Profession	Title protections (ss. 113–120)		Practice protections (ss. 121–123)		Advertising breach (s. 133)		Directing or inciting unprofessional conduct/ professional misconduct (s. 136)		Other offence		Total 2019/20		Total 2018/19	
	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed	Received	Closed
Aboriginal and Torres Strait Islander Health Practitioner	1	2									**1**	**2**	**1**	**0**
Chinese medicine practitioner	11	8	1		4	7					**16**	**15**	**27**	**31**
Chiropractor	5	10	1	1	9	7				2	**15**	**20**	**27**	**24**
Dental practitioner	30	40	8	6	42	22					**80**	**68**	**42**	**40**
Medical practitioner	96	98	1	1	62	69	2	2	1	6	**162**	**176**	**160**	**143**
Medical radiation practitioner	3										**3**	**0**	**3**	**2**
Midwife	8	7			1	1					**9**	**8**	**2**	**2**
Nurse	61	68	1	2	16	6	4	1		4	**82**	**81**	**64**	**49**
Occupational therapist	6	6			1	2					**7**	**8**	**16**	**13**
Optometrist	3	1			3	3					**6**	**4**	**3**	**4**
Osteopath	5	8			2	5					**7**	**13**	**11**	**2**
Paramedic	24	21		1	1	1	1	1			**26**	**24**	**13**	**7**
Pharmacist	10	7			3	1					**13**	**8**	**16**	**21**
Physiotherapist	23	22			12	11					**35**	**33**	**34**	**31**
Podiatrist	1	1			4	3					**5**	**4**	**4**	**3**
Psychologist	124	120	1	2	7	5				3	**132**	**130**	**123**	**109**
Unknown[2]	1	1			5	7					**6**	**8**	**5**	**0**
Total 2019/20	**412**	**420**	**13**	**13**	**172**	**150**	**7**	**4**	**1**	**15**	**605**	**602**		
Total 2018/19	**369**	**345**	**11**	**12**	**153**	**107**	**3**	**3**	**15**	**14**			**551**	**481**

1. All offences from sections 113–136 of the National Law, not only offences about advertising, title and practice protection.
2. Ahpra also received offence complaints about unregistered persons.

Figure 109. Offence complaints received in 2019/20

Figure 110. Offence complaints open at 30 June 2020



Managing offence complaints

Criminal offences are managed with a risk-based approach, focusing on protecting the public and ensuring the timely resolution of all complaints. All new offence complaints are risk assessed, and this dictates the course of action required to ensure public safety. Offences under the National Law are prosecuted in the court of the relevant state or territory.

As required, serious-risk criminal offence complaints are investigated by an inspector. This may include applying to the court for a warrant to search premises and seizing evidence.

Ahpra, in consultation with the relevant National Board, will prosecute criminal offences against individuals and/or corporate entities where there is a reasonable prospect of a conviction and the prosecution is in the public interest.

Advertising requirements

Guidelines for advertising regulated health services have been published to help anyone advertising regulated health services to do so appropriately. In turn, Ahpra and the National Boards have published and implemented an *Advertising compliance and enforcement strategy* that outlines the risk-based management of criminal offence complaints, particularly advertising complaints. Both documents are available on the Ahpra website, see www.ahpra.gov.au/publications/advertising-resources/legislation-guidelines/advertising-guidelines and www.ahpra.gov.au/publications/advertising-resources/legislation-guidelines.

For more information about the management of low-to-moderate-risk advertising complaints, see page 91 in the compliance section of this report.

Prosecutions under the National Law

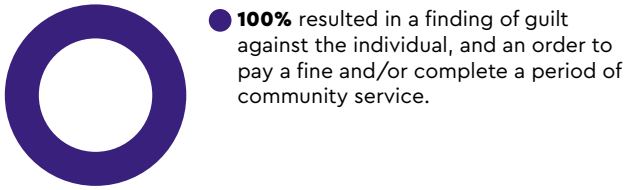
There has been a number of significant prosecutions this year that demonstrate the importance of the criminal offence function for the protection of the public.

Ahpra completed 11 proceedings in the courts for offences under the National Law across five jurisdictions. All prosecutions resulted in findings of guilt. One of these matters was pending appeal by the defendant at 30 June. These outcomes show that Ahpra continues to identify appropriate thresholds for referring offence complaints for prosecution to protect the public.

Further information about these matters is outlined in Table 30 and Figure 111. Information about Ahpra's prosecutions is available at www.ahpra.gov.au/news.

A further 11 prosecutions and two appeals (including one from a matter determined in 2018/19) are ongoing before the courts at 30 June.

Figure 111. Prosecution outcomes in 2019/20



COVID-19's effect on our legal practice

While the restrictions imposed in response to the COVID-19 pandemic had some effect, the impact was fairly limited. With a history of working flexibly, our move to having the entire practice working from home went very smoothly. Staff adapted to the new way of working quickly, finding innovative ways to stay in touch with their colleagues and stakeholders. In addition, regular online briefings were held to ensure that all staff were aware of the impact of decisions in significant cases and the development of important opinions and advices.

There were a number of external impacts during this time, including:

- Tribunals across the country deferred face-to-face hearings or scheduled them as virtual hearings. A significant number of hearings were adjourned. The impact of this will likely be felt over the next six to 12 months as tribunals work to move through the deferred hearings.
- Most Magistrates' and Local Courts deferred face-to-face hearings. This move saw the adjournment of some criminal prosecutions that we had instituted.
- Special arrangements had to be made for the execution of important legal documents – either being executed in rare personal meetings or done in accordance with the recently introduced legislative provisions allowing the remote witnessing of documents.

'The transition to working virtually from home was relatively seamless for me, having worked in a virtual team before COVID-19.

'The most significant matter that has impacted on my work has been the change in the way each of the tribunals hearing disciplinary referrals has operated. Most hearings (or tribunal-ordered mediations or conferences) that would ordinarily require a physical attendance have been occurring either by telephone, videoconference or "on the papers". In some jurisdictions, matters have been adjourned where the hearing can only proceed "face to face", but in many cases, matters have been able to proceed to a final hearing. As a team, we have continued to secure some excellent results across a range of complex matters in a challenging environment.'

Senior Legal Advisor

Table 30. Completed prosecutions at 30 June 2020

Defendant	Date of decision	Jurisdiction	Relevant Board[1]	Relevant section of the National Law[2]	Type of offence	Outcome	Sentence
Brittany Elise Fairthorne	4 July 2019	NSW	NMBA	s. 116(1)(c) Schedule 6 – Clauses 20 and 21	Claims as to registration False or misleading documents to an inspector False or misleading information to an inspector	Convicted	Fined $15,000 and ordered to pay $13,496 in costs
Craig Manwaring	11 July 2019	Vic	NMBA	s. 116(1)(b)(ii) s. 116(1)(c) s. 113(1)(a)	Claims as to registration Use of protected title	Convicted	Fined $60,000 and ordered to pay $4,000 in costs
Name withheld	8 November 2019	Qld	MBA	s. 116(1)(c)	Claims as to registration	No conviction recorded[3]	Fined $25,000 and ordered to pay $5,000 in costs
Scott Keith McLennan	21 November 2019	WA	NMBA	s. 116(1)(c)	Claims as to registration	Convicted	Fined $15,000 and ordered to pay $4,000 in costs
Eduardo Soares Penques	28 January 2020	NSW	DBA	s. 116(1)(c) s. 121	Claims as to registration Restricted dental act	Convicted	Fined $16,500 and ordered to pay $3,173 in costs
Panayiotis Marlassi-Bouras	31 January 2020	Vic	MBA	s. 113(1) s. 116(1)(c)	Claims as to registration Use of protected title	Convicted	Fined $10,000 and ordered to pay $1,308 in costs
Name withheld	17 February 2020 (first instance) Appeal pending	Qld	MBA	s. 116(1)(b)(i) s. 118(1)(b)(i)	Claims as to registration	No conviction recorded Appeal against conviction pending	Fined $15,000 and ordered to pay $10,000 in costs.
Alison Mibus	28 February 2020	SA	NMBA	s. 116(1)(c)	Claims as to registration	Convicted	Fined $10,500 and ordered to pay $1,210 in costs and $480 victims of crime levy
Shirin Ramezani Kharavani	12 March 2020	NSW	DBA	s. 116(1)(b)(i) s. 116(2)(b)(i) s. 121	Claims as to registration Claims as to registration of another Restricted dental act	Convicted	Fined $25,000 and ordered to pay $9,000 in costs and $3,425 in compensation to victim
Majid Rahebi	12 March 2020	NSW	DBA	s. 116(1)(b)(i) s. 121	Claims as to registration Restricted dental act	Convicted	Fined $38,000 and ordered to pay $9,000 in costs and $3,425 in compensation to victim
Helena Heaft	23 December 2019 (first instance) 11 May 2020 (appeal)	SA	NMBA	s. 116(1)(c)	Claims as to registration	Convicted	At first instance: Issued a $500 good behaviour bond, and ordered to pay costs of $1,100 and victims of crime levy of $10,560. Appeal by Ahpra allowed and re-sentenced to 80 hours community service and a $500 good behaviour bond, and ordered to pay total costs of $1,600 and victims of crime levy of $10,560

1. For a list of Board acronyms, see page 148.
2. The Health Practitioner Regulation National Law, as in force in each state and territory. Find it online at www.ahpra.gov.au/about-ahpra/what-we-do/legislation.
3. See page 150 of the *Glossary*.

Monitoring restrictions on practitioners

Snapshot

- **4,215 cases** were being actively monitored at 30 June – these cases related to 4,212 registered practitioners
- **1,313 cases** (31.1%) were about conduct, health or performance
- **2,520 cases** (59.8%) were about suitability/eligibility for registration
- **382 cases** (9.1%) related to prohibited practitioners/students
- There were **89 restrictions** (conditions or undertakings) in the National Restrictions Library at 30 June
- **412 new low-to-moderate-risk** advertising complaints about registrants were received under the *Advertising compliance and enforcement strategy*

How Ahpra monitors compliance

Ahpra monitors health practitioners and students with restrictions (conditions or undertakings) placed by National Boards on their registration, as well as those with suspended or cancelled registration. By identifying any non-compliance with restrictions and acting swiftly and appropriately, Ahpra supports Boards to manage risk to public safety.

To find out about active monitoring cases, refer to Tables 32 and 33 on pages 91–92. Table 32 reports on active monitoring cases by state and territory. Table 33 reports on these cases by each profession. Restrictions are placed on a practitioner's registration through several mechanisms, including as an outcome of a notification, or when a practitioner applies for registration or renewal of registration.

Each monitoring case is assigned to one of five streams.

Health

A practitioner or student is being monitored because they have a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence).

Performance

A practitioner is being monitored to ensure they practise safely and appropriately while demonstrated deficiencies in their knowledge, skill, judgement or care in the practice of their profession are addressed.

Conduct

A practitioner is being monitored to ensure they practise safely and appropriately following consideration of their criminal history, or they have demonstrated a lesser standard of professional conduct than expected.

Suitability/eligibility

A practitioner is being monitored because they:

- do not hold an approved or substantially equivalent qualification in the profession
- lack the required competence in the English language, or
- do not meet the requirements for recency of practice, or do not fully meet the requirements of any other approved registration standard.

Prohibited practitioner/student

A practitioner or student is being monitored because they:

- are subject to a cancellation order, suspension or restriction not to practise, or
- may have surrendered their registration or changed to non-practising registration, as an outcome of a notification.

This year, the number of active monitoring cases nationally increased by 8.9%. The cases monitored by Ahpra relate to 4,212 (3,826 in 2018/19) individual practitioners and the majority were about monitoring of eligibility/suitability requirements.

Implementing a national operating model

The delivery of our compliance functions moved to a full national operating model that aims to bring a range of benefits to practitioners, staff and Boards, through more consistent management of compliance matters. Clear visibility of national demand will allow us to better manage workloads, making the most of the skills and experience we have nationally to ensure timely management of compliance matters for practitioners. National Boards will gain from consistent, expert advice to underpin consistency in regulatory decision-making.

Reviewing the National Restrictions Library

In 2015, the National Restrictions Library (NRL) was launched at www.ahpra.gov.au/registration/monitoring-and-compliance/national-restrictions-library. This is an important national resource and documents common restrictions (e.g. conditions on registration) used across the regulatory functions of the National Boards to support:

- consistency in recommendations from Ahpra to the National Boards and delegates
- consistency in the restrictions appearing on the national public register of health practitioners
- a best practice approach to monitoring compliance with restrictions.

Consistent with the commitment to quality improvement, a review of the NRL began to ensure:

- each restriction is expressed in plain English while continuing to meet the 'good restriction test'
- each restriction remains fit for purpose
- all commonly used restrictions are available.

In the past few years, we have received feedback from stakeholders that the individual restrictions are lengthy and administratively complex and that this makes them less accessible when published on the *Register of practitioners*. Restrictions in the current version of the NRL include two key components as follows:

- **Core restriction** – this is the component of the restriction which addresses the behaviour or issue.
- **Operating restrictions** – this is the supplementary information that defines the practitioner's responsibilities, the Board's expectations, the monitoring activities and the information by which compliance with the core restriction will be monitored.

To reduce the length of restrictions, make them less complex and more accessible, the review has recommended that the future structure of restrictions be amended by:

- maintaining the core restriction for publication
- including all operating and administrative requirements in standard monitoring plans rather than as 'operating restrictions', and
- then applying the requirements detailed in the standard monitoring plan as enforceable requirements through the core restriction.

This amended approach will be implemented during 2020/21.

Performance reviews

During 2019/20 three performance and quality assurance reviews were carried out:

- Use of monitoring plans – we evaluated the use of monitoring plans and concluded in all but two cases that monitoring by staff was consistent with restrictions.
- Use of prescribing data – we evaluated use of prescribing data to identify any practitioners who were prescribing to a prohibited or restricted patient group such as female patients. We concluded it was appropriate to continue to use prescribing data to monitor practitioners subject to restrictions relating to sexual misconduct as 21% of the data reviewed did identify actual breaches.
- Aged restrictions on registration – we reviewed cases with restrictions on registration aged more than two years. We concluded from the review that the aged restrictions on each practitioner's registration were appropriate and current as they commonly related to: restricting scope of practice; monitoring long-term health issues; or the restrictions were imposed in circumstances required by the registration standard.

Top 10 restriction categories

The top 10 restriction categories (4,743 restrictions) by volume monitored by Ahpra at 30 June are shown in Table 31. Although 4,215 cases were being actively monitored by Ahpra, each case may have more than one restriction category requiring compliance by the practitioner.

- 60.7% of restrictions imposed (2,879) in the top 10 restriction categories by volume were as a result of the routine process of a health practitioner obtaining or renewing registration with a National Board.
- 39.3% (1,864) of the restrictions in the top 10 restriction categories by volume were imposed as a result of a finding made by a National Board, panel or tribunal about a practitioner's health, performance or conduct.

The top 10 restriction categories by volume at 30 June

Restriction on practice and employment

A requirement, imposed at registration or renewal, requiring the registrant to do or refrain from doing something in connection with their profession. This category would include practitioners who may only practise in certain locations, such as international medical graduates with limited registration working in a regulated area of need.

Requirement for supervision

A requirement, imposed at registration or renewal, requiring the registrant to do a certain amount of supervised practice under varying levels of supervision. This restriction is often imposed where a practitioner is re-registering in the profession after an absence.

Undertake education

A requirement that a registrant attends and completes a defined education course, training or upskilling activity.

Undertake assessment

A requirement, imposed at registration or renewal, requiring that a registrant, at some point in the next registration period, undergoes an assessment of their performance in the profession.

Restriction on scope of practice

A requirement, imposed at registration or renewal, requiring a registrant to restrict the type of practice they undertake.

Attend treating practitioner

A requirement that a registrant attends a treating health practitioner(s) for management of identified health issues.

Prohibition on practice

A restriction category used to manage cases for registrants who are prohibited from practising, including a practitioner whose registration is suspended.

Restriction on workplace location

A restriction on the location or the position in which a registrant may practise their profession.

Requirement to practise under indirect and remote supervision

A requirement, generally imposed due to health, performance or conduct concerns, that a practitioner practise the profession or an aspect of the profession under indirect or remote supervision from another registered health practitioner.

Restriction on work type

A restriction on the type or manner of work a registrant may undertake.

Table 31. Top 10 restriction categories by volume at 30 June 2020

Restriction category	Total
Restriction on practice and employment	**998**
Requirement for supervision	**976**
Undertake education	**484**
Undertake assessment	**454**
Restriction on scope of practice	**451**
Attend treating practitioner	**434**
Prohibition on practice	**284**
Restriction on workplace location	**256**
Requirement to practise under indirect and remote supervision	**216**
Restriction on work type	**190**

Advertising compliance and enforcement

Ahpra's compliance and legal divisions manage the enforcement aspects of the *Advertising compliance and enforcement strategy*. The advertising compliance team is responsible for triaging all offence complaints, assessing all advertising offence complaints and the ongoing management of low-to-moderate-risk advertising complaints under this strategy.

Responsible advertising is a professional and legal obligation. We recognise that most health practitioners want to comply with the law and their professional obligations, and we aim to make such compliance as easy as possible.

In 2019/20, 412 low-to-moderate-risk advertising complaints about registrants were received under the strategy. In 2018/19, 515 low-to-moderate-risk advertising complaints were received. The reduction of 20.0% in these types of advertising complaints received this year is the result of an increase in referral of:

- advertising complaints about those who are not registered health practitioners to the National Legal Practice for action (see page 86)
- complaints to be actioned as notifications as the matters raised related to the health, performance or conduct of a registered health practitioner (see page 67).

The data confirm that nearly 50% of registrants become compliant in response to an initial letter from Ahpra about the advertising breach. The remainder become compliant when the imposition of advertising restrictions is being considered and the practitioner is issued with the show cause notice where each breach and its location is specified. This demonstrates the effectiveness of the strategy in educating practitioners about their professional obligations and ensuring timely remediation of inappropriate advertising for the benefit of the public.

There were no instances of continued non-compliant advertising that required regulatory action through the imposition of advertising restrictions.

You can read the *Advertising compliance and enforcement strategy* at www.ahpra.gov.au/publications/advertising-resources/legislation-guidelines.

Table 32. Active monitoring cases at 30 June 2020, by state or territory (includes HPCA and OHO)

	Ahpra													
Stream	**ACT**	**NSW[1]**	**NT**	**QLD**	**SA**	**TAS**	**VIC**	**WA**	**No PPP[2]**	**Ahpra subtotal 2019/20[3]**	**HPCA[4]**	**OHO[5]**	**Total 2019/20**	**Total 2018/19**
Conduct	2	4	4	52	59	9	114	38	2	**284**	421	64	**769**	**731**
Health	13	5	11	179	69	18	116	73	10	**494**	368		**862**	**866**
Performance	16	8	8	157	88	20	172	65	1	**535**	263	9	**807**	**704**
Prohibited practitioner/student	11	3	5	80	60	6	164	47	6	**382**			**382**	**316**
Suitability/eligibility[6]	54	990	20	375	158	38	430	229	226	**2,520**			**2,520**	**2,279**
Total 2019/20	**96**	**1,010**	**48**	**843**	**434**	**91**	**996**	**452**	**245**	**4,215**	**1,052**	**73**	**5,340**	
Total 2018/19	**87**	**960**	**47**	**807**	**370**	**80**	**904**	**448**	**166**	**3,869**	**977**	**50**		**4,896**

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. For 2019/20, the 4,215 Ahpra monitoring cases relate to 4,212 registrants. The data provided by the HPCA report the number of registrants being monitored.
4. 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.

Table 33. Active monitoring cases at 30 June 2020, by profession and stream (includes HPCA and OHO)

Profession	Conduct			Health			Performance			Prohibited practitioner/ student	Suitability/ eligibility[1]	Total 2019/20			Total 2018/19		
	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	HPCA	OHO	Ahpra	Ahpra	Ahpra[2]	HPCA	OHO[3]	Ahpra[2]	HPCA	OHO[3]
Aboriginal and Torres Strait Islander Health Practitioner		1		2						1	1	**4**	**1**	**0**	**6**	**1**	**0**
Chinese medicine practitioner	2	5	2				4	9	1	4	808	**818**	**14**	**3**	**860**	**9**	**3**
Chiropractor	14	3		1	2		9			6	9	**39**	**5**	**0**	**41**	**9**	**0**
Dental practitioner	7	20	3	15	14		71	40	1	7	37	**137**	**74**	**4**	**132**	**75**	**3**
Medical practitioner	104	199	31	174	128		237	86	4	100	503	**1,118**	**413**	**35**	**1,043**	**403**	**24**
Medical radiation practitioner	3			9	3		1			3	25	**41**	**3**	**0**	**42**	**5**	**0**
Midwife	2			2	5		7	3	1	1	19	**31**	**8**	**1**	**69**	**5**	**1**
Nurse	80	80	19	239	167		130	80	2	197	758	**1,404**	**327**	**21**	**1,203**	**316**	**19**
Occupational therapist	1	1		4	2		1				73	**79**	**3**	**0**	**50**	**0**	**0**
Optometrist	4				1		2				3	**9**	**1**	**0**	**14**	**1**	**0**
Osteopath	1	3	1		1					3	4	**8**	**4**	**1**	**9**	**3**	**0**
Paramedic	5	3	2	12	11		1			11	139	**168**	**14**	**2**	**21**	**0**	**0**
Pharmacist	18	91		18	14		24	29		23	42	**125**	**134**	**0**	**143**	**100**	**0**
Physiotherapist	12	4	4	2	1		4	2		5	33	**56**	**7**	**4**	**63**	**8**	**0**
Podiatrist	3	1		3	2		4	1		3	4	**17**	**4**	**0**	**29**	**2**	**0**
Psychologist	28	11	2	13	16		40	13		18	62	**161**	**40**	**2**	**144**	**40**	**0**
Total 2019/20	**284**	**422**	**64**	**494**	**367**	**0**	**535**	**263**	**9**	**382**	**2,520**	**4,215**	**1,052**	**73**			
Total 2018/19	**254**	**433**	**44**	**514**	**352**	**0**	**506**	**192**	**6**	**316**	**2,279**				**3,869**	**977**	**50**

1. Ahpra monitors compliance cases in the 'suitability/eligibility' stream in NSW.
2. The Ahpra data structure provides reports by monitoring case 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. For 2019/20, the 4,215 Ahpra monitoring cases registrant may have a set of restrictions (conditions or undertakings) in more than one stream. For 2019/20, the 4,215 Ahpra monitoring cases relate to 4,212 registrants. The data provided by the HPCA report the number of registrants being monitored.
3. In Qld 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.

Research, strategy and policy

Research

Our regulatory research

Research projects that we concluded this year were:

- **qualitative research** to understand and improve the experience of notifiers and health practitioners
- a **cross-professional study of health practitioners** with multiple notifications to accurately describe drivers for notifications that may be amenable to a regulatory response
- a study **predicting the likelihood of notification outcomes** to support regulatory decision-making
- a **review of notifications** about pharmacists involving the dispensing of oral methotrexate
- an **analysis of notifications** about occupational therapists
- **conducting literature reviews**, including on complaint issue taxonomies.

The guiding framework

We reviewed and revised the current research framework to better align research and evaluation projects to the overall National Scheme objectives and strategy.

Research ethics

The National Scheme published a *Research ethics position statement*. We are finalising a formal arrangement with a human research ethics committee registered with the National Health and Medical Research Council (NHMRC) that will provide ethical oversight for relevant research projects.

International research collaboration

In 2018/19, we established an international regulatory expert group to strengthen our research governance systems and provide advice on research, quality improvement and evaluation projects. The group brings together regulatory experts from Australia, New Zealand, the United Kingdom, the United States and Canada.

As part of our research and evaluation activities to support the National Scheme, the National Boards and other scheme entities, we are collaborating with international partners from the UK and the US to investigate the potential of artificial intelligence to support regulatory decision-making in complaints about nurses.

Publications and presentations

As research and evaluation continues to evolve in the National Scheme, the 2020 National Scheme's Combined Meeting incorporated research and evaluation throughout its program. The key speakers – Dr Gerald Hickson, Professor Valerie Braithwaite and Professor Kieran Walshe – included research and evaluation-related content in their presentations and workshops. In addition, Ahpra researchers Dr Eva Saar and Mr Michael Rasmussen co-presented with Dr Finn Lattimore of the Gradient Institute, on how to harness digital technologies such as artificial intelligence and machine learning to identify risk and facilitate regulatory solutions.

