

AHPRA submission

8 April 2016

A review of hospital safety and quality assurance in Victoria

Introduction

AHPRA is pleased to provide a submission to the review of hospital safety and quality assurance in Victoria.

Our submission focuses on how the National Registration and Accreditation Scheme (the National Scheme) can work within Victoria to improve hospital safety and quality by:

1. improving the flow of information to manage public risks in notifications, complaints and compliance monitoring processes of practitioner regulation,
2. working collaboratively and reducing complexity in managing public risk, and;
3. ensuring regulatory responsiveness to public risk.

To achieve this, we make suggestions on improving how we work with the Department of Health and Human Services (DHHS) as the system owner, Victorian health services and employers, the Health Services Commissioner and the Mental Health Complaints Commissioner to manage public risk.

How the National Scheme works with the Victorian health system

The National Scheme commenced on 1 July 2010 in all states and territories (except Western Australia, which commenced from 18 October 2010). 97 separate health profession boards were consolidated and 75 Acts of Parliament were replaced by the Health Practitioner Regulation National Law (the National Law), as in force in each State and Territory. The key objective of the National Scheme (set out in s3 in 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 practice in a competent and ethical manner are registered'*.

While the National Scheme provides consistent national registration standards via its 14 National Boards, there is a local focus and a local presence in every state and territory, with direct accountability to each health minister. Strong local relationships are critical for us to do our job well. In the case of Victoria, there are Victorian Boards for the medicine and nursing and midwifery professions which are appointed by the Victorian Health Minister and are made up of both Victorian practitioners and community members. These local Boards make all regulatory decisions about practitioners in Victoria, who are assessed against national standards. These decisions draw on the judgement of Board members, based on the issues before them and their deep understanding of the Victorian health context.

Our Victorian AHPRA office administers the day-to-day work of registration, notifications and compliance monitoring in Victoria, in partnership with the Victorian Boards and the National Boards. We work with the local health complaints entities and the local tribunal (VCAT). We provide further information on our work in notifications and compliance monitoring, with a

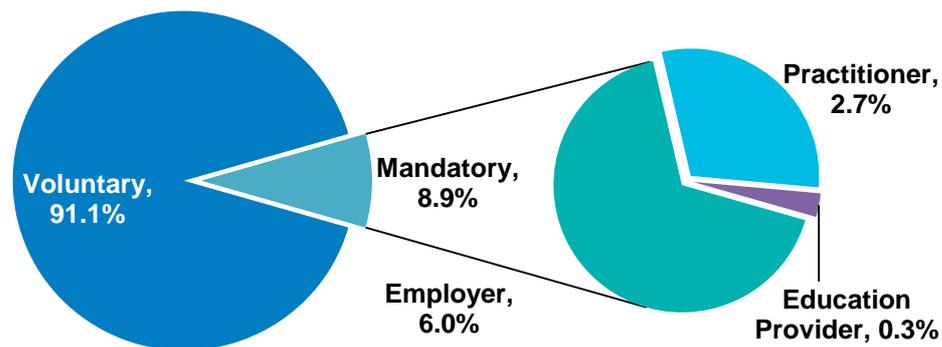
particular focus on how we work with other Victorian counterparts to manage risks to the public.

How the notifications and complaints process operates in Victoria

When a member of the public, an employer or another health practitioner raises a concern about the health, conduct or performance of a practitioner, AHPRA (as the administrative support for the Boards) obtains information to enable the Board to make informed decisions about the risks posed by the practitioner. In the National Registration and Accreditation Scheme, this is called a 'notification'.

We've provided an outline of the notification process in Attachment 1, with a particular focus on the flow of information between AHPRA, health services in the public and private sector (as the employer), the DHHS (as the system owner), the Health Services Commissioner, the Mental Health Complaints Commissioner (to be referred to as the Health Complaints Entities or 'HCEs' with a complaints resolution and health systems mandate) in the five stages of a notification process (Attachment 1).

The National Law sets out the grounds where a mandatory notification must be made by an employer, practitioner or education provider regarding a practitioner or a student. Over 90% of notifications are voluntary, and the diagram below provides a breakdown of the proportion of voluntary and mandatory notifications.



Mandatory notifications made by employers are an important part of our work, and highlight the need for effective communication with employers and with HCEs such as the Victorian Health Services Commissioner.

Recently, we've been working with HCEs across Australia (including the Victorian Health Services Commissioner and the Victorian Mental Health Services Commissioner) to improve the notifications and complaints process. Critical to this work is ensuring clear lines of accountability between AHPRA, National Boards and HCE's. In late 2015, HCEs, National Boards and AHPRA, endorsed the *HCE and National Board matrix* (shown in Attachment 2) for use when jointly considering a notification or complaint under s 150 of the National Law in Victoria, Tasmania, South Australia, Western Australia and Northern Territory (due to the similarities in the HCE legislation in those jurisdictions). The matrix was developed using a version initially adopted for use in Victoria.

Monitoring compliance of practitioners with restrictions in Victoria

Our work in public protection extends beyond managing notifications. AHPRA, on behalf of the Boards, monitors practitioners and students with restrictions placed on their registration (in the form of conditions or undertakings), or with a registration that is suspended or cancelled. By identifying and acting upon non-compliance with restrictions, AHPRA supports Boards to manage risk to public safety.

Each case of monitoring is assigned to one of four streams:

1. **Health:** the practitioner or student is being monitored because they have a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence).
2. **Performance:** the practitioner is being monitored to ensure they practise safely and appropriately while demonstrated deficiencies in their knowledge, skill, judgement or care in the practice of their profession are addressed.
3. **Conduct:** the practitioner is being monitored to ensure they practise safely and appropriately following consideration of their criminal history, or they have demonstrated a lesser standard of professional conduct than expected.
4. **Suitability/eligibility:** the practitioner is being monitored because they:
 - do not hold an approved or substantially equivalent qualification in the profession,
 - lack the required competence in the English language,
 - do not meet the requirements for recency of practice, or
 - do not fully meet the requirements of any other approved registration standard.

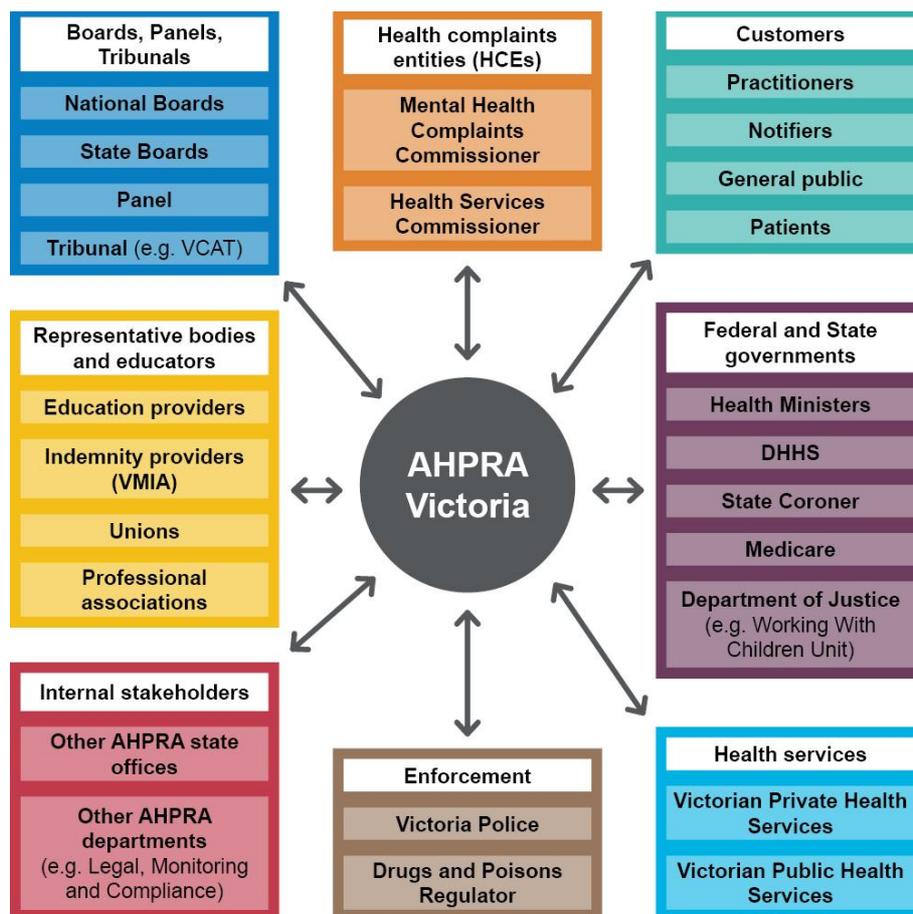
AHPRA has developed a National Restrictions Library (the library) to improve the consistency of monitoring of compliance across Australia. The library:

