Case review by the Health Ombudsman

Managing practitioner compliance with conditions of registration

March 2015
Executive summary

In July 2014, I received information about the Queensland Civil and Administrative Tribunal (QCAT) finding of professional misconduct relating to a general practitioner listed on the Australian Health Regulation Practitioner Agency (AHPRA) Register of Practitioners, including the suspension of the practitioner’s registration for a period of two years.

The practitioner had breached his conditions of registration at least 191 times and there was a considerable length of time between the breaches and the subsequent suspension of his registration. As a result, I undertook a case management review of the monitoring of the practitioner’s registration by AHPRA, and the Queensland Board of the Medical Board of Australia (QBMBBA). The purpose of the case review was to assess the quality and timeliness of the monitoring and management of the conditions imposed on the practitioner’s registration by AHPRA and the QBMBBA.

Conclusions

- AHPRA had evidence of breaches of chaperone conditions on more than a dozen occasions.
- If AHPRA had analysed the self-reported data as it became available, AHPRA could have identified the breaches of chaperone conditions and QBMBBA could have taken action within two months (rather than the ten months it took for the first evidence to go before the QBMBBA).
- No sanctions were imposed by the QBMBBA, despite evidence of substantial non-compliance with conditions by the practitioner across a considerable period of time.
- Despite evidence of the practitioner’s non-compliance with the conditions imposed on his registration on at least 191 occasions across a two year period, it required evidence of forgery for the practitioner’s registration to be suspended.

This case review identified a number of opportunities for improvement by AHPRA and the QBMBBA in the system of monitoring of practitioners’ compliance with conditions imposed on their registration.

I have formed the view that the processes followed by AHPRA and the QBMBBA during their monitoring of the practitioner’s compliance with the conditions imposed on his practice, including their decisions, do not meet reasonable expectations for high quality and timely compliance monitoring.

Recommendations

As a result of my investigation, I have made ten key recommendations to enhance AHPRA and the QBMBBA’s monitoring of practitioners’ compliance with conditions imposed on their registration.

1. AHPRA develop and document a clear, detailed compliance monitoring plan for each practitioner that has conditions imposed on their registration. Where practicable, this plan should be progressed in parallel with the development of the conditions to be applied to the practitioner’s registration.

2. AHPRA provide the practitioner with a documented compliance plan at the commencement of monitoring that includes specific information on what will be monitored and how frequently (full list of requirements can be found in Section 6.2 Recommendations of this report).
3. AHPRA work with Medicare to establish processes that provide AHPRA with more timely access to data for compliance monitoring purposes.

4. AHPRA develop and adopt a clear, risk-based compliance monitoring framework that provides a consistent set of principles and directions.

5. AHPRA’s compliance monitoring framework ensures that:
   a. self-reported data is assessed at intervals that allow for the early identification of non-compliance
   b. independent data for verification of the accuracy of self-reported data is obtained and assessed at intervals that allow for early identification of non-compliance.

6. AHPRA review their processes for counting and categorising breaches of conditions to ensure more accurate measurement and reporting of the extent and nature of any non-compliance.

7. AHPRA adopt a clear, transparent pyramid approach to regulating compliance that clearly outlines the hierarchy of responses from least restrictive to most restrictive for particular categories of non-compliance.

8. AHPRA outline in their hierarchy of responses clear sanctions for the late submission and non-submission of self-reported compliance data by practitioners.

9. AHPRA and the QBMA, including its committees, consider changes to their decision making processes to streamline decision making, including establishing timelines.

10. Decisions by AHPRA and the QBMA to take no further action in response to non-compliance with conditions should be accompanied by clear documented reasons for the decision and a plan to manage any outstanding risk associated with continuing non-compliance.

It should be noted that since 2012 (the time at which monitoring of the case on which this review is based commenced), AHPRA has undertaken and continues to undertake considerable action at both the state and national levels to improve their compliance monitoring processes and systems.

**AHPRA’s response to my recommendations**

Consistent with procedural fairness, I provided AHPRA with the opportunity to make a submission about comments in my draft report that could be construed as adverse to them. In my view, AHPRA’s submission demonstrates in-principle support for the ten recommendations made in this report.