To ensure our research and evaluation is communicated widely for better knowledge sharing, we aim to produce publications for peer-reviewed health journals, where appropriate. Publications include:

- Biggar, S, Lobigs, LM and Fletcher, M (2020) 'How can we make health regulation more humane? A quality improvement approach to understanding complainant and practitioner experiences' *Journal of Medical Regulation*, 106(1) pp. 7–15.

Research partnerships

Ahpra maintains and facilitates research partnerships. Previously, this included a NHMRC partnership grant with the University of Melbourne. While this partnership has concluded, the University of Melbourne research team has produced publications during 2019/20 related to investigating hotspots of risk using regulatory data collected by the National Scheme. Publications include:

- Veness, BG, Tibble, T, Grenyer, BFS, Morris, JM, Spittal, MJ, Nash, L, Studdert, DM and Bismark, MM (2019) 'Complaint risk among mental health practitioners compared with physical health practitioners: a retrospective cohort study of complaints to health regulators in Australia' *BMJ Open*.

We continue to collaborate with the Digital Health Cooperative Research Centre as a partner providing in-kind support. This program will invest over $200 million aimed at developing and testing digital health solutions for patients, while equipping Australians to better manage their own health and wellbeing. We have primarily focused on facilitating access to de-identified regulatory data. However, we are also exploring potential opportunities to contribute to specific projects, including projects related to improving quality and safety through enhanced performance feedback for practitioners.

Access to data for research

While the comprehensive national regulation data that Ahpra collects have registration, workforce planning, demographic, commercial and research value, the National Law and the *Privacy Act 1988* (Cth) impose strict limits on their use. Our data access and research policy focuses on helping researchers and other parties to better understand the process for considering requests for data and research.

Ahpra's website clearly details what data are already available and how to access them, the processes for accessing data that are not publicly available, and the policies and legislation that govern what can and cannot be released.

When our data and information are used for research, they are often published as research outcomes in academic journals. When information has been used by researchers and resulted in publication, we list them on our website. When publications can be accessed freely, we provide links to external websites.

Table 34. Data access requests by type in 2019/20

Request to contact or survey practitioners	1
Copies or extracts of the *Register of practitioners*	14
Quantitative statistics (regulatory data)	32
Research data	4
Other (general information)	32
Total	**83**

Strategy

Our vision in the *National Registration and Accreditation Scheme strategy 2015–20* is to be recognised as a leading risk-based regulator enabling a competent and flexible health workforce to meet the current and future health needs of the Australian community.

Through our strategy work we make sure that Ahpra, the National Boards and our stakeholders can identify and measure how they are contributing to achieving the objectives of the National Scheme strategy through their day-to-day work.

The balanced scorecard (BSC) is the framework we use to enable the efficient communication and delivery of the vision, mission and strategic outcomes of the National Scheme strategy.

Four themes

Our four strategic themes – risk-based regulation, strategic partnerships and service excellence, and capability and culture – have an aligned set of objectives, measures and targets that are used to monitor and communicate our progress. With the current strategy drawing to a close in June, we gained final insights into our performance:

- In risk-based regulation we have increased the percentage of common regulatory standards across the regulated health professions to reduce regulatory complexity and National Boards have increased their focus on initiatives that reduce risk within their regulatory plans.
- In strategic partnerships, we have engaged with our partners in the National Scheme to produce better outcomes for patient safety and quality healthcare. For example, 100% of National Boards executed their agreements with their respective accreditation authority by 1 July 2019 and we continue to meet our commitments to provide updates through the Jurisdictional Advisory Committee before progressing them to the Ministerial Council.
- In service excellence, work continues to redesign our processes with customer-focused approaches in mind to improve experiences for notifiers, practitioners, applicants and registrants. The majority of new registrants who applied online found their experience satisfactory, easy or very easy.
- Our performance in capability and culture continues to develop and align with activities within our *Ahpra people plan*, such as improving capability through learning and development, defining and promoting good leadership and simplifying fit-for-purpose policies, processes and procedures.

A major review of our strategy began in February 2019 to inform the development of a new *National Scheme strategy 2020–25*. Following consultation with a wide range of stakeholders across the scheme, we received support for a mission-led focus and for the inclusion of four new values for the first time. The four strategic themes of the new strategy – regulatory effectiveness, trust and confidence, evidence and innovation, and capability and culture – are a reflection of the wide feedback received on the importance of enhancing the trust and confidence of our stakeholders, doing our essential regulatory and registration work well, making a greater contribution to the broader healthcare environment and investing in our people.

The new strategy was approved in June 2020 and implementation has started. The strategy has been published on our website, and includes a supporting guide, implementation map and behavioural attributes aligned to our values. Implementation activities will continue into 2020/21.

Figure 112. National Scheme strategy 2020–25

Shared policy issues

National Boards and Ahpra regularly collaborate on shared policy issues. This collaboration helps to simplify the regulatory landscape, facilitates effective, collaborative care and supports good inter-professional practice. It makes it easier for everyone to know what to expect of registered health practitioners.

Policy support and coordination

Ahpra develops policy resources and provides policy advice to National Boards and also develops and coordinates responses for external policy consultations. This year the projects we contributed to included:

- the National Rural Health Commissioner's policy options to improve access, distribution and quality of rural allied health services
- proposed regulations and registration standards for the Victorian Disability Worker Regulation Scheme
- the Department of Employment, Skills, Small and Family Business' consultation on the Short-term Skilled Occupation List, the Medium and Long-term Strategic Skills List and the Regional Occupation List
- proposed regulations to improve the safe use of products commonly used in cosmetic procedures in NSW,[1] and
- the review of the *Victorian teaching profession code of conduct*.

Joint policy initiatives

Regulatory responses to COVID-19

Registered health practitioners are playing a vital role in treating and containing COVID-19. We developed, reviewed and refined policy advice to National Boards to support timely, proactive regulatory responses to the pandemic. For example, we developed telehealth guidance to support health practitioners to continue providing safe care to their communities.

Review of processes

We made substantial progress on reviewing our policy and consultation processes to provide a clearer and more transparent message about how the National Boards hold consultations.

This work included reviews of the *Consultation process National Boards 2020*, the *Procedures for development of accreditation standards* and the *Procedures for the development of registration standards, codes and guidelines*, all to be published in 2020/21.

In response to the two COAG Health Council policy directions issued in January, in addition to accounting for the policy directions in our broader review of policy and consultation processes, we developed two templates: *Patient health and safety impact statement* and *Patient health and safety impact assessment* to strengthen the involvement of patient safety and consumer perspectives in our work.

Mandatory notifications

We reviewed the mandatory notifications guidelines and published separate *Guidelines: mandatory notifications about registered health practitioners* and *Guidelines: mandatory notifications about registered students*. The guidelines help notifiers understand who must make mandatory notifications and when they must be made. The guidelines incorporate legislative amendments that established a new, higher risk threshold for treating practitioners to make a mandatory notification.

Registration standards

Following a joint review and Ministerial Council approval, revised continuing professional development (CPD), recency of practice (ROP) and professional indemnity insurance arrangements (PII) registration standards came into effect for several National Boards.

We coordinated implementation of revised guidelines for CPD, piloting a new approach to developing CPD guidance that involved testing guidance through surveys and focus groups with practitioners.

Cosmetic procedures

We launched 'be safe first', an education campaign to advise consumers of the risks associated with cosmetic procedures and to help consumers know what kinds of questions to ask before going ahead with a cosmetic procedure. This is part of a multifaceted approach across regulators to help address risks and poor outcomes associated with cosmetic procedures.

Advertising

We continued work on advertising policy issues, including evaluating the *Advertising compliance and enforcement strategy for the National Scheme*. We held public consultation on the revised *Guidelines for advertising a regulated health service*.

Supervised practice

We made substantial progress on a review of the supervised practice guidelines used by some National Boards to establish a *Supervised practice framework* (with some profession-specific exclusions). Public consultation was held during September to December.

Other initiatives

We worked on:

- the review of the *Code of conduct* shared by seven National Boards and used by an additional five with minor profession-specific variations, incorporating the National Scheme's definition of cultural safety, developed by the Aboriginal and Torres Strait Islander Health Strategy Group
- a literature review to inform the review of National Boards' English language skills registration standards.

1 Poisons and Therapeutic Goods Amendment Regulation 2020

Communicating and engaging

Communications snapshot

- **474 news items** published
- **51 e-newsletters** sent and published online
- **469 media enquiries** responded to
- **14 episodes** of our *Taking care* podcast released
- **Over 1,000 calls answered and 280 web enquiries** responded to every day
- **Over 1 million searches** of the *Register of practitioners*
- Our social media posts were seen **over 4 million times**
- The Ahpra website was viewed **almost 31 million times**

Responding to queries

Over 300,000 calls were made to the Customer Service team and over 70,000 web enquiries were lodged. Compared to last year the number of calls reduced by 8.5% and web queries increased by 23.2%. The team answered an average of 1,044 calls and responded to an average of 280 web queries per work day.

Social media

32,020 Facebook likes, 31.3% increase from last year

9,800 Twitter followers, 13.8% increase from last year

71,213 LinkedIn followers, 117.1% increase from last year

993 Instagram followers, in our first year

Our posts received 170,138 interactions (likes, shares and comments).

We responded to 1,181 enquiries and comments across our social media channels.

Our social media posts were seen over 4 million times.

Our goal on social media is not only to help achieve the National Scheme strategic objectives of 'improve customer experience' and 'enhance strategic partnerships' but to do so in a way that is interesting and engaging to our followers.

Providing information online

The Ahpra website was viewed almost 31 million times by external users.[1]

By far the most frequently visited section was 'Registration' with over 18 million page views. With almost 900,000 unique page views, the 'About Ahpra' section was the next.

The home page and the *Register of practitioners* page were the most popular pages with almost 4 million unique page views of the home page and over 3.5 million unique page views of the national register.

There were over 1 million searches of the register (practitioners also search the register to check the status of their registration).

Reminders about checking registration status online, registration renewal and registration fees were the most popular news items accessed from Google searches. The April announcement of the pandemic sub-register received over 13,000 page views and the March statement from the National Boards and Ahpra about COVID-19 almost 12,000.

Publications

This year we emailed a total of 51 e-newsletters to registrants and stakeholders. These included National Board newsletters with important information on registration and regulation sent to all registered practitioners, and our *Ahpra report* to around 6,000 external stakeholders in July and December. The Chinese Medicine Board newsletter is also published in Chinese translation online.

Newsletter production was severely affected by the COVID-19 pandemic and the resulting transfer of all Ahpra's functions and staff to working remotely and online in March. All National Board newsletters after 25 March, except for one pandemic-specific issue in late April, were put on hold while the Boards and Ahpra staff concentrated on the COVID-19 communications effort. This intense focus continued until late May, when normal newsletter production resumed.

We continue to see high rates of engagement with Board newsletters. The highest open rate was 75% (Chiropractic Board of Australia newsletter, June 2020). Of the 51 newsletters sent, 10 achieved open rates of 70% or higher, 13 had rates of 60–68%, and 26 newsletters had open rates of 45–59%. The lowest open rate was 40%. Current industry averages for Australia (government and healthcare) are around 26%.

We also published a booklet titled *A unique and substantial achievement: Ten years of national health practitioner regulation in Australia* to commemorate the 10th anniversary of the National Scheme on 1 July. This publication was launched early, at the National Scheme Combined Meeting in February when National Board members, national and international guest speakers and some of Ahpra's founding staff were present.

Ahpra successfully met the statutory reporting requirement by submitting the 2018/19 annual report in the required timeframe. At 30 June, the report had received over 13,000 unique page views.

Talking to the media

Ahpra and the National Boards responded to 469 media enquiries from journalists and media outlets across Australia and internationally. We also published 474 news items including 61 media releases.

Our media communications are an important extension of Ahpra and the National Boards' number one priority to ensure public safety. We are focused on educating the public about the important work of health practitioner regulation, what level of care to expect from a registered health practitioner in Australia and how to report a concern. As in previous years, we responded to numerous enquiries about the actions taken by National Boards about individual practitioners and related outcomes.

1. This year, with staff working from home in response to COVID-19, web statistics include staff working remotely as well as external visitors.

This year our proactive media activities included the public promotion of the *Aboriginal and Torres Strait Islander health and cultural safety strategy*, the changes to mandatory reporting requirements and the launch of Ahpra's Criminal Offence Unit.

We also initiated an important public safety campaign to raise awareness about cosmetic procedures.

Our media team played a key role during the COVID-19 response. The launch of the pandemic sub-register on 6 April generated significant media interest with 62 new enquiries received that month.

Throughout the year, Ahpra and the National Boards have continued to work cooperatively on a number of media and communications activities with our co-regulatory counterparts and the National Health Practitioner Ombudsman and Privacy Commissioner.

Our podcast: *Taking care*

In November we launched a podcast series called *Taking care* to share important discussions about healthcare in Australia, with a focus on public safety, featuring registered health practitioners and others in frank conversation.

At 30 June, we have published 14 episodes on varied topics including vexatious notifications, public expectations of health practitioners, eliminating racism from the health system, and a rural and remote health practitioner view.

The podcasts had 10,414 listens from launch to 30 June. At over 2,000 listens, the most popular episode, 'Telehealth in the pandemic era', looked at telehealth's rapid emergence as practitioners adapted to the changing needs of our population, continuing to practise and keep the public safe and healthy.

Everyone in the Ahpra community and beyond can listen, subscribe and share by searching 'Taking care' on any podcast player.

A new look

Growth in the number of regulated health professions led to a refresh of our branding. Simplified logos for Ahpra and National Boards were rolled out in late 2019.

Consulting with advisory groups

We regularly consult with advisory groups to gather feedback, information and advice.

Professions Reference Group

The Professions Reference Group (PRG) consists of a representative from professional associations for each of the regulated health professions and the Health Professions Accreditation Collaborative Forum. It provides an opportunity for Ahpra to engage on National Scheme, cross-profession and operational issues where members give feedback, information and advice. The past year was busy for the PRG with topics discussed including the graduate registration campaign, proposed supervised practice framework, cosmetic procedures and consumer-focused information, mandatory notification campaign, consultation on cultural safety, engagement strategy, multi-profession policy and accreditation, and consultation on amendments to the National Law.

Other matters discussed during this time include an update on the implementation of the Policy Directions issued by Health Ministers to Ahpra and National Boards, advertising guidelines consultation, and the *National Scheme strategy 2020–25*. See www.ahpra.gov.au/About-ahpra/Our-engagement-activities/Advisory-groups/Professions-Reference-Group.

At the start of the COVID-19 pandemic, the PRG adapted its meeting format and held regular virtual meetings so we could provide updates and consult members on our response to the pandemic, including the development of the pandemic response sub-register.

Community Reference Group

The Community Reference Group (CRG) provides a forum for Ahpra and National Boards to seek advice and feedback on how we engage with and meet community needs. Members provide their individual consumer and community perspective, rather than representing an identified community. The CRG comprises people from across the community with a range of expertise and experience. It is chaired by a community member of a National Board.

We sought the advice of the CRG on the draft *National Scheme strategy* and the draft *Engagement strategy*; how and why we conduct research within the National Scheme; accreditation standards, how we can strengthen the consumer voice as we implement the Ministerial policy directions made in late 2019, and how we could best inform consumers about making safe choices when considering cosmetic procedures and surgery. See www.ahpra.gov.au/About-ahpra/Our-engagement-activities/Advisory-groups/Community-Reference-Group.

Social research

We surveyed health practitioners and members of the community for the second time about their awareness and understanding of our work, and their levels of trust and confidence. The project included a short anonymous survey to random samples of practitioners and the community. There were nearly 6,000 responses from practitioners and 2,000 from the broader community. The results showed significant gains in some areas and consistent outcomes in others. Among members of the community who were aware of Ahpra and the National Boards, 74% expressed trust in Ahpra and 71% were confident Ahpra was doing everything it can to keep the public safe. A total of 67% said they trusted a National Board and 67% were confident the Board was doing everything it could to keep the public safe. Over half of practitioners expressed trust in Ahpra (55%) and National Boards (60%).

Engagement snapshot

- **First *Engagement strategy* approved**
- **The *Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025* launched**
- **Two policy directions** received from the Ministerial Council
- We continued our work as a **WHO Collaborating Centre for Health Workforce Regulation**
- **We connected** with international regulators through CLEAR

Engagement strategy

In June, Ahpra and the National Boards approved our first national *Engagement strategy*. The aim of the strategy is to build the trust and confidence of our key stakeholders in our work to protect the health and safety of the public.

We know that to do our work effectively we rely on members of the community, health practitioners, students, employers, co-regulators, educators and many others to engage and work with us, as we regulate more than 800,000 registered health practitioners across Australia. They rightly expect us to be fair, transparent, responsive, empathic and accountable.

The *Engagement strategy* provides a clear direction and commitment to effective engagement and is directly linked with the *National Scheme strategy 2020–25*. Our engagement will have a three-pronged emphasis on relationships and partnerships, cultural safety and a person-centred focus. An engagement reference group, made up largely of external members from our key stakeholder groups, has been formed to advise and support the implementation of this work, which will build over the next five years.

Launching the *Aboriginal and Torres Strait Islander health and cultural safety strategy*

The National Scheme's Aboriginal and Torres Strait Islander Health Strategy Group developed the *National Scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020–2025*. The strategy is endorsed by 43 organisations and entities, and academics and individuals, including accreditation authorities.

The strategy was launched in February. It focuses on achieving patient safety for Aboriginal and Torres Islander Peoples as the norm and the inextricably linked elements of clinical and cultural safety.

After public consultation, the Strategy Group in partnership with the National Health Leadership Forum developed a baseline definition of cultural safety for the National Scheme.

By definition, cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.

The Strategy Group farewelled and thanked inaugural co-chair Professor Gregory Phillips and welcomed Mr Karl Briscoe, CEO of the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) to co-chair with Ms Julie Brayshaw, Chair of the Occupational Therapy Board of Australia. Ms Jacqui Gibson-Roos, member of the Dental Board of Australia, was appointed to the newly created position of Deputy Chair.

PwC Indigenous Consulting (PIC) in conjunction with Griffith University First Peoples Health Unit (GUFPHU) are our partners providing the Moong-moong-gak Aboriginal and Torres Strait Islander cultural safety training. A pilot of the training was run between April and June. Due to the COVID-19 pandemic, the pilot program was adapted from an intended blended approach of online and face-to-face learning to completely online delivery.

There were 66 pilot participants including Ahpra staff from across all directorates and members of the Agency Management Committee, Strategy Group, the Strategy Group's Caucus of Aboriginal and Torres Strait Islander members, and National Boards. The pilot program included online learning, critical reflective activities, quizzes and collaborative sessions. Feedback from pilot participants will inform the full roll-out of training in 2020/21.

Working with governments

Health Ministers from the Commonwealth, state and territory governments have an important role to play in the National Scheme. Meeting as the Ministerial Council of the National Scheme, Health Ministers:

- appoint members to National Boards and the Agency Management Committee
- approve registration standards and endorsements developed by National Boards
- propose amendments to the National Law to improve the regulation of practitioners
- receive regular reports from Ahpra and the National Boards about their work and the performance of the National Scheme
- provide direction about the policies applied by Ahpra and National Boards as they exercise their responsibilities under the National Law.

Ahpra maintains a strong working relationship with Commonwealth, state and territory health departments, primarily through its Jurisdictional Advisory Committee (JAC). JAC is a forum consisting of members from each health department and is responsible for providing advice, direction or agreement on National Scheme matters, particularly those which require Australian Health Ministers to reach a decision under the National Law.

This year, we report on two significant decisions made by the Ministerial Council.

Policy directions

In January, Ahpra and the National Boards welcomed two new policy directions from Health Ministers that reinforce that Ahpra and National Boards are to prioritise public protection in the work of the National Scheme.

The first policy direction clearly states that public protection is the paramount consideration in the administering of the National Scheme. The second policy direction requires National Boards to consult with patient safety bodies and consumer bodies on registration standards, codes and guidelines when they are being developed or revised.

Ahpra and National Boards have established processes to ensure the requirements of both policy directions are met in its regulatory decision-making. In implementing these policy directions, Ahpra and National Boards will continue to ensure fairness for health practitioners in regulatory processes.

The directions are reproduced in *Appendix 7*.

National Law amendments

On 31 October, the Ministerial Council requested preparation of legislation to address proposed reforms to the National Law that cover the strengthening of public protection, improving the administration and operations of the National Scheme and amendments to the objectives and principles of the National Scheme. Ahpra is providing advice and assistance to health departments in preparing these draft amendments for their consideration by the Queensland Parliament.

Working internationally

World Health Organization

Ahpra has continued its work as a recognised World Health Organization (WHO) Collaborating Centre for Health Workforce Regulation. The objective of the Collaborating Centre is to work in partnership with WHO to strengthen the capacity and skills of regulators in the Western Pacific Region of WHO.

An important way to achieve this objective is the Western Pacific Regional Network of Health Workforce Regulators. Currently, this network has members from over 20 countries in the region, seeking to share knowledge about regulation and working together to improve standards. We held four regional network webinars in 2019, on a range of health workforce regulation topics, and we are continuing the series in 2020 and 2021.

We welcomed bilateral engagement opportunities with several nations in the region (Papua New Guinea, Laos, Malaysia, Vietnam, Brunei and Fiji, and also with Hong Kong) for the purpose of information sharing, policy development and technical advice.

Of note, in September the Chinese Medicine Board of Australia, RMIT University and our collaborating centre co-hosted a WHO meeting about strengthening regulatory systems for traditional and complementary medicine practitioners in the Western Pacific Region. Participants from 13 countries exchanged information on the current status of regulation of traditional and complementary medicine practitioners across the region and discussed opportunities for future collaboration to improve regulatory standards.

CLEAR

Aside from our work with WHO, National Boards and Ahpra have established strong relationships with regulators from around the world. These relationships help us to learn from the experiences of others and allow us to work together to lift the regulation standards for the health workforce globally.

Our work with the international organisation the Council for Licensure, Enforcement and Regulation (CLEAR) has led to not only significant information exchange between regulatory bodies but also the roll-out of a nationally based training program for all Ahpra investigators, which has led to greater consistency and quality in our work. This work was done in partnership with CLEAR and is based on a certified investigator training program.

An indicator of our close involvement is that in 2019 Ms Kym Ayscough, Ahpra's Executive Director for Regulatory Operations, was appointed as President of CLEAR, the first president from the Southern Hemisphere.

CLEAR presented the 2019 Regulatory Excellence Group Award to three staff – Mr Matthew Hardy, National Director, Notifications; Ms Susan Biggar, National Engagement Adviser; and Ms Monica Lambley, Program Manager, Notifications – for their work to improve the notifier and practitioner experience.

Organising, managing and directing

Snapshot

- **Introduced a new organisational structure** to reduce duplication, drive consistency and improve our ways of working
- **Completed a major upgrade** of software and platforms
- **Quickly transitioned all Ahpra staff to working from home** when COVID-19 hit and supported Boards and committees to work virtually
- **Equipped 1,000 staff** nationally with laptops and other support for remote working
- **Established the pandemic response sub-register** to fast track health practitioners back into the registered workforce

Table 35. Full-time equivalent staff at 30 June 2020

Directorate	Full-time equivalent staff
Regulatory Operations	763
Strategy and Policy	172
Information Technology	113
Finance and Risk	44
People and Culture	40
Office of the CEO	3
Total	**1,135**

Organisational structure and resources

Figure 113. Organisational structure

Organisational restructuring

Following an all-staff consultation, in September we introduced a new organisational structure to ensure a clear focus on organisational priorities. The changes included grouping together teams and roles that do similar things, addressing gaps, removing duplication and making it easier to know who does what within Ahpra.

The new structure saw the dissolution of the Business Services directorate and the creation of two new directorates, Finance and Risk, and Information Technology. Mr Clarence Yap was appointed Chief Information Officer in October and Ms Elizabeth Davenport Chief Financial Officer in January.

The two new directorates emphasise our focus on financial sustainability and information technology as key enablers of our regulatory work.

As part of the restructure, the role of state and territory managers was reviewed with a renewed focus on local stakeholder engagement.