- supports national consistency in the wording of conditions and publication of conditions to the national register,
- ensures that the best approaches to monitoring are implemented nationally.

In 2014-15, there were 948 monitoring cases in Victoria across all four streams.

Sharing information with our Victorian counterparts

Strong working relationships with our Victorian partners are critical to effectively managing risks to the public. The following diagram demonstrates the complex Victorian landscape for managing notifications.



This submission particularly focuses on how we work with DHHS as the system manager, Victorian health services and employers, the Health Services Commissioner and the Mental Health Complaints Commissioner to manage public risk.

Our assessment of the current information flows with Victorian partners can be summarised as follows:

- The exchange of information between AHPRA and DHHS has been limited to date, however, there are examples of where we have advised the DHHS of concerns about broader systems, clinical governance and policy issues which may arise from the notification process.

This two way information exchange is perhaps the most important information flow issue to be addressed in the context of strengthening the safety and quality of the Victorian health system and where we suggest most attention is given. It is important to ensure that the information flows support regulatory investigation and action (where it is warranted), the appropriate briefing of the DHHS of concerns regarding registered health practitioners and its potentially wider risks to the public, and awareness in AHPRA and Boards of broader systemic issues which impact upon the treatment of notifications about individual practitioners and the risk to public safety.

Overall, we believe that there are steps that could be taken within the National Law, to improve these information flows. This is also assisted by the Health Complaints Bill 2016.

- We routinely advise an employer of outcomes in the notification process when:
 - a board decides to take interim action necessary to protect the public,
 - a board decides to take regulatory action regarding a practitioner, and / or

- decisions are made by performance and professional standards panels or tribunals.

Where the regulatory outcome results in a restriction on registration, this is also published on the on line National Register as soon as possible.¹ Health services are able to subscribe to an automated service to access real time information about changes on the register, although the roll out of this is not widespread in Victoria.

- We consider that there is a strong relationship between AHPRA and the HCEs in Victoria. We regularly liaise with the HCEs (in accordance with s150 of the National Law) regarding notifications matters, and have implemented the HCEs and National Boards matrix to assist with effective decision-making about which entity in Victoria should manage a notification or complaint. Referrals are also made between AHPRA and the HCEs where this is necessary to respond to issues which emerge during the investigation or management of a matter.

There has also been an extensive program of national work with the HCEs from each of the States and Territories arising from the review of the National Scheme. This work is supporting smooth working relationships, clear information flows and community understanding of arrangements in each State and Territory.

In March 2016, National Boards and AHPRA endorsed an *Information Exchange Protocol* for use with the Victorian Health Services Complaints Commissioner, along with counterparts in Tasmania, South Australia, Western Australia and the Northern Territory. The purpose of this protocol is to set a framework for exchange of information between a National Board and a HCE that aims to:

- facilitate the referral of matters between a National Board and a HCE based on the functions of each entity,
- enable each entity to learn of the outcome of the matter that was shared during the assessment of the matter and/or referred between organisations,
- enable each organisation to manage its communication with the complainant/notifier and practitioner, and
- identify trends and developments during the management of complaints and notifications.

We would be happy to provide a further briefing on this work.

Opportunities for improvement in Victoria

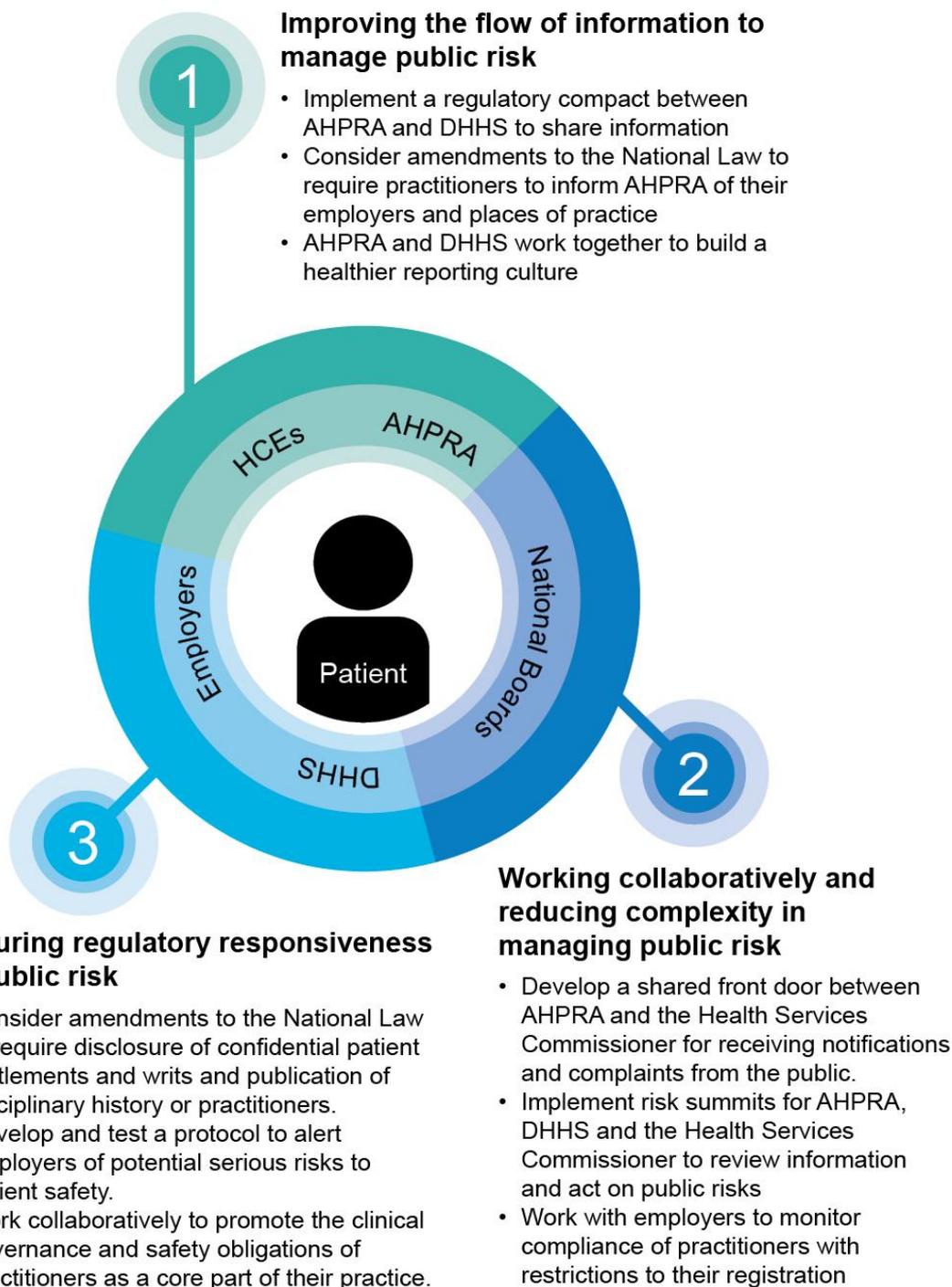
We consider there are a number of opportunities for improvement in safety and quality in the Victorian public health system by:

- improving the flow of information to manage public risk,
- working collaboratively and reducing complexity in managing public risk, and
- improving the regulatory responsiveness to public risk.