AHPRA’s submission outlines a suite of significant initiatives to improve the consistency, timeliness and effectiveness of AHPRA’s compliance monitoring and management capabilities that began after the case on which this report is based came to AHPRA’s attention. I consider that AHPRA (and the QBMA), through these recent state and national initiatives have, in effect, commenced implementation of many of the recommendations in this report.

While there continues to be considerable work to be done by AHPRA, I anticipate that, if fully implemented and sustained, these initiatives will achieve positive outcomes in registrant’s health service delivery and ensure adequate strategies are implemented to manage identified risks in registrant monitoring.
AHPRA stated in their submission an interest in working with me to progress specific actions against a number of the recommendations, in particular the development of a matrix of practitioner actions that constitute non-compliance with the conditions imposed on their registration, with a corresponding hierarchy of responses to the non-compliance, from least restrictive to most restrictive.

I welcome the opportunity for our two agencies to work collaboratively and have accepted AHPRA’s invitation to work with the National Director, Compliance and the Manager, Compliance (Queensland) on these matters.

I will continue to meet with AHPRA on an ongoing basis to exchange information, develop ways to strengthen co-regulatory responsibilities and discuss AHPRA’s progress in implementing the recommendations outlined in this report. I am mindful that AHPRA is a national organisation with responsibilities across all states and territories. As a result, I acknowledge the importance of addressing common regulatory challenges while recognising the issues that are specific to Queensland.

I intend to request quarterly reports from AHPRA on the status of the initiatives currently underway to improve AHPRA’s compliance monitoring and management capabilities, as well as any other steps taken by AHPRA to implement the recommendations. These reports may be supplemented by targeted assurance or audit activities undertaken by my office.

It is my intention to publish an update on progress achieved by AHPRA on the implementation of the recommendations six months after publication of this report.

Leon Atkinson-MacEwen  
**Health Ombudsman**  
24 March 2015
1. Introduction

1.1 Context for this case review

In July 2014, I received information about the Queensland Civil and Administrative Tribunal (QCAT) finding of professional misconduct by a general practitioner listed on the Australian Health Practitioner Regulation Agency (AHPRA) Register of Practitioners, including the suspension of his registration for a period of two years.

The practitioner had breached his conditions of registration at least 191 times and there was a considerable length of time between his breaching of the conditions of his registration and the subsequent suspension of that registration. As a result, I undertook a case management review of the monitoring of the practitioner’s registration by AHPRA, and the Queensland Board of the Medical Board of Australia (QBMBA). The purpose of the case review was to assess the quality and timeliness of the monitoring and management of the conditions imposed on the practitioner’s registration by AHPRA and the QBMBA.

The review was not intended to find individual fault or apportion blame but to identify opportunities for improvement in the processes and systems in place for monitoring and management of the compliance by all practitioners with conditions imposed on their registration.

It should be noted that, since 2012 (the time at which monitoring of the case on which this review is based commenced), AHPRA has undertaken and continues to undertake considerable action at both the state and national levels to improve their compliance monitoring processes and systems.

This report outlines the findings and recommendations arising from the case review, including AHPRA’s response to these recommendations.

1.2 The role of the Australian Health Regulation Practitioner Agency and the boards

The National Registration and Accreditation Scheme (NRAS) was established to protect the public by ensuring that only suitably trained and qualified practitioners are registered to provide healthcare.

Each of the 14 health professions that are part of the NRAS is represented by a national board which is responsible for regulating the profession and setting the standards the profession must meet.

AHPRA supports the national board’s to implement the NRAS.

AHPRA’s responsibilities include:

- publishing national registers of practitioners, to ensure that important information about the registration of individual health practitioners is available to the public
managing the registration and renewal processes for health practitioners and students around Australia, including monitoring compliance with any conditions imposed on a practitioner’s practice of their profession

working with health complaints entities to ensure the appropriate organisation deals with community concerns about individual, registered health practitioners.

1.3 The role of the Health Ombudsman

The Health Ombudsman is an independent statutory officer appointed to protect the health and safety of the public. The Health Ombudsman is supported by the Office of the Health Ombudsman (OHO). The Health Ombudsman’s functions include:

- receiving and investigating complaints about health services and health service providers, including registered and unregistered health practitioners
- deciding what action to take in relation to those complaints
- monitoring the health, conduct and performance functions of AHPRA and the National Boards.

