Appendix 1 - Reponses to the issues raised in other submissions and oral evidence to the Victorian Parliamentary Inquiry – Legal and Social Issues Legislation Committee/Inquiry into the Performance of the Australian Health Practitioner Regulation Agency

Attachment A: Medical Board of Australia, Health Profession Agreement

Attachment B: Joint response to the Review of the Health Services (Conciliation and Review) Act 1987

Attachment C: A guide for people making a notification or complaint and fact sheets

Attachment D: Terms of Reference and Membership of Community Reference Group

Issue	Response
English language requirements Some submissions raised issues about the English language requirements set by the National Boards and made suggestions for change.	English language skills are an important foundation for the delivery of quality health care by health practitioners. For this reason, the National Law requires all National Boards to set an English language skills (ELS) registration standard. Each National Board has an ELS standard that largely reflects requirements in place in states and territories before the start of the National Scheme. These requirements are aligned across professions. National Boards committed to review the ELS standard after three years. In preparation for this, research was commissioned into English language requirements for health practitioners, including global regulatory comparisons. The National Boards are now publicly consulting on a revised ELS standard and registration requirements, which are largely common across Boards. The consultation paper for the proposed registration standard is at www.ahpra.gov.au/News/Current-Consultations.aspx and is open for public comment until 23 December 2013. The revised standard has been informed by three years experience in the National Scheme and the commissioned research. The revised ELS standard aims to provide additional flexibility, consistent with best available evidence, without compromising public safety. The issues raised in the submissions and oral evidence to the Victorian Parliamentary Inquiry are consistent with the focus of the consultation. The consultation paper has been widely disseminated and Boards are looking forward to feedback from the community and the professions.

Issue	Response
International comparisons Some submissions to the Inquiry compared the National Scheme in Australia with multi-professional regulators overseas – particularly the Health and Care Professions Council (HCPC) in the United Kingdom, specifically in terms of fee setting.	International benchmarking is useful, if comparisons are made like for like. The Australian model of multi-profession regulation of health professions is unique. This view was endorsed by the Department of Health in its initial presentation to the committee. The National Scheme encompasses all Australia's regulated health professions – including medicine (most complex), nursing and midwifery (largest), dental, pharmacy and psychology. There is a range of high and low risk-profile professions, and small and large practitioner numbers in each profession. There are no other countries that regulate the same mix of professions. While there are some similarities with the UK Health Care Professions Council (HCPC), there are also significant differences. The National Scheme regulates 592,000 health practitioners across 14 National Boards. By comparison, the HCPC regulates 16 professions with a total of about 304,000 registrants in the UK.[1] There are only five professions common to both the HCPC and the National Scheme in Australia. Importantly, the HCPC does not regulate medicine, nursing and midwifery, pharmacy, dental practitioners, chiropractors, osteopaths and optometrists. Each of these professions has a separate profession specific council in the UK. As an indication of a greater level of risk and complexity, more than 95% of notifications (complaints) received by AHPRA in the 12 months to July 2013 relate to five professions (medicine, nursing and midwifery, psychology, pharmacy and dental), four of which are not regulated by the HCPC. Managing notifications is a significant driver of costs in health practitioner regulation. Therefore, any fee comparison to health regulators in the UK must not only consider the fees charged by the HCPC for its 16 professions (currently £76 ($129) per annum), but also the annual fees charged by the professions with separate councils – General Medical Council - £390 ($667), dentists - £576 ($984) and chiropractors - £800 ($1367). The fees charged by the separate councils are equal to or exceed the fees charged by the National Boards in the Australian scheme. Further, as a core principle, there is no cross-subsidisation between professions in the National Scheme. Each profession must meet the full costs of regulating itself in the National Scheme. In contrast, cross subsidisation is a feature of the HCPC. **International benchmarking** AHPRA is committed to comparing its performance with overseas regulators to identify opportunities to improve practice. We have established relationships with a number of the health profession regulators in the UK, including the HCPC, the General Medical Council and the Nursing and Midwifery Council. We have started a number of research and other collaborative projects to support effective, risk-

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

Issue	Response
	based regulation. This will ensure that into the future, AHPRA is able to more accurately compare its functions, processes and effectiveness with relevant overseas regulators, while recognising differences. **Fees** A number of submissions to the Inquiry argued that the increased fees for practitioners did not lead to better services to practitioners. Paragraph 3.104 of AHPRA's original submission to the Inquiry sets out the main factors that led to increased fees in the National Scheme at its inception. The submission from the Victorian Department of Health (page 13) provides further background. In general, the National Scheme is more robust and includes stronger public protections than previous regulatory arrangements. It is important to note that regulation is not a service to practitioners but rather, a decision by government about how best to protect the public. The Intergovernmental Agreement for the establishment of the National Scheme clearly states that it is the intention of governments that the scheme is self-funding (Section 12). While registration fees did initially increase to cover the more robust and protective requirements of national regulation, National Boards have since applied only national CPI fee increases to the national fees. The only exception is nursing and midwifery, which applied an above-CPI fee increase in 2012. However, the Nursing and Midwifery Board of Australia froze its fees in 2013 and has recently cut fees to graduates from Australian universities. Four National Boards decreased their registration fee for 2013/14. (Physiotherapy, Optometry, Occupational Therapy and Medical Radiation Practice). To ensure transparency, we publish the Health Profession Agreement between AHPRA and each National Board. These agreements detail the fees payable by health practitioners, the annual budget of the National Board and the services provided by AHPRA that enable the National Boards to carry out their functions under the National Law. An example from the Medical Board of Australia is attached. See Attachment A. All agreements are published on the AHPRA website and provide clear accountability to practitioners about how registrant fees are being used in the public interest. See www.ahpra.gov.au/About-AHPRA/Who-We-Are/Health-Professions-Agreements.aspx **No cross subsidisation** There is no cross subsidisation between professions in the National Scheme. AHPRA has conducted cost allocation studies, with independent advice, to provide a solid foundation for the proportionate costs attributed to the National Boards. This is kept under ongoing review. A report is published on our website (www.ahpra.gov.au/About-AHPRA/Who-We-Are/Cost-Allocation-Study.aspx)

Issue	Response
Health Programs The Nurses Board of Victoria and the Medical Practitioners Board of Victoria had established health programs, funded by the Boards, before the National Scheme. The ongoing funding of these programs was raised as an issue in some submissions and in oral evidence.	The National Law gives the National Boards discretion to fund health programs for practitioners and students. Decisions about the establishment and ongoing funding of health programs have been challenging for the Boards. Boards must ensure that any external health program they support is appropriate for the regulator to be funding and that the community is not put at risk as a result. They must also ensure that access to programs is equitable for registrants and deliver nationally consistent outcomes. The Nursing and Midwifery Board of Australia (NMBA) and the Medical Board of Australia (MBA) have each committed extended funding – to the Nursing and Midwifery Health Program Victoria (NMHPV) and the Victorian Doctors Health Program (VDHP) respectively - without increasing fees to registrants. **MBA** The MBA has committed to establishing a health program nationally that is equitable, fair and useful. The Board will fund a health program or programs for doctors from the 2013/2014 financial-year, from within existing resources. This external health program/s will complement the core role of the Board and AHPRA, which is to manage practitioners with impairment that may place the public at risk. The external health program/s will not have a regulatory role, but rather, will focus on supporting and promoting practitioners' health. The previous submission from AHPRA and the National Boards to this Inquiry set out the respective, different roles of the National Boards and/ AHPRA in managing impaired practitioners, and health programs. The MBA has appointed DLA Piper to provide advice to the Board on the governance of external health program/s for medical practitioners and to provide information on the scope of the work required to establish this service. **NMBA** The NMBA has committed ongoing funding for the NMHPV until 30 June 2016. In the meantime, the Board will continue its work, in partnership with the other National Boards and AHPRA, to further consider the national approach to managing nurses and midwives whose health impairment may pose a risk to the public. While the NMHPV approach has strong support in Victoria, there is no nationally agreed approach in other jurisdictions. The NMBA is taking the lead, in partnership with AHPRA, and funding the commissioning of a project on this issue, which will be able to be used by the other health professions, taking into consideration recommendations from the Siggins Miller Report. This report is available at www.nursingmidwiferyboard.gov.au/News/2012-11-15-media-release.aspx.

Issue	Response
Accreditation Some submissions appeared to misunderstand the role of AHPRA in the development and approval of accreditation standards. There were also concerns raised that the model of accreditation under the National Scheme does not reflect that originally proposed by the 2005 Productivity Commission report.	For the first time in health practitioner regulation in Australia, the National Law articulates the functions and governance processes for the development of accreditation standards and accreditation processes. The accreditation provisions set out in the National Law are broadly based on the Intergovernmental Agreement that underpins the National Scheme. If the Committee wishes to undertake a more detailed or specific review of accreditation functions, the forthcoming three year review of the National Scheme would be an appropriate avenue. A nationally agreed approach to these important functions is critical. **Roles and functions** Accreditation functions have a specific definition in the National Law. These relate to developing the standards that apply to education providers and programs of study to ensure that graduates are provided with the knowledge, skills and professional attributes to safely practise the profession in Australia. Accreditation functions can also relate to the assessment of overseas-qualified practitioners and the assessment of overseas accrediting authorities. The National Law sets out the functions delegated to each body - accreditation authorities, National Boards and AHPRA. It is important to note that AHPRA does not have a specific function in relation to accreditation, other than to support the National Boards and to establish procedures for the development of accreditation standards. See www.ahpra.gov.au/Education/Accreditation-standards.aspx. The roles and responsibilities are as follows: • Health Ministers (through the Australian Health Workforce Ministerial Council) – While the Ministerial Council does not approve accreditation standards or have any role in the accreditation function or process, it may give a National Board a direction about a proposed accreditation standard, or a particular proposed amendment of an accreditation standard if— (a) the proposed accreditation standard or amendment will have a substantive and negative impact on the recruitment or supply of health practitioners **and** (b) consideration had first been given to the potential impact of the AHWMC's direction on the quality and safety of health care. • National Boards - Approve accreditation standards on recommendation from the accreditation authority or accreditation committee. Approve or not approve programs of study, subject to the conditions the National Board considers necessary or desirable in the circumstance. • Accreditation authorities or accreditation committees of the National Board – Develop and consult on accreditation standards. Undertake the accreditation functions, including accrediting and monitoring accredited programs of study (which lead to registration in the health profession).

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	The National Boards, AHPRA and external accreditation authorities[2] have established an Accreditation Liaison Group, made up of representatives of National Board Chairs, external accreditation entities and AHPRA. This group has worked with the Accreditation Authorities and National Boards to meet the requirements set by the National Law and establish and disseminate examples of good practice, promoting consistency while taking into account the variation across entities**.** See accreditation information at www.ahpra.gov.au/Education/Accreditation-Authorities.aspx. The approach to accreditation taken by the National Boards and the Accreditation Authorities, including the review of the assignment of accreditation functions in 2012-13, is within the legislative mandate set out in the National Law. This draws on the Intergovernmental Agreement for the National Scheme. This includes: • governance arrangements that provide for community input and promote input from education providers and the professions but provide independence in decision- making; • financial viability, reporting and accountability requirements, quality assurance and audit and risk management plans; and • mechanisms to foster collaboration and consistency of processes across all profession- specific accreditation committees. **Establishment of Accreditation Committees** Three of the National Boards (the Chinese Medicine, Aboriginal and Torres Strait Islander Health Practitioner, Medical Radiation Practice Boards of Australia) have established Accreditation Committees to exercise accreditation functions. The work of these Committees is supported by AHPRA. The early work of the Committees has focused on developing accreditation standards and processes that will be consistent across professions. AHPRA's support of the Committees will be cross-professional in nature. The Committees will start to assess and accredit programs in late 2013. As the Accreditation Committees become more established in their work program during 2014/2015, AHPRA will be in a better position to compare the costs and outcomes of this model of delivery of accreditation with the assignment of the accreditation functions to external entities. Any such comparison would need to take into account the variation in the size, scope, complexity and longevity of the external entity.