We provide our suggestions in these three areas, noting this includes work we have already started.

¹ While health conditions are not recorded in full on the public register, employers are informed about the detail of the conditions. The details are also recorded on the certificate of registration.

Improving oversight and governance of practitioners in Victoria



Improving the flow of information to manage public risk

1. An administrative arrangement in the form of a Regulatory Compact (Memorandum of Understanding) to be agreed between AHPRA and the DHHS to establish a consistent application of principles and procedures for the sharing of information where clear grounds exist that a threshold risk exists to public health and safety. Section 220 of the National Law already provides for AHPRA to share protected information to entities such as the DHHS where there is a need for that information to be disclosed to ensure the

health and safety of the public. However, the development of an administrative agreement that sets out the governance arrangements and the roles and the responsibilities of the parties would facilitate this process. Given that a number of practitioners work across facilities in the public and private sectors, this would need to address the role of the DHHS for both the public and private sector.

We are currently developing a MOU that would describe:

- clear governance arrangements for disclosure of information between the parties,
- the grounds on which information is disclosed in either direction (for example, the ground for which AHPRA would disclose to the DHHS that a notification is the subject of a current investigation),
- information release principles and the arrangements for privacy protection for individuals, and
- responsibilities of both parties when notifications or complaints have been made and rules of engagement around information flows.

We provide an example of how such an agreement could support improved clinical governance and safety:

A notification has been made to a Board regarding a senior clinician who holds clinical governance responsibilities within a Victorian health service. On initial assessment, the Board determines that the notification does not meet the threshold for immediate action to be taken, but holds concerns that warrant further investigation. The information in the notification also suggests that other clinical governance risks may also exist within the health service, particularly as the practitioner holds supervisory and clinical governance responsibilities within the health service.

AHPRA discloses this information to the DHHS under the principles and provisions of the MOU that clearly establish the threshold for such a disclosure, the information release arrangements that protect the privacy for the individuals in the notification, and how the DHHS will both utilise the information and protect the privacy of the information. In receipt of the information, the DHHS can satisfy itself that appropriate safeguards are implemented in the place of practice to address any risks identified from the information provided to AHPRA.

A second example could be where the DHHS or other agency has conducted a non-scheduled review of a health service into significant safety and quality issues, clinical governance or safety breaches. These reports may lead to important information and potentially notifications for AHPRA and Boards to act upon. Further, a recently released advisory from the Australian Commission on Safety and Quality in Health Care has highlighted the importance for accrediting agencies to examine reports of this kind and take appropriate action.²

2. Consideration could be given by the Australian Health Workforce Ministerial Council to amending the National Law to require practitioners to inform AHPRA of their employers and places at which they practice, and for AHPRA to have the power to inform employers and places of practice of changes to a practitioner's registration status. This would assist in ensuring that the right health services and managers are directly notified of potential risks to the public and restrictions on registration, particularly where practitioners are self-employed or work under a visiting or contractual arrangement with a health service, in both the public and private sectors.

² Australian Commission for Safety and Quality in Health Care Advisory No: A16/01: Accreditation assessment requirements of health service organisations post significant clinical or governance review. Available at www.safetyandquality.gov.au/wp-content/uploads/2016/04/A16_01-Accreditation-assessment-requirements-of-health-service-organisations-post-significant-clinical-or-governance-review.pdf

3. We believe the DHHS could partner with us in building a healthier reporting culture within Victoria. A good example of this is the area of mandatory notifications. Attachment 3 provides a snapshot of mandatory reporting in Victoria in comparison to other States and Territories. We make three comments on these data:
 - a. a lower percentage of mandatory reports can be observed in Victoria compared to the national data in the financial years preceding 2015/16.
 - b. when analysed by profession, there are considerable variances in reporting between Victoria and the national figures, with some professions such as midwifery being significantly lower in previous financial years.
 - c. we also note that the rate of Victorian registrants who are the subject of a mandatory notification (ie the number of registrants who are the subject of a mandatory notification per 10,000 registrants) is also lower than the national average.

Of note, our year to date figures for 2015/16 suggest a trend of increasing mandatory reporting in Victoria. This is potentially due to increased levels of awareness brought about by high profile events such as what has occurred at Djerriwarrh and also our work to increase awareness of reporting that is currently occurring. Partnering with the DHHS in this work to improve reporting rates across the public and private sectors in Victoria would be particularly beneficial for all stakeholders in the process.

Working collaboratively and reducing complexity in managing public risk

4. We have commenced discussions with the DHHS and the Health Services Commissioner on the possibility of establishing a common shared front door between AHPRA and the Health Services Commissioner for the Victorian public to make notifications and complaints. The aim is to provide an integrated pathway for collection and assessment of complaints that would then effectively stream matters to the appropriate entity for further management, using the existing joint consideration provisions under the National Law and the provisions of the proposed Health Complaints Bill 2016. This would complement the existing pathways for notifications to be made by practitioners or employers directly to AHPRA to ensure rapid responses to high risk notifications.

Any such changes need to lead to added simplicity, not greater complexity. In particular, it would be important that any arrangement avoids bottlenecks in the notifications process and allows for AHPRA and National Boards to fulfil their obligations under the National Law in critical areas, such as the ability to take immediate action or to fast track a matter to investigation. Discussions to date have been positive, however, important issues such as governance and accountability need to be worked through.

5. Given the different roles and responsibilities of the organisations involved in working to protect public safety in Victoria (ie the system owner, the service providers and the regulators), no one organisation will have a complete understanding for the safety and quality of care provided in Victoria. A risk summit approach could provide a mechanism for the organisations with key safety and quality responsibilities to collectively share and review information when serious concerns about safety have been raised, generate intelligence on key risks and facilitate a rapid assessment and response to the service providers in question.

The risk summit approach outlined by the National Quality Board of the United Kingdom could provide a useful reference in this regard (available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/212820/How-to-Organise-and-Run-a-Risk-Summit.pdf).

6. We also work with employers where required to monitor compliance of practitioners with restrictions on their registration. Two standard or common restrictions included in the National Restrictions Library are directed to ensuring employers are fully aware of the restrictions applying to any registrants in the workplace. These restrictions, which will be

applied to all registrants subject to monitoring as the library is fully implemented, will require the registrant to:

- provide AHPRA with evidence that senior persons within the workplace are aware of the full list of restrictions applying to them, and
- provide AHPRA with information about all places where they are practising.

Previously where workplace supervision was required, restrictions placed the obligation of obtaining workplace supervision reports on the registrant being monitored. As a 'good restriction' cannot bind a third party, and to ensure transparency and the relevant sharing of information, the library now requires the registrant to acknowledge that AHPRA may obtain reports about their compliance with restrictions. In this way the management of risk is more effectively enabled through the establishment of a direct relationship between the employer, the workplace supervisor and AHPRA.