Regulatory Operations is responsible for carrying out Ahpra's core regulatory functions – registration, notifications, compliance, and legal – under the National Law. We moved our teams to a national structure working across our state and territory offices. This directorate is accountable for operational performance across the regulatory functions in the context of year-on-year growth in demand. It continues to mature in the application of risk-based assessment of regulatory matters, so we can focus our regulatory efforts and resources on matters of high risk and high complexity and resolve other matters more quickly, wherever possible.

Under the national structure we can drive greater consistency in experience, process and outcome, regardless of geography. We can see local issues and risks and can bring the collective expertise of our national network to manage and resolve these. Our priority is to build and maintain the trust and confidence of the people we interact with and who rely on us to contribute to the safety of our registered health workforce.

Strategy and Policy's purpose is to protect the public through effective and responsive whole-of-National-Scheme strategy, policy, engagement and regulatory governance. It provides high-quality national services that are multi-profession in their focus. It works in partnership with National Boards and collaboratively with accreditation authorities and partners, including governments. Strategy and Policy is organised under four functions – engagement, policy, regulatory governance and strategy.

People and Culture is accountable for whole-of-organisation people initiatives that drive employee engagement and include services such as learning and organisational capability, health, safety and wellbeing, recruitment, payroll, and property and facilities.

Finance and Risk comprises teams of business professionals responsible for efficient and effective financial strategy and management, procurement, risk management, assurance and audit programs.

Information Technology partners with all internal and external stakeholders across Ahpra in providing the required technology and services to support health practitioner regulation in Australia. It is an agile team in an ever-changing environment, providing technical solutions, strategy and initiatives; creating a more inclusive and efficient 'One Ahpra' working environment.

National Executive

The National Executive is Ahpra's national leadership group. Its members were:

- **Mr Martin Fletcher, Chief Executive Officer**
- Ms Kym Ayscough, Executive Director Regulatory Operations
- Ms Elizabeth Davenport, Chief Finance Officer Finance and Risk (from 28 January 2020)
- Mr Mark Edwards, Executive Director People and Culture
- Ms Sarndrah Horsfall, Executive Director Business Services (until 30 September 2019)
- Mr Chris Robertson, Executive Director Strategy and Policy
- Mr Clarence Yap, Chief Information Officer Information Technology (from 7 October 2019).

State and territory managers

Our state and territory managers are our senior leaders in each jurisdiction, and are based at each of our offices:

- Australian Capital Territory: Mr Anthony McEachran
- New South Wales: Ms Jane Eldridge
- Northern Territory: Ms Eliza Collier (to December 2019) Mr Anthony McEachran (acting December 2019–January 2020); Ms Helen Egan (from February 2020)
- Queensland: Mr Howard Spry (acting to 14 July 2020) Ms Heather Edwards (from 15 July 2020)
- South Australia: Ms Sheryle Pike
- Tasmania: Mr David Clements
- Victoria: Dr Clarissa Martin PhD
- Western Australia: Mrs Karen Banks.

Taking care of our own workforce

Despite the COVID-19 pandemic, the past 12 months have seen some substantial and positive changes for our staff.

We continued to support Ahpra employees through our clear *People plan*, including during the shift in our ways of working in March and April. The plan focused heavily on building our manager capability while also responding to the findings of the 2018 culture survey. The survey included a series of national focus groups that took an in-depth look at our culture and provide the foundation for a wider cultural change program.

Over the past year, we've also continued to develop our cultural measurement processes and tools through frequent employee 'pulse' surveys to understand contextual factors that drive employee engagement. In responding to the COVID-19 pandemic, each of our employees experienced establishing remote working arrangements in different ways due to a range of factors including geographic location, home arrangements and family commitments.

Despite the challenges presented by these new ways of working and the need to achieve balance, employee engagement results indicated that:

- 81% of all respondents were highly engaged, a 13% improvement on 2018 results, with the flexibility and benefits offered by working from home being major factors
- 91% responded positively to leaders' efforts supporting employees to adapt to organisational changes, and efforts to balance workload and personal responsibilities
- 93% said that their teams are working well together to support each other during the COVID-19 pandemic
- 90% responded positively to Ahpra's communication approaches, which included the daily *Three-minute mash* videos on the staff intranet, designed to engage and entertain as well as inform and connect.

Other highlights of the year:

- In July staff voted 87.72% in support of a new enterprise agreement.
- In August we appointed Assure as the new provider of our Employee Assistance Program (EAP).
- In September we re-launched a *Health and wellbeing hub* on our intranet.
- In December we launched *iinduct*, a new e-learning program, and all staff were required to complete six modules between February and April.
- In February we launched our Aboriginal and Torres Strait Islander cultural safety training pilot.
- We held 132 training/induction sessions. We aim to offer induction to new employees within four weeks of their start.
- The manager capability program was successfully completed by 200 managers.

In addition to our COVID-19 response, we revised the full suite of People and Culture policies, including our updated *Code of conduct* launched at the end of 2019.

While the longer-term impact of the COVID-19 pandemic is difficult to predict, the organisation has achieved some significant milestones, both in response to our changing external environment and demonstrated our commitment to our people in times of uncertainty and change.

Financial management

As we are self-funded by registrants' fees, it is important that we carry out our operations efficiently and effectively. We have to make good decisions, plan and invest wisely, and have the appropriate checks and balances in place to safeguard our funds.

We work to ensure the long-term sustainability of the scheme. We do this through strategic financial management with a long-term view considering the scheme's strategic goals and objectives. We plan, organise, direct and control the financial resources, ensure compliance with legislation and provide guidance and advice to the National Boards.

The Finance, Audit and Risk Management Committee (FARMC) is the principal committee of the Agency Management Committee that oversees finance, audit and risk. This committee reviewed the annual financial reports and projections with management, focusing on the integrity and clarity of disclosure, compliance with relevant legal and financial reporting standards, and the application of accounting policies and judgements.

The National Scheme income for the full financial year to 30 June was $220.43 million, an increase of $17.22 million on 2018/19. Income for the full year includes the components shown in Table 36 and includes grant funding revenue at 30 June.

Ahpra and the National Boards work in partnership to ensure long-term financial sustainability. The National Scheme recorded a net surplus of $6.65 million for the full financial year.

Table 36. Income type 2019/20

Income type	2019/20 $ million	2018/19 $ million
Registration income	194.98	177.02
Application income	14.95	15.72
Interest income	3.98	5.08
Legal fee recoveries	0.66	1.75
Exam fees	1.19	1.09
Late fees and fast-track fees	0.53	0.75
Certificate of registration status	0.30	0.34
Accreditation income	0.49	0.24
Application for registrar program	0.28	0.22
Government grants	1.68	0.00
Other income	1.38	1.00
Total	**220.43**	**203.21**

The financial statements section of the annual report describes our financial performance in more detail, including the net result and equity position for each National Board.

Fees set for each National Board aim to meet the full costs of regulation for each profession. Table 37 provides an overview of registration fees by profession since the start of the National Scheme.

Table 37. Registration fees for each profession

Profession	Fee ($)									
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Aboriginal and Torres Strait Islander Health Practice			100	100	100	100	120	150	150	154
Chinese medicine			550	563	579	579	579	579	579	579
Chiropractic	495	510	518	530	545	552	566	566	566	566
Dentists and specialists	545	563	572	586	603	610	628	647	663	681
Dental prosthetists	485	501	509	521	536	542	558	575	589	605
Dental hygienists and therapists	270	279	283	290	298	301	310	319	327	335
Medical	650	670	680	695	715	724	724	742	764	787
Medical radiation practice			325	295	250	180	180	180	185	191
Nursing and midwifery	115	160	160	160	150	150	150	155	170	175
Occupational therapy			280	230	160	130	110	110	110	113
Optometry	395	408	415	395	365	325	300	300	300	308
Osteopathy	480	496	504	516	416	386	376	376	376	376
Paramedicine									275	282
Pharmacy	295	305	310	317	317	320	328	336	396	408
Physiotherapy	190	196	199	179	159	120	110	110	140	144
Podiatry	350	362	368	377	388	378	378	378	378	378
Psychology	390	403	409	419	431	436	449	462	474	486

How Ahpra manages risk

Our Corporate Risk and Compliance team facilitates all strategic, enterprise and operational risk management and assurance activity for Ahpra and the National Boards.

This includes risk management, fraud and corruption control, critical and serious incident management, the insurance portfolio, internal audit and national quality assurance. Ahpra, in partnership with National Boards, seeks to manage risks in ways that allow us to meet the objectives of the National Scheme strategy.

Corporate Assurance Framework

The Corporate Assurance Framework aims to provide continuous and reliable assurance that major risks are being managed to continuously improve efficient and effective regulatory services to the Australian community. It enables leaders at all levels to demonstrate clear accountabilities for executing, managing, controlling and reporting risk to drive the continuous improvement of the National Scheme's work.

The framework provides a common platform for all strategic, enterprise and operational risk management and assurance activity for Ahpra and the National Boards. This requires consideration of a cross-section of risks to the National Scheme's objectives, including community trust and organisational, operational and financial risk.

The Corporate Assurance Framework is overseen by the Finance, Audit and Risk Management Committee (FARMC).

The framework

Assurance can come from many sources within an organisation. To enable the identification and coordination of those sources, Ahpra's assurance framework has adopted the 'three lines of defence' model.

The three lines are:

1. The chain of supervision. Those individuals who have direct control of operations routinely report performance and initiate periodic formal reviews to check or improve such performance. This form of review and reporting constitutes the bulk of assurance activities within Ahpra.
2. Reviews initiated by senior management. The CEO, executive directors and national directors may set up ongoing review functions or routine review activities that check the performance of operations. Typically, these activities include formal reviews, by teams that are independent of line management, of compliance, quality or risk management.
3. Reviews initiated by the Agency Management Committee or its committees. Typically, these reviews are initiated through FARMC. They are conducted by review teams which are independent of line management or through internal audit.

The system of internal control

The CEO is responsible for the effectiveness of the system of internal financial control. The Chief Financial Officer (CFO) has the designated operational responsibility for maintaining and developing the organisation-wide system of internal control.

The review of effectiveness of controls is informed by the work of internal auditors Deloitte in line with the internal audit plan. FARMC has been advised of the outcomes of these audits and monitors management plans to address identified issues and ensure continuous improvement.

The managers responsible for the system of internal control provide the CEO, through the CFO, with assurance that Ahpra's system of internal control is subject to consistent monitoring, review and improvement, and that key risks are being identified, assessed and managed appropriately.

Our risk mitigation strategy includes the appropriate and proportional placement of insurances. Throughout the financial year, our insurance portfolio was up to date and was reviewed and renewed for a further 12 months on 30 June.

We are not aware of any significant risk management issues that would prevent Ahpra from meeting the National Scheme's goals and objectives that have not been identified, assessed and which do not have an appropriate management and/or mitigation plan. We are satisfied that work is underway that is designed to ensure Ahpra identifies, assesses, monitors and manages risks appropriately.

COVID-19 business continuity planning response

In February Ahpra formed a Business Continuity Planning Working Group, in anticipation of government directives that people should work from home and to support a workforce surge. A complete governance framework was put in place to oversee Ahpra's pandemic response and recovery. The impact of COVID-19 is expected to continue into the future, so as the situation changes the governance arrangements will be adapted to ensure they are adequate and appropriate to meet needs in the recovery and transformation phases.

As well as our work to enable staff to work from home, we redeployed staff into our registration functions to fast-track the renewals process and to ensure health professionals were registered and available to work without delay.

Commonwealth grant: COVID-19 workforce surge capacity

In June, the Commonwealth Department of Health provided a one-off grant of $6.26 million to fund additional costs incurred and committed in response to COVID-19. The objective of the grant is to support Ahpra and National Boards to increase the pool of appropriately trained health practitioners registered and available to work in COVID-19-related roles. Other work, related to communicating with practitioners on changes to regulatory requirements and other relevant guidance, is also supported through this grant.

Corporate legal compliance

Ahpra is subject to a wide range of Commonwealth, state and territory legislation. We are committed to constantly reviewing and improving both Ahpra and National Board procedures and activities to comply with these laws and to promote a culture of positive compliance.

Where compliance concerns have been identified, relevant staff have been allocated responsibility to take practical steps to ensure compliance. Responsible officers regularly report to Ahpra's senior executives and the FARMC on the compliance steps they propose to take or have taken. This year, we comprehensively reviewed Ahpra's *Public interest disclosure (whistleblower) policy*. A dedicated lawyer has been assigned to review all instruments of delegation, sub-delegation and administrative authorisations. This work is ongoing and the review is expected to be completed in 2020/21, with management of these instruments to remain the responsibility of Corporate Legal.

Ahpra engages third party providers such as contractors and consultants to help administer the National Law. To ensure compliance with the National Law and the wider regulatory framework, Ahpra's standard contract terms require contractors to comply with applicable legislation and policies, including confidentiality, privacy, freedom of information (FOI), information security, record management, employment and workplace health and safety.

Corporate Legal has recently begun a review of its standard contractual terms to ensure that they are up to date with recent legal developments and reflect best practice procurement and contracting processes. This is occurring in parallel with Ahpra's review of its procurement processes more broadly, including drafting a revised procurement policy and holistic management of the contract lifecycle.

Freedom of information

The National Law provides that the Commonwealth *Freedom of Information Act 1982* (FOI Act) applies to Ahpra and National Boards as modified by the National Law.

Ahpra received 286 applications for access to documents under the FOI Act. We also received 20 applications for internal review of an FOI decision.

The National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC) notified Ahpra that 15 applications for external review of an Ahpra FOI decision had been made. The NHPOPC also notified Ahpra that seven external reviews had been closed as withdrawn. In one matter the NHPOPC decided to affirm Ahpra's decision. In one matter the NHPOPC notified Ahpra that a decision about whether to release documents was being upheld but that the reasons for withholding access to documents were being varied. There were no matters in which the NHPOPC notified Ahpra that the original decision was being replaced by decision to grant an applicant further access to documents.

During the year, 274 FOI applications were finalised. Outcomes are detailed in Table 38.

At 30 June, 34 FOI matters were open and had not been finalised.

Table 38. Finalised FOI applications in 2019/20

Application outcome	Number
Granted in full	34
Granted in part	110
Access refused	42
Withdrawn	88

Table 39 describes the nature of the documents sought by FOI applicants.

Table 39. Primary document category sought by FOI applicants

Document type	Number of FOI applications
Notifications	193
Registration applications and decisions	27
Monitoring and compliance of registration restrictions	35
Criminal offences	1
Policy, procedure and guidelines	7
Finances	1
Statistics and general data	8
Request to correct a record	2

Evidentiary certificates

Section 244 of the National Law provides for evidentiary certificates to be issued about specified matters relevant to the regulation of health professions. An evidentiary certificate is prima-facie evidence. Most evidentiary certificates issued are in response to requests from our co-regulatory partners, health complaints entities and police to assist them to perform their functions in the community. Ahpra issued 129 evidentiary certificates.

Production of documents required by law

We responded to 104 subpoenas and orders to produce documents issued by courts and tribunals about proceedings in which neither Ahpra nor a National Board were a party. Ahpra routinely cooperates with courts and tribunals through the production of documents that may assist in the resolution of legal disputes. Ahpra also works with police and other regulators by sharing information to help them perform their statutory functions within the community.

Case study

A former registered health practitioner faced criminal charges and occupational disciplinary proceedings about the alleged sexual assault of a former patient. The patient also started civil proceedings against the practitioner. The court, at the patient's request, issued a subpoena to Ahpra ordering that documents of potential assistance to the court in resolving the matter be produced within two weeks.

To respond to the subpoena Ahpra identified 447 documents, comprising 15,297 pages, that fell within the scope of the subpoena. Many of these documents were held in offsite archival storage. These documents were collated and assessed for return to the court along with submissions about the steps the court could take to protect the privacy and other interests of third parties referred to in the documents.

Administrative complaints

The purpose of Ahpra's *Administrative complaints handling policy and procedure* is to receive concerns that people have raised, respond to complaints promptly, empathetically and fairly and to learn from the issues people raise with us. We are committed to excellent service and continuous improvement. Feedback is always welcome and helps us improve our services.

Administrative complaints relate to concerns about the service delivery, policies, procedures and decisions of Ahpra, National Boards and Committees, and the Agency Management Committee.

Straightforward complaints (stage 1) are handled by the Ahpra area that receives them, and complex complaints (stage 2) are managed by a National Complaints team. Stage 3 complaints are investigated or reviewed externally by the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC). We report annually on all stage 2 and 3 complaints.

This year we recorded an increase in the number of complaint matters dealt with directly by Ahpra. This increase is largely attributed to improvements made in recording complaints received. We received 401 stage 2 complaints directly, up from 297 last year. Table 40 outlines the number of complaints we received by profession and compares these to the previous year.

We are continuing to refine our data to improve our reporting on administrative complaints and have recently invested in technical improvements to enable complaints to be submitted online.

Table 40. Stage 2 and 3 complaints by profession

Nature of complaint categorised by profession	Board complaint[1]	Registration complaint	Notification complaint	Other complaint[2]	Campaign[3]	Privacy complaint	Total 2019/20	Total 2018/19
Aboriginal and Torres Strait Islander Health Practice							**0**	**0**
Chinese medicine		2	1	1			**4**	**3**
Chiropractic		2	2				**4**	**3**
Dental		10	6	2			**18**	**15**
Medical		32	79	11			**122**	**121**
Medical radiation		4		2			**6**	**6**
Nursing and midwifery		86	8	3		1	**98**	**73**
Occupational therapy		6					**6**	**9**
Optometry				1			**1**	**2**
Osteopathy		1					**1**	**2**
Paramedicine	1	8					**9**	**2**
Pharmacy	1	14	7	2			**24**	**5**
Physiotherapy	1	1	4	1			**7**	**8**
Podiatry		1					**1**	**2**
Psychology		49	12	6	31	2	**100**	**46**
Total 2019/20	**3**	**216**	**119**	**29**	**31**	**3**	**401**	
Total 2018/19	**3**	**161**	**129**	**0**	**3**	**1**		**297**

1. Complaints about Board policies and standards
2. Miscellaneous complaints
3. Complaints driven by a public campaign encouraging people to complain to Ahpra

Notification complaints

This year we received 119 stage 2 complaints about notification matters. This is a decrease from the previous reporting period when we received 129. Of these 119 complaints, 35.3% were about dissatisfaction with the regulatory outcome of a notification. Other categories of complaint were about our processes and policies and communication during the management of a notification. Table 41 provides information about the number of notification complaints received directly.

Table 41. Stage 2 notification complaints by issue

Issue	Number (direct)
Dissatisfaction with decision	42
Process/policy	38
Communication	23
Delay	4
Other	12
Total	**119**

Registration complaints

This year we received 216 stage 2 complaints about registration matters. This is an increase from 161 the previous year. Of the 216 complaints received about registration matters, 36.1% were about delay in registration applications. Last year, 65.8% of registration complaints were about delay. Other categories of complaint were concerns about fees, registration policy and our communication with applicants. Table 42 provides information about the number of registration complaints received directly.

Table 42. Stage 2 registration complaints by issue

Issue	Number (direct)
Delay	78
Process/policy	61
Fees	34
Communication	30
Dissatisfied with decision	10
Other	3
Total	**216**

Engagement with the NHPOPC

The NHPOPC 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 assisted the NHPOPC with 117 investigations started during the reporting period.

This year we worked with the NHPOPC to implement an early resolution transfer process, which began in September 2019. This process was designed to allow Ahpra an opportunity to quickly resolve complaints directly without the need for investigation by the NHPOPC. The NHPOPC transferred 130 complaints to Ahpra under these arrangements. The NHPOPC also referred 38 (July–September 2019) complaints to Ahpra for response in accordance with the arrangements that were in place before the implementation of the early resolution transfer process. Table 43 provides information about the complaints transferred to Ahpra for early resolution.

Table 43. Type of early-transfer-process complaints received in 2019/20

Type of complaints received and progressed through the early transfer process[1]	2019/20[2]
Registration delay	49
Handling of a notification – complaint by a notifier	47
Registration process or policy	23
Handling of a notification – complaint by a practitioner	8
Breach of privacy/handling of personal information	1
Other	2
Total	**130**

1. There is a difference between the way that Ahpra and the NHPOPC record the number of complaints received as well as the nature of the concerns. In the next reporting period we intend to report not just on the number of complainants but also on the number of individual regulatory matters captured by all complaints.
2. Sometimes a person may complain directly to Ahpra and then to the NHPOPC, the NHPOPC may subsequently transfer a complaint to Ahpra and/or start an investigation. In these cases the complaint will be reported more than once.

Information technology

Cyber security update

The Australian cyber security landscape has been rapidly evolving, especially during COVID-19, and it requires organisations to adapt to changing risks. Ahpra reviews its cyber security risk constantly to adapt its capabilities accordingly. Ahpra follows a risk-based approach and has established a security assurance program based on internationally recognised information technology security standards.

Ahpra implemented new technologies to modernise its cyber security operations centre and strengthened the incident detection and response capabilities. Ahpra has also implemented a modern user awareness platform to train users in the defence of emailed threats such as phishing.

Ahpra developed a *Cyber security strategy 2020* with a roadmap to improve our IT security capabilities. It considers cyber security industry trends and provides a coherent portfolio of security initiatives that align with the overall business and IT strategy.

Other IT initiatives

We carried out a series of major initiatives to upgrade our technology infrastructure and capabilities. We performed core system updates to Sitecore, TRIM, Windows operating system, Pivotal, Microsoft Office 365 and Exchange Online to improve the usability, performance, stability and maintainability of those platforms. The Office 365 and Exchange Online platforms are cloud-based solutions that improve the accessibility of office productivity tools from any mobile device, outside of Ahpra's office environment.

New and improved business capabilities were also introduced. A new corporate intranet was launched with an improved design, modern content and staff search capability. Developed using the cloud-based Office 365 platform, it provides easy access from mobile devices for the first time. This initiative also introduced self-publishing and additional functions such as Stream and Yammer, which now give staff the ability to publish in the medium best suited to their audience.

A new Customer Service Call Centre platform using the Genesys Purecloud platform was also rolled out to replace the Cisco system. The new platform has not only improved the Customer Service team's call flow management but has also given them new capabilities and real-time reporting, which is a vast improvement on the previous system.

When COVID-19 arrived in early 2020, IT was at the forefront of Ahpra's response to upgrade existing capabilities and deliver new ones for all Ahpra staff to work remotely. IT worked in close partnership with the Business Continuity Planning team to complete this project successfully in a record time of 3.5 weeks. We equipped all 1,000+ Ahpra staff with laptops to work from home using upgraded virtual private networks integrated into Ahpra's IT environment.

Digital House

The recently completed components of the Digital House program created a foundation technology platform with key functions.

We moved our Trans-Tasman Mutual Recognition forms online and built a portal to support the online document upload. While this work was already well underway, we were able to rapidly speed up the final stages in response to the COVID-19 pandemic.

In March the new outcomes-based assessment for internationally qualified nurses and midwives (IQNMs) went live. For the first time IQNMs can self-check, create an account, establish and submit a portfolio, apply online and do Part 1 and 2 orientation to the Australian healthcare system and regulatory environment. The self-check also enables relevant applicants to schedule a multiple choice exam, and all of this through an online experience.

Our work in forms and registration has produced tangible benefits for staff, applicants and practitioners. However, some of our biggest efforts have been behind the scenes – establishing the digital foundations.

The continuation of the program will enable the work and experience gained to be extended to other professions and Ahpra functions and will culminate in the delivery of a business platform for Ahpra's staff and stakeholders.

Equipping a remote workforce: enabling staff to work from home

Ahpra formed a Business Continuity Planning Working Group in February, in response to COVID-19 and in anticipation of government directives that people should work from home if they can. This decision served us well as it meant we could start preparing for staff to work remotely, even before it became a requirement.

Early on, we ordered additional laptops for staff who didn't already have one, prioritising our Customer Service and Registration teams. More than 350 monitors and 65 dongles and accessories were also provided to staff who needed them to work effectively from home.

Our team prepared the laptops, including installing necessary software, upgraded Ahpra's virtual private network and spent time supporting staff to connect to their home internet and user profile. This work started on 17 March, with the last laptop dispatched on 25 March. The first 100 new laptops that arrived on the morning of 24 March were made ready in less than 24 hours. As well as preparing the laptops, the team produced guides and instructions for many staff who had never worked from home before.

By the time our Sydney office closed on Monday 30 March and Adelaide and Brisbane followed on Tuesday 31 March, all staff were able to work from home.

The service desk manager described the work effort as a 'race against time'. This project was one of many that, thanks to our dedicated staff, enabled us to become a fully functional remote-working organisation within weeks.