[2] At June 30 2013, the accreditation authorities for 11 professions in the National Scheme were:

1. Council on Chiropractic Education Australasia Inc.
2. Australian Dental Council
3. Australian Medical Council
4. Australian Nursing and Midwifery Accreditation Council
5. Occupational Therapy Council (Australia & New Zealand) Ltd
6. Optometry Council of Australia and New Zealand
7. Australian and New Zealand Osteopathic Council
8. Australian Pharmacy Council
9. Australian Physiotherapy Council
10. Australian and New Zealand Podiatry Accreditation Council
11. Australian Psychology Accreditation Council

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Consultation under the National Scheme Some submissions have questioned the consultation processes of the National Boards and AHPRA.	The National Law requires the National Boards to develop registration standards, codes and guidelines for their respective professions and to consult widely on their development. As required by the National Law, AHPRA has set procedures for the development of standards. The consultation processes used by National Boards and AHPRA are published on the AHPRA website: www.ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx AHPRA supports the National Boards to implement consultation processes. Routinely, these are structured, phased, coordinated and actively promoted. Consultation is a six-stage process (development, preliminary consulting (testing), review, public consultation, review and finalisation, and publication and implementation). Both the preliminary and public consultation phases include engagement with key stakeholders and the public. The consultation process is consistent with the national standards for best practice regulation set by COAG and overseen by the Office of Best Practice Regulation (OBPR). AHPRA and the National Boards have established a working relationship with the OBPR to ensure that OBPR has an opportunity to review standards, codes and guidelines developed by the National Boards to assess whether or not a formal regulatory impact statement (RIS) is required. In keeping with good regulatory practice and compliant with AHPRA's procedures, all consultations on proposed registration standards include a statement from the National Board addressing the COAG principles of best practice regulation. The National Boards consider all submissions made in a consultation and value the important perspectives provided through this process. Submissions are generally published unless requested otherwise. The Boards publish submissions on their websites to encourage discussion and inform the community and stakeholders. However, the Boards may decide not to publish submissions at their discretion, and will not place on their website, or make available to the public, submissions that contain offensive or defamatory comments or which are outside the scope of the consultation. The National Board's primary responsibility is to protect the public and the final content of any registration standards, codes and guidelines must reflect this and the Board's other responsibilities under the National Law. Registration standards are approved by Health Ministers, through the Australian Health Workforce Ministerial Council.

Issue	Response
Role of the Health Services Commissioner (HSC) and AHPRA Some submissions have indicated that there is confusion for the community about the role of the Victorian Health Services Commissioner and the role of the National Boards and AHPRA.	**Background** The National Scheme replicates, to a large extent, the relationship between health regulation boards and the Health Services Commissioner in Victoria that existed before 1 July 2010. In this, the National Law was informed by the previous Victorian *Health Professions Registration Act* 2005. **Requirement for joint consideration** Section 150 of the National Law requires that the Health Services Commissioner (HSC) and AHPRA jointly consider every notification / complaint made to either organisation, to decide the most effective way of dealing with it. This process is called 'joint consideration' and is designed to avoid double handling and ensure that legislative requirements are met. Each organisation has a role set down in the law and a different set of responsibilities. The joint consideration process between AHPRA and the HSC decides which organisation will deal with the issues raised. Sometimes a person raises a concern with one agency and it ends up being managed by the other, based on respective roles, responsibilities and the degree of risk posed to the public. **Summary of roles** The role of the National Boards and AHPRA is to protect the public, including by managing notifications about health practitioners, and when necessary restricting their registration and their practice in some way. AHPRA and the National Boards have no power to resolve complaints. Our focus is on managing risk to the public. The role of the HSC is to resolve complaints or concerns, including through conciliation or mediation. The strength of the current complaints process in Victoria is that the HSC can focus on an individual's grievance and seek resolution. In contrast, as regulators, the National Boards focus on remedial action to address the health, conduct or performance of individual practitioners to ensure the protection of the public. **How joint consideration works** The relationship between the Acting Health Services Commissioner in Victoria and AHPRA is constructive and effective, within the requirements of the current legal framework. There is a high level of accord in deciding which body should deal with notifications/complaints and respectful discussion on matters where opinion may differ. Joint consideration contributes to a robust, quality decision-making process. The most recent Annual Report[3] from the HSC states that the relationship between AHPRA and the HSC is consistent with the law and works well. Data from the 2012/13 annual report of AHPRA and the National Boards indicates that around 20 -25% of matters discussed through the consultation process are managed by the HSC without any involvement of Boards. This is consistent with the experience in other states and territories.

[3] Office of the Health Services Commissioner Annual Report 2013

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	The situation in Victoria is structurally different from the division of roles and responsibilities between the National Scheme and the Health Quality and Complaints Commission (HQCC) in Queensland. Overlap and lack of clarity in that state in notifications and complaints management was one of the triggers for legislative change in that state. The same issues do not apply in Victoria. **Other government reviews** The Victorian Government commissioned a review of the *Health Services (Conciliation and Review) Act 1987*, which underpins the work of the HSC. This review was led by Mr Michael Gorton AM, who is also a member of AHPRA's Agency Management Committee. The 2012 review was the first comprehensive review of this legislation since it came into effect. The submission of AHPRA and the National Boards to this review is attached. See Attachment B. The submission supports current complaints handling processes and makes detailed observations about the issues raised. The current Victorian act provides an important avenue for encouraging the settlement of complaints through conciliation (for appropriate matters). The review Discussion Paper proposes ways to enhance the effectiveness and responsiveness of conciliation. We support these as changes that will help to strike an appropriate balance between resolving the grievance and ensuring protection of the public. We are anticipating with keen interest the government's response to the recommendations of this review. Implementing these may constructively address some of the issues raised to this committee in this inquiry, in a Victoria-specific context. Ahead of this, we continue to review and improve our management of notifications and our working relationship with the HSC. **Community concerns** AHPRA and the National Boards recognise the importance of health consumers having a clear understanding of the role of the National Boards and AHPRA and the role of the Victorian Health Services Commissioner. We also recognise that some notifiers or complainants in Victoria are concerned that they do not have a right to choose which process they participate in and are not clear how this is decided. For example, they may make a complaint to the HSC seeking compensation, but the joint consideration process identifies a public safety risk which requires that the issue is dealt with by AHPRA and the National Boards, which can act to protect the public (by restricting a practitioner's registration) but has no power to award compensation to the individual notifier. From review of the evidence received by the Committee, there appear to be four key aspects of these community concerns: • Communication: How clear is the information about what each organisation does? How much do consumers understand about why some complaints/ notifications are dealt with by the HSC and some by AHPRA? How well does each organisation communicate with consumers involved in their processes? • Good systems: Are the systems in place to manage notifications effectively? Are resources in place to do our job well? • Public confidence: How confident are consumers that the process they are involved in is fair, timely and reasonable (even if they don't get the outcome they initially wanted)?

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	• Transparency: How transparent is the process of joint consideration and how can the public know that decisions made support the public interest? **AHPRA's response** It is important that the community has confidence in the processes in place to address their concerns about health practitioners. AHPRA has put in place a range of initiatives to help staff communicate more clearly with notifiers, including about the different roles of AHPRA, the National Boards and health complaints entities in managing notifications and complaints. In particular, since making our submission to this Inquiry in February 20113, AHPRA has published a guide for notifiers available online at www.ahpra.gov.au/Notifications/Fact-sheets.aspx). See Attachment C. AHPRA has also published on its website clear information about its notifications management process, including a fact sheet on how it works with health complaints entities. AHPRA has established a Community Reference Group to provide feedback on how it can improve community knowledge about health practitioner regulation. A current focus of the Community Reference Group is to review and improve the information we provide to notifiers. See Attachment D for Terms of Reference and membership of the Community Reference Group. AHPRA is also establishing a partnership with the Health Issues Centre (HIC)[4] to advise on specific actions AHPRA can take to increase public confidence in the joint consideration process between the HSC and AHPRA, in the context of the current legislative arrangements. We have asked the HIC to work with the Community Reference Group. It will also include a focus on how learning from complaints (notifications) for wider system improvements can be strengthened.

[4] The Health Issues Centre promotes improvements to the health care system from the perspectives of consumers, with an emphasis on equity, and promotes and provides expertise on consumer participation in health.

Issue	Response
Governance, control and responsibility of the National Scheme A number of the submissions raised the complexity of the National Scheme and a lack of clarity around the accountabilities of the National Boards and AHPRA, and the influence / control over the National Law by Health Ministers. The challenges of the requirement for consensus view among Health Ministers was raised.	The shared governance arrangements of the National Scheme established by the National Law, involve a range of entities and shared accountabilities and responsibilities for delivering the objectives of the National Law. AHPRA is focused on ensuring there is clarity about these complementary accountabilities and effective working relationships. The Australian Health Workforce Ministerial Council (AHWMC) provides the high-level Ministerial oversight of the National Scheme. Therefore, AHPRA and the National Boards are accountable to all nine Health Ministers and to AHWMC. Regular updates and information is provided to the AHWMC and individually in states, territories and the Commonwealth. It is important that each state, territory and Commonwealth Health Minister retains confidence in our work. Changes to the Health Practitioner Regulation National Law, as in force in each state and territory, must be agreed by the AHWMC as agreed under the Intergovernmental Agreement (section 13). AHPRA and the National Boards provide updates at all levels of joint health department committees, including the Australian Health Ministers' Advisory Council, and at Australian Health Workforce Ministerial Council meetings. The consultation processes adopted by National Boards and AHPRA include close involvement with governments and key stakeholders at all stages. Under the National Law, the Boards and AHPRA work in partnership to implement the National Scheme, each with specific roles, powers and responsibilities set down in the National Law. Each year each of the National Boards and AHPRA publish a health profession agreement that details the fees payable by health practitioners, the annual budget of the National Board and the services provided by AHPRA that enable the National Boards to carry out their functions under the National Law. These agreements are published on the AHPRA website at www.ahpra.gov.au/About-AHPRA/Who-We-Are/Health-Professions-Agreements.aspx.

Issue	Response
Community member involvement Some submissions advocated for an increased role for community members within the National Scheme and that further reform should be made in the structure of National Boards.	**National Boards** The Australian Health Workforce Ministerial Council (AHWMC) determines the size and composition of each National Board consistent with the requirements of the National Law. The AHWMC also appoints all members and decides who will be the National Board Chair. **National Board membership** The National Law requires a mix of both practitioner and community members on all National Boards. The National Law requires the practitioner membership of National Boards to be at least half, but not more than 2/3 of membership (and the Chair must be a practitioner member). In addition there are ratio requirements between 'large' jurisdictions and 'small' jurisdictions that apply to the practitioner membership of National Boards. There must be at least two community members on each National Board. Based on current composition, this results in one-third of each National Board being community members. The actual number of community members on each board depends on its size. When the statutory composition requirements are applied to each National Board, the following happens: On a nine person board, there are six practitioner members and three community members (the Aboriginal and Torres Strait Islander Health Practice Board of Australia; Chiropractic Board of Australia; Chinese Medicine Board of Australia; Optometry Board of Australia; Osteopathy Board of Australia, Podiatry Board of Australia; and the Occupational Therapy Board of Australia) On a 12-person board, there are eight practitioner members and four community members (the Dental Board of Australia; Medical Board of Australia; Nursing and Midwifery Board of Australia; Medical Radiation Practice Board of Australia; Pharmacy Board of Australia; Physiotherapy Board of Australia; and the Psychology Board of Australia). Community members have the same remuneration, voting and procedural rights as practitioner members of National Boards. The National Law currently requires that the Chair of the National Board must be a practitioner member, therefore community members are not eligible to seek appointment to this role. The forthcoming three year review of the National Scheme provides a timely opportunity to review National Board composition and eligibility requirements, including for the role of Board Chair. The Committee may support or provide advice to this review. **State and territory boards of National Boards** Under the National Law, a National Board may establish a special committee, called a state or territory board, to help exercise its functions. Appointments are made by the individual Health Minister or Health Ministers (if it is a regional board of more than one state or territory). The same ratio of community members and practitioner members is applicable to these state and territory boards. Unlike on the National Boards, there is no need to apply the 'large' jurisdiction / 'small' jurisdiction ratio to the practitioner membership. This may provide Ministers with more flexibility in deciding the size and composition of a state or territory board, when the Minister applies the ratio of at least 50% (but no more than 2/3 of the membership) being practitioners, and the balance of membership being community

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	members. **Other opportunities for community members and input** The National Scheme creates opportunities for community members across professions to strengthen their role, work together and share ideas. More widely, we have also strengthened links with the community through establishing a Community Reference Group, which is chaired by a community member of the Medical Board of Australia, Mr Paul Laris. Part of the work of the CRG is to promote community input into board consultations and other important regulatory issues. AHPRA has also held a series of community forums around Australia in conjunction with the Consumers' Health Forum.