Improving the regulatory responsiveness to public risk

7. Consideration could be given by the Australian Health Workforce Ministerial Council to:
 - a. expand the range of notifiable events under the National Law to include confidential settlements with patients and writs relating to professional negligence. Requirements on practitioners to disclose this information would ensure that National Boards and AHPRA had more complete information about possible risks to patient safety when investigating notifications and making appropriate decisions in the interests of public safety.
 - b. consult on options for publication of disciplinary history on the national register. Currently, only active sanctions or restrictions are published on the register (with the exception of health related restrictions). No history of disciplinary sanctions is currently provided. For example, if a practitioner is restored to the register following a suspension, details of the prior suspension are no longer available to the public.

The framework for what must be provided on the National Register is set out in the National Law. Debates have previously occurred on whether these arrangements appropriately balance the rights of the practitioner with the public 'right to know'. AHPRA believes that this warrants renewed consideration. We anticipate there would be a range of stakeholder views and a consultation process would be important.

8. We propose to develop and trial a protocol to alert employers where a notification regarding a practitioner has been assessed as posing a potentially serious risk to patient safety but the threshold for immediate action has not been reached. A risk based tool such as the PRONE score could be utilised^[1] for this process, which would also draw upon risk analysis of the open notification. Once AHPRA had advised the employer that a potential serious risk to patient safety had been identified, the employer would be able to interrogate their own data (such as adverse events and clinical audits) and assess the risks and need for clinical governance measures to manage these appropriately. We envisage this would require work with our Victorian partners to develop, trial and implement a protocol that validly addresses patient risks and meets our legislative obligations to practitioners. We note that the capacity to notify employers using this approach would presently be limited under s219 and s220 of the National Law to Commonwealth, State and Territory entities.

^[1] Spittal MJ, Bismark, MM and Studdert, DM. (2015) *The PRONE score: an algorithm for predicting doctors' risks of formal patient complaints using routinely collected administrative data*. *BMJ Qual Saf* 2015;0:1-9.

9. The definition of practice³ commonly used within the National Scheme is broad and extends to non-clinical aspects of management, administration and safe delivery of services in the profession and use of professional skills. This means that clinical governance and patient safety can be considered part of a registrants practice and responsibilities. Accordingly, most of the National Boards have codes of practice for practitioners that set out an expectation that practitioners will participate in the safety, quality and adverse incident reporting requirements of their workplace.

However, in our experience in dealing with notifications, and borne out in some high profile matters, practitioners do not always understand that clinical safety and governance requirements are a core responsibility of registration. Further, there is not always the understanding that management duties that require clinical governance and oversight of others in the workplace can be considered part of their practice.

The reviewer may wish to consider how AHPRA, National Boards and DHHS could work together to provide clear guidance to practitioners on their obligations and promote this important message to employers and practitioners.

Summary

AHPRA recognises its primary objective is to protect the public through effective practitioner regulation. We value the effective working relationships that we have with our Victorian partners and believe there are opportunities to strengthen public protection by improving the sharing of information, working collaboratively with to manage risk and improve health services and regulatory responsiveness. We look forward to future engagement in this work.

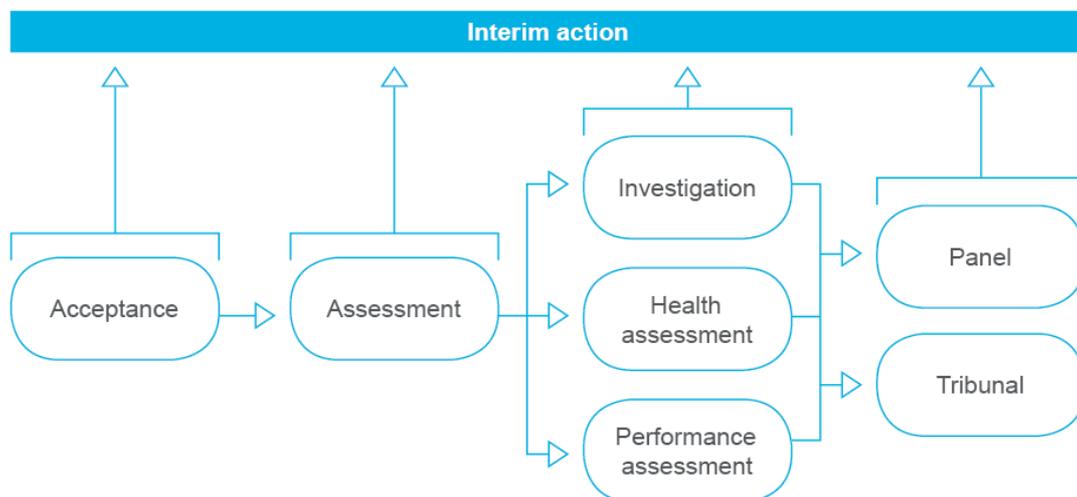
³ **Definition of practice:** Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a nurse or midwife. For the purposes of registration standards, practice is not restricted to the provision of direct clinical care. It also includes working in a direct nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession and/or use their professional skills.



Information flow between AHPRA, employers, the Department of Health and Human Services (DHHS), the Health Complaints Entities (HCEs), and employers in the notification process.

Anyone can make a complaint about a registered health practitioner's [health, performance or conduct](#). This is called a notification because AHPRA and the National Boards are notified about concerns or complaints.

A high level diagram of the notifications process is provided below. While the diagram shows the flow of the process, we highlight that as the process of notifications progresses, interim or final action may be taken at any of the stages of the process, and that the majority of notifications are concluded without the need for a panel or tribunal hearing.



In this attachment, we provide information on the process in each stage and what information may be shared. We also identify what legislative or administrative improvements could be made to sharing information. There are clear statutory provisions for information sharing between AHPRA, the Boards and the HCEs (both the Health Services Commissioner and the Mental Health Complaints Commissioner). Accordingly, the information in this document primarily refers to information sharing with employers and the DHHS. It should be noted that AHPRA may share information with other entities in accordance with the National Law, such as the police or the coroner, and this occurs. These entities have not been included in this advice.

Our description below of the notifications process does not include the important role of the National Health Practitioner Ombudsman and Privacy Commissioner (NHPOPC). The NHPOPC's role is to receive complaints from people who have concerns about the administrative processes of the National Scheme and review handling of Freedom of Information processes of the National Scheme. For more information, please refer to the website below.⁴

Interim action (Immediate action)

From the time that we first receive a notification, we evaluate the types and magnitude of risks that a practitioner might pose to the public. This has a significant influence on how we manage the notification.

⁴ More information on the National Health Practitioner Ombudsman and Privacy Commissioner can be found at www.nhpopc.gov.au/

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If a notification discloses a serious risk to the public, National Boards have the power to take interim action. This follows the principles of procedural fairness by informing the health practitioner, who has the opportunity to make submissions to the National Board.

Nevertheless, these interim actions can (and do) occur with or without the cooperation of the health practitioner. They can take place at any time once the notification has been received. They do not end the matter – they protect the public while the orderly process of managing the notification continues.