Australian Health Practitioner Regulation Agency

Financial statements for the year ended 30 June 2020

Declaration by Chair of the Agency Management Committee, Chief Executive Officer and Chief Financial Officer

The attached financial statements for the Australian Health Practitioner Regulation Agency have been prepared in accordance with Part 3 of Schedule 3 to the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory, Australian Accounting Standards and Interpretations, and other mandatory professional reporting requirements.

We further state that, in our opinion, the information set out in the Statement of comprehensive income, Statement of financial position, Statement of changes in equity, Statement of cash flows, and accompanying notes presents fairly the financial transactions during the year ended 30 June 2020 and financial position of the Australian Health Practitioner Regulation Agency as at 30 June 2020.

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

27 August 2020

Martin Fletcher
Chief Executive Officer

27 August 2020

Elizabeth Davenport FCPA
Chief Financial Officer

27 August 2020

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 2020 • 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 2020 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 3 of the *Health Practitioner Regulation National Law Act* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the agency in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Agency Management Committee's responsibilities for the financial report	The Agency Management Committee of the agency is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Health Practitioner Regulation National Law Act*, and for such internal control as the Agency Management Committee determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Agency Management Committee is responsible for assessing the agency's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

Level 31 / 35 Collins Street, Melbourne Vic 3000
T 03 8601 7000 enquiries@audit.vic.gov.au www.audit.vic.gov.au

Auditor's responsibilities for the audit of the financial report

As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the agency's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Agency Management Committee
- conclude on the appropriateness of the Agency Management Committee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the agency's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the agency to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Agency Management Committee regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

MELBOURNE
3 September 2020

Travis Derricott
as delegate for the Auditor-General of Victoria

Australian Health Practitioner Regulation Agency

Statement of comprehensive income for the year ended 30 June 2020

Continuing operations	Note	2020 $'000	2019 $'000
Income from transactions			
Registration fee income	*A1*	210,464	193,499
Interest income	*A2*	3,977	5,085
Grant income	*A3*	1,679	0
Other income	*A4*	4,311	4,634
Total income from transactions		**220,431**	**203,218**
Expenses from transactions			
Employee costs	*A5*	130,552	125,045
Board and committee sitting fees	*A5*	6,188	6,236
Legal and notification costs	*A5*	12,487	11,586
Accreditation expenses	*A5*	9,535	9,676
Other operating expenses	*A5*	41,981	53,023
Depreciation and amortisation	*B5(1)*	12,092	3,465
Finance costs – leases	*B6*	941	0
Total expenses from transactions		**213,776**	**209,031**
Net result for the year		**6,655**	**(5,813)**
Total other economic flows included in net result		0	0
Net result from continuing operations		**6,655**	**(5,813)**
Other comprehensive income		0	0
Comprehensive result for the year		**6,655**	**(5,813)**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency

Statement of financial position as at 30 June 2020

	Note	2020 $'000	2019 $'000
Current assets			
Cash and cash equivalents	*C1*	15,812	10,170
Receivables	*B2*	2,379	2,412
Investments	*C2*	63,000	64,000
Prepayments	*B2*	2,313	1,789
Leased assets	*B6*	0	534
Total current assets		**83,504**	**78,905**
Non-current assets			
Long-term investments	*C2*	116,500	110,000
Leased assets	*B6*	0	3,953
Property, plant and equipment	*B4*	58,090	11,117
Intangible assets	*B5*	8,312	4,155
Total non-current assets		**182,902**	**129,225**
Total assets		**266,406**	**208,130**
Current liabilities			
Payables and accruals	*B3*	7,873	15,865
Income in advance	*A1*	107,062	96,222
Employee benefits	*D1*	21,439	17,315
Lease liability	*B6*	7,191	1,284
Other provisions	*B7*	921	1,301
Total current liabilities		**144,486**	**131,987**
Non-current liabilities			
Employee benefits	*D1*	3,855	3,990
Lease liability	*B6*	47,728	8,471
Make-good provision	*B7*	817	817
Total non-current liabilities		**52,400**	**13,278**
Total liabilities		**196,886**	**145,265**
Net assets		**69,520**	**62,865**
Equity			
Contributed capital	*C3*	43,895	43,895
Accumulated surplus	*C3*	25,625	18,970
Total equity		**69,520**	**62,865**
Commitments	*B6(1)*		
Contingent assets and liabilities	*B8*		

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 2020

	Note	Contributed capital $'000	Accumulated surplus $'000	Total equity $'000
Balance at 1 July 2018		**43,895**	**24,783**	**68,678**
Net result for the year			(5,813)	(5,813)
Balance at 30 June 2019		**43,895**	**18,970**	**62,865**
Net result for the year			6,655	6,655
Balance at 30 June 2020	C3	**43,895**	**25,625**	**69,520**

This statement should be read in conjunction with the accompanying notes.

Australian Health Practitioner Regulation Agency

Statement of cash flows for the year ended 30 June 2020

	Note	2020 $'000	2019 $'000
Cash flows from operating activities			
Payments to suppliers, employees and others		(212,346)	(204,598)
Receipts relating to registrant fees		216,725	204,580
Receipts from government grant	*A3*	6,260	0
Net Goods and Services Tax (GST) received from the Australian Taxation Office (ATO)		6,344	7,401
Other receipts		4,547	7,166
Interest received		3,771	5,467
Interest paid		(941)	0
Net cash flows from operating activities	*B1*	**24,360**	**20,016**
Cash flows from investing activities			
Payments for plant and equipment, intangibles and work-in-progress		(7,265)	(7,138)
Purchase of investments		(87,500)	(81,000)
Proceeds of investments		82,000	73,000
Net cash flows used in investing activities		**(12,765)**	**(15,138)**
Cash flows from financing activities			
Repayment of principal portion of lease liabilities		(5,953)	0
Net cash flows used in financing activities		**(5,953)**	**0**
Net increase in cash and cash equivalents		**5,642**	**4,878**
Cash and cash equivalents at beginning of the year		10,170	5,292
Cash and cash equivalents at end of the year	*C1*	**15,812**	**10,170**

All amounts are inclusive of GST.

This statement should be read in conjunction with the accompanying notes.

Note A: Funding and cost of delivering our services

Introduction

This section provides a breakdown of income and an account of the expenses incurred by Ahpra in delivering services in partnership with the National Boards.

Structure

A1. Registration fee income

A2. Interest income

A3. Grant income

A4. Other income

A5. Expenses from transactions

A6. Events occurring after the balance sheet date

Income is recognised to the extent that it is probable that the economic benefits will flow to Ahpra and it can be reliably measured. Income over which Ahpra does not have control is disclosed as administered income (see *Note E5*).

Note A1: Registration fee income

AASB 15, AASB 1058 and the related guidance came into effect for not-for-profit entities for annual reporting periods beginning on or after 1 January 2019. Ahpra adopted these standards in the 2019/20 financial year.

Ahpra has assessed AASB 15 as the applicable standard and determined registration revenue as a non-IP licence providing the right to practise.

Applying the low-value licences and short-term licences (has a term of 12 months or less) exemptions under AASB 15 to the recognition of registration and application income, Ahpra will continue to recognise registration fees over the term of the registration and recognise application income up front. There will be no impact for each major class of revenue and income in this initial year of application.

Registrations are payable periodically in advance. Only those registration fees that are attributable to the current financial year are recognised as income. Registration fees that relate to future periods are recorded as income in advance within the Statement of financial position.

When a person pays an application fee, the fee is recognised in the financial year in which it is received.

	2020 $'000	2019 $'000
Registration fees	195,509	177,775
Application fees	14,955	15,724
Total registration fee income	**210,464**	**193,499**

Income in advance	2020 $'000	2019 $'000
Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA)	49	44
Chinese Medicine Board of Australia (CMBA)	850	843
Chiropractic Board of Australia (ChiroBA)	1,095	1,051
Dental Board of Australia (DBA)	4,839	4,618
Medical Board of Australia (MBA)	19,123	18,160
Medical Radiation Practice Board of Australia (MRPBA)	1,125	1,065
Nursing and Midwifery Board of Australia (NMBA)	57,568	53,682
Occupational Therapy Board of Australia (OTBA)	999	916
Optometry Board of Australia (OptomBA)	661	632
Osteopathy Board of Australia (OsteoBA)	371	341
Paramedicine Board of Australia (ParaBA)	2,049	1,897
Pharmacy Board of Australia (PharmBA)	4,448	4,180
Physiotherapy Board of Australia (PhysioBA)	1,721	1,591
Podiatry Board of Australia (PodBA)	763	734
Psychology Board of Australia (PsyBA)	6,820	6,376
Government grant	4,581	0
Other	0	92
Total income in advance	**107,062**	**96,222**

Note A2: Interest income

Interest income is accrued by reference to the principal of a financial asset at the effective interest rate when earned.

	2020 $'000	2019 $'000
Interest on term deposits	3,977	5,085
Total interest income	**3,977**	**5,085**

Note A3: Grant income

A $6.26 million grant was received from the Commonwealth Government in supporting Ahpra to increase the pool of appropriately trained health practitioners registered and available to work in COVID-19 related roles, or to backfill where needed. Other work, related to communicating with practitioners on changes to standards of practice as determined by the National Cabinet, is also supported through this grant.

The grant encompasses activities with measurable performance indicators. All work covered by the grant needs to be delivered by 7 April 2021.

Income from grants that are enforceable and with sufficiently specific performance obligations are accounted for under AASB 15 as *Revenue from contracts with customers*, with revenue recognised as these performance obligations are met. As a result, Ahpra has recognised $1.679 million as income in 2019/20 and deferred recognition of a portion of the grant received as income in advance (*Note A1)*.

As a result of the transitional impacts of adopting AASB 15, a portion of the grant consideration ($4.581 million) has been deferred to income in advance. If the grant was accounted for under the previous accounting standard in 2018/19, the total grant received would have been recognised as revenue upon receipt.

Note A4: Other income

Other income includes income that is not registration fees or interest. Key items of other income include certificates of registration status requested by registrants, legal fee recoveries and fees related to the Pharmacy Board of Australia's examinations.

	2020 $'000	2019 $'000
Accreditation	490	242
Certificate of registration status	302	337
Legal fee recovery	657	1,748
Pharmacy Board of Australia examinations	762	729
Practitioner Information Exchange (PIE)	888	875
Other	1,212	703
Total other income	**4,311**	**4,634**

Note A5: Expenses from transactions

Expenses from transactions are recognised in the Statement of comprehensive income when they are incurred.

Employee costs

Employee costs relate to all Ahpra employment costs, including wages and salaries, fringe benefit tax, leave entitlements and on-costs, termination payments, WorkCover premiums, superannuation, contractors and recruitment cost.

Board and committee sitting fees

Board and committee sitting fee costs include national, state and regional board expenditure relating to meetings held by the National Boards and their committees.

Legal and notification costs

Legal costs include external costs relating to managing the notification (complaint) process by Ahpra. These costs include legal fees paid to external firms and costs of civil tribunals. They do not include the costs associated with Ahpra staff in the assessment and investigation of notifications, or the cost of legal staff employed by Ahpra.

Accreditation expenses

Accreditation expenses relate to payments to external accreditation bodies to exercise accreditation functions, as defined in section 42 of the National Law. Staff costs and committee sitting fees when these functions are carried out by accreditation committees are not included.

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.

Other operating expenses

Other operating expenses	Note	2020 $'000	2019 $'000
Systems and communications		11,461	10,897
Travel and accommodation		5,547	7,796
Property expenses	*B6*	2,708	9,097
Strategic and project consultant costs		2,467	1,682
Office of the Health Ombudsman (OHO, in Queensland)	*E5*	5,684	7,188
National Health Practitioner Ombudsman and Privacy Commissioner Office		2,200	1,500
Health programs		3,380	3,328
External contract services		484	2,702
Bank charges and merchant fees		1,213	1,083
Insurance		907	1,264
Criminal history checks		1,283	1,681
Printing, postage and publications		1,730	1,870
Funding for intern training accreditation authorities (section 52)		907	888
Internal audit fees		311	406
Other		1,699	1,641
Total other operating expenses		**41,981**	**53,023**

Systems and communication

Systems and communication costs relate to the technology systems of Ahpra.

Travel and accommodation

Travel and accommodation relate to flights, taxis and hotel costs incurred by Ahpra, National Boards and their committees for travel for attending scheduled board and committee meetings.

Property expenses

Property expenses include maintenance of all leased properties. Since the AASB 16 *Lease* application, from 1 July 2019, operating lease expenses such as office rental previously classified under property expenses are accounted as depreciation of right-of-use assets and interest on leases (*Note B6*).

Strategic and project consultant costs

Strategic and project consultant costs relate to project costs incurred in the year for both National Boards and Ahpra projects. These expenses are assessed as not meeting the definition of an asset under AASB 138 *Intangible Assets*.

A5 (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.

The total amount transacted is reflected in the Statement of comprehensive income and accompanying financial statements. The aggregated total income and total expenditure transacted and attributed to each National Board is shown in the table below.

National Boards	2020 Income $'000	2020 Expenses $'000	2020 Net result $'000	2019 Income $'000	2019 Expenses $'000	2019 Net result $'000
ATSIHPBA	543	543	0	521	521	0
CMBA	2,312	1,871	441	2,371	1,755	616
ChiroBA	2,813	1,784	1,029	2,727	1,752	975
DBA	12,077	11,968	109	11,673	11,282	391
MBA	78,119	80,578	(2,459)	74,583	78,661	(4,078)
MRPBA	3,219	3,550	(331)	3,055	3,793	(738)
NMBA	71,972	67,979	3,993	63,052	67,857	(4,805)
OTBA	2,716	3,549	(833)	2,606	3,241	(635)
OptomBA	1,677	1,790	(113)	1,633	1,698	(65)
OsteoBA	1,003	907	96	931	883	48
ParaBA	5,505	3,550	1,955	6,162	3,721	2,441
PharmBA	12,037	11,528	509	10,841	11,539	(698)
PhysioBA	4,573	4,797	(224)	3,981	4,643	(662)
PodBA	2,045	1,843	202	1,926	1,684	242
PsyBA	17,856	15,575	2,281	16,276	15,121	1,155
Other	1,964	1,964	0	880	880	0
Total	**220,431**	**213,776**	**6,655**	**203,218**	**209,031**	**(5,813)**

Note A6: 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 that 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 B: Operating assets and liabilities

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.

This section also includes information on Ahpra's financial liability to external suppliers.

Structure

B1. Reconciliation of net result for the year to operating cash flows

B2. Receivables and prepayments

B3. Payables and accruals

B4. Property, plant and equipment (PPE)

B5. Intangible assets, depreciation and amortisation

B6. Right-of-use assets and lease liabilities

B7. Make-good and other provisions

B8. Contingent assets and liabilities

Judgement required

The assets included in this section are carried at cost, less accumulated depreciation and impairment. Judgement has been applied in assessing the useful lives of plant and equipment. Assessment of intangible assets resulted in a change to their useful lives in 2019/20.

Note B1: Reconciliation of net result for the year to operating cash flows

	2020 $'000	2019 $'000
Net result for the year	**6,655**	**(5,813)**
Adjustments for:		
Depreciation and amortisation	12,092	3,465
Recognition of lease assets	0	520
Make-good and other provisions	558	76
Provision for doubtful debts	(26)	353
Changes in assets and liabilities		
Decrease in receivables	532	1,861
(Increase)/decrease in prepayments	(524)	1,501
(Increase)/decrease in accrued income	(473)	290
Increase in income in advance	10,840	11,173
(Decrease)/increase in payables and accruals	(7,594)	3,558
Increase in employee benefits	3,051	4,316
(Decrease) in lease liability	(751)	(1,284)
Net cash flows from operating activities	**24,360**	**20,016**

Note B2: Receivables and prepayments

Receivables consist of:

- contractual receivables, such as debtors in relation to goods and services, and
- statutory receivables, such as Goods and Services Tax (GST) input tax credits recoverable.

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 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 E2*.

	Note	2020 $'000	2019 $'000
Contractual			
Trade receivables	*E2*	1,943	2,174
Credit loss allowance	*E2*	(1,375)	(1,401)
Accrued income		1,334	861
Statutory			
GST receivable		477	778
Total receivables		**2,379**	**2,412**

Movement in the loss allowance for contractual receivables	Note	2020 $'000	2019 $'000
Balance at beginning of year		1,401	775
Opening accumulated surplus adjustment on adoption of AASB 9	*E2*	0	318
Opening loss allowance		**1,401**	**1,093**
Increase in allowance recognised in net result for the year		0	366
Reversal of provision of receivables written off during the year as uncollectable		(26)	(45)
Decrease in amounts written off as uncollectable		0	(13)
Balance at end of year		**1,375**	**1,401**

Prepayments

Prepaid expenditure is recognised when payments are 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 to the period in which the service relates.

Note B3: Payables and accruals

Payables consist of:

Contractual payables, 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; and

Statutory payables, that 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	2020 $'000	2019 $'000
Contractual			
Trade creditors	*E2*	757	2,380
Accrued expenses	*E2*	6,686	11,935
Statutory			
Payroll tax and other payable		430	1,550
Total payables and accruals		**7,873**	**15,865**

Note B4: Property, plant and equipment (PPE)

	Note	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 2018		0	14,396	1,374	4,888	351	21,009
Additions		0	571	98	2,058	88	2,815
Balance at 30 June 2019		**0**	**14,967**	**1,472**	**6,946**	**439**	**23,824**
Recognition of right-of-use assets on initial application of AASB 16	*B6*	56,473	0	0	0	0	56,473
Adjusted balance at 1 July 2019		**56,473**	**14,967**	**1,472**	**6,946**	**439**	**80,297**
Additions		343	85	43	1,322	108	1,901
Disposals/write-offs			(810)	0	0	0	(810)
Balance at 30 June 2020		**56,816**	**14,242**	**1,515**	**8,268**	**547**	**81,388**
Accumulated depreciation							
Balance at 30 June 2018		0	(6,313)	(295)	(3,053)	(187)	(9,848)
Depreciation charge during the year		0	(1,291)	(171)	(1,353)	(44)	(2,859)
Balance at 30 June 2019		**0**	**(7,604)**	**(466)**	**(4,406)**	**(231)**	**(12,707)**
Depreciation charge during the year		(7,826)	(1,110)	(177)	(1,778)	(50)	(10,941)
Disposals/write-offs		0	350	0	0	0	350
Balance at 30 June 2020		**(7,826)**	**(8,364)**	**(643)**	**(6,184)**	**(281)**	**(23,298)**
Net book value							
At 30 June 2019		**0**	**7,363**	**1,006**	**2,540**	**208**	**11,117**
At 30 June 2020		**48,990**	**5,878**	**872**	**2,084**	**266**	**58,090**

B4(1): Written-down value of non-financial assets written off

All non-financial assets are assessed annually for indications of impairment. If there is an indication of impairment, the asset concerned is tested as to whether its carrying amount exceeds its possible recoverable amount. The difference is written off as an expense (Other operating expenses – other) except to the extent that the write-down can be debited to an asset revaluation surplus account applicable to that same class of asset. As a result of the implementation of AASB 16 *Leases* from 1 July 2019, $460k leasehold improvement assets previously recognised for make-good purpose are written off and reclassified as right-of-use assets.

	2020 $'000	2019 $'000
Leasehold improvement	460	0
Total written-down value of non-current assets written off	**460**	**0**

B4(2): Net gains/(loss) on disposal of non-financial assets

The net gain or loss arising from the sale of non-current assets is included as revenue (Other income) or expenses (Other operating expenses – other) at the date control passes to the buyer, usually when an unconditional contract of sale is signed.

The net gain or loss on disposal is calculated as the difference between the carrying amount of the asset at the time of the disposal and the net proceeds on disposal. No asset has been disposed in sales during 2019/20.

Note B5: Intangible assets

When the recognition criteria in AASB 138 *Intangible Assets* is 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, and
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 2018	12,483	118	12,601
Additions	132	4,205	4,337
Disposals/write-offs	0	(14)	(14)
Transfer to additions	2,835	(2,835)	0
Balance at 30 June 2019	**15,450**	**1,474**	**16,924**
Additions	0	5,706	5,706
Disposals/write-offs	0	(105)	(105)
Completed projects	4,945	(5,238)	(293)[1]
Balance at 30 June 2020	**20,395**	**1,837**	**22,232**
Accumulated amortisation			
Balance at 30 June 2018	(12,163)	0	(12,163)
Amortisation during the year	(606)	0	(606)
Balance at 30 June 2019	**(12,769)**	**0**	**(12,769)**
Amortisation charge during the year	(1,151)	0	(1,151)
Balance at 30 June 2020	**(13,920)**	**0**	**(13,920)**
Net book value			
At 30 June 2019	**2,681**	**1,474**	**4,155**
At 30 June 2020	**6,475**	**1,837**	**8,312**

B5(1): Depreciation and amortisation

Plant and equipment are measured at cost less accumulated depreciation and impairment. These assets are depreciated at rates based on their expected useful lives, using the straight-line method, which is reviewed annually.

Intangible assets are amortised annually at a rate of between 10% and 40% depending on their useful life. Work in progress is not depreciated until it reaches service delivery capacity.

The annual depreciation rates and assets useful life used for major assets in each class are as follows:

	2020		2019	
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	10–40%	2.5–10 years	10–40%	2.5–10 years

Leasehold improvements are amortised over the term of the lease, or the life of the assets, whichever is shorter.

The right-of-use asset is depreciated using the straight-line method from the commencement date to the earlier of the end of the useful life of the right-of-use asset or the end of the lease terms, ranging from 2 to 12 years. The estimated useful lives of right-of-use assets are determined on the same basis as those of property, plant and equipment. In addition, the right-of-use asset is periodically reduced by impairment losses, if any, and adjusted for certain measurements of the lease liability.

	2020 $'000	2019 $'000
Depreciation		
Leasehold improvements	1,110	1,291
Furniture and fittings	177	171
Computer equipment	1,778	1,353
Office equipment	50	44
Right-of-use assets	7,826	0
Amortisation		
Computer software	1,151	606
Total depreciation and amortisation	**12,092**	**3,465**

1 Balance of $293k is a result of work-in-progress expenditure being allocated to computer equipment on completion.

Note B6: Right-of-use assets and lease liabilities

Policy applicable before 1 July 2019

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. The leased asset is not recognised in the Statement of financial position. Ahpra is not party to a finance lease.

In the event that lease incentives are received to enter into operating leases, the aggregate cost of incentives is recognised as a reduction of rental expense over the lease term on a straight-line basis.

Some lease contracts include lease incentive clauses, comprising reimbursement for the fit-out of the new premises and rental abatement. Ahpra has recognised the reimbursement as a leasehold improvement asset and the rental abatement as a lease asset.

Policy applicable after 1 July 2019

AASB 16 sets out the requirements for the recognition, measurement, presentation and disclosure of leases and requires lessees to account for all leases in the Statement of financial position by recording a Right-of-Use (RoU) asset and a lease liability except for leases that are shorter than 12 months and leases where the underlying asset is of low value (deemed to be below $10,000).

At transition, Ahpra has applied AASB 16 *Leases* using a modified retrospective approach with no restatement of comparative information. For office leases previously classified as operating leases, Ahpra chose to measure the RoU asset at an amount equal to the lease liability as permitted by the standard.

Ahpra elected to use the exemptions for all short-term leases (lease term less than 12 months) and low value leases (deemed to be below $10,000) in application of AASB 16.

Right-of-use assets

From 1 July 2019, for any contracts entered into or changed, Ahpra considers whether a contract is, or contains, a lease. A contract is, or contains, a lease if the contract conveys the right to control the use of an identified asset for a period of time in exchange for consideration. To apply this definition Ahpra assesses whether the contract meets three key criteria which are:

- The contract involves the use of an identified asset;
- Ahpra has the right to obtain substantially all of the economic benefits from use of the asset throughout the period of use; 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 less 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; and
- *less* any lease incentive received.

Lease liabilities

The lease liability is initially measured at the present value of the lease payments that are not paid at the commencement date, discounted using the interest rate implicit in the lease or, if that rate cannot be readily determined, an appropriate incremental borrowing rate. Generally, Ahpra uses an appropriate incremental borrowing rate as the discount rate.

Lease payments included in the measurement of the lease liability comprise the following:

- Fixed payments;
- Variable lease payments that depend on an index or a rate, initially measured using the index or rate as at the commencement date;
- Amounts expected to be payable under a residual value guarantee; and
- Lease payments in an optional renewal period if Ahpra is reasonably certain to exercise an extension option.