2. Background

2.1 Circumstances leading to conditions imposed on, and suspension of, registration

The practitioner came to the attention of AHPRA in September 2011 as a result of a complaint relating to his failure to observe professional boundaries during a consultation, including allegations of touching a female patient inappropriately and making inappropriate comments.

Immediate conditions

In May 2012, following AHPRA’s investigation into the complaint, the QBOMBA’s Performance and Professional Standards Committee (PPSC) took immediate action and imposed conditions on the practitioner’s registration, including that:

- a chaperone must be present at all times during his appointments with female patients
- he must maintain a patient log/chaperone report for all appointments with female patients
- the patient/chaperone report must be forwarded to the board by the practitioner at the end of every month
- the practitioner must provide a monthly statutory declaration testifying to his compliance with the conditions imposed on his registration (see Appendix A for complete list of conditions).

AHPRA’s monitoring of the practitioner’s compliance with the conditions imposed on his registration commenced in June 2012. A timeline of major monitoring events is presented in Appendix B.

1 A condition aims to restrict a practitioner’s practice in some way to protect the public.
Referral to Queensland Civil and Administrative Tribunal for disciplinary proceedings

In June 2012, after taking immediate action, the QBMBBA also referred the matter to QCAT for disciplinary proceedings.

In September 2013, as a result of AHPRA’s monitoring of the practitioner’s compliance with the conditions imposed on his practice, the QBMBBA amended the grounds of their referral for disciplinary proceedings to QCAT to include, in addition to the original matter, 142 instances of failure to comply with the conditions imposed on his practice.

In November 2013, the QBMBBA again amended the grounds of their referral for disciplinary proceedings to QCAT to include a further 41 instances of failure to comply with the conditions imposed on his practice.

In April 2014, the QBMBBA made a third amendment to the original referral for disciplinary proceedings to QCAT to include attempting to improperly influence persons in respect to the legal proceedings relating to the matter.

Queensland Civil and Administrative Tribunal decision

On 20 May 2014, two years after the imposition of conditions on the practitioner’s registration arising from the QBMBBA’s immediate action, QCAT found professional misconduct was proven and ordered that the practitioner be reprimanded and his registration as a medical practitioner suspended for a period of two years, with conditions imposed on his registration similar to those originally imposed by the QBMBBA, for a period of one year after his resumption of clinical practice.

In addition to the conditions imposed on his registration (should he return to practice), the practitioner was required to:

- undertake further education and counselling about professional responsibilities and professional obligations, including providing the QBMBBA with a written report from the provider of the education and counselling on any remaining areas of concern
- pay costs associated with the investigation and disciplinary proceedings.

2.2 Review objectives

The purpose of my case review was to assess the quality and timeliness of the monitoring and management of the original conditions imposed on the practitioner’s registration by AHPRA and the QBMBBA as a result of the QBMBBA’s immediate action (i.e. prior to the QCAT decision to suspend the practitioner’s registration), specifically the:

- adequacy of the monitoring plan, including timeliness, clarity, appropriateness and comprehensiveness of proposed processes
- timeliness of identification of, and responses to, non-compliance with conditions
- timeliness and appropriateness of responses to instances of identified non-compliance.
As previously stated, the focus of the review was not to find individual fault or apportion blame but to identify opportunities for improvement in the processes and systems in place for monitoring and management of practitioners’ compliance with conditions imposed on their registration.

2.3 Review methods

Under s206(b) of the Health Practitioner Regulation National Law (Queensland), I requested from AHPRA all documents in AHPRA’s power, possession and control relating to the:

- initial complaint and decision to refer the practitioner to QCAT for disciplinary action
- monitoring of the practitioner’s compliance with the conditions placed on his registration
- subsequent decisions and actions taken in response to the practitioner’s breaches of his registration conditions.

My staff conducted a review of the documents between September and December 2014. In total 2,162 pages of documentation were reviewed.

Limitations

The findings outlined in this report are based on a retrospective examination of documents about a single case for which compliance monitoring commenced in 2012.

Documents subject to legal professional privilege were not provided or available for review.

Additionally, as part of this case review, I did not receive or examine any internal policies, procedures or directives governing or guiding AHPRA’s compliance monitoring approach or breach response protocols.