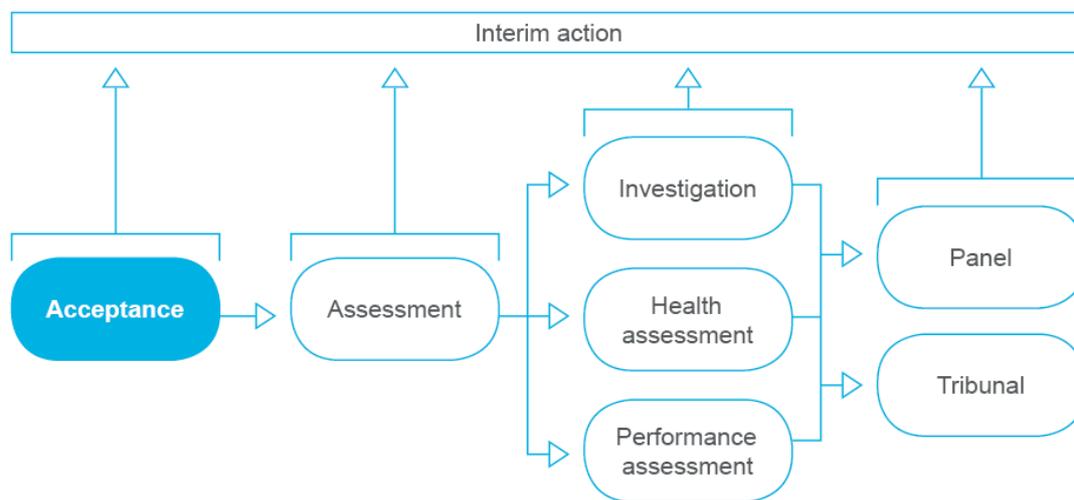
As a result of interim (immediate) action, National Boards can:

- accept an undertaking by the health practitioner
- impose conditions on the health practitioner's registration
- suspend the registration of the health practitioner pending further investigation
- accept the surrender of registration by the health practitioner.

Changes to registration as a result of interim action are published to the online register of practitioners.

The need for interim action can be initiated at any stage in the management of a notification.

1. Acceptance



What occurs in this stage?

At acceptance, AHPRA appraises:

- whether or not the notification relates to a person who is a health practitioner or a student registered by the Board
- whether or not the notification relates to a matter that is a ground for notification, and
- whether or not the notification could also be made to a health complaints entity.

If the notification isn't about a registered health practitioner, or doesn't relate to a ground for notification, then it can't be accepted for management by AHPRA⁵.

What information do we provide employers or the DHHS in this stage?

We do not share information with employers or the DHHS at the acceptance stage.

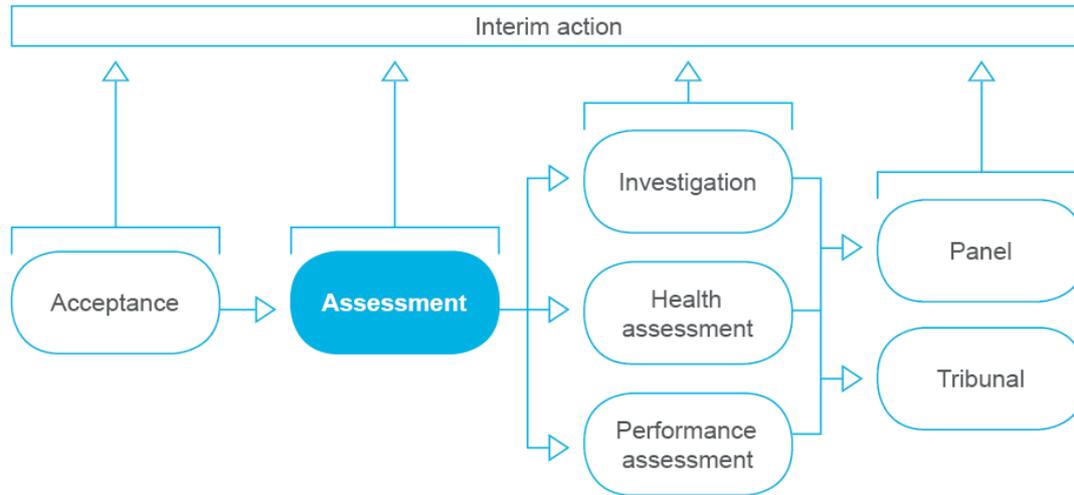
What administrative or legislative improvements could be made to the information flows in this stage?

⁵ note: grounds for a notification to be accepted or action to be taken may still exist where a person who is not a registered practitioner is holding out to be a registered practitioner.

Attachment 1

- Providing a common, single front door with the HSC for the public to make notifications and complaints to provide an integrated pathway for collection and assessment of complaints that would then effectively stream matters to the appropriate entity for further management. However, it is important to guard against bottlenecks or delays.
- Section 219 (b) of the National Law provides for AHPRA to share protected information to entities such as the DHHS. AHPRA is reviewing the thresholds and circumstances to maximise our use of these provisions to share information when warranted for protection of the public. A formalised administrative arrangement could assist in the consistency and benefits of information sharing.

2. Assessment



What occurs in this stage?

Following acceptance, notifications regarding a practitioner are assessed by a national committee of a National Board or a Committee of the Victorian Board for the profession.

AHPRA may ask the person who made the notification for more information. It will usually send the health practitioner a copy of the notification and ask them to respond. This is not done if it would:

- prejudice an investigation
- place a person's safety at risk, or
- place a person at risk of intimidation.

If the Committee / National Board decides that they have sufficient information to deal with the matter at assessment they may:

- close the notification, with an outcome of no further action, OR
- propose to take 'relevant action' such as to caution the practitioner, impose conditions on the practitioner's registration or accept undertakings from the practitioner, OR
- refer the notification for investigation, health or performance assessment, or directly to hearing if warranted.

We aim to complete assessments within 60 days, but the process can take longer if a National Board proposes to caution the practitioner, impose conditions on a practitioner's registration or accept an undertaking from a practitioner. In those circumstances, a final decision cannot be made until a practitioner has an opportunity to *show cause* as to why the National Board should or should not proceed with its proposal.

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What information do we provide employers or the DHHS in this stage?

- We do not routinely share information with an employer in this stage unless the Board takes immediate action or regulatory action, in which case employers are informed.
- If the matter is closed at assessment with regulatory action taken, any conditions would appear on the public register. These would also be notified to the employer.
- If interim (immediate) action is taken, any changes to registration are published to the online register of practitioners, and employers would be notified.
- We may advise the DHHS of any concerns about broader systems, clinical governance or policy issues which may arise from this stage.

How may we work with the HCEs in this stage?

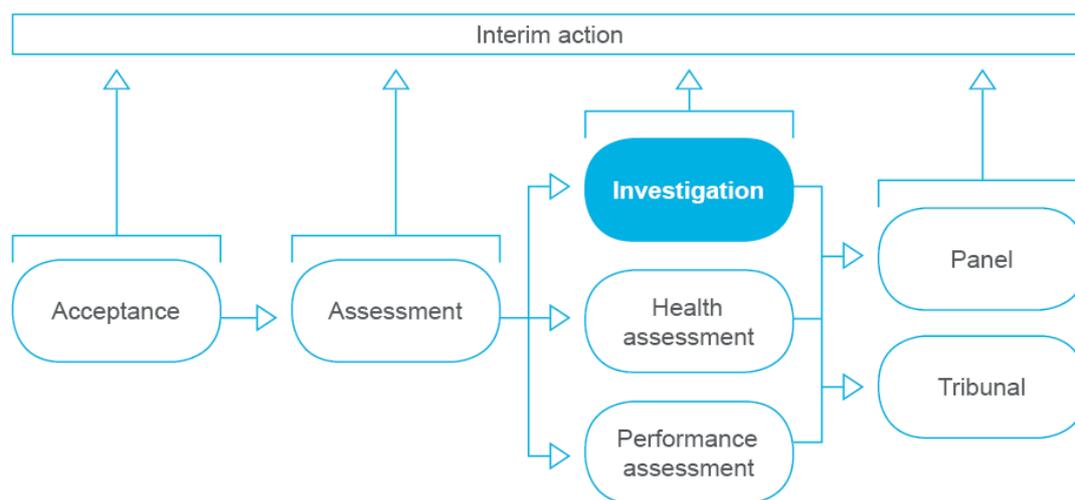
- Information on a notification is shared with the HCEs in accordance with the provisions of the National Law. This flow is two-way and allows for both of the parties to fulfil their obligations in parallel.