Issue	Response
Mandatory Reporting Some submissions expressed support for the position taken in Western Australia with respect to mandatory reporting	**Background** In Victoria under the *Health Professions Registration Act* 2005, which commenced on 7 December 2005 and was in place until 1 July 2010, there was a requirement for medical practitioners to report the ill-health of registered health practitioners. Mandatory reporting requirements were then strengthened under the National Law in 2010 and applied to **all** registered health practitioners. Reporting requirements were extended to include practise while intoxicated by alcohol or drugs; sexual misconduct in connection with practice; and significant departure from accepted professional standards. Under the National Law, the threshold for mandatory notifications is high. Mandatory notifications are an important public safety mechanism of the scheme. Given this is a new regulatory requirement in many jurisdictions, there has been some misunderstanding of these thresholds among practitioners. In response, AHPRA and National Boards have conducted a range of educational and awareness raising activities, and each National Board has – since the start of the National Scheme – published approved *Guidelines for mandatory notifications.* These guidelines are consistent and common to all 14 boards and professions regulated under the National Scheme. They provide helpful step-by-step guidance for practitioners. When the West Australian Parliament passed the Health Practitioner Regulation National Law in WA an additional exemption for 'treating' practitioners was included that only has effect in that state. Practitioners in Western Australia are not required to make a mandatory notification about patients (or clients) who are practitioners or students in one of the health professions. However, practitioners in Western Australia continue to have a professional and ethical obligation to protect and promote public health and safety. They may therefore make a voluntary notification or may encourage the practitioner or student they are treating to self-report. The recently passed Queensland *Health Ombudsman Act 2013* modifies the way that the National Law applies in that state, by introducing an additional but more limited exemption from mandatory notification requirements for treating health practitioners in Queensland. The exemption will only apply if the matter relates to an impairment, **does not** relate to professional misconduct, **and** the treating practitioner forms the reasonable view that the other practitioner does **not** pose a serious threat to the public (e.g. because the practitioner has agreed to a rehabilitation program). The Health Ombudsman Act has not yet commenced. Similar issues about the merit of mandatory reporting and the balance of practitioner privacy and public safety were debated when the Victorian legislation was originally introduced in 2005 and with the introduction of the National law in July 2010. The approved *Guidelines for Mandatory Notifications* will be updated to identify the new Queensland-specific exemption, alongside requirements in WA. However, as expressed most recently during consideration of the Health Ombudsman Bill by the Queensland Parliamentary Committee, AHPRA and the National Boards remain concerned that state-by-state variations create confusion for practitioners about their reporting obligations and risk reducing compliance with this important public safety obligation. The forthcoming three-year review of the National Scheme would be an appropriate mechanism for review of mandatory reporting provisions,

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	as a nationally consistent approach is imperative for the effectiveness of this important public safety requirement. **Mandatory reporting data update** Data on mandatory reporting is detailed in the 2012/13 annual report of AHPRA and the National Boards. In summary: • Mandatory reporting has increased in Victoria since the commencement of the National Scheme; see Table 7A of Appendix 2. In Victoria there were 200 mandatory notifications received during 2012/13, compared to 111 in 2011/12 and 164 in 2010/11. • Nationally, a mandatory report is three times more likely to result in immediate action than a voluntary notification. A voluntary notification that was closed during 2012/13 led to action by a board in 20% of cases. A mandatory notification that was closed during 2012/13 led to action by a board in 45% of cases – 10% included a caution or reprimand; 33% led to conditions or an undertaking; 1% to a suspension of registration. The outcome of mandatory reports in Victoria is broadly consistent with the outcomes of mandatory reports nationally (including WA). AHPRA and the National Boards have commissioned research through the University of Melbourne to understand more about trends and characteristics of mandatory reporting. This research will be published when completed.

Issue	Response
Notifications A number of submissions raised issues associated with the management and processes surrounding notifications, including the balance of timeliness and quality.	**Background** The National Law replicates, to a large extent, the notification provisions that existed in Victoria under the *Health Professions Registration Act* 2005. While the Health Practitioner Regulation National Law Act (National Law) sets out the mechanism for complaints handling across Australia, the scheme in operation is effectively a state-based complaints system for the largest professions. In Victoria, 86% of notifications (complaints) received in 2012/13 were dealt with by the local boards of medicine, nursing/midwifery and psychology. These boards are made up of Victorian practitioner and community members appointed by the Minister for Health in Victoria. These boards are supported by staff in the Victorian AHPRA office who receive and manage notifications and provide advice to inform board decision-making. The complaints handling system in Victoria relies on the Health Services Commissioner, the Victorian Civil and Administrative Tribunal, boards and AHPRA to deliver effective and timely outcomes and protect the public. **Notifications management: 2013 outcomes** Data about notifications management in the National Scheme in the 12 months to 30 June 2013 are published in the 2012/13 annual report of AHPRA and the National Boards. Appendix 2 of this submission provides a Victoria-specific analysis of notifications management, and updates the 2012 calendar-year view provided in our previous submission to this Inquiry. See also page 135 and following, of the 2012/13 annual report. Comparing the Victorian and national outcomes in notifications management confirms: • A 17% increase in notifications in Victoria which is slightly higher than the 14% increase nationally (varied across professions and jurisdictions). • A 80% increase in mandatory notifications in Victoria compared to a national increase of 33% Broadly, analysis of notifications management in Victoria demonstrates there is consistency of outcome and approach in Victoria and nationally. There is no apparent 'light touch' regulation in this state. National Boards take action in some way on about 20% of voluntary notifications and about 45% of mandatory notifications. AHPRA and the National Boards are closely monitoring the upward trend in the number of notifications lodged in the National Scheme. We do not yet have enough information to fully understand this trend, however, it does appear to be consistent internationally and in line with a rise in complaints made to health complaints entities in Australia. Importantly, regulation is about protection of the public not punishment. It has a different purpose than the criminal law. First and foremost, Boards have to decide whether and how to limit someone's registration to keep the public safe. The Boards takes this role seriously and do not compromise on patient safety. Practitioners must comply with and practise within any restrictions on their registration. AHPRA recognises the ongoing work in educating the public about its role, the scope of its work and regulatory priorities.

Issue	Response
	Improvements since February 2013 ***Systems and process improvements*** The 2013 annual report of AHPRA and the National Boards outlines the work AHPRA has done nationally to improve the systems and processes that support our management of notifications. In summary, AHPRA's priority has been to bring greater consistency and improve timeliness, and to ensure management of notifications is risk-based. Improvements to notifications management made during in 2013 ensure that AHPRA processes and board decisions aim to assess and manage risk. AHPRA's processes systematically ensure that all notifications are assessed quickly. High-risk matters are dealt with quickly; lower risk matters are managed through routine processes. Boards and AHPRA identify high risk matters up front and these are often managed using the 'immediate action' powers in the National Law designed to enable boards to keep the public safe as an interim step, pending other action (including investigations). AHPRA has also been improving its capacity to measure and report on its work. With greater consistency of approach, AHPRA is able to generate more consistent data. AHPRA is implementing Key Performance Indicators to set benchmarks for timeliness in notifications management. We will routinely publish performance data against these KPIs commencing financial year 2014/15, in addition to extensive data published in our Annual Report which is tabled in all parliaments in Australia. With this focus, and these initiatives, AHPRA will be able to satisfy ourselves and the public that it is regulating effectively and efficiently by managing quality, timeliness and volume in all areas of its work. ***Clearer information*** During the year AHPRA published new guides for health practitioners and the community about how notifications are managed in the National Scheme. See www.ahpra.gov.au/Notifications/Fact-sheets.aspx. The guide for practitioners, and a series of information sheets aim to explain to practitioners what happens when AHPRA receives a notification on behalf of a National Board. The information complements the direct correspondence that individuals receive if a notification is made about them. AHPRA also developed a guide for the community about making a complaint (or notification) about a health practitioner. This guide for notifiers, *Do you have a concern about a health practitioner? A guide for people raising a concern,* is being reviewed by the Community Reference Group. Both guides are published on the AHPRA website in a revised section on complaints and notifications, and are accessible through the National Board websites. AHPRA collaborated with the professional associations for practitioners registered in the National Scheme to develop the guide for practitioners. The guides include visual and text-based descriptions of our processes and aim to make it clear what practitioners and notifiers can expect when they raise a concern with us.

Issue	Response
	Community engagement AHPRA and the National Boards have substantially increased community engagement and outreach during 2012/13. AHPRA recognises this as a critical future focus of its work. During 2013, since making our earlier submission, AHPRA has established a Community Reference Group which had its first meeting in June 2013, to work with AHPRA and the National Boards. This is the first time a national group of this kind, with a focus on health practitioner regulation, has been established in Australia. The group has a number of roles, including providing feedback, information and advice on strategies for building better knowledge in the community about health practitioner regulation, advising AHPRA on how to better meet community needs. AHPRA has also worked with the Consumers Health Forum to work with AHPRA to expand and improve AHPRA's community engagement initiatives. The CHF helped AHPRA recruit participants to state and territory briefings on the National Scheme; advertise among members for interest in joining our Community Reference Group; conducted an online survey about health practitioner regulation and awareness of AHPRA; and encourage consumer awareness of and participation in National Board consultations about important regulatory issues. This has allowed us to extend our online community of interest, made up of members of the public and other stakeholders, to whom AHPRA sends information about current consultations and news of the National Scheme, and seek feedback on a range of issues. **Review process for notifiers** One submission to the Committee proposed the consideration of a review process for notifiers. This was in place in Victoria under the *Health Professions Registration Act* 2005 before the National Scheme. The Act allowed review, in limited circumstances, of a finalised notification by an independent review panel. The outcomes of the review process reported by the Victorian state boards between 2005-2010 showed that a significant proportion of the notification outcomes were upheld. In only a small number of matters did the review panels recommend reconsideration of matters. In addition, the review processes added additional costs to state boards. This independent review process, as well as other external oversight models, was considered and publicly consulted on in developing the National Law. They were not supported by the jurisdictions in the final development of the National Law.

Issue	Response
Revalidation	A challenge to all professional regulators is to ensure the ongoing competence of the profession it regulates. One of the key objectives of the National Law is to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered. The National Law requires the National Boards to establish Registration Standards for Continuing Professional Development (CPD) and Recency of Practice. Before the National Scheme some professions set clear requirements for CPD, but these were not mandated in legislation and were not a pre-requisite for renewal of registration. The concept of revalidation was consulted on as a part of the development of the registration requirements of the National Law. At that time it was generally not supported by the professions, and governments instead opted for mandatory CPD and Recency of Practice requirements. Since the consultation about the National Law, revalidation has become an increasingly common topic of discussion by health regulators internationally. In the UK it took considerable effort and consultation to reach the approach now in place. The Medical Board of Australia has started a conversation in Australia about revalidation with the medical profession and the community.

Attachment A

Medical Board of Australia | AHPRA

Health Profession Agreement

Medical Board of Australia

and

The Australian Health Practitioner Regulation Agency

2013 - 2014

Health Profession Agreement

1. Preamble

1.1. The Health Practitioner Regulation National Law Act 2009 requires the Australian Health Practitioner Regulation Agency (Agency) and the Medical Board of Australia (the Board) to enter a Health Profession Agreement (Agreement) that provides for the following:

1.1.1. the services to be provided by the Agency to the Board to enable it to carry out its functions;

1.1.2. the fees payable by health practitioners; and

1.1.3. the annual budget of the Board.

1.2. The National Law framework for this Agreement is set out in Attachment 1.

1.3. In developing and signing this Agreement:

1.3.1. both parties agree that a successful Health Profession Agreement is an important element of an effective working relationship;

1.3.2. the Board will do everything it can to make its requirements clear; and

1.3.3. the Agency will do everything it can to provide the services required by the Board to perform its functions.

1.4. The NRAS Strategy 2011 -2014 outlines an agreed high level strategy for the joint work of National Boards and AHPRA. See Attachment 2.

1.5. Boards commit to actively co-operate and collaborate with other national Boards wherever appropriate, in areas of mutual interest and of wider importance for the implementation of the National Scheme as a whole.

2. Guiding principles for the Agreement

2.1. The guiding principles, which underpin this Agreement, are as follows:

2.1.1. the Board and the Agency recognise each other's distinct and complementary statutory responsibilities;

2.1.2. the Board and the Agency recognise their mutual accountability and partnership;

2.1.3. the implementation of the agreement provides mutually beneficial outcomes for both parties and the community we jointly serve;

2.1.4. the Board and the Agency are committed to the efficient management and continuous improvement of their respective functions;

2.1.5. the Board and the Agency have a commitment to resolve problems or disputes promptly.

3. Scope of this Agreement

3.1. This Agreement is for the period 1st July 2013 to 30th June 2014.

3.2. Under this Agreement, the Board will recognise its statutory and policy responsibilities. In particular, it will:

3.2.1. advise the Agency of any risks which may impact on its ability to meet its statutory obligations; and

3.2.2. ensure prompt consideration of policy matters necessary to fulfil its obligations under this agreement.

3.3. The Board will also recognise the operational responsibilities of the Agency. It will:

3.3.1. provide clear directions on its requirements in relation to the services from the Agency as specified in Schedule 1;

3.3.2. develop a fee structure which provides adequate financial resources to the Agency to enable it to perform its functions under this agreement and which provides an adequate level of equity as agreed between the Board and the Agency;

3.3.3. ensure that Board members are accessible to Agency staff;

3.3.4. ensure prompt consideration of operational matters raised by the Agency as a consequence of its fulfilling its obligations under this agreement and in relation to the shared objective of national consistency and improving the ways AHPRA delivers services on behalf of the Board;

3.3.5. ensure adherence to AHPRA's financial responsibilities in procurement and other operational processes in fulfilling the Board's work plans;

3.3.6. direct any requests for additional tasks, beyond those detailed in Schedule 1 of this Agreement, through the Director, National Board Services. Time frames and impact on other services and priorities will then be negotiated;

3.3.7. authorise the Chair of the Board (or his/her nominee) to act as liaison officer with respect to this Agreement;

3.3.8. provide information requested by the Agency on the Board's performance of its functions for inclusion in the Agency's annual report and other agreed purposes;

3.3.9. liaise and consult with the Agency to develop the Board's strategic and work plans.