Adverse comment

Consistent with procedural fairness, I provided AHPRA with the opportunity to make a submission about comments in this report that could be construed as adverse to them. The Queensland State Manager, AHPRA provided me with a ten page submission and accompanying attachments (dated 16 February 2015). My staff also met with AHPRA to discuss the contents of their submission and outline the office’s plan for monitoring AHPRA’s implementation of the recommendations. I have subsequently reflected the contents of AHPRA’s submission in this report.
3. Establishing the compliance monitoring system

In order to monitor compliance effectively, regulators should employ a planned, systematic, risk-based approach that can be adjusted as necessary to respond to changing risks.\(^2\)

Whatever the particular monitoring strategy, at a minimum the details of the monitoring strategy (such as type and frequency of monitoring activities) should be communicated to the entity or person subject to monitoring in a timely and clear manner, to ensure they have an adequate understanding of their compliance requirements and are better able to comply.\(^3\)

To this end, I have examined the information provided to determine if the compliance requirements were communicated to the practitioner in a timely and clear manner.

3.1 Findings and comments

Eleven working days after the immediate action conditions were imposed on the practitioner by the QBMBMA, an AHPRA compliance officer was allocated to monitor the practitioner’s compliance with his conditions.

Five working days after the case was allocated to the compliance officer, correspondence was sent to the practitioner confirming the immediate action conditions imposed on his registration.

The first self-reported compliance data from the practitioner was due within six weeks of the imposition of conditions, and less than one month after the practitioner was informed of the commencement of monitoring.

To supplement the self-reported data, AHPRA also obtained authority from the practitioner to access Medicare and insurance fund data relating to his consultations with patients. This authority was provided by the practitioner within five weeks of the imposition of conditions.

I consider that:

- AHPRA contacted the practitioner to inform him of the imposition of conditions on his registration in a timely manner
- AHPRA requested and received authority from the practitioner to access various forms of data to support monitoring of compliance in a timely manner.

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\(^3\) Regulator Performance Framework (2014). Licenced from the Commonwealth of Australia under a Creative Commons Attribution 3.0 Australia Licence.
The initial correspondence from AHPRA to the practitioner post the imposition of the conditions by the QBMBA (see Appendix C) included a list of all the conditions imposed on the practitioner’s registration with some additional instructions, including specifying the provision of:

- a copy of the practitioner’s chaperone log, patient appointment diary and statutory declaration of compliance by the seventh day of every month
- written authority to access Medicare and private health insurance fund information
- a list of the employers and work colleagues the practitioner notified of the conditions imposed on his registration.

The correspondence:

- did not explicitly state a date on which monitoring of compliance with the conditions commenced, only that the conditions were effective as of a specific date.
- did not distinguish between:
  - administrative conditions (for example, all costs and expenses in relation to the terms are to be at the practitioner’s expense)
  - reporting conditions (for example, the practitioner will provide a monthly statutory declaration that they have complied with the board’s requirements and the conditions of their registration)
  - practice conditions (for example, the practitioner must not consult, assess, examine or treat any female person without a chaperone being present at all time)
- did not explicitly identify what would constitute non-compliance with a condition
- did not identify potential responses by AHPRA to non-compliance with the conditions, with the exception that one of the conditions stated that ‘failure to comply with the conditions may be a ground for health, conduct or performance action against the practitioner’.

In subsequent communication with the practitioner, AHPRA used a range of terminology when communicating about deadlines for the provision of the information required as part of the conditions imposed on his regulation, for example identifying a specific date, and using the terms ‘shortly’, ‘as soon as possible’, and ‘within five days of receipt’.

I have formed the view that the expression, design and format of AHPRA’s initial written communication to the practitioner following the imposition of conditions on his registration did not clearly outline a compliance monitoring plan. In my view, AHPRA’s initial written communication:

- had the potential to give rise to misunderstanding by the practitioner of the compliance requirements
- may have, in turn, contributed to instances of non-compliance by the practitioner with the conditions imposed on his registration.
3.2 Recommendations

I recommend that AHPRA:

1. Develop and document a clear, detailed compliance monitoring plan for each practitioner that has conditions imposed on their registration. Where practicable, this plan should be progressed in parallel with the development of the conditions to be applied to the practitioner’s registration.