What administrative or legislative improvements could be made to the information flows in this stage?

An arrangement could be made to inform the DHHS if clear grounds were established that the DHHS needed this information to manage its obligations to public health and safety. The development of a compact agreement that set out the governance arrangements and the roles and the responsibilities of the parties would greatly assist this process. Development of an MOU is already in train with the DHHS.

Many practitioners are self-employed or in contractual arrangements such as Visiting Medical Officers. Some practitioner and insurer organisations contest the definition of employer. We propose amendments to the National Law that require practitioners to inform AHPRA of employers and places of practice, and for AHPRA to have the power to inform employers and places of practice of changes to a practitioner's registration status. We further propose clarification of the definition of employer in the National Law.

3. Investigation



What occurs in this stage?

Not every notification lodged is investigated, and not every investigation arises from a notification. A National Board has the power to initiate an investigation without a notification. It might do this when it becomes concerned about a practitioner through information that is in the public domain, or when information about a practitioner is revealed in an investigation about another practitioner.

A National Board may also conduct an investigation to ensure that a practitioner or student is complying with conditions imposed on their registration or an undertaking given by the practitioner or student to the Board.

If the Board decides that the notification requires further information, it can instruct AHPRA to investigate the practitioner, arrange a performance assessment by peers of the practitioner, or arrange a health

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assessment. The investigation is usually carried out by a trained AHPRA staff member. The investigation process actively seeks the necessary information to inform the committee's decision through a variety of means, such as:

- obtaining further information from the notifier,
- interviewing third party witnesses,
- site visits or inspections,
- obtaining clinical records or other relevant documents,
- responses and explanations from the practitioner about whom the notification was made,
- information from other practitioners involved in the care of the patient ,
- independent expert opinions,
- police reports, and
- data from other sources such as pharmacy records, Medicare Australia etc.

After an investigation, a National Board may decide to:

- take no further action
- caution the practitioner
- accept an undertaking from the practitioner
- impose conditions on the practitioner's registration
- refer the matter to another entity
- require the practitioner to undergo a health or performance assessment
- refer the matter for hearing by a panel, or
- refer the matter for hearing by a tribunal.

We aim to complete investigations in under six months. But sometimes gathering the information needed to complete the investigation is complex, and the investigation takes longer. All investigations are audited at six, nine and 12 months to make sure that the information we are gathering is necessary to complete the investigation.

What information do we provide employers or the DHHS in this stage?

- We do not inform employers that an investigation is occurring (and its progress) unless they are the notifier.
- If the matter was closed following investigation with regulatory action taken, any conditions would appear on the public register. These would also be notified to the employer.
- Cautions do not appear on the national register.
- Where serious concerns arise we do advise the DHHS of any concerns about broader systems, clinical governance or policy issues which may arise from this stage.

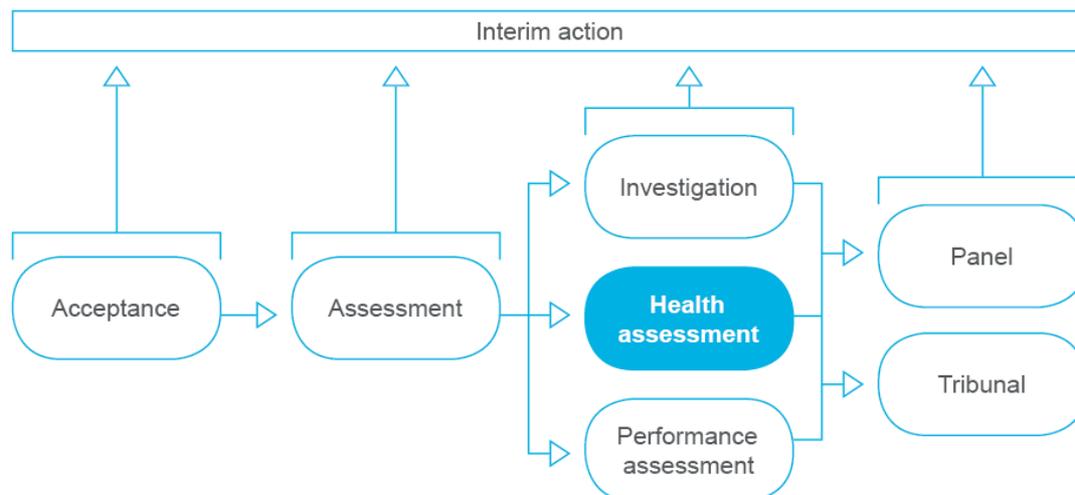
How may we work with the HCEs in this stage?

Information on a notification is shared with the HCEs in accordance with the provisions of the National Law. This flow is two-way and allows for both of the parties to fulfil their obligations in parallel.

What administrative or legislative improvements could be made to the information flows in this stage?

Similar to the assessment stage, an arrangement could be made to inform the DHHS that a practitioner was being investigated if clear grounds were established that the notification being investigated raises a risk to public health. An important limitation under the current National Law arises because s219 and s220 restrict us to informing entities of the Commonwealth or State. This leaves a gap in opportunity to directly advise employers or places of practice outside of the public sector when serious concerns exist.

4. Health assessment (may include a panel hearing)



What occurs in this stage?

A health assessment will usually be required if a practitioner's health is believed to be impaired and impacting on their ability to practise safely. On the basis of the health assessment and any other information, the Committee / National Board will decide whether regulatory action needs to be taken to manage risk to the public. A practitioner always has a right to make submissions to a committee before any of these actions are taken.

The results of the health assessment are discussed with the health practitioner. This allows an honest discussion of any adverse findings, and ways to deal with them. It also gives the health practitioner the chance to discuss any recommendations made by the assessor.

After a health assessment, a National Board may decide to:

- take no further action
- caution the practitioner
- accept an undertaking from the practitioner
- impose conditions on the practitioner's registration
- refer the matter to another entity
- investigate the matter further
- require the practitioner to undergo a performance assessment
- refer the matter for hearing by a panel, or
- refer the matter for hearing by a tribunal.

What information do we provide employers, the DHHS in this stage?

- We advise employers of the regulatory action that is taken.
- Any conditions are published on the national register, noting that while health conditions are not recorded in full on the public register, employers are informed about the detail of the conditions. The details are also recorded on the certificate of registration.
- We may advise the DHHS of any concerns about broader systems, clinical governance or policy issues which may arise from this stage.

How may we work with the HCEs in this stage?

Information on a notification is shared with the HCEs in accordance with the provisions of the National Law. This flow is two-way and allows for both of the parties to fulfil their obligations in parallel.