3.4. Under this Agreement the Agency will recognise its statutory and policy responsibilities. It will:

3.4.1. advise the Board of any risks which may impact on its ability to meet its statutory obligations;

3.4.2. provide policy, secretariat and research support for the Board and its delegate to enable effective and timely decision making including;

3.4.2.1. policy advice

3.4.2.2. advice on regulatory or legislative changes

3.4.2.3. responses to questions from Ministers and parliaments

3.4.2.4. Board appointments

3.4.2.5. Freedom of Information and Privacy legislation and the Ombudsman

3.4.2.6. media, public relations, issues management and communication support.

3.4.3. ensure that services comply with Board policy and relevant laws;

3.5. The Agency will also recognise its operational responsibilities to enable the Board to exercise its functions. It will:

3.5.1. fulfil the requirements for the delivery of services as outlined in Schedule 1 through the provision of appropriately trained and experienced staff;

3.5.2. provide registration and notification services to delegated decision-makers in accordance with agreed Board delegations, operational policies and the National Law;

3.5.3. provide National Boards with information that will enable them to perform their notifications functions in a timely and efficient way;

3.5.4. facilitate Board access to relevant information, facilities and staff of the Agency;

3.5.5. ensure that senior Agency staff liaise and consult with the Board to provide guidance and advice and raise issues likely to impact on the Board's strategic and work plans;

3.5.6. manage financial resources in an efficient, transparent and accountable way ensuring that there are appropriate internal safeguards which are subject to controls and audit;

3.5.7. enter into and manage any third party contracts, agreements or key relationships required by the Board to support its statutory obligations and provide agreed services to support such contracts;

3.5.8. develop and implement operational protocols and guidance to promote nationally consistent service delivery which reflects the Board's standards, guidelines and policies;

3.5.9. maintain relevant website content in line with Board's direction and expectations including updates relating to board activities;

3.5.10. provide responsive customer services including counter, email response and telephone services in support of Board and Agency functions and services;

3.5.11. monitor and regularly report on performance and provide feedback on the level of performance in relation to the standards for the agreed services;

3.5.12. undertake specific projects as requested by the Board within agreed priorities and agreed timeframes. Additional funding may be negotiated with the Board where the work impacts on normal operational staffing and is considered not to be part of routine roles and functions performed by the Agency;

3.5.13. monitor and regularly report on the management of significant risks which may impact the Board's ability to meet its statutory obligations;

3.5.14. manage a program of projects to continuously improve the consistency and quality of services, promote innovation and to adopt contemporary business and service delivery models;

3.5.15. authorise the Director, National Board Services as the Agency's liaison officer with respect to this agreement.

4. Dispute resolution

4.1. If a dispute arises, the parties will raise the matter with each other setting out the issues in dispute and the outcome desired. Each party agrees to use its best endeavours to resolve the dispute fairly and promptly.

4.2. If the dispute cannot be resolved, the matter will be referred to the Chief Executive Officer of the Agency and the Chair of the Board.

4.3. If the dispute cannot be resolved following the steps above, it will be referred to the Chair of the Agency Management Committee and the Chair of the Board.

4.4. Either party may request the appointment of an independent, accredited mediator at any stage in the process.

4.5. If the Agency and the Board(s) are unable to resolve the dispute it may be referred to the Ministerial Council, consistent with the requirements of the National Law.

5. Review

5.1. The Agency and the Board agree to review this agreement on an annual basis. The Agreement continues on the same terms and conditions until either revoked or replaced.

6. Schedules

- **Schedule 1: Services to be provided to the Board by AHPRA**
- **Schedule 2: Board's annual work plan**
- **Schedule 3: Income and expenditure budget, balance sheet and budget notes**
- **Schedule 4: Schedule of fees**
- **Schedule 5: Performance indicators and reporting**

This Agreement is made between

The Medical Board of Australia

and

The Australian Health Practitioner Regulation Agency (AHPRA)

Signed for and on behalf of AHPRA by:	Signed for and on behalf of the Medical Board of Australia by:
Signature of Chief Executive Officer	Signature of the Board Chair
Mr Martin Fletcher	Dr Joanna Flynn AM
Date 16/9/2013	Date 11/9/2013

Attachment 1: Legislative framework

Health Practitioner Regulation National Law, as in force in each state & territory (the National Law).

Objectives and guiding principles of the legislation

(1) The object of this Law is to establish a national registration and accreditation scheme for:

(a) the regulation of health practitioners; and

(b) the registration of students undertaking;

(i) programs of study that provide a qualification for registration in a health profession; or

(ii) clinical training in a health profession.

(2) The objectives of the national registration and accreditation scheme are:

(a) to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered; and

(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction; and

(c) to facilitate the provision of high quality education and training of health practitioners; and

(d) to facilitate the rigorous and responsive assessment of overseas-trained health practitioners; and

(e) to facilitate access to services provided by health practitioners in accordance with the public interest; and

(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners.

(3) The guiding principles of the national registration and accreditation scheme are as follows:

(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;

(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;

(c) 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.

The Australian Health Practitioner Regulation Agency

Section 26 of the National Law sets out the requirement as follows.

"(1) The National Agency must enter into an agreement (a health profession agreement) with a National Board that makes provision for the following:

(a) the fees that will be payable under this Law by health practitioners and others in respect of the health profession for which the Board is established (including arrangements relating to refunds, waivers, or reductions and penalties for late payment),

(b) the annual budget of the National Board (including the funding arrangements for its committees and accreditation authorities),

(c) the services to be provided to the National Board by the National Agency to enable the National Board to carry out its functions under the national registration and accreditation scheme."

Among the functions of the National Agency, section 25(d) provides that the Agency must negotiate in good faith with, and attempt to come to agreement with each National Board on the terms of a health profession agreement. Section 35(1)(f) provides a corresponding function for a National Board.

The National Law in section 32(2) limits the powers of the National Board so that, among other limitations, it cannot enter a contract. In this regard the National Board may only engage services through the National Agency.

The activities provided for in a health profession agreement must necessarily relate to the functions of a National Board and the functions of the National Agency.

Finance

Part 9 of the National Law regulates finance for the national scheme. Section 208 establishes the Australian Health Practitioner Regulation Agency Fund (the Agency Fund), to be administered by the National Agency. Sections 209-211 provide for the payments into and out of the Agency Fund as well as the investment of money in the Agency Fund.

Financial management duties of the National Agency and National Boards are provided in section 212. Duties are imposed on the National Agency to ensure its financial management and operations are efficient, transparent and accountable and its financial management practices are subject to appropriate internal safeguards.

A National Board is required to ensure its operations are efficient, effective, and economical, and to take any necessary action to ensure the National Agency is able to comply with its financial management responsibilities.

The National Law provides in section 236(1) protection from personal liability for persons who act in good faith in the exercise of functions under the law. Any liability that arises in this regard attaches to the National Agency.

Attachment 2: NRAS Strategy 2011 – 2014

Schedule 1: Services to be provided to the Board by AHPRA

Business Operations

Notifications, registration applications and renewals

Within approved delegations:

- Manage applications for registration consistent with approved registration standards.
- Manage student registrations.
- Receive and investigate notifications about health practitioners in relation to performance, conduct or health matters and students on grounds specified in the National Law.
- Provide effective coordinated support and comprehensive data and advice for state and territory boards, national committees and registration and notifications committees in their decision making about registration and notification matters.
- Manage matters relating to practitioner impairment.
- Facilitate communication with stakeholders and manage key relations.
- Provide support for hearing panels - preparation and circulation of agendas and associated papers, drafting decisions and correspondence.
- Establish effective arrangements for professional advisers
- Continuously improve the design and implementation of delegations
- Provide communications support for issues and media management which is consistent with the Board's media strategy
- Increase national consistency of processes and decision making to implement standards
- Provide legal advice and services

Liaison with external authorities

Where appropriate and in agreement with the Board, enter into memorandums of understanding with relevant authorities to facilitate the application of sections 219 and 221 of the National Law.

Where service levels can be enhanced, work in partnership with external authorities to ensure that relevant issues are considered by both entities.

Online service delivery

Develop online services for health practitioners consistent with agreed business priorities

Promote uptake of online services by health practitioners.

National registers

Maintain a current online national register of registered health practitioners and specialists.

Implement strategies to ensure the accuracy and completeness of data on the registers

Maintain a current national register of students of the profession.

Provide the Board and key partners with relevant workforce registration information.

Customer service

Ensure that practitioners and members of the public can have their phone, email and in person queries dealt with by AHPRA within agreed response times.

Develop and disseminate communications including production of practitioner newsletters

Compliance

Monitor those practitioners who are subject to conditions on their registration, undertakings or who are suspended.

Implement an agreed program of audit of registration standards.

Examinations

Manage examinations where agreed with Board. Detailed arrangements for the conduct of examinations will be agreed with each Board.

Business Support

Board and committee support

Develop registration standards, codes, guidelines and policy as agreed with the Board and across Boards on agreed priority areas.

Stakeholder engagement, government relations including Health Workforce Principal Committee and coordination of whole-of-scheme issues such as community engagement.

Operational support - arrange Board and committee meetings, travel, accommodation, payment of sitting fees and expenses. Where meetings are held on Agency premises the costs will be charged to the allocated cost pool. Where the Board chooses to meet elsewhere, meeting costs will be charged as a direct cost to the Board and will be treated as part of the Board's budget.

Secretariat services - prepare and circulate agendas and associated papers, draft decisions, correspondence and communiqués for the Board and its committees.

Project management – deliver agreed projects on behalf of the Board.

Legal advice - provide legal advice and services.

Board effectiveness – services including training, recruitment and succession planning.

Communication

Provide high quality, relevant and current information to stakeholders in a timely and positive manner, enhancing the stakeholder confidence in the Board and the National Scheme and to assist in building key stakeholder relationships. The communications program will be developed in consultation with the Board and will include:

- production and distribution of newsletters to practitioners;
- continual development and enhancement of the Board's website, management of publications, Board events and advice and support on media issues, consistent with the Board's media strategy.

Financial management

Maintain a specific account for the Board within the Agency Fund.

Manage funds in accordance with requirements of the National Law and within guidelines agreed with the Board.

Provide agreed regular financial and performance reports.

Implement appropriate procedures for the collection, refund, reduction and waiver of fees.

Provide financial support and advice to the Board and relevant committees, including strategies for managing specific issues, fee setting and achievement of agreed levels of equity.

Implement measures to improve efficiency and productivity of AHPRA performance through adoption of contemporary business and service delivery models.

Manage and report costs according to established cost allocation principles.

Cost allocation principles

The main objective of cost allocation is to assign each cost to the activity that is most responsible for the generation of that cost. Some costs can be easily identified and attributed to Boards or AHPRA cost centres based on direct causal relationships. Other common or indirect costs need to be shared using accepted cost allocation methodologies.

The allocation methodology used for indirect costs should meet the following criteria.

- Defensible – able to be scrutinised and tested both internally and externally by all impacted parties.
- Auditable – ready to be tested from a financial perspective by an independent arbitrator.
- Understandable – simple, non-complex and understood by all stakeholders, irrespective of their level of financial acumen.
- Flexible – able to alter its calculations and approach as the structure of costs changes over time.

- Accurate – ensures that all costs required to be passed on are calculated accurately and that data capture is robust to enable all costs to be charged back appropriately.

Cost allocation business rules

The principle of no cross-subsidisation of costs will be maintained.

As a first step, where possible AHPRA will allocate costs directly to Boards. If direct allocation is not possible through the identification of a direct causal relationship, costs will be allocated to the indirect cost pool.

The application of the indirect cost allocation framework will result in different cost allocation percentages each year, depending on changes to inputs to the allocation base.

Outcomes of the cost allocation framework will be described in reports to all National Boards each year and will be used as a basis for determining Boards' budgets.

AHPRA will not allocate the same cost more than once. That is, the same cost will not be treated as both a direct and shared (allocated) cost. A direct cost will only be attributed once to a Board. A shared cost will only be allocated once across Boards.

AHPRA will identify to all Boards which costs are charged directly and which are allocated to the indirect cost pool. That is, Boards will be given a clear statement of what services are being delivered via either direct charge or indirect cost allocation.

Risk management

Manage a risk management strategy for both AHPRA and the National Boards.

Communicate to National Boards the identification of and mitigation strategies for extreme and high risks.

Implement an internal audit function to improve AHPRA's management and mitigate risk.

Accreditation

Where accreditation functions are provided by an independent accreditation authority, negotiate and manage an agreement on behalf of the Board for the provision of those functions including any agreed specific projects.