2. Provide the practitioner with a documented compliance plan at the commencement of monitoring that clearly states:
   a. the conditions imposed on the practitioner’s registration
   b. the methods and data that will be used to monitor and assess compliance with each of the conditions (including the rationale for each)
   c. reporting requirements, including the format, content and specific due dates for any self-reported compliance data, including if these are one-off or ongoing requirements
   d. processes for communication by the practitioner to AHPRA of routine self-reported compliance data and any immediate reporting of significant monitoring issues
   e. the frequency of assessment of compliance
   f. a description of actions that would constitute non-compliance with a condition
   g. a description of responses to non-compliance, including likely or actual penalties for breaches, relative to their severity
   h. that adjustments to the monitoring plan may occur in response to any changes in the level of risk and, if this does occur, it will be communicated to the practitioner.

See AHPRA’s response to the recommendations in Section 6.3 of this report.
4. Obtaining and assessing compliance information to identify breaches of conditions

A range of activities may be used to measure levels of compliance and detect non-compliance, such as on-site inspections, audits and analysis of various other sources of information.

Prioritising and planning of monitoring work ideally should target resources and activities at the highest risks, including matching the type and frequency of monitoring activity to the risk associated with non-compliance. Developing relevant and appropriate measures to assess compliance performance can be difficult, and a mix of self-report and independent information may need to be examined to assess aspects of compliance accurately and at a reasonable cost to both parties.

Appropriate information for monitoring needs to be obtained, and assessed, at an interval frequent enough to allow for early identification of non-compliance. This will allow timely intervention to mitigate any risks that arise from any non-compliance. To this end, I examined the type and frequency of monitoring activities used by AHPRA and the QB MBA to determine if these monitoring activities enabled timely identification of any non-compliance with conditions.

AHPRA’s two main sources of information for assessing the practitioner’s compliance with the conditions imposed on his registration were:

3. Monthly, self-reported information from the practitioner, including a statutory declaration testifying to compliance with the conditions imposed on his registration, a copy of a completed chaperone log and a copy of his patient appointment diary.

4. Data from Medicare on:
   – services provided by the practitioner to female patients for which a Medicare benefit was claimed
   – pharmaceutical items prescribed by the practitioner to female patients.

4.1 Findings and comments

Self-reported data

During the two-year monitoring period, the practitioner failed to provide one or more of the required self-report documents by the due date on at least 30 occasions, commencing with the first self-reported compliance data submitted. In this instance, while the practitioner submitted a copy of his completed chaperone log, he did not provide a copy of his appointment diary and a statutory declaration. The practitioner submitted the outstanding information 17 days after a follow-up request from AHPRA.

With the exception of one month in which the data is unclear, it appears the practitioner provided all required documents for each period; these were, however, frequently submitted after the due date (for example, the practitioner’s self-reporting data due on 7 September 2012 was not received by AHPRA until 15 October 2012).

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Within one week of receipt of the first self-reported compliance data from the practitioner, AHPRA reviewed the information provided and identified that the practitioner had not provided all of the information required to comply with the conditions imposed on his registration. On this initial occasion, the practitioner had not submitted a copy of their appointment diary or a statutory declaration i.e. the practitioner had failed to comply with a ‘reporting’ condition of their registration.

While the practitioner supplied copies of both the practitioner’s completed chaperone log and patient appointment diary monthly, AHPRA did not examine this material until receipt of the patient and prescription reports from Medicare, which was received quarterly.

I consider that the:
- requirement for copies of the practitioner’s patient appointment diary and a self-reported chaperone log were appropriate for providing information to assess compliance with chaperone conditions
- frequency of self-report data requested by AHPRA for monitoring (i.e. monthly) was congruent with the risks to patients associated with the nature of the behavior that led to the imposition of conditions
- review of the completeness of the information provided by the practitioner (i.e. whether all of the required information had been submitted) was conducted in a timely manner.

I also formed the view that the:
- pattern of late submission of the required monitoring information by the practitioner jeopardised the timeliness of identification of non-compliance with conditions
- review and analysis of the practitioner’s self-reported chaperone data against the self-reported patient appointment data did not occur in a timely manner, due to AHPRA waiting for access to Medicare data to confirm the information
- the wait for Medicare data delayed the identification of potential non-compliance and any subsequent response to any risk arising from non-compliance with the conditions imposed on the practitioner.