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 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.

On transition to AASB 16, Ahpra recognised $56.473 million right-of-use assets (*B4*) and $56.012 million of lease liabilities.

Lease liabilities	2020 Minimum future lease payments (undiscounted) $'000
Repayment in relation to leases are payable as follows:	
Less than one year	7,278
One to five years	32,363
More than five years	14,652
Total undiscounted lease liabilities as at 30 June 2020	**54,293**

Undiscounted lease liabilities of $54.293m is reflective of nominal future payments of lease liabilities excluding GST. Included in this amount is finance costs of $3.96m, resulting from the implementation of AASB 16 *Leases*.

Lease liabilities	2020 $'000
Lease liabilities included in the Statement of financial position at 30 June	
Current	7,191
Non-current	47,728
Total lease liabilities	**54,919**

Lease liabilities reported on the Statement of financial position at 30 June 2020 include liabilities relating to leases ($50.4m) and those relating to lease incentives received as a contribution to office fit-out ($4.52m).

Finance costs – leases	2020 $'000
Interest – lease liabilities	941
Total finance costs	**941**

Note B6(1): Commitments

Commitments include operating and capital commitments arising from non-cancellable contractual or statutory obligations. These commitments are recorded below at their nominal value and inclusive of GST.

Ahpra does not have capital commitments.

Commitments in relation to non-cancellable contractual obligation are payable as:

	2020 $'000		2019 $'000		
Nominal amounts	**Other commitments**	**Total commitments**	**Operating and lease commitments payable [a]**	**Other commitments**	**Total commitments (inclusive of GST)**
Not later than 1 year	2,353	**2,353**	9,024	3,080	**12,104**
Later than 1 year but not later than 5 years	3,808	**3,808**	37,315	2,383	**39,698**
Later than 5 years	0	**0**	17,498	0	**17,498**
Total	**6,161**	**6,161**	**63,837**	**5,463**	**69,300**

[a] For 2019 operating and lease commitments relate to office leases with terms between three and 10 years. These contracts do not allow Ahpra to purchase the office after the lease ends, but Ahpra can renew the lease for a further period. These future expenditures on office leases cease to be disclosed as commitments and the related liabilities are recognised in the Statement of financial position as lease liabilities (*Note B6*) after application of AASB 16 *Leases* at 30 June 2020.

Note B7: Make-good and other provisions

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.

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 provision, assumptions and estimations have been applied to work out the average make-good cost per square metre when on-going maintenance and updating is committed to, and/or the local market conditions in re-negotiating an incentive at lease expiration for each office.

The make-good provision is recognised in accordance with the lease agreement over the offices' leases.

A provision for restructure arises when there is a change in organisation structure. There must exist a detailed formal plan for the restructuring and there must be a valid expectation for those affected that the entity will carry out the restructuring by starting to implement that plan or announcing its main features to those affected by it. Towards the end of 2019/20, Ahpra has announced an internal restructure by Information Technology and Regulatory Operations, and is currently underway with the change and consultation process.

Ahpra has also made a provision for contractor claims in 2019/20.

Reconciliation of movements in provisions	**Make-good $'000**	**Restructure $'000**	**Other contractual $'000**	**Total $'000**
Opening balance at 30 June 2019	**817**	**1,301**	**0**	**2,118**
Additional provisions recognised	0	341	558	899
Reductions arising from payments	0	(1,039)	0	(1,039)
Reductions due to transfer out	0	(240)	0	(240)
Closing balance at 30 June 2020	**817**	**363**	**558**	**1,738**
Current	0	363	558	921
Non-current	817	0	0	817
Total	**817**	**363**	**558**	**1,738**

Note B8: Contingent assets and liabilities

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	**2020 $'000**	**2019 $'000**
Legal proceeding and disputes	0	0

No claim for damages was lodged during the year.

Contingent liabilities	**2020 $'000**	**2019 $'000**
Legal proceeding and disputes	0	0

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 C: Equity, investment and commitments

Introduction

This section provides information on Ahpra's cash and investment position along with a detailed breakdown of equity by National Boards

Structure

C1. Cash and cash equivalents

C2. Investments

C3: Equity by board

Note C1: Cash and cash equivalents

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.

	Note	2020 $'000	2019 $'000
Cash and cash equivalents, at bank		15,812	10,170
Total cash and cash equivalents	*E2*	**15,812**	**10,170**

Note C2: Investments

Investments include term deposits that Ahpra has the positive intent and ability to hold to maturity at fixed or repricing interest rates.

	Note	2020 $'000	2019 $'000
Current			
Bank term deposits maturing less than 90 days		28,000	20,000
Bank term deposits maturing more than 90 days but less than 1 year		35,000	44,000
Total current investments		**63,000**	**64,000**
Non-current			
Bank term deposits maturing greater than 1 year		116,500	110,000
Total non-current investments		**116,500**	**110,000**
Total investments	*E2*	**179,500**	**174,000**

Note C3: Equity by board

Consistent with the requirements of AASB 1004 *Contributions*, contributions by owners (that is, contributed capital) are treated as equity transactions and, therefore, do not form part of the income and expenses of Ahpra.

Additions to net assets designated as contributions by all former boards at transition to Ahpra are recognised as contributed capital.

Summary of contributed capital, equity and accumulated surplus/(deficit) by board

National Boards $'000	Contributed capital $'000	Accumulated surplus/ (deficit) to 30 June 2019 $'000	Equity at 30 June 2019 $'000	2019/20 net result $'000	2019/20 net result funded from equity $'000	Total $'000	Accumulated surplus/ (deficit) to 30 June 2020 $'000	Equity at 30 June 2020 $'000
ATSIHPBA	276	(275)	**1**	0	0	0	(275)	**1**
CMBA	1,293	4,672	**5,965**	441	0	441	5,113	**6,406**
ChiroBA	1,164	2,957	**4,121**	1,029	0	1,029	3,986	**5,150**
DBA	3,120	1,253	**4,373**	109	0	109	1,362	**4,482**
MBA	12,257	3,469	**15,726**	0	(2,459)	(2,459)	1,010	**13,267**
MRPBA	2,218	1,645	**3,863**	0	(331)	(331)	1,314	**3,532**
NMBA	12,816	(8,887)	**3,929**	3,993	0	3,993	(4,894)	**7,922**
OTBA	3,574	2,168	**5,742**	0	(113)	(113)	2,055	**5,629**
OptomBA	1,061	719	**1,780**	96	0	96	815	**1,876**
OsteoBA	996	261	**1,257**	0	(833)	(833)	(572)	**424**
ParaBA	0	3,143	**3,143**	1,955	0	1,955	5,098	**5,098**
PharmBA	2,716	(615)	**2,101**	509	0	509	(106)	**2,610**
PhysioBA	2,728	698	**3,426**	0	(224)	(224)	474	**3,202**
PodBA	420	2,695	**3,115**	202	0	202	2,897	**3,317**
PsyBA	2,194	2,129	**4,323**	2,281	0	2,281	4,410	**6,604**
Other	(2,938)	2,938	**0**	0	0	0	2,938	**0**
Total	**43,895**	**18,970**	**62,865**	**10,615**	**(3,960)**	**6,655**	**25,625**	**69,520**

	2020 $'000	2019 $'000
(a) Contributed capital		
Balance at beginning of the financial year	43,895	43,895
Capital contributions from former boards	0	0
Balance at end of the financial year	**43,895**	**43,895**

	2020 $'000	2019 $'000
(b) Accumulated surplus		
Balance at beginning of the financial year	18,970	25,101
Opening accumulated surplus adjustment on adoption of AASB 9	0	(318)
Net result for the year	6,655	(5,813)
Balance at end of the financial year	**25,625**	**18,970**

Note D: Employee benefits

Introduction

This section provides information on liabilities Ahpra set aside to meet employment terms and conditions.

Structure

D1. Employee benefits and on-costs

D2. Remuneration of executives

D3. Superannuation

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.

Note D1: Employee benefits and on-costs

Provision is made for benefit accruing to employees in respect of wages and salaries, 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.

(a) Annual leave

Employee benefits including on-costs benefits and annual leave are recognised in the provision for employee benefits as current liabilities.

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) Long service leave

The long service leave entitlement under existing arrangements is recognised from an employee's start date and becomes payable according to the employment arrangements in place. The valuation of long service leave for employees who have met the conditions of service to take long service leave is recognised as a current liability, while the valuation 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 a single weighted average interest rate on national government guaranteed securities to estimate future cash outflows.

On 30 July 2019, Ahpra staff voted in favour of a new enterprise agreement (EA), commencing 1 July 2019. The EA was approved by the Fair Work Commission. An improved benefit is access to long service leave for all employees at seven years' completed service, affecting staff in New South Wales, Northern Territory and Tasmania who previously accessed at 10 years. This change is reflected as an increase to the employee benefits liability ($101k) through a higher long service leave expense.

(c) 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 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.

(d) Employee benefits on-costs

Employee benefits on-costs include payroll tax, WorkCover insurance premium and superannuation entitlements. The benefits on-costs are recognised as liabilities when the employee benefits to which they relate are recognised.

	2020 $'000	2019 $'000
Current employee benefits and on-costs		
Unconditional annual leave expected to be settled within 12 months	8,511	6,797
Unconditional annual leave expected to be settled after 12 months	2,339	2,036
Unconditional long service leave expected to be settled within 12 months	1,710	1,413
Unconditional long service leave expected to be settled after 12 months	8,879	7,069
Total current employee benefits and on-costs	**21,439**	**17,315**
Non-current employee benefits and on-costs		
Conditional long service leave entitlements expected to be settled after 12 months	3,855	3,990
Total non-current employee benefits and on-costs	**3,855**	**3,990**
Total employee benefits and on-costs	**25,294**	**21,305**

	2020 $'000	2019 $'000
Current employee benefits		
Annual leave	9,468	7,717
Long service leave	9,185	7,355
Non-current employee benefits		
Long service leave	3,358	3,472
Total employee benefits	**22,011**	**18,544**
On-costs		
Current on-costs	2,494	2,243
Non-current on-costs	789	518
Total on-costs	**3,283**	**2,891**
Total employee benefits and on-costs	**25,294**	**21,305**

(e) Reconciliation of movement in employee benefit provision

	Annual leave $'000	Long service leave $'000	Total $'000
Opening balance	**8,833**	**12,472**	**21,305**
Additional provisions required	9,253	3,546	12,799
Reductions arising from payments	(7,236)	(1,574)	(8,810)
Closing balance	**10,850**	**14,444**	**25,294**
Current	8,511	10,589	19,100
Non-current	2,339	3,855	6,194
Total	**10,850**	**14,444**	**25,294**

Note D2: Remuneration of executives

The Chief Executive Officer (CEO) is Mr Martin Fletcher who held the position throughout the period 1 July 2019 to 30 June 2020.

The aggregate compensation made to the CEO and National Executive team is set out below:

	2020 $	2019 $
Short-term employee benefits	1,790,370	1,495,020
Long-term employee benefits	21,211	38,312
Post-employment benefits	127,121	109,664
Termination benefits	76,856	0
Total	**2,015,558**	**1,642,996**
Total number of executives	7	5
Total annualised employee equivalents	5.40	4.92

Note D3: Superannuation

The amount expensed in respect of superannuation represents Ahpra contributions for members of both defined benefit and defined contribution superannuation plans that are paid or payable during the reporting period.

Employees of Ahpra are entitled to receive superannuation benefits and Ahpra contributes to both defined benefit and defined contribution plans. The defined benefit plans provide benefits based on years of service and final average salary.

Ahpra does not recognise any defined benefit liability in respect of the plans because it has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due.

Superannuation contributions paid or payable for the reporting period are included as part of 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 and salary sacrifice arrangements.

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	
	2020	2019	2020	2019
Fund	**$'000**	**$'000**	**$'000**	**$'000**
Defined benefit plans:				
Southern State Superannuation Scheme	211	202	0	0
Qsuper	132	131	0	1
Other	165	253	0	5
Defined contribution plans:				
Australian Super	3,688	3,359	0	0
First State accumulation	468	458	0	0
HESTA	387	364	0	0
VicSuper	377	367	0	0
QSuper accumulation	403	394	0	0
UniSuper	428	363	0	0
Sunsuper	424	337	0	0
Other (215)	3,785	3,499	13	18
Total	**10,468**	**9,727**	**13**	**24**

Note E: Other

Introduction

This section sets out financial instrument specific information (including exposures to financial risks) as well as additional material disclosures required by accounting standards or otherwise, for the understanding of these statements.

Structure

E1. Summary of significant accounting policies

E2. Financial instruments

E3. Related party disclosures

E4. Remuneration of external auditor

E5. Co-regulatory jurisdictions

Note E1: Summary of significant accounting policies

Statement of compliance

These financial statements are referred to as a general purpose financial report which have been prepared in accordance with Australian Accounting Standards (AAS) and Interpretations and other mandatory requirements. AAS include Australian equivalents to the International Financial Reporting Standards.

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.

These financial statements were authorised to be issued by the Agency Management Committee on 27 August 2020.

(1) Reporting entity

Ahpra is the organisation responsible for the administration of the National Scheme across Australia.

Ahpra's operations are governed by the National Law, which came into effect on 1 July 2010 and on 18 October 2010 in Western Australia. This law means that registered health professions are regulated by nationally consistent legislation.

Ahpra supports the National Health Practitioner Boards in the administration of the National Scheme. 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 until 15 July 2019 was Mr Michael Gorton, Ms Gill Callister succeeded on 15 July 2019. 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.

(2) Basis of accounting preparation and measurement

Accounting policies are selected and applied in preparing the financial statements for the year ended 30 June 2020 in a manner that ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is appropriately reported.

The financial statements, other than the Statement of cash flows, have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definition and recognition criteria for those items, that is, they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

The financial report is prepared in accordance with the historical cost convention.

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 AAS that have significant effects on the financial statements and estimates relate to:

- 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 D1)*
- the fair value of intangible assets (refer to *Note B5*)
- the fair value measurement of financial assets and liabilities (refer to *Note E2*)
- 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 substance short-term or low value (refer to *Note B6*).

(3) Corporate structure

Ahpra is a statutory body governed by the National Law.

(4) Goods and services tax (GST)

All application, registration and late fees are exempt from GST legislation. Income, expenses and assets are recognised net of GST except where the amount of GST incurred is not recoverable, in which case it is recognised as part of the cost of acquisition of an asset or part of an item of expense or revenue. GST receivable from or payable to the Australian Taxation Office (ATO) is included in the statement of financial position. The GST component of a receipt or payment is recognised on a gross basis in the Statement of cash flows in accordance with AASB 107 *Statement of Cash Flows*.

(5) Income tax

Tax effect accounting has not been applied as Ahpra is exempt from income tax under section 50–25 of the Income Tax Assessment Act 1997.

(6) Functional and presentation currency

All amounts specified in these statements are presented in Australian dollars.

(7) Rounding of amounts

Amounts in the financial statements have been rounded to the nearest thousand dollars unless otherwise stated. Figures in the financial statements may not equate due to rounding.

(8) Australian Accounting Standards issued that are not yet effective

This table outlines the accounting pronouncements that have been issued but are not effective for 2019/20, 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[1]	Summary	Applicable for annual reporting periods beginning on or after	Impact on Ahpra financial statements
AASB 2018–7 *Amendments to Australian Accounting Standards – Definition of Material*	This standard principally amends AASB 101 *Presentation of Financial Statements* and AASB 108 *Accounting Policies, Changes in Accounting Estimates and Errors*. The amendments refine the definition of material in AASB 10 *Events after the Reporting Period*, include some supporting requirements in AASB 101 in the definition to give it more prominence and clarify the explanation accompanying the definition of material. The amendments also clarify the definition of material and its application by improving the wording and aligning the definition across AASB standards and other publications.	1 January 2020	The assessment has indicated that there is no significant impact on Ahpra.
AASB 2020–1 *Amendments to Australian Accounting Standards – Classification of Liabilities as Current or Non-Current*	This standard amends AASB 101 to clarify requirements for the presentation of liabilities in the statement of financial position as current or non-current. A liability is classified as non-current if an entity has the right at the end of the reporting period to defer settlement of the liability for at least 12 months after the reporting period. The meaning of settlement of a liability is also clarified.	1 January 2022 However, ED 301 has been issued with the intention to defer application to 1 January 2023.	The standard is not expected to have a significant impact on Ahpra.

1. Ahpra does not anticipate early adoption of any of the above Australian Accounting Standards or Interpretations, however further analysis of these standards will occur during 2020/21.

(9) Changes in accounting policy

The following AASBs become effective for reporting periods commencing after 1 July 2019.

AASB 16 *Leases*

Ahpra's adoption of AASB 16 is stated in *Notes B4* and *B6*.

AASB 15 *Revenue from Contract with Customers* and **AASB 1058** *Income for Not-for-Profit Entities*

Ahpra's assessment and application of AASB 15 and AASB 1058 is stated in *Note A1*.

Note E2: 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. 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*.

Ahpra applies AASB 9 and classifies all of its financial assets based on the business model for managing the assets and the assets' contractual terms.

Categories of financial instruments under AASB 9 include:

Financial assets at amortised cost

Ahpra recognises the following assets in this category:

- cash and cash equivalents
- term deposit investments, and
- receivables (excluding statutory receivables).

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 doesn't hold financial assets within the two other categories i.e. financial assets at **fair value through other comprehensive income** such as unlisted equity instruments and **financial assets at fair value through net result** such as listed equity securities.

Impairment of financial assets

From 1 July 2018, Ahpra has been recording the allowance for expected credit loss for the relevant financial instruments, replacing previous incurred loss approach with 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.

Application of the lifetime ECL allowance method results in an increase in the impairment loss allowance of $318,000 in 2018/19. Refer to *Note B2* for details about the calculation of the allowance. The loss allowance decreased by $26,000 for the financial assets during the current financial year.

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.

Financial instrument liabilities measured at amortised cost include all of Ahpra's contractual payables and lease liabilities.

(a) Financial risk management

Ahpra's principal financial instruments consist of at call variable interest deposits, fixed and repricing term deposits and trade receivables and payables. Ahpra has no exposure to foreign exchange rate risk and equity price risk.

(b) Credit risk exposure

Credit risk is the risk that a party will fail to fulfil its obligations to Ahpra resulting in financial loss. The maximum exposure to credit risk, excluding the value of any collateral or other security at balance date, is the carrying amount, net of any provisions for impairment of those assets, as disclosed in the statement of financial position and notes to the financial statements. Credit risk associated with Ahpra's contractual financial assets is minimal because Ahpra mainly obtains contractual financial assets that are term deposits and cash at bank. As with the policy for investment, Ahpra's policy is to only deal with banks with high credit ratings. As a result, Ahpra does not have any material credit risk exposure to any single receivable or group of receivables under financial instruments entered into by the entity.

Ahpra monitors the credit risk by actively assessing the rating quality and liquidity of counterparties. Except as otherwise detailed in the following table, the carrying amount of contractual financial assets recorded in the financial statements, net of any allowances for losses, represents Ahpra's maximum exposure to credit risk.

There has been no material change to Ahpra's credit risk profile in 2019/20.

Credit quality of financial assets [a] 2020	Financial institutions (AA- credit rating)[1] $'000	Other $'000	Total $'000
Financial assets			
Financial assets with loss allowance measured at 12 month expected credit loss:			
Cash and cash equivalents	15,812	0	15,812
Investments	179,500	0	179,500
Accrued income	1,334	0	1,334
Financial assets with loss allowance measured at lifetime expected credit loss:			
Contractual receivables applying the simplified approach for impairment	0	568	568
Total financial assets	**196,646**	**568**	**197,214**

Credit quality of contractual financial assets that are neither past due nor impaired[a] 2019	Financial institutions (AA- credit rating)[2] $'000	Other $'000	Total $'000
Financial assets			
Cash and cash equivalents	10,170	0	10,170
Investments	174,000	0	174,000
Accrued income	861	0	861
Financial assets with loss allowance measured at lifetime expected credit loss:			
Contractual receivables applying the simplified approach for impairment	0	773	773
Total financial assets	**185,031**	**773**	**185,804**

[a] The total amount disclosed here excludes statutory amounts (e.g. GST input tax credit recoverable)

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.

On this basis, Ahpra determines the loss allowance at end of the financial year as follows:

	Current $'000	Less than 1 month $'000	1–3 months $'000	3–12 months $'000	More than 1 year $'000	Total $'000
30 June 2020						
Expected loss rate	5%	20%	17–36%	41%	94%	
Contractual receivables	115	340	94	84	1,310	1,943
Loss allowance	**(5)**	**(69)**	**(31)**	**(34)**	**(1,236)**	**(1,375)**
30 June 2019						
Expected loss rate	0%	23%	33–43%	55%	95%	
Contractual receivables	159	405	247	216	1,147	2,174
Loss allowance	**0**	**(91)**	**(98)**	**(118)**	**(1,094)**	**(1,401)**

1 Standard & Poor's rate AA-. Moody's Investors Service rate Aa3. Fitch ratings A+.

2 Fitch Ratings and Standard & Poor's both rate AA-. Moody's Investors Service rate Aa3.

Reconciliation of the movement in the loss allowance for contractual receivables can be found in *Note B2*.

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 2019 under AASB 139. No additional loss allowance required upon transition into AASB 9 on 1 July 2019.

(c) Liquidity risk exposure

Liquidity risk is the risk that Ahpra will encounter difficulty in meeting obligations associated with financial liabilities. Ahpra manages liquidity risk by monitoring cash flows' forecast and ensuring that adequate liquid funds are available to meet current obligations.

Ahpra's exposure to liquidity risk is deemed insignificant based on prior period's data and current assessment of risk. Cash for unexpected events is generally sourced from liquidation of available to recall term deposits.

These tables disclose the maturity analysis of Ahpra's financial liabilities.

		Maturity dates		
Payables [a]	**Carrying amount $'000**	**Less than 1 month $'000**	**1–3 months $'000**	**3 months-1 year $'000**
2020				
Trade creditors	757	737	2	18
Accrued expenses	6,686	6,686	0	0
Total	**7,443**	**7,423**	**2**	**18**
2019				
Trade creditors	2,380	2,252	82	46
Accrued expenses	11,935	11,935	0	0
Total	**14,315**	**14,187**	**82**	**46**

[a] The total amount disclosed here excludes statutory amounts (e.g. payroll tax payable)

The maximum exposure to liquidity risk is the total carrying amount of the financial liabilities as shown above.

(d) Market risk exposure

Currency risk

Ahpra had no exposure to currency risk at 30 June 2020 or at 30 June 2019.

Equity price risk

Ahpra had no exposure to equity price risk at 30 June 2020 or at 30 June 2019.

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]

Interest rate exposure of financial instruments

	Weighted average interest rate	**Non-interest bearing $'000**	**Floating interest rate $'000**	**Fixed interest rate $'000**	**Total $'000**
2020 financial assets					
Cash and cash equivalents	0.31%	0	0	15,812	**15,812**
Investments	2.15%	0	75,500	104,000	**179,500**
Receivables	0.00%	1,045	0	0	**1,045**
Accrued income	0.00%	1,334	0	0	**1,334**
Total		**2,379**	**75,500**	**119,812**	**197,691**
2020 financial liabilities					
Payables	0.00%	757	0	0	**757**
Accrued expenses	0.00%	6,686	0	0	**6,686**
Lease liabilities	1.28–2.09%	0	0	50,402	**50,402**
Total		**7,443**	**0**	**50,402**	**57,845**
2019 financial assets					
Cash and cash equivalents	1.25%	0	0	10,170	**10,170**
Investments	2.63%	0	103,000	71,000	**174,000**
Receivables	0.00%	1,551	0	0	**1,551**
Accrued income	0.00%	861	0	0	**861**
Total		**2,412**	**103,000**	**81,170**	**186,582**
2019 financial liabilities					
Payables	0.00%	2,380	0	0	**2,380**
Accrued expenses	0.00%	11,935	0	0	**11,935**
Total		**14,315**	**0**	**0**	**14,315**

1 Standard & Poor's rate AA-. Moody's Investors Service rate Aa3. Fitch ratings A+.

Sensitivity analysis

Taking into account past performance, future expectations, economic forecasts, and management's knowledge and experience of the financial markets, Ahpra believes the following movements are 'reasonably possible' over the next 12 months:

- A parallel shift of +0.25% and -0.25% (2019: +0.5% and -0.5%) in market interest rates (AUD) from year-end rates of 2.15% and 0.31% due to current historical low interest rate and central bank's intention to keep interest rates low to stimulate the economy.