Manage accreditation arrangements on behalf of Boards where the Board decides in consultation with AHPRA, that accreditation functions should be established within AHPRA.

Maintain a current and publicly accessible list of approved programs of study for the profession.

Board work program

Deliver agreed Board-specific work program within agreed priorities, resources and service standards.

Schedule 2

Work plan 2013 - 2014

The Medical Board of Australia has agreed to undertake the following works and projects over the 2013/14 year. It is expected that some of the projects will extend into the 2014/15 year.

This work plan will be reviewed periodically, as new issues arise that require further work.

Note: this work plan is in addition to the regular work of the Board.

Current projects that are planned include:

Details and background	Works
Revalidation The Board held a forum on revalidation in March 2013 and agreed to prepare a paper to promote further discussion.	• Prepare a paper on revalidation • Publish the paper and seek feedback from stakeholders • Board members to accept invitations from stakeholders to discuss revalidation
External doctors' health programs In 2013, the Board decided to fund external health programs. These programs will not have a regulatory role, but rather, will focus on supporting and promoting doctors' health.	• Develop a request for quote for advice and options about how to set up an optimal delivery of external health programs. This will include options on governance arrangements, organisational structure and funding models • Decide on the organisational structure, governance arrangements and funding model and communicate with stakeholders • Communicate the Board's decision to stakeholders • Progress the establishment of external health programs.
Work on the arrangements for the intern year The Board has asked the Australian Medical Council to do work on: 1. Setting learning objectives for the PGY1 year (intern year) 2. Intern assessment and sign off and 3. Establishing a national framework for intern training accreditation process The AMC is expected to deliver this work in 2013.	• Communicate with stakeholders on the new procedures for the intern year • Support the AMC to implement the new procedures for the intern year • Agree on a national framework for intern training accreditation processes • Approve organisations that will accredit intern positions • Agree on a funding model to support the national framework for intern training accreditation processes from 1 July 2014 • Work with AHPRA to formalise the arrangements with agencies who will accredit intern positions

Details and background	Works
IMG pathways to registration The Board consulted on proposed changes to the competent authority pathway and specialist pathway in 2013.	• Analyse responses to feedback • Finalise changes to the pathways • Develop an implementation and communication plan for any proposed changes • With the assistance of AHPRA, implement changes
Specialist pathway – short term training The Board started preliminary consultation on this pathway	• Undertake public consultation and then finalise documents • Develop a communication plan and implementation plan if changes are proposed
Performance Assessment The Board can require a practitioner to undergo a performance assessment. The Board held a workshop on performance assessments in 2013 and a work plan was developed on the basis of feedback from the workshop	• Progress the work plan in relation to performance assessment
Supervision guidelines for IMGs The Board has previously developed supervision guidelines for IMGs that are due for review	• Internal review of the current supervision guidelines • Consultation with stakeholders • Finalise and implement any changes
National consistency The Board has delegated powers for the management of registrations and notifications to a range of state and territory boards, committees and staff. It wants to promote good and consistent regulatory decision-making across all jurisdictions.	• Review the mechanisms in place to promote good and consistent regulatory decision-making, particularly in notifications • Develop new mechanisms to promote good and consistent regulatory decision-making
Establishment of a notifications committee The Board has established committees to manage notifications in each state and territory. The Board has received feedback that it would streamline operations if these committees were combined into a single notifications committee.	• Amend delegations to support the move to a notifications committee • Implement notifications committees in each state and territory
Guideline for testing practitioners who have abused drugs, for blood-borne viruses There has been a well publicised case of a medical practitioner who admitted to infecting patients with a blood-borne virus.	• The Board to consider whether to develop a guideline about this and if so, to progress the guideline.
Guidelines on cosmetic medicine and surgery The Board has agreed to develop guidelines on cosmetic medicine and surgery	• Draft guidelines and consult on draft guidelines.

Details and background	Works
Registration standards The following registration standards are due for review on 1 July 2013: CPD, recency, PII, English language, criminal history, limited registration	• Review registration standards, consult on revised standards and submit revised standards to the Ministerial Council for approval
Issues related to Queensland Minister Springborg has indicated that he will be reviewing arrangements for the management of complaints/notifications in Queensland.	• To be scoped on the basis of new legislation to be introduced in Queensland. Works will include integrating the new system for management of complaints into the national scheme and managing issues that arise

Schedule 3: Income and expenditure budget and balance sheet summary, budget notes

MEDICAL BOARD OF AUSTRALIA
SUMMARY BUDGET 2013-14

Item	$
Total income	**57,298,746**
Total expenses	**56,335,391**
Surplus (deficit)	**963,355**
Equity at start	12,265,000
Equity at end *	13,228,355
Board indirect cost allocation rate for 2013-14	35.6%

*It is expected that the board will have sufficient equity throughout 2013/14

MEDICAL BOARD OF AUSTRALIA
DETAILED BUDGET 2013-14

Item	$
Income	
Registration	49,226,921
Application income	4,482,002
Interest	1,627,870
Other income *	1,961,953
Total Income	**57,298,746**
Expenses	
Board and committee expenses (see note 2)	2,879,714
Legal, tribunal costs and expert advice (see note 3)	7,063,247
Accreditation (see note 4)	3,550,000
Other direct expenditure (see note 5)	2,153,140
Indirect expenditure (see note 6)	40,689,290
Total Expenses	**56,335,391**
Net Surplus (Deficit)	**963,355**
Equity at start	12,265,000
Change	**963,355**
Equity at end	13,228,355

*Other income includes cost recoveries, PESCI and miscellaneous fees

Budget Notes

1. Registrant numbers	The registration income is derived from the following assumptions. Budgeted registrants invited to renew at 30 September 2013: 95,505 Budgeted lapse rate of renewals: 1%
2. Board and committee expenses	Total $2,879,714 This covers the meeting costs of the National Board, as well as the eight state and territory boards and their committees, which have the delegated authority to make decisions about individual registered medical practitioners. Costs include sitting fees, travel and accommodation while attending meetings for the Board.
3. Legal, tribunal costs, and expert advice	Total $7,063,247 Note: These legal costs do not include the significant proportion of the Board's direct costs (including sitting fees) and a substantial amount of the work of state and territory boards also relates to managing and assessing notifications. A substantial proportion of the staff costs in each state and territory office relate directly to staff who support work about notifications about practitioners as well as introducing nationally consistent systems and processes to manage notifications.
4. Accreditation	Total $3,550,000 Accreditation expenses include the costs of funding provided to the AMC for accreditation and functions and projects and to post graduate medical councils.
5. Other direct expenditure	Total $2,153,140 Costs associated with the Board's work on registration standards, policies and guidelines. See work plan 2013/14. This includes the following activities: • costs involved in consultation with the community and the profession • engagement of consultants necessary to support the work of the Board • publication of material to guide the profession, such as the Board's newsletter Update • Board member professional development • policy development and projects • funding of external doctors' health programs and costs associated with the development of a new national health program.

6. Indirect expenditure	Total $40,689,290 Proportion of indirect costs allocated to the Board is 35.6%. The percentage allocation for the MBA in 2012-13 was 37.15%. Indirect costs are shared by the National Boards, based on an agreed formula. The percentage is based on an analysis of historical and financial data to estimate the proportion of costs required to regulate the medical profession. In 2012/13, the Boards and AHPRA reviewed the formula. It is a principle of the National Scheme that there is no cross subsidisation between the professions. Costs include salaries, systems and communication, property and administration costs. AHPRA supports the work of the National Boards by employing all staff and providing systems and infrastructure to manage core regulatory functions (registration, notifications, compliance, accreditation and professional standards), as well as the support services necessary to run a national organisation with eight state and territory offices, and support all National Boards and their committees. The 2013-14 AHPRA business plan sets out AHPRA objectives for 2013-14 and how they will be achieved.

Schedule 4: Schedule of fees effective 1 July 2013

Item	National Fee $	Rebate for NSW registrants $	Fee for registrants with principal place of practice in NSW $
Application fee for general registration*	695		695
Application fee for specialist registration*	695		695
Application fee for provisional registration*	0		0
Application fee for general registration after converting from provisional registration*	0		0
Application fee for limited registration*	695		695
Application fee for limited registration (public interest – occasional practice)*	0		0
Application fee for non practising registration*	135		135
Application fee for endorsement of registration*	96		96
Application fee for fast track registration*	348		348
Application fee to add specialist registration to current general registration	174		174
Application fee to add general registration to current specialist registration	174		174
Registration fee - general registration	695	83	612
Registration fee – general registration applying from limited registration (public interest-occasional practice)	680	83	597
Registration fee - specialist registration (who are not general registrants)	695	83	612
Registration fee - limited registration	695	83	612
Registration fee - limited registration (public interest – occasional practice)	269	32	237
Registration fee - provisional registration	348	33	315
Registration fee - non practising registration	135		135
Registration fee - general registration (teaching and assessing)	135		135
Late renewal fee for general registration	174		174
Late renewal fee for specialist registration	174		174
Late renewal fee for limited registration	174		174
Late renewal fee for limited registration (public interest – occasional practice)	67		67
Late renewal fee for provisional registration	87		87
Late renewal fee for non-practising registration	34		34

Item	National Fee $	Rebate for NSW registrants $	Fee for registrants with principal place of practice in NSW $
Late renewal fee for general registration (teaching and assessing)	34		34
Replacement registration certificate	20		20
Extract from the register	10		10
Copy of the register (if application is assessed as in the public interest)	2,000		2,000
Verification of registration status	50		50

*Payment of both an application fee and a registration fee is required at the time of application.

Schedule 5: Performance Indicators and Performance Reporting

Reporting principles:

The following principles underpin performance measures and performance reporting:

- Performance measures must be based on consistent and reportable data that is taken from a common electronic data base
- Data for performance measure reporting should be collected automatically as part of a normal business process (i.e. not separately collected after the event)
- Changes to performance target standards will be based on assessment of current baseline performance and planned initiatives that will impact on baseline
- Priority will be given to performance measures and performance reporting that meets requirements of all boards for monitoring of performance. Consideration will be given to developing customised reports for Boards where appropriate.

Business Operations Performance Reporting

Report Type	Notifications reporting	Registrations reporting	Other performance reporting
Monthly report	**Activity trend lines** Notifications received and finalised YTD trend line: • current year and prior year all notifications • current year by state breakdown Notifications open at beginning and end of month: • trend line YTD all notifications • Trend line YTD x state Notifications inactive at end of month: • trend line YTD all notifications • breakdown x state Prior law cases open at end of month: • trend line YTD all notifications • breakdown x state Immediate actions initiated: • trend line YTD all notifications • current month & YTD breakdown x profession Mandatory notifications received: • trend line YTD all notifications • current month :& YTD breakdown x profession National Law offences received: • trend line YTD all notifications • current month & YTD breakdown x profession **Performance trend lines** Time at stage for lodgement, assessment, investigations, performance/health assessments, panel hearings and tribunal hearings: • Trend line for Av time at stage for stages closed during the month • Trend line for Av time at stage for notifications open at stage at end of month **Attachments** • Tribunals	**Activity trend lines** Registration applications received and finalised trend line YTD: • current year and prior year all applications • current year by state • current year by subtype **Performance** Registration process time by profession and registration type (current month and YTD) **Attachments** • Appeals	Customer Service: • telephone grade of service • Web enquiry grade of service • call volumes & abandonment rate • team activity levels by channel • service requests created Public register availability Website usage

Attachment A

Report Type	Notifications reporting	Registrations reporting	Other performance reporting
Quarterly report • **Dental** • **Medical** • **Nursing & midwifery** • **Pharmacy** • **Psychology**	**KPI report**: % notifications meeting target where stage has closed within the quarter - • all professions x state • your profession x state **Open notifications** time in stage breakdown - • all professions x state • your profession x state **Received notifications**: breakdown x state for your profession - • x stream • x grounds • x source **Outcomes** of notifications breakdown x state: • at assessment • at investigation • IA - all • IA linked to mandatory reporting. **Mandatory** notification breakdown x state: • x stream • x grounds • x source **Aged** notifications breakdown by state: • current stage **Prior** law breakdown by state: • current stage	**Registrant profile** Registrant numbers x registration type x state Limited registrants x sub type x state Registrant numbers by division x state Registered practitioners by endorsement by state **Performance reports** **KPI report**: To be published after finalisation of KPIs for registrations operations	Customer service trend line of performance across quarters: • telephone grade of service • Web enquiry grade of service • call volumes & abandonment rate • team activity levels by channel • service requests created Analysis of service type (application)