**Medicare data**

During the two year monitoring period, AHPRA made seven requests to Medicare for data. The first request was made about three months after conditions were imposed on the practitioner’s registration.

On at least one occasion, Medicare did not provide all of the requested data initially, requiring follow-up by AHPRA and a delay in the provision of the monitoring information. The time between AHPRA’s request to Medicare for data and the provision of that data ranged from 28 to 162 days, with an average of 77 days taken for the data to be provided to AHPRA by Medicare.

AHPRA commenced the first verification of the self-reported data provided by the practitioner against the independent Medicare data 167 calendar days after the imposition of conditions. AHPRA took 36 and 46 days respectively to undertake analysis of the information after receiving the second and third batches of Medicare data.

While it was unclear from the information provided what data capture and management systems AHPRA use to collect and analyse monitoring information, nevertheless AHPRA’s analysis of more than 150 calendar days of appointment diaries, chaperone logs and Medicare data for the first verification check was completed within 16 working days.
I consider that:

- selection of Medicare information as a source of independent data for verification of the practitioner’s self-reported information on consultations with patients was appropriate
- cross-referencing by AHPRA of the practitioner’s self-reported data against the Medicare data was undertaken in a timely manner once the Medicare data was received, particularly given the large amount of information that accumulated over the time periods analysed.

I also formed the view that the receipt of Medicare data by AHPRA was not sufficiently timely, with the considerable delays in the provision of Medicare data as well as the provision of large volumes of data requiring review, delaying:

1. the assessment of compliance with the conditions imposed
2. the timely identification of and response to any risk arising from non-compliance.

Other data sources

During the two year monitoring period, AHPRA requested confirmation from the practitioner’s chaperones that they had acted as a chaperone for the practitioner in six specific consultations with patients. These requests for confirmation occurred 23 months after the imposition of conditions and related to consultations with patients that had occurred more than six months prior to the request.

There is no indication in the information provided to me that AHPRA obtained other potentially useful data for monitoring compliance, such as patient records, private health insurance fund data, audit results or interview data from patients or practice staff, or that AHPRA obtained other independent data to verify compliance with all conditions. For example, no data was obtained to verify if the name of the chaperone had been recorded in the patient’s clinical record.

On all but one occasion, AHPRA provided the practitioner with an opportunity to respond to the potential breaches AHPRA had identified through the verification of the self-reported data against the Medicare data. The time between AHPRA’s receipt of the information from Medicare and subsequent request to the practitioner for explanations of potential breaches ranged from 21 days to 98 days. The time between AHPRA’s request to the practitioner for a response to the possible breaches they had identified and the practitioner’s provision of his response to AHPRA ranged from 7 days to 56 days.

I consider that:

- Undertaking verification of the chaperone reports submitted by the practitioner by requesting confirmation from chaperones of the performance of their responsibilities was appropriate but not undertaken in a timely manner. Requests at an earlier stage in monitoring may have expedited the identification of breaches, and any subsequent response by AHPRA and the QBMA.
- Given that the conditions imposed on the practitioner related to professional boundary violations, it would have been appropriate for AHPRA to access additional forms of verification and monitoring data at an earlier stage in the monitoring process e.g. checks with patients, site visits
- While AHPRA acted appropriately in notifying the practitioner of the instances of potential breaches and providing the practitioner with the opportunity to respond, this process was not always undertaken in a timely manner and contributed to delays in progressing AHPRA’s response to the breaches.
Identification of breaches

During the first verification of the self-reported data provided by the practitioner against the independent Medicare data, AHPRA identified 142 occasions across a five month period on which the practitioner may have breached the conditions. Reviews of the self-reported and Medicare data by AHPRA for subsequent time periods identified a further 41 occasions on which non-compliance with a conditions may have occurred across a nine month period and further eight occasions across another three month period.

There was evidence to suggest that the practitioner had breached the conditions by:

- failing to maintain his chaperone log appropriately, including omitting entries (i.e. no record of appointment with female patient in the chaperone log) and pre-signing of entries in the chaperone log by the chaperone
- using a chaperone under the age of 18 years
- not using a chaperone on at least one occasion where he saw a female patient
- failing to use acceptable wording in his statutory declaration of compliance.