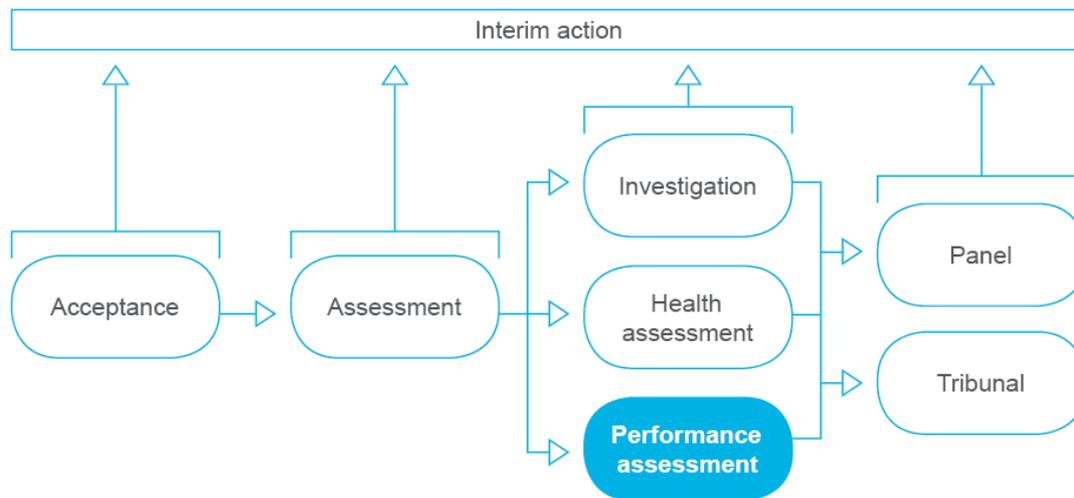
What administrative or legislative improvements could be made to the information flows in this stage?

Sections 219 and 220 provide powers to disclose information to the DHHS. These powers are not routinely used for health conditions related to individual practitioners, given that employers are informed

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directly. However, subject to the provisions of the National Law, these powers can be used to advise the DHHS where broader concerns arise about risk to public health or safety.

5. Performance assessment (may include a panel hearing)



What occurs in this stage?

A National Board may require a health practitioner to have a performance assessment if it believes that the way they practise is or may be unsatisfactory.

A performance assessment is an assessment of the knowledge, skill, judgement and care shown by a health practitioner in their work. It is carried out by one or more independent health practitioners who are not Board members.

The results of the performance assessment are discussed with the health practitioner. This allows an honest discussion of any adverse findings, and ways to deal with them. It also gives the health practitioner the chance to discuss any recommendations for upskilling, education, mentoring or supervision made by the assessor.

After a performance assessment, a National Board may decide to:

- take no further action
- caution the practitioner
- accept an undertaking from the practitioner
- impose conditions on the practitioner's registration
- refer the matter to another entity
- investigate the matter further
- require the practitioner to undergo a health assessment
- refer the matter for hearing by a panel, or
- refer the matter for hearing by a tribunal.

Panels

A National Board can refer a matter to a health panel or a performance and professional standards panel.

A health panel is formed if a National Board believes that a health practitioner or student has, or may have, an impairment that impairs their ability to practise.

A performance and professional standards panel is formed if a National Board believes that the way a health practitioner practises is, or may be, unsatisfactory, or that the health practitioner's professional conduct is, or may be, unsatisfactory.

The panel has all of the powers that the Committee / National Board has, but can also reprimand a practitioner. A reprimand appears on the national, public register of practitioners, as do conditions and undertakings.

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What information do we provide employers, the DHHS in this stage?

- Employers are advised of any decisions by a Performance and Professional Standards Panel regarding a practitioner and the action to be taken.
- Any conditions are published on the national register, noting that while health conditions are not recorded in full on the public register, employers are informed about the detail of the conditions. The details are also recorded on the certificate of registration.
- We may advise the DHHS of any concerns about broader systems, clinical governance or policy issues which may arise from this stage.
- De-identified summary information is published about panel outcomes.

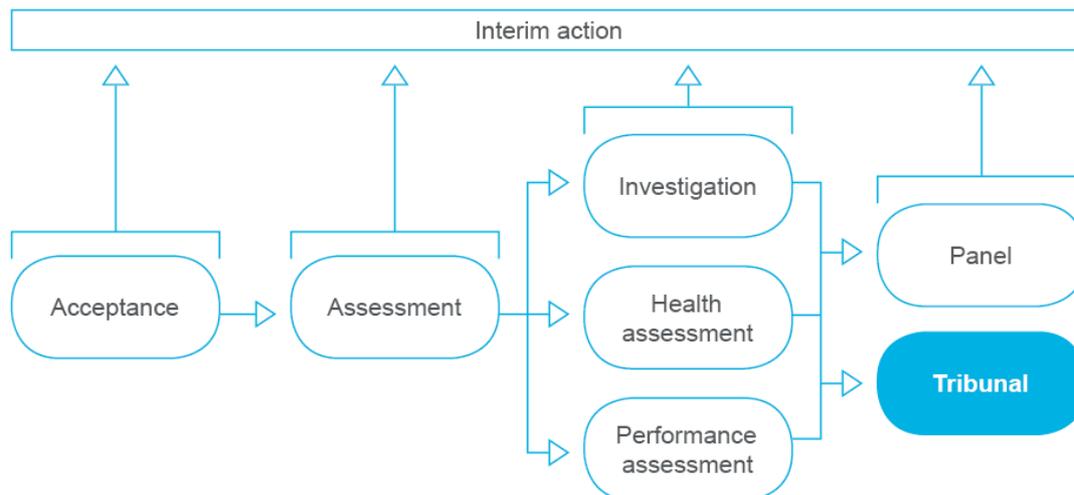
How may we work with the HCEs in this stage?

Information on a notification is shared with the HCEs in accordance with the provisions of the National Law. This flow is two-way and allows for both of the parties to fulfil their obligations in parallel

What administrative or legislative improvements could be made to the information flows in this stage?

The National Law already provides for the DHHS to be notified that a notification was being managed by a Performance and Professional Standards Panel where the notification raises a risk to public health and safety. Administrative arrangements may support consistent and beneficial information sharing where consistent with the National Law.

6. Tribunal (professional misconduct)



What occurs in this stage?

If a Committee / National Board forms a view that a practitioner's conduct or performance amounts to professional misconduct, then the matter *must* be referred to a tribunal. In Victoria, this is VCAT. Generally, tribunals are presided over by a judge or magistrate together with at least one member of the profession and a community member of the tribunal. The tribunal has a wide range of powers and can cancel the registration of the practitioner if necessary.

What information do we provide employers, the DHHS in this stage?

- We advise employers of the decision of the tribunal and the action being taken.
- We may advise the DHHS of any concerns about broader systems, clinical governance or policy issues which may arise from this stage.
- Tribunal decisions are published and we often disseminate media releases to highlight outcomes to educate the professions and promote wider community awareness.

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What administrative or legislative improvements could be made to the information flows in this stage?

The National Law already provides for the DHHS to be notified that a notification was being managed by a tribunal where the notification raises a risk to public health and safety. Administrative arrangements may support consistent and beneficial information sharing where consistent with the National Law.