Attachment A

Report Type	Notifications reporting	Registrations reporting	Other performance reporting
Quarterly reports: • **ATSI** • **Chinese medicine** • **Chiropractic** • **MRP** • **OT** • **Optometry** • **Osteopathy** • **Physiotherapy** • **Podiatry**	**KPI report**: % notifications meeting target where stage has closed within the quarter - • your professions cf all professions **Open notifications** time in stage breakdown for each stage- • your profession cf all professions **Received notifications**: breakdown - • x stream • x grounds • x source **Outcomes** of notifications: • at assessment • at investigation • IA - all • IA linked to mandatory reporting. **Mandatory** notification breakdown: • x stream • x grounds • x source **Aged** notifications breakdown: • current stage **Prior** law breakdown: • current stage	**Registrant profile** Registrant numbers x registration type x state Limited registrants x sub type x state Registrant numbers by division x state Registered practitioners by endorsement by state **Performance reports** **KPI report**: To be published after finalisation of KPI for registrations operations	Customer Service trend line of performance across quarters: • telephone grade of service • Web enquiry grade of service • call volumes & abandonment rate • team activity levels by channel • service requests created Analysis of service type (application)
End of cycle report		**Renewal outcomes**: • by channel • status of renewals • registrants who did not renew • outcomes by registration type **Late** renewals **Disclosures**: • nature of disclosures • responses to disclosure questions • registrants with disclosures **Not to renew**: registrants by state	

Attachment A

Key performance indicators 2013-14: Notifications

Notification Stage & Performance Measure	Start Date	End Date	KPI
1. Lodgement Time taken from date of enquiry to start of assessment. *This covers the activities for evaluating the initial risk presented, determining whether particulars have been provided and following up where they have not been.*	Receipt of notification enquiry	Assessment commences (notification particulars established)	• 60% within 14 days • 100% within 30 days
2. Lodgement Time taken from date of enquiry to closure at lodgement. *This covers the activities as described above however represents those matters which are closed as enquiries due to the lack of particulars being established.*	Receipt of notification enquiry	Matter closed as there are insufficient particulars/no identifiable, named individual.	• 100% within 30 days *NB: This may require review where the practitioner has been identified and matter is considered by board (require longer timeframe).*
3. Initial risk evaluation Time taken to complete triage and initial risk evaluation. *NB: use of the word evaluation is to address issues raised by the Risk Manager with respect to what meaning is conveyed by the term "risk assessment" (being a formal analysis using a framework of likelihood and consequence)*	Receipt of notification enquiry NB capability to capture date being investigated (audit logging on priority field and amending default behaviour would be required).		• 100% within 3 days
4. Immediate action (new matters) Time from receipt of notification to IA being convened.	Assessment start date	IA proposed IAC meeting date (committee convened to decide whether to commence IA or not)	• 100% within 5 days • Report on all exceptions to 5 day KPI
5. Preliminary assessment Time from receipt of notification to the completion of preliminary assessment (s149) *This covers the activities of performing a preliminary assessment in accordance with s149 only.*	Assessment commences	Date s149 preliminary assessment decision is made	• 100% within 14 days
6. Assessment Time from receipt of notification to completion of assessment stage. *This covers the activities of performing a preliminary assessment in accordance with s149, seeking practitioner responses, assessing and developing recommendations for boards and consulting with health complaints entities.*	Assessment commences (notification particulars established)	First Board decision at assessment stage	• 100% within 60 days

Attachment A

Notification Stage & Performance Measure	Start Date	End Date	KPI
7. S178 If s178 proposed then time from Board decision to end of assessment stage.	Board decision at Assessment stage: • conditions • cautions • accept an undertaking • refer the matter to another entity	Board decision which closes or progresses the matter at end of show cause period.	• 60% within 60 days • 100% within 90 days
8. Investigation Time from beginning to completion of investigation stage.	Board decision to commence investigation	Board decision on outcome of investigation	• 80% within 6 months • 95% within 12 months • 100% within 18 months
9. Appointment of investigator Time from decision to direct an investigation to appointment of investigator.	Board decision to commence investigation	Appointment of investigator	• 100% within 5 days
10. **Health assessment** Time from decision to conduct a health assessment to completion of assessment.	Board decision to undertake assessment (May be outcome of assessment, investigation or panel or tribunal).	Board decision on outcome of health assessment	• 90% within 3 months • 100% within 6 months
11. Performance assessment Time from decision to conduct a health assessment to completion of assessment.	Board decision to undertake performance assessment (May be outcome of assessment, investigation or panel or tribunal).	Board decision on outcome of performance assessment	• 90% within 6 months • 100% within 12 months
12. Panel hearing **12a**. Time from decision to conduct a panel hearing to establishment of panel.	Board decision to go to panel hearing (May be outcome of Assessment, Investigation or panel or tribunal).	12a. Panel meeting date	• 80% within 3 months • 100% within 5 months
12b. Time from decision to conduct a panel hearing to completion of panel.		12b. Decision date on outcome of panel hearing	• 80% within 4 months • 100% within 6 months
13. Tribunal hearing **13a** Time from decision to go to tribunal to date of file letter of referral	Board decision to go to tribunal (May be outcome of assessment, investigation, panel or tribunal	13a Date of file letter of referral	• 95% within 3 months • 100% within 4 months
13b Time from decision to go to tribunal to completion of tribunal		13b Decision on outcome on tribunal hearing	Provide report on performance, no KPI set. Report on: • Cases settled within 6 months • Cases settled within 12 months

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Notification Stage & Performance Measure	Start Date	End Date	KPI

			• Cases settled within 18 months
			• Cases settled beyond 18 months
			• Cases currently beyond 12 months
			  ○ 0-6 months
			  ○ 0-12 months
			  ○ 0-18 months
			  ○ 18+ months
			• OR
			  ○ 0-6 months
			  ○ 6-12 months
			  ○ 12-18 months
			  ○ 18+ months

Business Support Performance Reporting

Business domain	Service level standard	Standard reports
Financial management	Monthly report provided at each Board meeting based on financial performance during the preceding month and year to date.	Income and expenditure report with analysis and narrative.
Accreditation		Availability of scheduled reports from accrediting authorities as per the signed agreements.
Legal	Legal update at end of each quarter.	Quarterly legal update providing detail on key matters in progress and key legal advice provided. Legal Practice Notes to all Boards. Legal advices for Boards as required.
Board Support for National and State Boards, committees and panels	Timeliness. Board, committee and panel papers available no later than 5 working days prior to the scheduled date of the meeting.	Quarterly report
	Remuneration. Reimbursement of sitting fees and claims paid by electronic funds transfer on the agreed day each month. Measure will be 90% accuracy based on number of corrections to total payments made. Payments will be for all meetings held more that 5 days prior to the scheduled payment date.	Quarterly report
	Financial Reports and Budgets. Financial reports and budgets delivered to National Boards and committees as per dates indicated in the tables below.	Progress reports to National Boards
Risk management	Quarterly report highlighting the current risk management rating for all significant risks.	Quarterly risk management report, including mitigating strategies for extreme and high risks within all areas of AHPRA's and Boards' operations.
	Administrative complaints and Freedom of Information handling in accordance with AHPRA policy	Half yearly report of complaints lodged, detailing the total number of complaints for the profession, trends and learning.
Quality of support services	Administration of annual structured survey of quality of service support provided.	Report on survey results Action plan to address issues raised in survey.

Reporting timetable for 2013/14

Month	Upload to SAI
June 2013	22 July
July	15 August
August	13 September
September	14 October
October	15 November
November	13 December
December	22 January
January	17 February
February	20 March
March	14 April
April	15 May
May	19 June
June 2014	23 July

Budgeting timetable for 2014-15 budget

Month of Board Meeting	Upload to SAI Global
December	AHPRA tables the budget assumptions and principles for 2014-15
February	Budget assumptions provided by National Boards to AHPRA for costing
March	AHPRA tables 1st draft budget to National Boards
April	First draft 2014/15 Business Plan
April	AHPRA tables 2nd draft budget to National Boards
May	AHPRA tables proposed final budget to National Boards for approval

Attachment B

AHPRA
Australian Health Practitioner Regulation Agency

Aboriginal and Torres Strait Islander Health Practice
Chinese Medicine
Chiropractic
Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

10 August 2012

Expert Review Panel
Review of the Health Services (Conciliation and Review) Act
Policy Coordination and Projects Branch
Strategy and Policy Division
Department of Health
Level 21, 50 Lonsdale Street
MELBOURNE VIC 3000 E: hscrareview@health.vic.gov.au

Dear Panel

Joint response to the Review of the Health Services (Conciliation and Review) Act 1987

The Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards are pleased to provide a joint response to the Victorian Review of the *Health Services (Conciliation and Review) Act 1987* (the Review).

AHPRA and the National Boards strongly support the current Victorian health complaints system and its interface with the National Registration and Accreditation Scheme's national notifications system, established under the Health Practitioner Regulation National Law (the National Law) as in force in each state and territory.

The attached joint response focuses on three key themes from the Discussion Paper. There is support for the Victorian Commissioner's current role and opportunities for strengthening key functions as canvassed in the Discussion Paper.

We appreciate the opportunity to make a contribution to the Review to inform the considerations of the Expert Review Panel.

If you require any further information, please contact Mr Richard Mullaly, State Manager Victoria, AHPRA on (03) 8708 9071.

Yours sincerely

Martin Fletcher

Martin Fletcher
Chief Executive Officer

Stephen Marty
Chair, Forum of National Board Chairs

Attachment: Joint Response to Victorian Review

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Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Joint response to the Victorian Government's Review of the *Health Services (Conciliation and Review) Act 1987*

Introduction

AHPRA and the National Boards note that the *Health Services (Conciliation and Review) Act 1987* (the Victorian Act) has not been comprehensively reviewed since its introduction. The impact of this legislation on the resolution of health complaints has been significant – not only in Victoria, but as a model of health complaints resolution. Elements of the model have been applied from time to time in other Australian jurisdictions, with the exception of New South Wales, whose Health Care Complaints Commission has a prosecutorial function.

The National Registration and Accreditation Scheme (the National Scheme) has now been fully operational for two years. When the National Scheme commenced in most jurisdictions on 1 July 2010, a new national system of managing notifications about the health, conduct or performance of registered health practitioners was introduced. A key feature of the scheme's national system of notifications – as noted in the Discussion Paper – is the interface with each state and territory health complaints entities (HCEs) under s.150. The *Health Practitioner Regulation National Law* (the National Law), as in force in each state and territory, requires the boards and the HCEs to share complaints and notifications and to agree on how to deal with each complaint or notification. If the HCE and board cannot agree, the most serious action proposed must be taken.

In Victoria, this interface is effectively and efficiently managed between AHPRA's Victorian Office (under delegation from the national boards) and the Health Services Commissioner and her office. A strong, cooperative working relationship has been developed between the two organisations. There is a high level of accord when it comes to deciding which body should deal with notifications/complaints and respectful debate on matters where opinion may differ. Joint consideration contributes to a robust, quality decision making process.

As reported in the AHPRA and National Boards 2011 Annual Report (available from http://www.ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx), the largest number of notifications in 2010-11 (1,903 or 36%) came directly from the community (patients, self-reports, relatives or the public). However, a further 1,401 notifications (26%) across all professions were received from HCEs in each state or territory, reflecting the importance of the joint consideration of notifications between the National Boards and HCEs under the National Scheme. For the period 2010-11 (ie to 30 June 2011), AHPRA received 8,139 notifications about health practitioners regulated under the national scheme (or 1.3% of the national registrant base). Of these, 1,712 notifications were about health practitioners from the ten professions practising in Victoria (1% of the registrant base in Victoria).

Over the last twelve months in particular, AHPRA in consultation with the National Boards, has made considerable business improvements to ensure consistency and efficiency of notifications processing across the country. With the National Scheme maturing and the Victorian health complaints system being in place for 25 years, it is timely for the Victorian Government to consider how best to ensure that the Victorian Act continues to reflect best practice, provides a prompt responsive and cost-effective system for the resolution of health complaints, delivers tangible outcomes for consumers, continues to provide an effective way of identifying systemic issues to improve health services, and ensures that the Commissioner continues to effectively and efficiently resolve and/or conciliate matters within her mandate, while ensuring scope to refer appropriate matters to the National Boards for action.

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Feedback on key discussion points

Improving every Victorian's healthcare experience (4.1 of the Discussion Paper)

Commissioner's capacity to deal with significant public interest issues and identify systemic issues

AHPRA and the National Boards generally support the strengthening of the Commissioner's powers to ensure systemic improvements can be identified, investigated, and disclosed, in the public interest.

In particular, the Commissioner could be provided with broader powers to deal with 'public interest' issues and subsequently disclose information to an appropriate body if the public interest outweighs the protection of confidentiality.

The Discussion Paper notes a public interest issue may be a system issue in the way a health service is delivered by, or involve a series of complaints about the way an unregistered health practitioner or an organisational provider delivers health services. Providing the Commissioner with clear authority to deal with these matters would be advantageous, noting that the National Boards can deal with registered health practitioners. The National Law, as contemporary state and territory applied legislation, has provisions (s.149) to enable a National Board to conduct a preliminary assessment on the basis of a 'cluster' of matters (ie to decide that there are grounds for a notification based on receipt of a number of notifications that suggest a pattern of conduct and notifications made to a health complaints entity.)