This table discloses the impact on net operating result and equity for each category of financial instrument held by Ahpra at year end. Investments which have fixed rate of return over the next 12 months are assessed as not subject to the market interest rates shift. Investments which will mature during the next 12 months or invested in floating rate of return are assessed accordingly for the impacts on net operation result and equity.

	Carrying amount $'000	At +0.25% $'000 Surplus	At +0.25% $'000 Equity	At −0.25% $'000 Surplus	At −0.25% $'000 Equity
2020 financial assets					
Cash and cash equivalents	15,812	40	40	(40)	(40)
Investments	179,500	240	240	(240)	(240)
Total		**280**	**280**	**(280)**	**(280)**

	Carrying amount $'000	At +0.5% $'000 Surplus	At +0.5% $'000 Equity	At −0.5% $'000 Surplus	At −0.5% $'000 Equity
2019 financial assets					
Cash and cash equivalents	10,170	51	51	(51)	(51)
Investments	174,000	738	738	(738)	(738)
Total		**789**	**789**	**(789)**	**(789)**

Other market risk

Ahpra had no exposure to other market risk at 30 June 2020 or at 30 June 2019.

(e) Fair value

The fair values and net fair values of financial instrument assets and liabilities are determined as follows:

Level 1 – the fair value of financial instrument with standard terms and conditions and traded in active liquid markets are determined with reference to quoted market prices.

Level 2 – the fair value is determined using inputs other than quoted prices that are observable for the financial asset or liability, either directly or indirectly.

Level 3 – the fair value is determined in accordance with generally accepted pricing models based on discounted cash flow analysis using unobservable market inputs.

Ahpra considers that the carrying amount of financial instrument assets and liabilities recorded in the financial statements to be a fair approximation of their fair values, because of the short-term nature of the financial instruments and the expectation that they will be settled in full.

This table shows that the fair values of the contractual financial assets and liabilities are the same as the carrying amounts.

Comparison between carrying amount and fair value

	Note	Carrying amount 2020 $'000	Fair value 2020 $'000	Carrying amount 2019 $'000	Fair value 2019 $'000
Contractual financial assets					
Cash and cash equivalents		15,812	15,812	10,170	10,170
Investments		179,500	179,500	174,000	174,000
Receivables	*B2*	1,943	568	2,174	773
Accrued income		1,334	1,334	861	861
Total contractual financial assets		**198,589**	**197,214**	**187,205**	**185,804**
Contractual financial liabilities					
Payables		757	757	2,380	2,380
Accrued expenses		6,686	6,686	11,935	11,935
Lease liabilities		50,402	50,402	0	0
Total contractual financial liabilities		**57,845**	**57,845**	**14,315**	**14,315**

Note E3: Related party disclosures

Key management personnel (KMP) of Ahpra include the responsible Minister in each jurisdiction that forms parts of the Ministerial Council under the National Law, members of the Agency Management Committee, Chief Executive Officer and members of the National Executive team.

(a) Ministerial Council

The Ministerial Council comprises Ministers of the governments of the participating jurisdictions and the Commonwealth with portfolio responsibility for health. The following Ministers were members of the Ministerial Council (formally known as the Australian Health Workforce Ministerial Council) during the year 1 July 2019 to 30 June 2020, unless otherwise noted.

Name	Portfolio	Jurisdiction
Ms Rachel Stephen-Smith MLA	Minister for Health (from July 2019) Minister for Children, Youth and Families Minister for Aboriginal and Torres Strait Islander Affairs	Australian Capital Territory
The Hon Greg Hunt MP	Minister for Health	Commonwealth
The Hon Bradley Hazzard MP	Minister for Health Minister for Medical Research	New South Wales
The Hon Natasha Fyles MLA	Attorney-General and Minister for Justice Minister for Health Minister for Arafura Games Minister for Disabilities Chair, COAG Health Council (from November 2019)	Northern Territory
The Hon Dr Steven Miles MP	Deputy Premier (from May 2020) Minister for Health and Minister for Ambulance Services	Queensland
The Hon Stephen Wade MLC	Minister for Health and Wellbeing	South Australia
The Hon Sarah Courtney MP	Minister for Health Minister for Strategic Growth Minister for Women Minister for Small Business, Hospitality and Events	Tasmania
The Hon Jenny Mikakos MP	Minister for Health Minister for Ambulance Services	Victoria
The Hon Roger Cook MLA	Deputy Premier Minister for Health, Mental Health Chair, COAG Health Council (to 1 November 2019)	Western Australia

Amounts relating to responsible Ministers' remuneration are reported in the financial statements of the relevant Minister's jurisdiction.

(b) Agency Management Committee members

Member	Period
Mr Michael Gorton AM, Chair	1/7/2019 – 15/7/2019
Ms Gill Callister PSM, Chair	15/7/2019 – 30/6/2020
Dr Peggy Brown AO	1/7/2019 – 30/6/2020
Adjunct Professor Karen Crawshaw PSM	1/7/2019 – 30/6/2020
Ms Philippa Smith AM	1/7/2019 – 30/6/2020
Ms Jenny Taing OAM	1/7/2019 – 30/6/2020
Ms Barbara Yeoh AM	1/7/2019 – 30/6/2020
Dr Susan Young	1/7/2019 – 30/6/2020

(c) Chief Executive Officer and National Executive team

- Chief Executive Officer, Martin Fletcher
- Executive Director, Regulatory Operations, Kym Ayscough
- Executive Director, Strategy and Policy, Chris Robertson
- Executive Director, People and Culture, Mark Edwards
- Executive Director, Business Services, Sarndrah Horsfall (to September 2019)
- Chief Information Officer, Clarence Yap (from October 2019)
- Chief Financial Officer, Elizabeth Davenport (from January 2020)

Other than the responsible Ministers, the remuneration for KMP is disclosed as follows.

	2020 $	2019 $
Short-term employee benefits	1,887,681	1,603,472
Long-term employee benefits	21,211	38,312
Post-employment benefits	136,326	119,966
Termination benefits	76,856	0
Total	**2,122,074**	**1,761,750**

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 other than those disclosed below. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

All other transactions that have occurred with KMP and their related parties have not been considered material for disclosure. In this context, transactions are only disclosed when they are considered necessary to draw attention to the possibility that Ahpra's financial position and profit or loss may have been affected by the existence of related parties, and by transactions and outstanding balances, including commitments, with such parties.

Mr Michael Gorton AM was Chair of Agency Management Committee until 15 July 2019. He is a principal of Russell Kennedy Solicitors which provides legal services on notification matters to Ahpra on normal commercial terms and conditions.

	2020 $'000	2019 $'000
Russell Kennedy Solicitors	523	327

There were no transactions involving the Ministerial Council during 2019/20.

Note E4: Remuneration of external auditor

	2020 $'000	2019 $'000
Victorian Auditor-General's Office	169	165
Total	**169**	**165**

Note E5: 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 onto 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 flow.

Transactions relating to this activity are reported as administered (non-controlled) items per this table.

Summary of HPCA fee collected and payable

National Board	2020 $'000	2019 $'000
ATSIHPBA	8	7
CMBA	358	447
ChiroBA	426	416
DBA	3,918	2,775
MBA	15,388	14,573
MRPBA	292	283
NMBA	9,884	9,492
OTBA	248	265
OptomBA	247	235
OsteoBA	205	199
ParaBA	646	589
PharmBA	3,051	2,308
PhysioBA	485	649
PodBA	266	297
PsyBA	1,635	1,804
Total	**37,057**	**34,339**

Office of the Health Ombudsman (OHO) Queensland

In Queensland, the Health Minister informs Ahpra and the National Boards of the amount to be paid to the Office of the Health Ombudsman (OHO). This payment is included in the Statement of comprehensive income as an expense. In 2019/20, Ahpra was required to pay $4.14 million (2018/19: $3.94 million) to OHO under these arrangements.

A further $1.94 million (2018/19 $3.18 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 determined $4.14 million. Along with the final 2018/19 reconciliation adjustment 404k credit processed in 2019/20, total reported expenses in 2019/20 is 5.684m. The breakdown of the payment, accrual and 2018/19 reconciliation adjustment is shown in this table.

	2020		2019			
National Board	Minister's determination $'000	QCAT accrual $'000	Reported $'000	Adjusted $'000	Total reported 2020 $'000	Total reported 2019 $'000
ATSIHPBA	1	1	0	1	**3**	**0**
CMBA	91	(54)	86	4	**41**	**86**
ChiroBA	26	(10)	6	4	**20**	**6**
DBA	176	158	373	(14)	**320**	**373**
MBA	2,225	683	2,666	(205)	**2,703**	**2,666**
MRPBA	2	0	58	(1)	**1**	**58**
NMBA	1,093	681	3,262	(137)	**1,637**	**3,262**
OTBA	3	7	11	(1)	**9**	**11**
OptomBA	2	4	(5)	2	**8**	**(5)**
OsteoBA	65	0	11	(1)	**64**	**11**
ParaBA	6	31	32	(27)	**10**	**32**
PharmBA	189	167	446	(24)	**332**	**446**
PhysioBA	65	56	(1)	(1)	**120**	**(1)**
PodBA	14	105	12	(7)	**112**	**12**
PsyBA	186	115	231	3	**304**	**231**
Total	**4,144**	**1,944**	**7,188**	**(404)**	**5,684**	**7,188**

Appendices

Appendix 1: Structure of the National Boards

National Board	National committees	Regional boards	State and territory boards	State and territory/ regional committees
ATSIHPBA	Immediate Action Committee[1] Registration and Notifications Committee	N/A	N/A	N/A
CMBA	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	Accreditation Committee Conscious Sedation Advisory Panel Equivalence Assessment Panel for overseas-trained dental specialists Expert Reference Group – Specialist Notifications Committee: Assessment (Qld and Vic) Recency of Practice Advisory Panel	N/A	N/A	Immediate Action Committee (excluding NSW) Registration Committee (NSW only) Registration and Notifications Committee (excluding NSW)
MBA	Finance Committee Notifications Committee: Assessment Sexual Boundaries Notifications Committee Standing Notifications Committee: Assessment	N/A	All states and territories	Immediate Action Committee (excluding NSW) Notifications Committees (excluding NSW) Registration Committees
MRPBA	Immediate Action Committee[1] National Examination Committee Registration and Notifications Committee Supervised Practice Committee Policy Committee	N/A	N/A	N/A
NMBA	Accreditation Committee (Assessment of Overseas Qualified Nurses and Midwives) Finance, Governance and Communications Committee Notifications Committee Midwifery Assessment Notifications Committee Nursing Assessment Program Approval Committee Registration and Notifications Committee State and Territory Chairs' Committee	N/A	All states and territories	Immediate Action Committee (excluding NSW) When required: Notifications Committee (excluding NSW) Registration Committee
OTBA	Immediate Action Committee[1] Registration and Notifications Committee	N/A	N/A	N/A
OptomBA	Finance and Risk Committee Immediate Action Committee[1] Policy and Education Committee Registration and Notifications Committee Scheduled Medicines Advisory Committee	N/A	N/A	N/A
OsteoBA	Immediate Action Committee[1] Registration and Notifications Committee	N/A	N/A	N/A
ParaBA	Immediate Action Committee[1] Registration, Notifications and Compliance Committee Notifications Committee: Assessment	N/A	N/A	N/A
PharmBA	Finance, Risk and Governance Committee Immediate Action Committee Notifications Committee Notifications Committee: Assessment Policies, Codes and Guidelines Committee Registration and Examinations Committee	N/A	N/A	N/A
PhysioBA	Immediate Action Committee[1] Registration and Notifications Committee	N/A	N/A	N/A
PodBA	Immediate Action Committee[1] Registration and Notifications Committee Strategic Planning and Policy Committee	N/A	N/A	N/A
PsyBA	Immediate Action Committee National Psychology Examination Committee	ACT, Tas and Vic NT, SA and WA	NSW Qld	N/A

1. As part of the Multi-Profession Immediate Action Committee. See page 141.

Appendix 2: Meetings of Boards and committees

This table details the number of National Board, national committee, state/territory board and committee meetings held during 2019/20. 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 (see *Appendix 1*).

The purposes of committees vary, and include decision-making about individual practitioners (e.g. registration, notifications, immediate action and compliance matters) and finance and policy-oriented committees looking at standards, codes and guidelines for the profession.

All of the meetings listed in the table as either state/territory board or state/territory committee, along with the majority of national committee meetings, were engaged in regulatory decision-making affecting individual practitioners. Numbers include out-of-sessions 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	11	7	**18**			**0**	**18**
CMBA	16	28	**44**			**0**	**44**
ChiroBA	16	28	**44**			**0**	**44**
DBA	13	32[1]	**45**		111	**111**	**156**
MBA	13	366	**379**	123	471	**594**	**973**
MRPBA	13	34	**47**			**0**	**47**
NMBA	20	54	**74**	107	426	**533**	**607**
OTBA	13	26	**39**			**0**	**39**
OptomBA	12	23	**35**			**0**	**35**
OsteoBA	12	18	**30**			**0**	**30**
ParaBA	17	95	**112**			**0**	**112**
PharmBA	16	113	**129**			**0**	**129**
PhysioBA	16	56	**72**			**0**	**72**
PodBA	17	25	**42**			**0**	**42**
PsyBA	15	48	**63**	57		**57**	**120**
Total	**220**	**953**	**1,173**	**287**	**1,008**	**1,295**	**2,468**

1. Includes the Notifications Committee: Assessment, which considers matters from Qld and Vic.

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 2019/20 are listed, so some committees appear to have a larger membership than they actually do, at any given time. Term dates are only shown for Chairs.

All boards have practitioner and community members. A third of all National Board positions are filled by community members: 52 of 156 positions.

On state, territory and regional boards 35.5% of positions are filled by community members: 75 of 211 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

Policy, Planning and Communication Committee

Dr David Graham PhD (community) (Chair)

Ms Christine Berle (practitioner)

Dr Liang Zhong Chen PhD (practitioner)

Dr Di Wen Lai (practitioner) (Deputy Chair)

Mr Roderick Martin (practitioner) (Deputy Chair)

Ms Glenys Savage (practitioner)

Registration and Notifications Committee

Mr David Brereton (community) (Chair)

Ms Stephanie Campbell (community) (Deputy Chair)

Dr Liang Zhong Chen PhD (practitioner)

Dr Di Wen Lai (practitioner)

Mr Roderick Martin (practitioner) (Deputy Chair)

Dr Li Mei-Kin Rees PhD (practitioner)

Ms Jacinta Ryan (practitioner)

Ms Bing Tian (practitioner)

Chinese Medicine Reference Group

Individual practitioner members

Dr Kevin Ryan

Ms Laura Sutton

Ms Dina Tsiopelas

Ms Honglin (Linda) Yang

Dr Shengxi (George) Zhang

Community representatives

Ms Sophy Athan, Ahpra's Community Reference Group

Ms Tricia Greenway, Community representative

Dr Cheryl McRae PhD, Assistant Secretary, Complementary & Over the Counter Medicines Branch, Therapeutic Goods Administration

Professional association representatives

Mr Peter Berryman, Australian Traditional Medicine Society (ATMS)

Ms Jeanetta Gogol, 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)

Ms Robin Marchment, Federation of Chinese Medicine & Acupuncture Societies of Australia (FCMA)

Mr Harry Wu, Chinese Medicine and Acupuncture Society of Australia Ltd (CMASA)

Education institution representatives

Associate Professor Xiaoshu Zhu

Dr Greg Cope

Chiropractic Board of Australia: National committee members

Registration, Notifications and Compliance Committee

Dr Michael Badham (practitioner) (Presiding Member from 22 Jun)

Mr Frank Ederle (community) (Chair to 19 Jun)

Ms Anne Burgess (community)

Dr Abbey Chilcott (practitioner)

Dr Wayne Minter AM (practitioner)

Dr Arcady Turczynowicz (practitioner)

Ms Alison von Bibra (community)

Dr Ailsa Wood (practitioner)

Dental Board of Australia: Committee, group and panel members

ACT Registration and Notifications Committee and Immediate Action Committee

Dr Peter Wong (practitioner) (Chair)

Ms Sarah Byrne (community)

Dr Kerrie O'Rourke (practitioner)

NSW Registration Committee

Professor Iven Klineberg (practitioner) (Chair)

Dr Alexander Holden (practitioner)

Mr Michael Miceli (community)

Dr Philippa Sawyer (practitioner)

NT Registration and Notifications Committee and Immediate Action Committee

Dr Erna Melton (practitioner) (Chair)

Mrs Megan Lawton (community)

Dr Quentin Rahaus (practitioner)

Dr Michael Rees (practitioner)

Qld Registration and Notifications Committee and Immediate Action Committee

Dr Robert McCray (practitioner) (Chair)

Mrs Brydget Barker-Hudson (community)

Professor Robert Love (practitioner)

Dr Bruce Newman (practitioner)

Mr Stuart Unwin (community)

SA Registration and Notifications Committee and Immediate Action Committee

Dr Cosimo Maiolo (practitioner) (Chair)

Ms Michelle Kuss (practitioner)

Dr Sophia Matiasz PhD (community)

Dr Heidi Munchenberg (practitioner)

Ms Joanna Richardson (community)

Dr Michael Rees (practitioner)

Tas Registration and Notifications Committee and Immediate Action Committee

Dr Ioan Jones (practitioner) (Chair)

Mr Leigh Gorringe (practitioner)

Dr Kylie McShane PhD (community)

Mr Nikolas Peacock (practitioner)

Professor Craig Zimitat (community)

Vic Registration and Notifications Committee and Immediate Action Committee

Dr Werner Bischof (practitioner) (Chair)

Dr Janice Davies PhD (community)

Professor Lesleyanne Hawthorne (community)

Dr Ioan Jones (practitioner)

Dr Rachel Martin (practitioner)

WA Registration and Notifications Committee and Immediate Action Committee

Dr Simon Shanahan (practitioner) (Chair)

Dr Susan Anderson (practitioner)

Dr Erna Melton (practitioner)

Ms Yvonne Parnell (community)

Dr Bernadette Pilkington (practitioner)

Professor Craig Zimitat (community)

Accreditation Committee

Dr Kate Raymond (practitioner) (Chair)

Winthrop Professor Paul Abbott AO (practitioner)

Ms Jacqueline Gibson (community)

Mr Tan Nguyen (practitioner)

Mrs Janice Okine (practitioner)

Ms Carolynne Smith (practitioner)

Notifications Committee: Assessment (Qld and Vic)

Dr Werner Bischof (practitioner)

Dr Erna Melton (practitioner)

Dr Ioan Jones (practitioner)

Professor Robert Love (practitioner)

Dr Simon Shanahan (practitioner)

Medical Board of Australia: State and territory board, national committee and group members

Australian Capital Territory

Dr Kerrie Bradbury (practitioner) (Chair)

Mrs Gulnara Abbasova (community)

Dr Emma Adams (practitioner)

Ms Vicki Brown (community)

Ms Catherine Gauthier (community)

Dr Janelle Hamilton (practitioner)

Mr Robert Little (community)

Associate Professor Rodney Petersen (practitioner)

Dr Louise Stone (practitioner)

Dr Jill Van Acker (practitioner)

Professor Peter Warfe (practitioner)

New South Wales

Associate Professor Stephen Adelstein (practitioner) (Chair)

Dr Costa Boyages (practitioner)

Dr Jennifer Davidson (practitioner)

Dr Sergio Diez Alvarez (practitioner)

Dr Amanda Mead PhD (community)

Professor Abdullah Omari (practitioner)

Ms Jebby Phillips (community)

Professor Allan Spigelman (practitioner)

Ms Amanda Wilson (community)

Northern Territory

Dr Hemanshu Patel (practitioner) (Chair) (from 13 Oct)

Dr Charles Kilburn (practitioner) (Chair) (to 1 Oct)

Mrs Lea Aitken (community)

Mrs Julia Christensen (community)

Dr Tamsin Cockayne (practitioner)

Dr Henry Duncan (practitioner)

Ms Annette Flaherty (community)

Dr Paul Helliwell (practitioner)

Dr Verushka Krigovsky (practitioner)

Associate Professor Dianne Stephens (practitioner)

Queensland

Dr Susan O'Dwyer (practitioner) (Chair) (to 31 Dec)

Dr Philip Richardson (practitioner) (Chair) (from 30 Mar)

Dr Cameron Bardsley (practitioner)

Dr Anelisa Dazzi Chequer De Souza (practitioner)

Dr Patrick Clancy (practitioner)

Mr Timothy Cole (community)

Dr Caron Forde (practitioner)

Ms Christine Gee (community)

Dr Genevieve Goulding (community)

Dr Robert Ivers (practitioner)

Dr Gordon McGurk PhD (community)

Professor Eleanor Milligan (community)

Ms Megan O'Shannessy (community)

Mr George Seymour (community)

Dr Morgan Windsor (practitioner)

Dr Susan Young EdD (community)

South Australia

Dr Mary White (practitioner) (Chair)

Professor Andrew Carney (practitioner)

Dr Daniel Cehic (practitioner)

Dr Carolyn Edmonds (practitioner)

Dr Catherine Gibb (practitioner)

Ms Kate Ireland (community)

Mr Paul Laris (community)

Professor Guy Maddern (practitioner)

Ms Louise Miller-Frost (community)

Dr Bruce Mugford (practitioner)

Dr Lynne Rainey (practitioner)

Dr Leslie Stephan (practitioner)

Ms Katherine Sullivan (community)

Mr Thomas Symonds (community)

Tasmania

Dr Andrew Mulcahy (practitioner) (Chair)

Dr Anelisa Dazzi Chequer De Souza (practitioner)

Dr Kristen Fitzgerald (practitioner)

Mr Fergus Leicester (community)

Ms Leigh Mackey (community)

Ms Louise Mason (community)

Dr Gavin Mackie (practitioner)

Dr Colin Merridew (practitioner)

Dr Phillip Moore (practitioner)

Dr Kim Rooney OAM (practitioner)

Dr David Saner (practitioner)

Dr Brooke Sheldon (practitioner)

Mrs Joan Wylie (community)

Victoria

Dr Debra O'Brien (practitioner) (Chair)

Mrs Jennifer Barr (community)

Dr Christine Bessell (practitioner)

Dr John Carnie PSM (practitioner)

Dr Anthony Cross (practitioner)

Dr Susan Gould PhD (community)

Ms Louise Johnson (community)

Associate Professor Solomon Menahem (practitioner)

Dr Pamela Montgomery PhD (community)

Dr Ines Rio (practitioner)

Dr Abhishek Verma (practitioner)

Dr Ruth Vine (practitioner)

Dr Miriam Weisz DBA (community)

Western Australia

Professor Constantine (Con) Michael AO (practitioner) (Chair)

Dr Richelle Douglas (practitioner)

Dr Alan Duncan (practitioner)

Dr Pathma Edge (practitioner)

Professor Mark Edwards (practitioner)

Dr George Eskander (practitioner)

Dr Michael Levitt (practitioner)

Dr Clare Matthews (practitioner)

Ms Sonia McKeiver (community)

Ms Meneesha Michalka (community)

Ms Colleen Rebelo (community)

Ms Virginia Rivalland (community)

Mr Liam Roche (community)

Non-Board members appointed to national committees

ACT

Ms Vicki Brown (community)

Dr Janelle Hamilton (practitioner)

NSW

Dr Maria (Tessa) Ho (practitioner)

Qld

Ms Heather Eckersley (community)

Professor Harry McConnell (practitioner)

Mr Geoff Rowe (community)

Dr Samuel Stevens (practitioner)

SA

Dr Carolyn Edmonds (practitioner)

Dr Rakesh Mohindra (practitioner)

Dr Harshita Pant (practitioner)

Dr Melanie Turner (practitioner)

Mr Paul Laris (community)

Vic

Dr Alison Lilley (practitioner)

WA

Ms Mary Carroll (community)

Dr Steven Patchett (practitioner)

Clinical Advice Committee

Associate Professor David Hillis (practitioner) (Chair)

Dr Rebecca (Bec) Bennett (practitioner)

Dr Christopher Cunneen (practitioner)

Dr Jane Hecker (practitioner)

Dr Margaret Kay (practitioner)

Professor Constantine (Con) Michael AO (practitioner)