Due to the method AHPRA uses for counting and reporting non-compliance with conditions, the actual number of times the practitioner breached the conditions of his registration is not known. AHPRA’s processes identify occasions on which a breach may have occurred (example below), as opposed to identifying the number of breaches against each condition or element of a condition.

Table 1: Example of AHPRA’s method for counting and reporting non-compliance with conditions

<table>
<thead>
<tr>
<th>Date of service provided by Medicare</th>
<th>Patient first name provided by Medicare</th>
<th>Patient surname provided by Medicare</th>
<th>Patient date of birth and gender provided by Medicare</th>
<th>Medicare item number</th>
<th>Issues for clarification</th>
</tr>
</thead>
</table>
| xx/xx/20xx                          | Jane                                   | Smith                               | 30/05/19xx                                          | 23                   | - The appointment diary indicates the patient was seen at 5:15
  - The Medicare report indicates the patient was billed for a level ‘B’ consultation
  - There is no entry recorded in the patient log/ chaperone report |

In this example, AHPRA identified one occasion on which the Medicare report indicated a female patient had been billed by the practitioner but there was no record of that patient in the practitioner’s chaperone log for the date the billing occurred.
Although reported by AHPRA as one occasion of non-compliance, this could reflect a number of breaches. For example, a breach of:

- the condition to have a chaperone at the consultation, or
- the condition to record the chaperone’s name in the patient’s file, or
- each of the six elements required for the chaperone log (i.e. completed at the time, in indelible ink, include data and time of consultation, name of patient, name of chaperone and chaperon’s signature).

This one occasion could have represented one breach or could have represented up to seven breaches.

As previously outlined, AHPRA sent correspondence to individual chaperones seeking verification that they had, indeed, acted as chaperone for specific consultations as per the practitioner’s self-reported data. This process identified a number of further potential breaches, otherwise unable to be identified via analysis of the practitioner’s self-reported data.

I consider that cross-referencing of Medicare data with the self-reported data and verification of chaperone reports with the chaperones were both effective methods to identify potential breaches.

I also formed the view that the manner in which potential breaches were counted and recorded by AHPRA does not accurately quantify or reflect, and may underestimate, the extent and severity of the practitioner’s non-compliance.

### 4.2 Recommendations

I recommend that:

1. AHPRA work with Medicare to establish processes that provide AHPRA with more timely access to data for compliance monitoring purposes.

2. AHPRA develop and adopt a clear, risk-based compliance monitoring framework that provides a consistent set of principles and directions on:
   a. undertaking risk assessments of monitoring cases
   b. the choice of monitoring methods and activities, including the data that will be used to monitor specific conditions by categories of conditions
   c. the frequency and extent of monitoring activity by categories of conditions.

3. AHPRA’s compliance monitoring framework ensures that:
   a. self-reported data is assessed at intervals that allow for the early identification of non-compliance
   b. independent data for verification of the accuracy of self-reported data is obtained and assessed at intervals that allow for early identification of non-compliance.

4. AHPRA review their processes for counting and categorising breaches of conditions to ensure more accurate measurement and reporting of the extent and nature of any non-compliance.

See AHPRA’s response to the recommendations in Section 6.3 of this report.
5. Responding to breaches of conditions

Where non-compliance is identified or suspected, decisions must be made and implemented in a timely manner to manage any ongoing risks that may result from the non-compliance.

Enforcing compliance through the use of a graduated hierarchy of responses to non-compliance allows the regulator to select enforcement strategies that not only allows for the use of more stringent responses in cases of the most serious non-compliance, but also allows regulators to focus most of their activity on encouraging compliance through the use of educative and persuasive approaches.\(^5\)

While such a responsive regulation approach encourages compliance, there remains a need for real and immediate escalation should lower level responses fail.\(^6\) Clear and consistent application of proportionate responses to particular types of breaches can send a strong message of general deterrence to the regulated community.

The office examined the type and timeliness of responses to non-compliance used by AHPRA and the QBMBBA to determine if these responses addressed the non-compliance and risks to the community in an appropriate and timely manner.

5.1 Findings and comments

As noted earlier, it appears AHPRA did not substantially address the practitioner’s repeated failure to submit self-reported compliance data on time and in the appropriate format. While the practitioner failed to submit his reports by the due date on over 30 occasions in the two-year monitoring period (approximately 42% of all required monthly data submissions), it does not appear AHPRA took any action in response, with the exception of reminders and follow-up correspondence on three occasions.