Further, the Commissioner currently has some powers to initiate inquiries and investigations as outlined in the Discussion Paper. However, this review provides an opportunity for amendments to the Victorian Act to be made to better align the Commissioner's powers with those of other Commissioners (including in the ACT, Queensland, South Australia, Tasmania and New Zealand) and strengthen the Commissioner's 'own motion' powers. Under the National Law (s.160) a National Board may investigate a registered health practitioner on their own motion if it decides it is necessary or appropriate because the Board for any other reason (other than receiving a formal notification) believes the practitioner has or may have an impairment; or the way the practitioner practises the profession is or may be unsatisfactory; or the practitioner's conduct is or may be unsatisfactory.

Unregistered providers of health services

The Discussion Paper explores the question of whether the current powers of the Commissioner are sufficient to deal with unregistered providers of health services in order to protect the public. The powers of the New South Wales Health Care Complaints Commissioner and a statutory code of conduct are considered as a potential model.

The National Law has established a comprehensive national regulatory regime for the regulated health professions by the National Boards. One consequence of the establishment of the National Scheme has been the creation of an even larger gap between the regulated and unregulated professions. The National Law, in the main, regulates the relevant health professions by means of protection of title. The National Law protects the 'doing' of a health service only to a limited extent (restrictions in relation to dental acts, optical appliances and spinal manipulation). The outcome of this is that it creates circumstances where a regulated practitioner could be disciplined for the same act an unregulated practitioner may not. The fact that some unregulated practitioners may have less (or perhaps no) formal training nor ongoing professional development only increases the risk to the public.

It is critical that the Victorian community has redress with respect to all health service providers – including cancelled or suspended practitioners who may seek to provide health services as an 'unregistered' health professional. The case of former dentist, Noel Campbell

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in Victoria, is a case in point – see the Office of the Health Services Commissioner: http://www.health.vic.gov.au/hsc/resources/pubs.htm

It is noted that in 2011, the Australian Health Ministers Advisory Council (AHMAC) consulted nationally at the request of all state, territory and Commonwealth health ministers on options for dealing with unregulated/unregistered health practitioners.

In its joint submission to the AHMAC consultation (May 2011), AHPRA and the National Boards indicated support for a uniform, cross-jurisdictional, regulatory protection for the Australian public for the health related services provided by unregistered health practitioners. The joint submission considered that the best way to achieve this was via strengthening health complaints mechanisms through a statutory code of conduct as per the NSW model. The model provides a balanced approach to this issue as it protects the public through the establishment of a scheme targeted at the small numbers of unregistered health practitioners who practice in an inappropriate manner.

In terms of administering this strengthened health complaints mechanism, AHPRA and the National Boards supported strengthening the HCEs' capacity to deal with and manage the unregulated health practitioners as well as provide a clear standard under which they should practise. The NSW model of 'negative licensing' appears to provide an appropriate, cost-effective solution given that it protects the public by being able to investigate matters which are raised and then undertake appropriate responses or actions as allowed under the regulatory framework without imposing unnecessary and costly restrictions on the majority of providers of health related services. It is a model that works and would be a good starting point for other jurisdictions to adopt.

Other than in NSW (and soon in South Australia), this approach would be a change for the HCEs to include the ability to sanction in their suite of public protection mechanisms, along with their existing powers of investigation, conciliation and resolution. The transition to a punitive rather than a wholly conciliatory function may be seen as a significant shift but one that can be justified by the success of the NSW model in dealing with unregistered practitioners.

It is understood that the final report from the AHMAC consultation is yet to be considered by all health ministers, but will be taken into account during this review of the Victorian Act. A code of conduct which is enforceable through a prohibition order and ultimately jail will decrease the risk to the public, particularly if it is uniform across Australia and the practitioner cannot simply move interstate to avoid sanction. Uniformity is always desirable in cross jurisdictional regulatory protections.

However, the Victorian Government may consider it appropriate to move forward and strengthen the Victorian's Commissioner's powers and enable prohibition orders to be issued to protect the public from unsafe and unregistered providers of health services.

Making the complaints process more responsive to people's needs (4.2 of the Discussion Paper)

Commissioner's complaints handling processes

It is important for consumers of health services to have an appropriate avenue of redress for complaints and that there is confidence that complaints processes are responsive to their needs.

A strength of the current complaints process is that the Commissioner can focus on an individual's grievance and seek resolution. By contrast, as regulators of the professions, the National Boards must focus on remedial action to address the health, conduct or performance of individual practitioners to ensure the protection of the public. This difference in focus can be seen by consumers of health services as a disconnect that is not readily understood. Complainants often seek a sincere response to resolve their complaint and receiving this

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through an independent body such as the Commissioner adds weight and credibility to the exchange and can allay the complainant's fear that the matter may be 'swept under the carpet' if the exchange is just between them as complainant and the practitioner or health facility.

AHPRA and the National Boards support current complaints handling processes and agree that good working relationships combined with established referral pathways between the Commissioner and most possible first points of contact by health consumers allows the majority of complaints to be referred in an appropriate and timely way and results in a complaints process that is responsive to people's needs.

Conciliation of complaints

The current Victorian Act provides an important avenue for encouraging the settlement of complaints through conciliation (for appropriate matters) and the Discussion Paper considers ways to enhance the effectiveness and responsiveness of conciliation.

The ability for the Commission to conciliate complaints is strongly supported. Further, AHPRA and the National Boards are confident that the existing provisions of the Victorian Act enable the Commissioner to notify the relevant National Board of any health, conduct or performance issues with respect to registered health practitioners more appropriate for the Boards to deal with. This enables an appropriate balance to be struck between resolving the grievance and ensuring protection of the public. Accordingly, these provisions are supported.

It is noted that s.20(14) of the Victorian Act prohibits evidence of anything said or admitted during conciliation being admitted in proceedings before a court or tribunal, and s.32 defines confidential information and restricts its disclosure. The protection from disclosure of conciliation admissions enables an honest exchange of information, explanations and apologies that may otherwise not be forthcoming for fear of litigation. Even with changes to the legislative environment (including extensive changes to the *Wrongs Act 1958)* to better support and encourage open disclosure, the reality can often be one of fear on the part of the health practitioner or health facility, of possible legal action against them.

Continuous quality improvement (4.4 of the Discussion Paper)

Using systemic analysis to improve the quality of health services across Victoria

As noted earlier, the focus of National Boards (as regulators of the professions) is to deal with notifications about the health, conduct and performance of individual registered practitioners. There are numerous systemic problems that can emerge during the delivery of health services that only the Commissioner has jurisdiction to investigate, and the Commissioner's ability to address systemic issues in health service delivery is supported.

The Commissioner collects a large amount of data on the provision of health care in Victoria. It is a large repository of information that should be used to inform, educate and guide health service providers. The Discussion Paper proposes that the Commissioner's quality functions could be consolidated and reframed, emphasising the importance of the system improvement function and enabling effective linkages with a range of state and federal healthcare quality bodies.

This proposal is supported by AHPRA and the National Boards. In particular:

- As the Office of the Health Services Commissioner will soon have a new database with increased capacity to support a systemic analysis of health complaints data, the provision of de-identified systemic learnings being provided to the Department of Health, AHPRA and the National Boards, the HIRC and the ACSQHC would be invaluable and could lead to further improvements in the quality of health services across Victoria.
- Amending the Commissioner's functions to enable recommendations to be made to the Victorian Minister on policy or process changes arising from an analysis of

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complaints or experience in complaints resolution could also lead to improvements to the quality of healthcare for patients. Further, it may be appropriate to strengthen the Commissioner's powers to enable an audit of whether quality improvement recommendations have been implemented.

- It is noted that the Coroner has the capacity to make recommendations after a coronial enquiry and such recommendations draw on the learnings from some of the unexpected deaths in Victoria and how a repeat of such deaths may be avoided. Providing the Commissioner with the same capacity to make recommendations with respect to matters where there have been 'near misses' or patients left with an adverse outcome other than death could provide another source of learnings for health service providers.

~~AH~~ C.

Notifications in the National Scheme

Do you have a concern about a health practitioner?

A guide for people raising a concern (making a notification or complaint)

AHPRA

Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

What is this document for?

Raising a concern about a health practitioner can be stressful. This brochure explains what happens after you have raised a concern about a registered health practitioner and tells you about:

- what we do: the role of the National Boards and the Australian Health Practitioner Regulation Agency (AHPRA)
- what a notification is
- what we can do
- what we can't do
- what you can expect as a notifier (the person who raises the concern)
- the role of health complaints entities
- what you can expect from the notifications process
- what Boards can decide after assessing your notification, and
- answers to some common questions.

What we do: the role of National Boards and AHPRA

The National Boards for 14 health professions and the Australian Health Practitioner Regulation Agency (AHPRA) work together to implement Australia's National Registration and Accreditation Scheme (the National Scheme). The National Boards regulate the health professions by setting the requirements for registration and the standards that practitioners must meet.

Information about the 14 professions in the National Scheme and our work is published on our website at **www.ahpra.gov.au**. More information about how we do what we do is published in our *Service charter* at **www.ahpra.gov.au/About-AHPRA/Service-Charter**.

What is a notification?

'Notifications' are concerns or complaints about registered health practitioners. Anyone can raise a concern about a registered health practitioner by contacting AHPRA, which has an office in each capital city.

There are different arrangements in NSW where the Health Care Complaints Commission (HCCC) is the body which receives complaints. If you want to make a complaint about something that happened in NSW go to **www.hccc.nsw.gov.au** for more information.

Keeping the public safe is the goal that guides the way we deal with each notification we receive. When we look at notifications, we consider:

- whether the practitioner has failed to meet the standards set by the Board, and
- what needs to happen to make sure that the practitioner is aware of what has gone wrong and learns from this, so the same problem doesn't happen again.

The Boards also consider if they need to limit the practitioner's registration in some way to keep the public safe.

The powers of the National Boards and AHPRA are set down in the Health Practitioner Regulation National Law (the National Law). Responding to notifications about the health, performance or conduct of health practitioners is one of the most important parts of our role.

We also work with the independent health complaints entities (HCEs) in each state and territory to make sure the most appropriate organisation is dealing with the concern that has been raised. A list of the HCEs is available on our website at **www.ahpra.gov.au/Notifications/About-notifications/Working-with-health-complaints-entities/Health-complaints-entities**.

The role of the National Boards

National Boards are made up of community and practitioner members. Board members are appointed by governments.

When dealing with notifications, the Boards and their committees make all the decisions about registered health practitioners. AHPRA staff work on behalf of the Boards to manage the notifications process.

Each notification is carefully considered to assess whether there is evidence that the practitioner poses a risk to patient and public safety. We will take action to manage any risks and to keep the public safe. If the Boards need more information before deciding what to do, we will investigate.

The Boards make every decision on the facts of each individual case. The focus is on:

- the health, performance or conduct (behaviour) of the practitioner
- understanding what has happened, and
- deciding what action, if any, the Board needs to take to make sure the public is safe and that the same thing won't happen again.

The actions the Boards can take are set down in the National Law.

To stop or limit a health practitioner's right to practise, a Board needs evidence, for example, that they:

- have not kept their clinical knowledge and skills up to date and are not competent
- have taken advantage of their role or have done something wrong, or
- are too ill, or have not adequately managed a personal health problem, to work safely.

In a small number of cases the Board may take immediate action to manage any risk to public safety while more information is gathered. This could include restricting what the practitioner can do at work, requiring extra supervision of their practice or in the most serious cases, suspending their registration.

AHPRA's role

AHPRA staff receive concerns/complaints and manage the notifications process on behalf of the Boards.

Any correspondence you receive from AHPRA and the Board will be from AHPRA, on behalf of the National Board. Your contact person throughout the notification process will be an AHPRA staff member.

AHPRA does not make decisions about how to deal with notifications. These decisions are made by Boards.

What we can do

We are responsible for making sure that registered health practitioners meet the standards of good practice set for them by each of the National Boards. If we identify serious concerns about a health practitioner we can:

- manage the risk to the public
- make sure the practitioner understands what went wrong, so the same thing doesn't happen again
- limit the practitioner's registration in some way, to change the way they practise, and
- share the lessons from what happened with other practitioners to help keep the public safe.

What we can't do

There are some things that National Boards and AHPRA can't do.

We can't:

- order a health practitioner to provide the treatment you want

- pay you compensation or order a health practitioner to pay you compensation or repay you
- order a health practitioner to give you access to your records
- make a health practitioner apologise to you
- conciliate between you and the health practitioner
- resolve complaints about health systems
- advocate for you or the practitioner, or
- investigate concerns about health service providers such as hospitals or community health centres.

What you can expect as a notifier

When you raise a concern about a registered health practitioner you are called the notifier. As a notifier, your role is to inform the Board and AHPRA of your concerns about the practitioner and to provide us with all the information you can about what has happened. We will ask you for information that is relevant to the concerns you have raised, and any supporting documentation you might have.