National Board and HCE Matrix - joint consideration section 150 of the National Law

*The framework should not be too determinative and it allows for flexible processes suitable to the respective States and Territories

Which entity is to deal with the matter?		Source of the complaint or notification	Notifier's or complainant's desired outcome	Is the timeframe for making a complaint due to expire?	Nature and severity of the complaint/notification
1	Must be AHPRA and National Board			<ul style="list-style-type: none"> The timeframe for prosecution of offences under the National Law has not expired in the Criminal Procedure Act (WA) 2004 or equivalent 	<ul style="list-style-type: none"> Severe allegation that may result in a risk to public safety and there is an urgency to take action (including taking immediate action) Mandatory notification with allegations that a health practitioner has engaged in notifiable conduct under National Law Offences under the National Law Practitioner or student has a health impairment Breach of conditions or undertaking Allegations relating to professional misconduct Allegations relating to unprofessional conduct
2	More likely AHPRA and National Board	<ul style="list-style-type: none"> Anonymous Coroner Police Employer Health practitioner 	<ul style="list-style-type: none"> The notifier or complainant refuses to engage with the HCE process The practitioner refuses to engage with the HCE process Disciplinary action e.g. cancellation or suspension of practitioner's registration 	<ul style="list-style-type: none"> The timeframe for making a complaint to the HCE has expired and Commissioner is not satisfied that the complainant had good reasons for not making the complaint within the specified timeframe 	<ul style="list-style-type: none"> Moderate allegations relating to unsatisfactory conduct or unsatisfactory professional performance Pattern of conduct or performance
3	More likely HCE		<ul style="list-style-type: none"> Explanation Doesn't want it to happen to someone else Apology Refund Compensation Access to records A policy change A practice change 	<ul style="list-style-type: none"> The timeframe for claiming compensation or making a complaint to the HCE is due to expire in Statute of Limitations Timeframe for prosecuting offences under the National Law has expired in the Criminal Procedure Act (WA) 2004 or equivalent. 	<ul style="list-style-type: none"> Less severe allegations relating to unsatisfactory conduct or unsatisfactory professional performance e.g.: <ul style="list-style-type: none"> Communication issues or manner of practitioner Manner of providing a health service for the user Refusing to provide a service Breaches of confidentiality Denying or restricting access to records Charging excessive fees or acting unreasonably with respect to a fee
4	Must be HCE				<ul style="list-style-type: none"> Complaint involves a health professional not regulated by a National Board Complaint about a health or community service Complaint about systemic issues

Attachment 3

Table 1. Comparison of the % of national and Victorian mandatory notifications*.

Jurisdiction	2013/14			2014/15			2015/16 YTD (29/02/2016)		
	Mandatory Notifications Received	Total Notifications Received	% of Mandatory Notifications	Mandatory Notifications Received	Total Notifications Received	% of Mandatory Notifications	Mandatory Notifications Received	Total Notifications Received	% of Mandatory Notifications
National	1,145	10,047	11.40%	833	8,426	9.89%	382	3,798	10.06%
National, excluding VIC	956	7,935	12.05%	661	6,525	10.13%	243	2,637	9.22%
VIC	189	2,112	8.95%	172	1,901	9.05%	139	1,161	11.97%

Notes*

- Data from New South Wales (NSW) is included for 2013/14 and 2014/15 but not for 2015/16 YTD. The NSW data is provided to AHPRA by the Health Professional Councils Authority at the end of each financial year. However, we do not as yet have NSW data for 2015/16 YTD.

Table 2. Comparison of mandatory notifications (Notific'ns) by profession: National vs Victorian **

Jurisdiction	2013/14				2014/15				2015/16 YTD (29/02/2016)			
	Mandatory Notific'ns Received (National)	Total Notific'ns Received (National)	% of Mandatory Notific'ns (National)	% of Mandatory Notific'ns (Victoria)	Mandatory Notific'ns Received (National)	Total Notific'ns Received (National)	% of Mandatory Notific'ns (National)	% of Mandatory Notific'ns (Victoria)	Mandatory Notific'ns Received (National)	Total Notific'ns Received (National)	% of Mandatory Notific'ns (National)	% of Mandatory Notific'ns (Victoria)
Aboriginal and Torres Strait Islander Health Practitioner	0	6	0.00%	0.00	2	7	28.57%	0.00%	0	4	0.00%	0.00%
Chinese Medicine Practitioner	0	26	0.00%	0.00%	1	22	4.55%	0.00%	0	16	0.00%	0.00%
Chiropractor	7	111	6.31%	2.94%	4	75	5.33%	18.75%	6	52	11.54%	5.26%
Dental Practitioner	26	951	2.73%	1.83%	22	766	2.87%	3.23%	17	331	5.14%	8.70%
Medical Practitioner	351	5,585	6.28%	3.47%	212	4,541	4.67%	5.61%	113	1,930	5.85%	7.47%
Medical Radiation Practitioner	8	28	28.57%	33.33%	6	31	19.35%	10.00%	4	22	18.18%	0.00%
Midwife	34	110	30.91%	12.50%	20	74	27.03%	8.33%	6	62	9.68%	7.14%
Nurse	590	1,900	31.05%	32.36%	472	1,733	27.24%	23.50%	191	832	22.96%	27.62%
Occupational Therapist	9	43	20.93%	9.09%	4	49	8.16%	4.76%	1	19	5.26%	0.00%
Optometrist	2	66	3.03%	0.00%	1	55	1.82%	7.69%	0	11	0.00%	0.00%
Osteopath	0	11	0.00%	0.00%	1	13	7.69%	0.00%	0	9	0.00%	0.00%
Pharmacist	55	514	10.70%	5.63%	38	490	7.76%	10.64%	21	204	10.29%	9.30%

Physiotherapist	14	134	10.45%	7.14%	6	97	6.19%	4.00%	1	40	2.50%	0.00%
Podiatrist	4	54	7.41%	8.33%	2	37	5.41%	9.09%	3	21	14.29%	25.00%
Psychologist	45	487	9.24%	7.02%	42	432	9.72%	5.80%	19	217	8.76%	13.25%
Not identified	0	21	0.00%	0.00%	0	4	0.00%	0.00%	0	28	0.00%	0.00%
Total	1,145	10,047	11.40%	8.95%	833	8,426	9.89%	9.05%	382	3,798	10.06%	11.97%

Notes **

- Victorian figures in bold highlight where the Victorian proportion is lower than the national proportion.
- The rate of mandatory notifications in Victoria is the number of notifications received in Victoria as a percentage of all notifications received in Victoria.
- Data from New South Wales (NSW) is included for 2013/14 and 2014/15 but not for 2015/16 YTD.

Table 3. Registrants involved in mandatory notifications by jurisdiction – 2011/12 to 2014/15***

	2014/15	2014/15	2013/14	2013/14	2012/13 ¹	2012/13 ¹	2011/12	2011/12
	No. Practitioners ²	Rate / 10,000 practitioners ³	No. Practitioners ²	Rate / 10,000 practitioners ³	No. Practitioners ²	Rate / 10,000 practitioners ³	No. Practitioners ²	Rate / 10,000 practitioners ³
Queensland	14	1.1	301	25.6	208	18.4	229	22.1
New South Wales	298	16.1	220	12.2	222	12.9	170	10.6
Victoria	159	9.7	163	10.2	189	12.3	108	7.5
South Australia	153	29.3	148	28.8	180	36.1	115	24.8
Western Australia	110	16.8	80	12.5	88	14.2	56	10
Tasmania	32	23.0	46	33.9	37	28.1	18	14.4
Australian Capital Territory	19	17.3	10	9.3	18	17.4	23	24
Northern Territory	4	6	8	12	9	14.2	13	23.3
Total Australia	789	12.4	976	15.8	951	16.1	732	13.3

Notes***

1. Regulation of four new professions, Aboriginal and Torres Strait Islander health, Chinese medicine practitioners, medical radiation and occupational therapy practitioners, started on 1 July 2012.
2. Figures present the number of practitioners involved in the mandatory reports received.
3. Practitioners with no principal place of practice are not represented in the calculation of a rate for each state, but are included in the calculation of the total Australia rate.
4. In Queensland, in 2014/15, the consultation forms used for complaints were produced by the Office of the Health Ombudsman and do not indicate whether the complaint made is a voluntary or mandatory complaint.