Professor Constance (Dimity) Pond (practitioner)

Dr Mark Renehan (practitioner)

Dr Prasanna (Chanaka) Wijeratne (practitioner)

Finance Committee

Ms Fearn (Michelle) Wright (Chair)

Mr Mark Bodycoat (community)

Dr Samuel Goodwin (practitioner)

Dr Anne Tonkin (practitioner)

Good Practice Guidelines Working Group

Professor Richard Doherty (practitioner) (Chair)

Dr Kaye Atkinson (practitioner)

Dr Caroline Clarke (practitioner)

Ms Gregoria Fanourakis (community)

Dr Daniel Heredia (practitioner)

Dr Pamela Robinson (practitioner)

Dr Andrew Singer (practitioner)

Associate Clinical Professor Christine Tippett (practitioner)

Medical Training Survey Advisory Group

Associate Professor Stephen Adelstein (practitioner) (Chair)

Dr Mohamed Abdeen (practitioner)

Dr Monica Chen (practitioner)

Ms Helen Craig (community)

Dr Marco Giuseppin (practitioner)

Dr James Edwards (practitioner)

Mr Warwick Hough (community)

Dr Kym Jenkins (practitioner)

Mr Oliver Jones (community)

Dr Joanne Katsoris (practitioner)

Professor Robyn Langham (practitioner)

Mr John McGurk (community)

Dr David Mountain (practitioner)

Dr Susan O'Dwyer (practitioner)

Dr Annette Pantle (practitioner)

Dr Andrew Singer (practitioner)

Professor Richard Tarala (practitioner)

Professor Susan Wearne (practitioner)

Dr Christopher (Chris) Wilson (practitioner)

Ms Fearn (Michelle) Wright (community)

Ms Jessica Yang (community)

Dr John Zorbas (practitioner)

Mr Daniel Zou (practitioner)

Medical Training Survey Steering Committee

Associate Professor Stephen Adelstein (practitioner) (Chair)

Dr Joanne Katsoris (practitioner)

Dr Linda MacPherson (practitioner)

Dr Bavahuna Manoharan (practitioner)

Dr Susan O'Dwyer (practitioner)

Ms Theanne Walters (community)

Ms Kirsty White (community)

Ms Fearn (Michelle) Wright (community)

National Specialist International Medical Graduate Committee

Dr Susan O'Dwyer (Chair)

Ms Sophy Athan (community)

Dr Sergio Diez Alvarez (practitioner)

Ms Kym Ayscough (community)

Associate Professor Terry Brown (practitioner)

Professor Gavin Frost (practitioner)

Dr Patrick Giddings (practitioner)

Ms Lynne Gillam (community)

Dr Paul Helliwell (practitioner)

Dr Jon Hodge (practitioner)

Dr Joanne Katsoris (practitioner)

Ms Megan Lewis (community)

Dr Andrew Mulcahy (practitioner)

Dr Bruce Mugford (practitioner)

Mr Philip Pigou (community)

Dr Diane Neill (practitioner)

Adjunct Associate Professor Andrew Singer AM (practitioner)

Dr Janaka Tennakoon (practitioner)

Professional Performance Framework Implementation Working Group

Dr Anne Tonkin (practitioner) (Chair)

Mr Mark Bodycoat (community)

Associate Professor David Hillis (practitioner)

Professor Katherine (Kate) Leslie (practitioner)

Professor Constantine (Con) Michael AO (practitioner)

Dr Joanne Katsoris (practitioner)

Sexual Boundaries Notifications Committee

Ms Christine Gee (community) (Chair)

Mr Mark Bodycoat (community)

Mrs Julia Christensen (community)

Dr Anthony Cross (practitioner)

Dr Sergio Diez Alvarez (practitioner)

Dr Alan Duncan (practitioner)

Dr Kristen Fitzgerald (practitioner)

Dr Janelle Hamilton (practitioner)

Dr Maria (Tessa) Ho (practitioner)

Dr Robert Ivers (practitioner)

Dr Verushka Krigovsky (practitioner)

Professor Eleanor Milligan (community)

Dr Debra O'Brien (practitioner)

Dr Kim Rooney OAM (practitioner)

Ms Katherine Sullivan (community)

Dr Anne Tonkin (practitioner)

Professor Peter Warfe (practitioner) (Deputy Chair)

Dr Miriam Weisz DBA (community)

Mrs Joan Wylie (community)

Standing Notifications Committee: Assessment (from 25 Sep)

Dr Maria Ho (practitioner) (Chair)

Mrs Lea Aitken (community)

Mr Mark Bodycoat (community) (Deputy Chair)

Ms Vicki Brown (community)

Dr Patrick Clancy (practitioner)

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)

Ms Louise Miller-Frost (community)

Dr Pamela Montgomery (community) (Deputy Chair)

Dr Bruce Mugford (practitioner)

Dr Kim Rooney OAM (practitioner)
Dr Morgan Windsor (practitioner)
Mrs Joan Wylie (community)

The Board is grateful for the contribution of the many national, state and territory board members, as well as non-board members who serve on state-based and national regulatory committees. These include Registration Committees, Immediate Action Committees and Notifications Committees, including Notifications Committee: Assessment.

Medical Radiation Practice Board of Australia: National committee members

National Examination Committee

Dr Susan Gould PhD (community) (Chair)
Mr James Green (practitioner)
Mr Roger Weckert (practitioner)
Dr Caroline Wright PhD (practitioner)

Policy Committee

Mr Christopher Hicks (practitioner) (Chair)
Ms Joan Burns (community)
Ms Donisha Duff (community)
Mr James Green (practitioner)
Dr Susan Gould PhD (community)
Ms Tracy Vitucci (practitioner)
Dr Caroline Wright PhD (practitioner)

Registration and Notifications Committee

Mr Mark Marcenko (practitioner) (Chair)
Mr Richard Bialkowski (community)
Mr Brendan McKernan (practitioner)
Ms Cara Miller (practitioner)
Mr Roger Weckert (practitioner)

Supervised Practice Committee

Mr Brendan McKernan (practitioner) (Chair)
Mr Gerard Amirtham (practitioner)
Mr Richard Bialkowski (community)
Mrs Nainaben Dhana (practitioner)
Mrs Kelly Elsner (practitioner)
Ms Fiona Franklin (practitioner)
Mr Simon Lejcak (practitioner)
Ms Cara Miller (practitioner)
Miss Lauren Moon (practitioner)

Nursing and Midwifery Board of Australia: State and territory board and national committee members

State and Territory Chairs' Committee

Associate Professor Lynette Cusack (Chair)
Ms Carol Baines (practitioner) (Tas) (Presiding Member)
Ms Angela Bull (practitioner) (NT)
Ms Felicity Dalzell (practitioner) (ACT)
Ms Amanda Singleton (practitioner) (Vic)
Mrs Eithne Irving (practitioner) (NSW)
Associate Professor Bethne Hart (Nursing and Midwifery Council of NSW)
Ms Marie Louise MacDonald (practitioner) (WA)
Associate Professor Linda Starr (practitioner) (SA)
Professor Patsy Yates (practitioner) (Qld)

Australian Capital Territory

Ms Felicity Dalzell (practitioner) (Chair)
Mrs Gulnara Abbasova (community)
Mrs Alison Archer (community)
Ms Marjorie Atchan (practitioner)
Ms Janet Baldock (practitioner)
Dr Katrina Cubit PhD (practitioner)
Ms Eileen Jerga AM (community)
Ms Kelley Stewart (practitioner)
Professor Karen Strickland (practitioner)

New South Wales

Mrs Eithne Irving (practitioner) (Chair)
Ms Kathryn Adams (practitioner)
Ms Katherine Becker (practitioner)
Mr Bruce Brown (community)
Mr Roderick Cooke (community)
Ms Adrienne Farago (community)
Dr Joanne Gray PhD (practitioner)
Mrs Susan Greig (practitioner)
Ms Melissa Maimann (practitioner)

Northern Territory

Ms Angela Bull (Chair) (practitioner)
Mrs Leanne Chapman (practitioner)
Mrs Emma Childs (practitioner)
Ms Heather King (community)
Ms Aislinn McIntyre (community)
Dr Brian Phillips PhD (practitioner)
Ms Alison Phillis (community)
Dr Joanne Seiler DBA (practitioner)
Mr Jonathan Wright (practitioner)

Queensland

Professor Patsy Yates (practitioner) (Chair)
Ms Suzanne Cadigan (practitioner)
Mrs Karen Dolci (community)
Ms Tracey Duke (practitioner)
Ms Michelle Garner (practitioner)
Dr Amanda Henderson PhD (practitioner)
Mr Stanley Macionis (community)
Ms Catherine Mickel (community)
Ms Helen Towler (practitioner)

South Australia

Associate Professor Linda Starr (practitioner) (Chair)
Mr Mark Bodycoat (community)
Mrs Zinta Docherty (community)
Ms Elisa Gardiner (practitioner)
Mrs Gillian Homan (practitioner)
Ms Paula Medway (practitioner)
Dr Philippa Rasmussen PhD (practitioner)
Ms Katherine Sullivan (community)
Mr Thomas Symonds (community)
Mrs Lisa Turner (practitioner)

Tasmania

Ms Carol Baines (practitioner) (Presiding Member)
Mrs Sharon Bingham (practitioner)
Mrs Briony Brown (practitioner)
Professor Rosalind Bull (practitioner)
Ms Hazel Bucher (practitioner)
Mr Stephen Carey (community)
Dr Kylie McShane PhD (community)
Ms Christine Schokman (community)
Mrs Lynette Staff (practitioner)

Victoria

Ms Amanda Singleton (practitioner) (Chair)
Dr Leslie Cannold PhD (community)
Professor Maxine Duke (practitioner)
Mr Matthew Grace (practitioner)
Associate Professor David Hills (community)
Ms Helen Karagiozakis (community))
Mrs Joanne Mapes (practitioner)
Ms Paula Stephenson (practitioner)
Mrs Brenda Waites (practitioner)

Western Australia

Ms Marie Louise MacDonald (practitioner) (Chair)
Dr Sara Bayes PhD (practitioner)
Dr Margaret Crowley PhD (community)
Adjunct Associate Professor Karen Gullick (practitioner)
Mr Evan Hill (practitioner)
Mr John Laurence (community)
Mrs Kristian Malic (practitioner)
Mr Michael Piu (community)

Accreditation Committee (Assessment of Overseas Qualified Nurses and Midwives)

Professor Denise Fassett (practitioner) (Chair)
Mr Ian Frank AM (community)
Ms Marie Heartfield (practitioner)
Dr Daniel Malone PhD (community)
Professor Catherine Nagle (practitioner)
Ms Fiona Stoker (practitioner)
Mr Brett Vaughan (community)

Finance, Governance and Communications Committee

Mrs Allyson Warrington (community) (Chair)
Ms Maria Ciffolilli (community)
Ms Melodie Heland (practitioner)
Dr Jessica (Jessa) Rogers PhD (community)
Ms Catherine Schofield (practitioner)

Notifications Committee Midwifery Assessment

Mrs Gulnara Abbasova (community)
Dr Sara Bayes PhD (practitioner)
Mr Stephen Carey (community)
Mr Stanley Macionis (community)
Ms Paula Medway (practitioner)
Ms Amanda Singleton (practitioner)

Notifications Committee Nursing Assessment

Dr Sara Bayes (practitioner)
Ms Felicity Dalzell (practitioner)
Ms Michelle Garner (practitioner)
Ms Paula Medway (practitioner)
Ms Amanda Singleton (practitioner)
Associate Professor Linda Starr (practitioner)
Ms Paula Stephenson (practitioner)
Mrs Brenda Waites (practitioner)

Program Approval Committee

Adjunct Associate Professor Veronica Casey AM (practitioner) (Chair)

Dr Christopher Helms PhD (practitioner)

Mr Max Howard (community)

Dr Jessica (Jessa) Rogers PhD (community)

Mrs Allyson Warrington (community)

Registration and Notifications Committee

Ms Annette Symes (practitioner) (Chair) (from 1 Aug)

Adjunct Associate Professor Veronica Casey (Chair) (to 31 Jul)

Mr David Carpenter (practitioner)

Ms Maria Ciffolilli (community)

Dr Christopher Helms PhD (practitioner)

Mrs Jennifer Wood (practitioner)

Non-Board members appointed to committees

Vic Registration Committee and Notifications Committee

Mrs Jennifer Gilmartin (practitioner)

Ms Karen Sawyer (practitioner)

Occupational Therapy Board of Australia: National committee and working group members

Registration and Notifications Committee

Ms Roxane Marcelle-Shaw (community) (Chair)

Ms Julie Brayshaw (practitioner)

Mr James Carmichael (practitioner)

Ms Sally Cunningham (practitioner)

Mrs Rachael Kay (practitioner)

Dr Catherine McBryde PhD (practitioner)

Mr Areti Metuamate (community)

Miss Jennifer Morris (community)

Mrs Terina Saunders (practitioner)

Dr Justin Scanlan PhD (practitioner)

Ms Rebecca Singh (practitioner)

Optometry Board of Australia: National committee members

Finance and Risk Committee

Mr Anthony Evans (community) (Chair)

Mr Stuart Aamodt (practitioner)

Associate Professor Ann Webber (practitioner)

Policy and Education Committee

Associate Professor Ann Webber (practitioner) (Chair)

Dr Carla Abbott (practitioner)

Associate Professor Daryl Guest (practitioner)

Ms Adrienne Farago (community)

Associate Professor Rosemary Knight (community)

Registration and Notifications Committee

Mr Ian Bluntish (practitioner) (Chair)

Mrs Nancy Atkinson (practitioner)

Ms Adrienne Farago (community)

Mrs Judith Hannan (Irvine) (practitioner)

Mr Kenneth Ingram (practitioner)

Ms Surabhi Payne (practitioner)

Mr Neville Turner (practitioner)

Scheduled Medicines Advisory Committee

Associate Professor Daryl Guest (practitioner) (Chair)

Professor Alex Gentle (practitioner)

Mr Benjamin Hamlyn (practitioner)

Dr Graham Lakkis (practitioner)

Professor Danny Liew (practitioner)

Ms Angela Stathopoulos (practitioner)

Associate Professor Robert (Andrew) Symons (practitioner)

Associate Professor James Ziogas (community)

Osteopathy Board of Australia: National committee members

Registration and Notifications Committee

Dr Nikole Grbin (practitioner) (Chair)

Members are the National Board.

Paramedicine Board of Australia: National committee members

Notifications Committee: Assessment

Mr Keith Driscoll ASM

Associate Professor Ian Patrick ASM

Ms Angela Wright

Mr Howard Wren ASM

Registration, Notifications and Compliance Committee

Ms Linda Renouf (community) (Chair)

Members are the National Board.

Pharmacy Board of Australia: National committee members

Finance, Risk and Governance Committee

Mr Laurence (Ben) Wilkins (practitioner) (Chair)

Dr Alice Gilbert PhD (practitioner)

Mr Mark Kirschbaum (practitioner)

Dr Suzanne Martin (veterinarian) (community)

Mr Brett Simmonds (practitioner)

Dr Rodney (Rod) Wellard PhD (community)

Mr Rodney Wellington (community)

Immediate Action Committee

All members of the Pharmacy Board of Australia are eligible for appointment to the Immediate Action Committee.

Notifications Committee

Mr Mark Kirschbaum (practitioner) (Chair)

Ms Melissa Cadzow (community)

Dr Alice Gilbert PhD (practitioner)

Ms Hannah Mann (practitioner)

Dr Suzanne Martin (veterinarian) (community)

Mr Brett Simmonds (practitioner)

Mr Laurence (Ben) Wilkins (practitioner)

Notifications Committee: Assessment

Mr Mark Kirschbaum (practitioner) (Chair)

Ms Melissa Cadzow (community)

Policies, Codes and Guidelines Committee

Mr Brett Simmonds (practitioner) (Chair)

Mrs Elise Apolloni (practitioner)

Ms Melissa Cadzow (community)

Dr Alice Gilbert PhD (practitioner)

Ms Joy Hewitt (practitioner)

Mr Cameron Phillips (practitioner)

Mr Rodney Wellington (community)

Mr Laurence (Ben) Wilkins (practitioner)

Registration and Examinations Committee

Ms Joy Hewitt (practitioner) (Chair)

Mrs Elise Apolloni (practitioner)

Ms Hannah Mann (practitioner)

Mr Mark Kirschbaum (practitioner)

Mr Cameron Phillips (practitioner)

Mr Brett Simmonds (practitioner)

Dr Rodney (Rod) Wellard PhD (community)

Mr Rodney Wellington (community)

Physiotherapy Board of Australia: National committee members

Registration and Notifications Committee

Ms Fiona McKinnon (practitioner) (Chair)

Ms Maureen Capp OAM (community)

Mr David Cross (practitioner)

Mr Mark Hindson (practitioner)

Mr Peter Kerr AM (community)

Mr Lachlan Mortimer (practitioner)

Ms Elizabeth Soderholm (practitioner)

Podiatry Board of Australia: National committee members

Registration and Notifications Committee

Dr Janice Davies PhD (community) (Chair)

Dr Paul Bennett PhD (practitioner)

Miss Julia Kurowski (practitioner)

Dr Kristy Robson PhD (practitioner) (Deputy Chair)

Mr Anthony Short (practitioner)

Ms Shellee Smith (community)

Strategic Planning and Policy Committee

Mrs Kathryn (Kate) Storer (Chair)

Mr Andrew van Essen (practitioner)

Dr Cylie Williams PhD (practitioner)

Psychology Board of Australia: Regional board and national committee members

ACT/Tas/Vic Regional Board

Dr Melissa Casey (practitioner) (Chair)

Mr Robin Brown (community)

Mr Frank Ederle (community)

Dr Joel Godfredson (practitioner)

Dr Sally Kalek (practitioner)

Dr Elke Kellis (practitioner)

Ms Sabina Lane (practitioner)

Dr Rosamond Lethbridge (practitioner)

Professor Anthony Love (practitioner)

Dr Miriam Weisz DBA (community)

NSW Regional Board

Associate Professor Michael Kiernan (practitioner) (Chair)

Mr Roderick Cooke (community)

Mrs Margo Gill (community)

Mr Timothy Hewitt (practitioner)

Ms Maralean McCalman (community)

Ms Pauline O'Connor (community)

Professor Nickolai Titov (practitioner)

Ms Lila Vrklevski (practitioner)

Dr Ann Wignall (practitioner)

NT/SA/WA Regional Board

Mr Neil McLean (practitioner) (Presiding Member)

Ms Cathy Beaton (community)

Ms Carolyn Bright (practitioner)

Ms Jacqueline Fidler (practitioner)

Ms Deearne Gould (practitioner)

Mrs Megan Lawton (community)

Mr Colby Pearce (practitioner)

Ms Elizabeth Pritchard (practitioner)

Ms Claire Simmons (practitioner)

Mr Theodore Sharp (community)

Queensland Regional Board

Dr Jane Scott (practitioner) (Chair) (to 9 Mar)

Dr Fiona Black (practitioner) (Presiding Member) (from 27 Mar)

Ms Kathryn Bekavac (practitioner)

Mr Robert Blin (community)

Ms Julia Duffy (community)

Ms Karen Dunshea (practitioner)

Associate Professor Gene Moyle (practitioner)

Ms Linda Renouf (community)

Mr David Rodwell (practitioner)

Immediate Action Committee

Ms Mary Brennan (community) (Chair)

Dr Fiona Black (practitioner)

Dr Melissa Casey (practitioner)

Ms Julia Duffy (community)

Mr Frank Ederle (community)

Dr Sally Kalek (practitioner)

Dr Elke Kellis (practitioner)

Associate Professor Michael Kiernan (practitioner)

Mr Neil McLean (practitioner)

Dr Jane Scott PhD (practitioner)

Professor Jennifer Scott (practitioner)

Mr Theodore Sharp (community)

Ms Claire Simmons (practitioner)

Multi-Profession Immediate Action Committee

Mr Bruce Brown (ATSIHPBA) (community) (Chair)

Dr Janice Davies PhD (PodBA) (community) (Alternate Chair)

Ms Linda Renouf (ParaBA) (community) (Alternate Chair)

Dr Michael Badham (ChiroBA) (practitioner)

Dr Paul Bennett PhD (PodBA) (practitioner)

Ms Christine Berle (CMBA) (practitioner)

Mr Ian Bluntish (OptomBA) (practitioner)

Mr James Carmichael (OTBA) (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)

Ms Celia Harnas (ATSIHPBA) (practitioner)

Mr Christopher Hicks (MRPBA) (practitioner)

Miss Julia Kurowski (PodBA) (practitioner)

Dr Di Wen Lai (CMBA) (practitioner)

Mr Mark Marcenko (MRPBA) (practitioner)

Mr Brendan McKernan (MRPBA) (practitioner)

Dr Wayne Minter AM (ChiroBA) (practitioner)

Mr Lachlan Mortimer (PhysioBA) (practitioner)

Ms Renee Owen (ATSIHPBA) (practitioner)

Associate Professor Ian Patrick (ParaBA) (practitioner)

Ms Bing Tian (CMBA) (practitioner)

Associate Professor Ann Webber (OptomBA) (practitioner)

Dr Cylie Williams PhD (PodBA) (practitioner)

Dr Ailsa Wood (ChiroBA) (practitioner)

Ms Angela Wright (ParaBA) (practitioner)

Mr Andrew Yaksich (OsteoBA) (practitioner)

Accreditation Committees

Aboriginal and Torres Strait Islander Health Practice Board of Australia Accreditation Committee

Professor Elaine Duffy (community) (Chair)

Mrs Elizabeth Shuttle (community)

Mrs Norma Solomon (practitioner)

Ms Sharon Wallace (practitioner)

Chinese Medicine Board of Australia Accreditation Committee

Dr Meeuwis Boelen PhD (community) (Chair)

Mrs Suzi Mansu (practitioner)

Mr David Schievenin (practitioner)

Dr Wei Hong (Angela) Yang (practitioner) (Deputy Chair)

Associate Professor Christopher Zaslawski (practitioner)

Dr Jian Sheng Zhang (practitioner)

Medical Radiation Practice Board of Australia Accreditation Committee

Professor Brian Jolly (community) (Chair)

Mrs Allison Dry (practitioner)

Dr Daphne James PhD (practitioner)

Dr Sarah Lewis PhD (practitioner) (Deputy Chair)

Dr Louise McCall PhD (community)

Ms Natalie Pollard (practitioner)

Mrs Jane Shepherdson (practitioner)

Paramedicine Board of Australia Accreditation Committee

Professor Eileen Willis (community) (Chair)

Mr Anthony Hucker (practitioner)

Mr Richard Larsen (practitioner)

Dr William Lord PhD (practitioner) (Deputy Chair)

Mr Alan Morrison (practitioner) (Deputy Chair)

Mr Martin Nichols (practitioner)

Dr Helen Webb PhD (practitioner)

Podiatry Board of Australia Accreditation Committee

Dr Meeuwis Boelen PhD (community) (Chair)

Ms Alison Bell (community)

Dr Alan Bryant PhD (practitioner)

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 meetings of the Agency Management Committee and its subcommittees

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 2019/20 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.