The Board can only make a decision based on the information it has. For this reason it is important that you provide all the information you can about what happened, so the Board can make an informed decision about what to do next. If you need help to provide this information, or need help understanding what we do, we can help you. Please contact us on 1300 419 495 if you need further assistance.

We must provide a copy of your notification to the practitioner you are concerned about, unless there is a risk to your safety if we do that.

Under the National Law, the National Boards and AHPRA are not advocates for you or for the practitioner. Our job is to:

- find out what happened
- decide whether the practitioner has failed to meet the required standards
- take any action needed to keep the public safe, and
- stop the same thing happening again.

More information about AHPRA and the notification process is published at **www.ahpra.gov.au/Notifications/The-notifications-process**.

The role of health complaints entities

AHPRA and the National Boards work closely with the health complaints entities (HCEs), or commissioners, in each state and territory. We work closely with each of the HCEs to make sure that the right organisation deals with your concerns. There are different arrangements in NSW for dealing with notifications.

- The role of the National Boards and AHPRA is to **protect the public**, including by managing notifications about health practitioners and when necessary, restricting their registration and their practice in some way.
- The role of health complaints entities is to **resolve complaints or concerns**, including through conciliation or mediation.

AHPRA and the National Boards have no power to resolve complaints. Our focus is on managing any risk to the public.

HCEs deal with concerns about	National Boards and AHPRA deal with concerns about
Health systems	Health practitioners' conduct, health or performance
Health service providers (like hospitals or community health centres)	
Fees and charges	

Sometimes a person raises a concern with one agency and it ends up being managed by the other. This is because the HCEs and AHPRA work together and agree on which organisation should take responsibility for dealing with the concerns you have raised.

Each organisation has a role set down in the law and a different set of responsibilities. If you raised a concern with a health complaints entity and it is referred to AHPRA for the National Boards to deal with, this is because the issues you have raised relate to the **conduct, health or performance** of an individual registered health practitioner.

More information about HCEs and how they work with the National Boards and AHPRA is published in an fact sheet on the AHPRA website **www.ahpra.gov.au/Notifications/Fact-sheets/Health-complaints-entities**.

What you can expect from the notifications process

Getting started

You can raise a concern about a registered health practitioner with AHPRA by telephone, in writing in a notifications form (sent by email or in hard copy), or in person at an AHPRA office. The notifications form is available at: **www.ahpra.gov.au/Notifications**.
Please contact us on 1300 419 495 if you need further assistance.

We can only do something about your concerns if they meet the legal grounds to be called a notification. This means your concerns must be about a registered health practitioner who:

- did not provide safe care because their standard of professional conduct was too low, and/or
- does not have reasonable knowledge, skill or judgement or exercise enough care, and/or
- is not a suitable person to hold registration, and/or
- is or may be ill and pose a risk to the public, and/or
- has or may have broken the National Law, and/or
- has or may have breached a condition on their registration or an undertaking, and/or
- obtained their registration improperly.

The exact legal grounds for a notification under the National Law are detailed on the website at **www.ahpra.gov.au/Notifications/What-is-a-notification/What-can-notifications-be-about**.

If at first you do not provide us with enough information for your concerns to be considered a notification, we will contact you to find out more. We can help you to work out if your concerns meet the legal grounds for a notification. If **within 30 days** we cannot establish that your concerns are grounds for a notification, we will write to you and tell you we can't take any further action.

If your concerns do meet the grounds for a notification it is assessed by a National Board (see next section).

Assessment

We conduct an assessment to see if the concerns raised in your notification can be quickly and easily addressed and if not, to make sure they are dealt with in the most effective way possible.

As part of the assessment process, we will send your notification to the health practitioner and ask them to respond, unless we believe your safety is at risk.

At this stage, the National Board has to decide if the notification raises issues of unprofessional conduct, unsatisfactory professional performance or impairment (illness) of a registered practitioner.

The decisions the Board can make after assessing the notification fall into three broad categories.

1. There is enough information to decide no further action is necessary to protect the public.
2. There is enough information to decide to take action now to protect the public.
3. There is not enough information, we need to seek more.

We will write to you after the assessment to let you know what the Board has decided to do about the notification you have lodged. We aim to conduct the assessment and let you know what has happened **within 60 days** of establishing that the concerns you raise meet the legal definition of a notification.

What Boards can decide after assessing your notification

1. There is enough information to decide no further action is necessary to protect the public.

When there is enough information available at this stage, a National Board may decide there is no risk to the public that it needs to manage. In these cases the Board can decide to take no further action.

When a Board decides to take no further action after an assessment, it means it has decided that:

- there is no risk to the public that needs to be managed
- the issue does not require the practitioner's registration to be restricted in some way, or
- progressing the matter would not lead to any action being taken on the practitioner's registration.

If a Board decides to take no further action, it does not mean that the issue you raised was not important or that it was not worth making a notification. It means that the Board has decided there is not a risk to the public that it needs to address, or that managing the issue does not require the practitioner's registration to be restricted in some way. The information you provided stays on the practitioner's file, and can be considered again at a later time.

2. There is enough information to decide to take action now to protect the public.

In some cases a National Board believes it has enough information from the notifier, and perhaps the practitioner, to decide what action it needs to take to keep the public safe. In these cases, it can take any one or more of the following six courses of action:

1. caution the practitioner
2. accept an undertaking from the practitioner (to do or to not do something in relation to their practice)

3. impose conditions on the registration of the practitioner), for example that the practitioner:
   - undertakes further education or training and/or
   - has their practice supervised and/or
   - does, or does not do, something in relation to their practice and/or
   - manages their practice in a certain way and/or
   - reports to a specified person at set times about their practice and/or
   - does not employ someone or a type of person
4. refer the concerns to a health complaints entity because it relates to a wider health system issue, or refer the concerns to another organisation outside the National Scheme, for example, Medicare Australia or health insurance companies
5. take immediate action to protect the public by limiting the practitioner's registration in some way. This is an interim step and always involves another course of action as well, such as referral to an investigation
6. refer the practitioner to a panel hearing, or
7. refer the practitioner to a tribunal hearing.

When a National Board decides to **take immediate action, caution or impose conditions** on a practitioner's registration, it is legally required to seek submissions from the practitioner about what the Board proposes to do. These submissions can be made face-to-face or in writing and will inform the final decision made by the National Board.

More information about immediate action is published in this fact sheet available at **www.ahpra.gov.au/Notifications/Fact-sheets/Immediate-action**.

If the Board decides to **limit a practitioner's registration** in some way, any restrictions are

published on the register of practitioners at **www.ahpra.gov.au/Registration/Registers-of-Practitioners**. This online public register provides information about the current registration status of every registered health practitioner in Australia. The only exception is in relation to private health information, which is not published.

It is not common for a Board to refer a matter directly to a panel or a tribunal without investigation, but this is possible under the National Law.

3. Not enough information is available, seek more information.

Sometimes the Board decides it needs more information before it can make an informed decision about what, if any, action might be necessary to keep the public safe. In these cases, the Board can:

- refer the matter to investigation, and/or
- refer the practitioner for a health or performance assessment.

If the Board decides to investigate a matter, the investigation will usually be undertaken by AHPRA staff. During an investigation, we may seek more information from you or other people or organisations (such as hospitals, other practitioners or witnesses), including records, reports or expert opinions. This information forms the basis for a decision by the Board at the end of the investigation.

Practitioners can continue to practise while an investigation is underway, consistent with any limits on their registration a Board has put in place to keep the public safe in the meantime.

We will write to you every three months to inform you about the progress of the investigation and we will write to you at the end of the investigation to tell you what action the Board decided to take. After an investigation a National Board can decide to:

- take no further action
- refer the practitioner for a health or performance assessment
- refer the matter to a health or performance and professional standards panel
- impose conditions on/accept an undertaking from the practitioner
- caution the practitioner
- refer the matter to a tribunal, or
- refer the matter to another entity.

Information about performance assessments, health assessments and the role of panels and tribunals is available at **www.ahpra.gov.au/Notifications/The-notifications-process**.

Answers to some common questions

Can I seek compensation through a Board and AHPRA?

No, the Board cannot deal with issues of compensation.

Sometimes notifiers do seek compensation for what has occurred. The health complaints entity in your state or territory can advise you about compensation, even if your concerns are being handled by AHPRA and the National Boards.

Can I seek advice about health treatment from a Board and AHPRA?

No, the Board cannot provide any advice about the health treatment you should seek or recommend which practitioners you should or could seek treatment from.

Can I appeal a Board's decision if I am not happy with it?

Under the National Law this is not possible. The role of the Board is to assess the concerns you have raised about the practitioner and take action to protect the public. The Board conducts this assessment and decides what to do as a result.

If you are not happy with our processes or you think our systems were not fair and robust, you can make a complaint to AHPRA. If you are not satisfied with our response, you can also make a complaint to the National Health Practitioner Ombudsman and Privacy Commissioner at **www.nhpopc.gov.au**. The Ombudsman cannot overturn a decision of the Board but can review the process for managing the notification.

How long does an investigation take?

Each investigation is guided by the facts of the individual case. How long an investigation takes is influenced by a number of issues including:

- how much evidence is available
- whether we need to get other expert opinions, and
- whether we are relying on information being provided by other people or organisations.

Most straightforward investigations are completed within nine to 12 months.

More common questions and answers are published on our website at **www.ahpra.gov.au/Notifications/Fact-sheets**.

AHPRA state and territory offices

Australian Capital Territory
RSM Bird Cameron Building
103-105 Northbourne Avenue
Canberra
ACT 2601

New South Wales
Level 51
680 George Street
Sydney
NSW 2000

Northern Territory
Level 5
22 Harry Chan Avenue
Darwin
NT 0800

Opening hours:
Monday to Friday
8:00am - 4:30pm

Queensland
Level 18
179 Turbot Street
Brisbane
QLD 4000

South Australia
Level 8
121 King William Street
Adelaide
SA 5000

Tasmania
Level 12
86 Collins Street
Hobart
TAS 7000

Victoria
Level 8
111 Bourke Street
Melbourne
VIC 3000

Western Australia
Level 1
541 Hay Street
Subiaco
WA 6008

Opening hours for all offices, except Northern Territory:
Monday to Friday
9:00am - 5:00pm (local time)

Website
www.ahpra.gov.au

Phone enquiries
1300 419 495

AHPRA mailing address
AHPRA
GPO Box 9958
(In your capital city)

Aboriginal and Torres Strait Islander health practice
Chinese medicine
Chiropractic
Dental
Medical
Medical radiation practice
Nursing and Midwifery
Occupational therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Community Reference Group

24 September 2013

Terms of Reference

Purpose

The Community Reference Group will complement the role of community members of National Boards, by:

- providing information and advice on strategies for building community knowledge and understanding of the role of AHPRA and National Boards in protecting the community and managing professional standards
- providing information and advice to AHPRA and National Boards on strategies for consulting the community about issues relevant to their work
- providing feedback and advice from a consumer and community perspective on National Board standards, codes, guidelines, policies, publications and other specific issues, as requested by National Boards, and
- providing consumer and community perspectives and advice to the National Boards and AHPRA about issues relevant to the National Scheme.

Accountability

The Community Reference Group will have an advisory role. The recommendations of the Community Reference Group will be provided for information to the Agency Management Committee, National Boards and AHPRA's National Executive.

Advice and reflections will be provided through the Communiqué on the AHPRA website.

National Boards may choose to seek advice from the Community Reference Group through its Secretariat.

Membership

The Community Reference Group will have up to 10 community members and a Chair, selected through an expression of interest process. Members will be appointed for up to three years.

AHPRA staff may attend as observers at the discretion of the group.

Chair

The Reference Group will be chaired by a community member of a National Board. The Chair is selected through an Expression of Interest process and appointed by the CRG Steering Committee.

Meetings

The Community Reference Group will meet face to face at least twice each year and by teleconference as required. The Group may also make decisions out of session electronically. Members to abide by their signed confidentiality agreement.

Quorum

The quorum is to be at least 50% of members.

Procedures

The Community Reference Group will adopt its own procedures, which will include declarations of any conflicts of interest.

Media

The Community Reference Group Chair or delegate is authorised to speak to the media on behalf of the Community Reference Group.

TOR Review Period

The Community Reference Group TOR to be reviewed on a biennially basis.

Remuneration

The Community Reference Group will be paid for attending meetings at the same rate as National Board members.

Secretariat

The Secretariat will be provided by AHPRA.

Community Reference Group Member

Name	State
Paul Laris, Chair	WA
Ms Darlene Cox	ACT
Ms Fearn M Wright	Vic
Ms Jacqui Gibson	Vic
Ms Jennifer Morris	Vic
Ms Melissa Cadzow	SA
Mrs Merle Smith	Tas
Ms Sue Viney	Vic
Ms Becky Hirst	SA
Mr John Stubbs	NSW