Meeting attendance

Name	Number of meetings attended/eligible to attend
Agency Management Committee	
Ms Gill Callister PSM, Chair	**11/11**
Dr Peggy Brown AO	10/11
Adjunct Professor Karen Crawshaw PSM	11/11
Ms Philippa Smith AM	10/11
Ms Jenny Taing OAM	9/11
Ms Barbara Yeoh AM	11/11
Dr Susan Young	11/11
Accreditation Advisory Committee	
Ms Gill Callister PSM, Chair	**3/5**
Adjunct Professor Karen Crawshaw PSM	4/5
Dr Susan Young	5/5
Associate Professor Lynette Cusack	3/5
Dr Susan Gould	4/5
Emeritus Professor Christine Ewan	3/5
Finance, Audit and Risk Management Committee	
Ms Barbara Yeoh AM , Chair	**4/4**
Ms Jenny Taing	3/4
Mr David Balcombe	4/4
Mr Anthony Evans	3/4
Ms Kim Jones	4/4
Ms Allyson Warrington	4/4
Pandemic Preparedness Oversight Group	
Ms Gill Callister PSM, Chair	**9/9**
Dr Peggy Brown AO	9/9
Dr Susan Young	8/9
Associate Professor Lynette Cusack	9/9
Mr Brett Simmonds	7/9
Dr Anne Tonkin	9/9
Regulatory Performance Committee	
Dr Peggy Brown AO, Chair	**4/4**
Adjunct Professor Karen Crawshaw PSM	4/4
Ms Philippa Smith AM	4/4
Dr Susan Young	4/4
Mr Ian Bluntish	3/4
Mr Mark Bodycoat	0/2
Associate Professor Lynette Cusack	4/4
Ms Rachel Phillips	3/4
Mr Brett Simmonds	4/4
Dr Murray Thomas	4/4
Dr Anne Tonkin	4/4
Ms Jeanette Barker	1/1
Remuneration Committee	
Ms Gill Callister PSM, Chair	**3/3**
Adjunct Professor Karen Crawshaw PSM	3/3
Ms Jenny Taing OAM	2/3
Dr Wayne Minter	3/3
Dr Murray Thomas	3/3

Appendix 5: National Board consultations

National Board	Name of consultation	Start date	End date
All	*Guidelines: mandatory notifications about registered health practitioners*	11 September 2019	6 November 2019
All	*Guidelines: mandatory notifications about registered students*	11 September 2019	6 November 2019
All	*Guidelines for advertising a regulated health service*	11 September 2019	26 November 2019
All	*Supervised practice framework*	11 September 2019	17 December 2019
DBA; MBA; NMBA; ParaBA; PodBA	*Guidelines for registered health practitioners and students in relation to blood-borne viruses*	5 September 2019	1 November 2019
DBA	*Dental records guidelines*	20 November 2019	24 January 2020
	Proposal to close the *Public Sector Dental Workforce Scheme*	4 September 2019	2 November 2019
ParaBA	Draft proposed *Professional capabilities for paramedicine practitioners*	18 December 2019	13 March 2020
MBA	Public consultation: Draft revised *Registration standard: continuing professional development*	13 November 2019	14 February 2020
	Public consultation: Draft revised *Good practice guidelines for the specialist international medical graduate assessment process*	13 November 2019	14 February 2020
MRPBA	Public and targeted consultation on revised *Professional capabilities for medical radiation practice*	18 February 2019	16 September 2019

Appendix 6: Registration standards, codes and guidelines

For the reporting period 1 July 2019 to 30 June 2020, several registration standards for the 16 health professions in the National Scheme were approved by the Ministerial Council after submission by the relevant National Board in accordance with the National Law.

Codes and guidelines were also developed and approved by the relevant National Boards. Before approval, there must be public consultation on the proposed registration standards, codes and guidelines.

Registration standards, codes and guidelines are developed by the relevant National Board in accordance with the National Law and Ahpra's *Procedures for the development of registration standards, codes and guidelines*.

You can find out more about these procedures at www.ahpra.gov.au/publications/procedures.

National Board	Registration standard, code or guideline	Approved and/or came into effect in 1 July 2019 to 30 June 2020	Approved by	Date of approval	Status: effective from
All	*Guidelines: mandatory notifications about registered health practitioners*	Approved and came into effect	All National Boards	29 November 2019	1 March 2020
All	*Guidelines: mandatory notifications about registered students*	Approved and came into effect	All National Boards	29 November 2019	1 March 2020
ATSIHPBA; CMBA; OTBA; PsyBA	*Professional indemnity insurance arrangements registration standard*	Came into effect	Ministerial Council	30 June 2019	1 December 2019
ATSIHPBA; ChiroBA; CMBA; OTBA	*Continuing professional development registration standard*	Came into effect	Ministerial Council	30 June 2019	1 December 2019
ATSIHPBA; ChiroBA; CMBA; OTBA	*Guidelines: continuing professional development*	Approved and came into effect	Relevant National Boards	30 August 2019	1 December 2019
ATSIHPBA; CMBA; OTBA	*Recency of practice registration standard*	Came into effect	Ministerial Council	30 June 2019	1 December 2019
DBA; MBA; NMBA; ParaBA; PodBA	*Guidelines: registered health practitioners and students in relation to blood-borne viruses*	Approved	Relevant National Boards	26 February 2020	6 July 2020
ATSIHPBA	*English language skills registration standard*	Came into effect	Ministerial Council	30 June 2019	1 December 2019
	Aboriginal and Torres Strait Islander registration standard	Came into effect	Ministerial Council	30 June 2019	1 December 2019
DBA	*Scope of practice registration standard*	Approved	Ministerial Council	1 November 2019	1 July 2020
NMBA	*Decision-making framework for nursing and midwifery*	Approved and came into effect	National Board	26 September 2019	3 February 2020
OptomBA	*Guidelines: continuing professional development*	Approved	National Board	30 August 2019	1 December 2020
PsyBA	*Guidelines for the national psychology exam*	Came into effect	National Board	28 June 2019	19 July 2019
	Area of practice endorsement registration standard	Approved and came into effect	Ministerial Council	30 September 2019	1 December 2019
	Guidelines for area of practice endorsement	Approved and came into effect	National Board	1 March 2019	1 December 2019

For information about codes, guidelines and policies for each profession, see the *Codes and guidelines* section of a Board's website. For information about registration standards, see the *Registration standards* section of a Board's website.

Appendix 7: Policy directions

COAG HEALTH COUNCIL

PO Box 3410
Rundle Mall
South Australia 5000

08 8226 6191
healthCHCSecretariat@sa.gov.au

www.coaghealthcouncil.gov.au

Ms Gill Callister PSM	Chair, Australian Health Practitioner Regulation Agency Management Committee
Ms Renee Owen	Chair, Aboriginal and Torres Strait Islander Health Practice Board of Australia
Distinguished Professor Charlie C. Xue	Chair, Chinese Medicine Board of Australia
Dr Wayne Minter AM	Chair, Chiropractic Board of Australia
Dr Murray Thomas	Chair, Dental Board of Australia
Emeritus Professor Anne Tonkin	Chair, Medical Board of Australia
Mr Mark Marcenko	Chair, Medical Radiation Practice Board of Australia
Associate Professor Lynette Cusack	Chair, Nursing and Midwifery Board of Australia
Ms Julie Brayshaw	Chair, Occupational Therapy Board of Australia
Mr Ian Bluntish	Chair, Optometry Board of Australia
Dr Nikole Grbin	Chair, Osteopathy Board of Australia
Professor Stephen Gough ASM	Chair, Paramedicine Board of Australia
Mr Brett Simmonds	Chair, Pharmacy Board of Australia
Ms Kim Gibson	Chair, Physiotherapy Board of Australia
Dr Cylie Williams	Chair, Podiatry Board of Australia
Ms Rachel Phillips	Chair, Psychology Board of Australia

GPO Box 9958
MELBOURNE VIC 3001

Dear Colleagues

At its meeting on 31 October and 1 November 2019, the COAG Health Council resolved to issue two policy directions to Ahpra and National Boards to make clear that when administering the National Registration and Accreditation Scheme (the National Scheme) public protection is paramount, and to require consultation with patient safety bodies and health care consumer bodies on new and revised registration standards, codes and guidelines. These policy directions are given under section 11 of the *Health Practitioner Regulation National Law 2009*, as in force in each state and territory (the National Law).

The policy directions are as follows.

POLICY DIRECTION 2019-1

Paramountcy of public protection when administering the National Scheme

The purpose of this policy direction is to provide clarity to the Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards on the application of the guiding principle for the National Registration and Accreditation Scheme provided in section 3(3)(c) of the National Law. This principle requires that *restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.*

1

However, Ahpra and the National Boards need a clear mandate to prioritise public protection, and this policy direction is intended to give effect to this intent. It is the responsibility of Ahpra and the National Boards to protect the public and prevent harm.

The policy direction is:

1. The Council supports that regulatory decision making by Ahpra and National Boards within the National Registration and Accreditation Scheme must act in the interests of public protection, patient safety and support the safety and quality of health services.
2. In applying the guiding principle contained in section 3(3)(c) of the National Law, when determining whether it is necessary for regulatory action to be taken, National Boards and Ahpra must:
    a. take into account the potential impact of the practitioner's conduct on the public, including vulnerable people within the community such as children, the aged, those living with disability and people who are the potential targets of family and domestic violence; and
    b. consider the extent to which deterring other practitioners from participating in similar conduct would support the protection of the public and engender confidence in the regulated profession.
3. When considering whether a registered practitioner's conduct may be considered unprofessional conduct or professional misconduct, National Boards and Ahpra must give at least equal weight to the expectations of the public as well as professional peers with regards to the expected standards of practice by the registered practitioner.
4. In considering the nature of regulatory action that should be taken with regard to matters of unprofessional conduct or sanctions sought with regard to professional misconduct by a registered health practitioner, the risk that the practitioner poses to the public and the need for effective deterrence must outweigh consideration of the potential impacts upon the practitioner from any regulatory action.

To support the policy direction, and the protection of the public, the COAG Health Council authorises disclosures of information under section 216(2)(h) as per the following:

1. Where a matter regarding potential unprofessional conduct or professional misconduct by a registered health practitioner has been referred to a responsible tribunal, Ahpra and National Boards are authorised to disclose the following information to other registered practitioners with whom the practitioner shares premises and other entities referred to in section 132(4) of the National Law at the point of filing:
    - the name of the practitioner,
    - the tribunal that the practitioner has been referred to, and
    - the nature of the referral of the practitioner to the Tribunal.
2. Where a matter regarding potential unprofessional conduct or professional misconduct by a registered health practitioner is being investigated by Ahpra, Ahpra and National Boards are authorised to disclose the following information to other registered practitioners with whom the practitioner shares premises and other entities referred to in section 132(4) of the National Law on commencement of the investigation:

- the name of the practitioner, and
- the subject of the investigation.

3. Where a matter regarding potential unprofessional conduct or professional misconduct by a registered health practitioner has been referred to a responsible tribunal, Ahpra and National Boards are authorised to disclose the following information to the state or territory health department in the jurisdiction in which the conduct is alleged to have occurred at the point of referral to the tribunal:
    - the name of the practitioner,
    - the tribunal that the practitioner is being referred to,
    - the nature of the referral of the practitioner to the Tribunal, and
    - the known employer(s) and/or locations where the registered practitioner provide health services.

POLICY DIRECTION 2019-2

Requirement to consult with patient safety bodies and health care consumer bodies on every new and revised registration standard, code and guideline

The purpose of this policy direction is to provide clarity to Ahpra and the National Boards on consultation requirements with patient safety bodies and consumer bodies on every new or revised registration standard, code and guideline prepared under sections 25(c) and 35(c) of the National Law. Section 25(c) of the National Law requires that Ahpra establish procedures for the development of registration standards and codes and guidelines approved by National Boards, for the purpose of ensuring the national registration and accreditation scheme operates in accordance with good regulatory practice. Section 35 of the National Law tasks National Boards with functions including to develop registration standards (for approval by the COAG Health Council) and develop and approve codes and guidelines for the relevant health profession (section 35(c)).

Section 40 of the National Law requires National Boards to ensure that there is wide-ranging consultation during the development of a registration standard, code, or guideline. However, Ahpra and the National Boards need a clear mandate and clear direction from the COAG Health Council that this wide-ranging consultation must include consultation with patient safety bodies and health care consumer bodies. This is to ensure the health and safety of patients and to prevent harm by ensuring that the perspectives, experience, and expertise of patient safety organisations and consumers are considered during the development and review of standards, codes and guidelines.

The policy direction is:

1. The Council directs Ahpra and National Boards to consult with patient safety bodies and consumer bodies on every new or revised registration standard, code and guideline.
2. In applying the requirements under section 40 of the National Law, National Boards and Ahpra must:
    a. consult with patient safety bodies and healthcare consumer bodies

b. take into account the health and safety of vulnerable members of the community, and Aboriginal and Torres Strait Islander people

c. prepare a patient health and safety impact statement to accompany advice and recommendations in relation to the new or revised registration standard, code or guideline

d. publish a patient health and safety impact assessment when a new or revised registration standard, code or guideline is published.

In line with section 17 of the National Law, it is requested that these directions be published by Ahpra and National Boards on their websites as soon as practicable, and in the 2019–20 Ahpra annual report. The Council thanks Ahpra and National Boards for their timely response to implementing these policy directions.

Yours sincerely

Natasha

Hon Natasha Fyles MLA
Chair
COAG Health Council

- 3 JAN 2020

cc: Mr Martin Fletcher, CEO, AHPRA: martin.fletcher@ahpra.gov.au

Common abbreviations and acronyms

National Board abbreviations

ATSIHPBA

Aboriginal and Torres Strait Islander Health Practice Board of Australia

CMBA

Chinese Medicine Board of Australia

ChiroBA

Chiropractic Board of Australia

DBA

Dental Board of Australia

MBA

Medical Board of Australia

MRPBA

Medical Radiation Practice Board of Australia

NMBA

Nursing and Midwifery Board of Australia

OTBA

Occupational Therapy Board of Australia

OptomBA

Optometry Board of Australia

OsteoBA

Osteopathy Board of Australia

ParaBA

Paramedicine Board of Australia

PharmBA

Pharmacy Board of Australia

PhysioBA

Physiotherapy Board of Australia

PodBA

Podiatry Board of Australia

PsyBA

Psychology Board of Australia

AHMAC

Australian Health Ministers' Advisory Council. Advisory and support body to the COAG Health Council. See www.coaghealthcouncil.gov.au/AHMAC/Introduction.

Ahpra

Australian Health Practitioner Regulation Agency, established by section 23(1) of the National Law. See www.ahpra.gov.au.

COAG

Council of Australian Governments. See www.coag.gov.au.

CRG

Community Reference Group. See www.ahpra.gov.au/About-ahpra/Our-engagement-activities/Advisory-groups.

HCCC

Health Care Complaints Commission. Manages complaints about health service providers in NSW. See www.hccc.nsw.gov.au.

HCE

Health complaints entity. An entity that is established by or under an Act of a participating jurisdiction, and whose functions include conciliating, investigating and resolving complaints made against health service providers and investigating failures in the health system. See www.ahpra.gov.au/notifications/further-information/health-complaints-organisations.

HPCA

Health Professional Councils Authority. Manages complaints and concerns about practitioners in NSW. See page 14 or go to www.hpca.nsw.gov.au.

NHPOPC

National Health Practitioner Ombudsman and Privacy Commissioner. See https://nhpopc.gov.au.

NRAS

National Registration and Accreditation Scheme (also referred to as the National Scheme). See www.ahpra.gov.au/about-ahpra/what-we-do/faq.

OHO

Office of the Health Ombudsman. Manages complaints and concerns about practitioners in Queensland. See page 14 or go to www.oho.qld.gov.au.

PRG

Professions Reference Group. See www.ahpra.gov.au/About-ahpra/Our-engagement-activities/Advisory-groups.

Glossary

A comprehensive list of definitions is available on the Ahpra website at www.ahpra.gov.au/support/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.

Division

Part of a health profession. A practitioner can be registered in more than one division within a profession. Not all professions have divisions.

For more information, please refer to the list published online at www.ahpra.gov.au/registration/registers-of-practitioners/professions-and-divisions.

Education provider

A university, tertiary education institution, specialist medical or other health-profession college that provides a program of study.

Endorsement

An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the National Board.

There are a number of different types of endorsement available under the National Law, including:

- scheduled medicines
- nurse practitioner
- acupuncture
- approved area of practice.

In psychology, these are divided into 'subtypes' that describe additional qualifications and expertise. An endorsement can include more than one 'subtype'.

Health impairment

Physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects, or is likely to detrimentally affect, a registered health practitioner's capacity to safely practise the profession or a student's capacity to do clinical training.

Immediate action

Immediate action (also referred to as interim action) can be taken as an interim step to restrict a practitioner's registration while a complaint is investigated. Immediate actions include:

- the suspension of, or imposition of a condition on, a registered health practitioner's or student's registration
- accepting an undertaking from a registered health practitioner or student
- accepting the surrender of a registered health practitioner's or student's registration.

Mandatory notifications

Notification that an entity is required to make to Ahpra under Division 2 of Part 8 of the National Law. It is mandatory that colleagues, employers or education providers of a registered practitioner or student submit a notification about them if they have behaved in a way that constitutes notifiable conduct. Refer to each Board's website for *Guidelines for mandatory notifications*.

Ministerial Council

Ministerial Council, as defined in the National Law, is 'the Council of Australian Governments COAG 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. See page 14 to find out about health regulation in Australia.

National Restrictions Library (NRL)

The National Restrictions Library documents common restrictions (conditions or undertakings) used across the regulatory functions of the National Boards to support:

- consistency in recommendations from Ahpra to the National Boards and delegates
- consistency in the restrictions appearing on the national public register of health practitioners
- a best practice approach to monitoring compliance with restrictions.

The NRL is available at www.ahpra.gov.au/registration/monitoring-and-compliance/national-restrictions-library.

National Scheme

The National Registration and Accreditation Scheme for registered health practitioners was established by the Council of Australian Governments (COAG). In 2010, under the National Law, 10 professions became nationally regulated by a corresponding National Board. In 2012, four additional professions joined the National Scheme. In 2017 the Paramedicine Board of Australia was established and the regulation of paramedics began in late 2018.

No conviction recorded

No conviction recorded is an outcome that is available to a court after either a plea or finding of guilt. This is a common outcome for first offenders for 'low level' offences, which reflects the willingness of the legislature and the community to give first offenders, in certain circumstances, a second chance to maintain a reputation of good character.

No further action

No further action is taken when, based on the available information, the Board determines there is no risk to the public that requires regulatory action.

Notation

Records a limitation on the practice of a registrant. Used by National Boards to describe and explain the scope of a practitioner's practice by noting the limitations on that practice. The notation does not change the practitioner's scope of practice but may reflect the requirements of a registration standard.

Notifiable conduct

When a registered health practitioner has:

- practised their profession while intoxicated by alcohol or drugs
- engaged in sexual misconduct in connection with the practice of their profession
- placed the public at risk of substantial harm in the practice of their profession because they have an impairment, or
- placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.

Notification

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 action if:

- the practitioner's conduct was unsatisfactory, or below a reasonable standard
- the practitioner's professional performance was unsatisfactory, or
- the practitioner has a health impairment and the impairment detrimentally affects their ability to practise safely.

The National Board is 'notified' of an issue. The word 'notification' is deliberate and reflects that the Boards are not complaint resolution agencies.

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.

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.

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 the profession. If the practitioner is not practising, or not practising mostly at one address, then the practitioner's principal place of residence is used.

If the location of the principal place of practice is in Australia, the following information is displayed on the *Register of practitioners*:

- suburb
- state
- postcode.

If the location is outside Australia, the following information is displayed on the *Register of practitioners*:

- international state/province
- international postcode
- country.

In rare cases, when a practitioner has demonstrated that their health and safety may be at risk from the publication of this information about their principal place of practice, a National Board may choose to not publish this information.

Qualifications

Professional qualifications that a practitioner must have to meet the requirements for registration in a profession. Undergraduate and postgraduate Australian qualifications recognised by National Boards are published on the National Boards' websites. Individual practitioners' approved qualifications are published on the *Register of practitioners*.

Prohibited practitioner/student

A prohibited practitioner or student is a person who is being monitored because they are subject to a cancellation order, suspension or a restriction not to practise. Alternatively, as an outcome of a notification they may have surrendered their registration or changed to non-practising registration.

Register of practitioners

Also known as the public register, the online national *Register of practitioners* is a publicly accessible database of all currently registered health practitioners with a principal place of practice in Australia. Ahpra also maintains a list of cancelled practitioners and a list of practitioners who have given an undertaking not to practise. You can search these databases at www.ahpra.gov.au/registration/registers-of-practitioners.

Registered health practitioner

An individual who is registered under the National Law to practise a health profession, other than as a student, or who holds a non-practising registration in a health profession under the National Law.

Registration expiry date

Date when a practitioner's current registration expires. Practitioners must apply to renew their registration annually. If the practitioner's name appears on the register, they are registered and can practise within the scope of their registration, consistent with any conditions or undertakings that apply.

Under the National Law, registrants who apply to renew on time can practise while their annual renewal application is being processed. Practitioners remain registered for one month after their registration expiry date. If they apply to renew their registration during this period, they are required to pay a late fee and can continue to practise while their application is being processed.

Registration number

Since March 2012, practitioners have been allocated one unique registration number for each profession in which they are registered. This number stays with the practitioner for life, even if they have periods when they are not registered. Practitioners registered in more than one profession have one registration number for each profession.

Registration status

The status of a registration can be:

- Registered: The practitioner is registered.
- Suspended: The registration has been suspended and the practitioner is not permitted to practise while suspended. The practitioner's name is published on the *Register of practitioners*.
- Cancelled: The registration has been cancelled and the practitioner is not permitted to practise. The practitioner's name is not published on the *Register of practitioners* but is published on the list of cancelled practitioners.

Registration type

The National Law defines the type of registration that a National Board can grant to an eligible practitioner. More information is available on the Ahpra website at www.ahpra.gov.au/support/glossary.

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: podiatry, dental and medical. 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 (medical, dental and podiatry).

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
- are public interest grounds for suspending a practitioner's registration, because, for example, the practitioner has been charged with serious criminal conduct.

A health panel can suspend a practitioner's registration if the panel finds that the practitioner (or student) has an impairment and it is necessary to suspend the practitioner's registration to protect the public.

Undertaking

National Boards can accept an undertaking from a practitioner to limit their practice in some way if this is necessary to protect the public. The undertaking means the practitioner agrees to do, or to not do, something in relation to their practice of the profession. Current undertakings that restrict a practitioner's practice of the profession are published on the *Register of practitioners*. When a National Board or adjudication body decides the undertakings are no longer required to ensure safe practice, they are revoked and are no longer published. Current undertakings that relate to a practitioner's health are mentioned on the public register but details are not provided.

An undertaking is voluntary (but enforceable), whereas a condition is imposed on a practitioner's registration.

Unprofessional conduct

Unprofessional conduct is conduct that is of a lesser standard than that which might reasonably be expected of a health practitioner by the public or the practitioner's professional peers. A more extensive definition is available under section 5 of the National Law.

Each profession has a set of standards and guidelines that clarify the acceptable standard of professional conduct.

Unsatisfactory professional performance

This is when the knowledge, skill or judgement possessed, or care exercised by, a practitioner in the practice of the health profession in which they are registered is below the standard reasonably expected for a health practitioner with an equivalent level of training or experience.

Voluntary notification

A notification made on a voluntary basis. The grounds for a voluntary notification are set out in section 144 of the National Law.

Index

Published by

Australian Health Practitioner Regulation Agency

Ahpra and National Boards annual report 2019/20

ISSN 1858–5060

Melbourne, November 2020

Copyright

To request print copies of this report or to offer feedback, please contact Communications team, Ahpra National Office, GPO Box 9958, Melbourne VIC 3001.

Phone

1300 419 495 (within Australia)

+61 3 9285 3010 (outside Australia)

Email

Via the online enquiry form on the Ahpra website at www.ahpra.gov.au/about-ahpra/contact-us/make-an-enquiry

Useful links

Register of practitioners: www.ahpra.gov.au/registration/registers-of-practitioners

Complaints portal: www.ahpra.gov.au/about-ahpra/complaints

Court and tribunal outcomes: www.ahpra.gov.au/publications/tribunal-decisions

National restrictions library: www.ahpra.gov.au/registration/monitoring-and-compliance/national-restrictions-library

Acknowledgements

Thank you to all Ahpra, National Board and co-regulatory partner contributors.

Follow us on social media

twitter.com/Ahpra

facebook.com/ahpra.gov.au

instagram.com/ahpra_nationalboards

vimeo.com/ahpra

Search for Ahpra on YouTube and LinkedIn

Australian Health Practitioner Regulation Agency

GPO Box 9958 in your capital city

www.ahpra.gov.au

1300 419 495

Australian Capital Territory

Ground floor
50 Blackall St
Barton ACT 2600

New South Wales

Level 51
680 George St
Sydney NSW 2000

Northern Territory

Level 5
22 Harry Chan Ave
Darwin NT 0800

Queensland

Level 4
192 Ann St
Brisbane QLD 4000

South Australia

Level 11
80 Grenfell St
Adelaide SA 5000

Tasmania

Level 5
99 Bathurst St
Hobart TAS 7000

Victoria

Level 8
111 Bourke St
Melbourne VIC 3000

Western Australia

Level 1
541 Hay St
Subiaco WA 6008

@ahpra

ahpra.gov.au

@ahpra_nationalboards

Search for Ahpra

Search for Ahpra

Search for Ahpra

#forsaferhealthcare