While this may be considered a lower level or less severe breach (reporting condition vs chaperone condition), there is no evidence to suggest AHPRA was monitoring, or recording breaches of this nature, nor that it had a plan to address any continuing failure on the practitioner’s part to provide the self-reported compliance data by the required due date. Absence of compliance information not only limits the ability to assess risk but repeated non-compliance also indicates a lack of regard for the monitoring process by the practitioner.


I formed the view that, in instances where a registration condition requires a practitioner to provide stated information by a specific deadline, it is appropriate to monitor the actual dates the information is received, and address any failure to provide the information by the due date as it arises. Consequences of continued or ongoing failure to provide the information in a timely manner should be communicated clearly to practitioners and their understanding confirmed. Acceptance by AHPRA of ongoing late submission of information from the practitioner may contribute to a perception on the part of practitioners that a lack of compliance with other conditions is acceptable.

As a result of AHPRA’s identification of the practitioner’s failure to comply with the chaperone conditions imposed on his registration, AHPRA escalated their response to the case twice.

In the first instance, in response to the 142 occasions of identified potential breaches, a compliance report was submitted by AHPRA to the QBMBBA’s Performance and Professional Standards Committee. This report was considered by the Committee two months after the receipt of the practitioner’s response to the first AHPRA correspondence identifying potential breaches of chaperone conditions - effectively 10 months after the imposition of the conditions and commencement of AHPRA’s monitoring of the practitioner’s compliance with those conditions.

The compliance report recommended immediate action to impose more stringent conditions on the practitioner’s registration, specifically that the practitioner not provide healthcare to any female patient. The Committee accepted this recommendation and the QBMBBA resolved to take this immediate action.

Figure 1: AHPRA process for responding to non-compliance

1. Data reviewed and breaches identified
2. Request for comment sent to provider
3. Response reviewed and compliance report compiled
4. Recommendation to Performance and Professional Standards Committee
5. Endorsed recommendation to Immediate Action Committee
6. Show Cause Notice to provider
7. Show Cause submission reviewed by Immediate Action Committee
8. Notice of Immediate Action sent to provider
This required that QBMBBA offer the practitioner another opportunity to explain the non-compliance. The practitioner was served with a show cause notice within 10 calendar days of the QBMBBA’s decision and his response to the show cause notice was provided 14 calendar days after the notice was sent.

One month after QBMBBA’s draft decision to impose more stringent conditions, the QBMBBA considered the practitioner’s response to the show cause notice and decided not to impose the more stringent conditions. The QBMBBA’s final decision was that the practitioner should be monitored frequently and be advised that any further breaches would not be tolerated.

As a result of the identification of the 142 occasions on which the practitioner had failed to comply with his conditions, the QBMBBA also determined to amend the grounds of their referral for disciplinary proceedings to QCAT. This first amendment occurred fifteen months after the original referral to QCAT and took almost two months to file with QCAT following the QBMBBA’s decision.

I consider that:

- the recommendation to impose more stringent conditions on the practitioner’s registration by AHPRA and the QBMBBA Performance and Professional Standards Committee’s original endorsement of that recommendation was appropriate
- providing the practitioner with a further opportunity to respond to the identified non-compliance, while consistent with natural justice principles and necessary, had the effect of delaying the final decision of the committee with regard to what action would be taken in response to the non-compliance.

I also formed the view that:

- given the extent of non-compliance (142 occasions), deliberation by the Performance and Professional Standards Committee on the AHPRA recommendation to impose more stringent conditions on the practitioner was not timely
- it was not clear on what grounds QBMBBA decided not to proceed with the decision to impose more stringent conditions on the practitioner’s registration after receiving the practitioner’s submission
- the QBMBBA, by deciding not to proceed with the decision to impose more stringent conditions, did not respond appropriately to the extent of non-compliance and may not have addressed an ongoing risk to the public.

On the second occasion, when AHPRA escalated the case in response to the identification of a further 41 potential breaches, there is no information to suggest that the QBMBBA considered imposing more stringent conditions or taking any other immediate action (such as suspending the practitioner’s registration), despite their previous communication to the practitioner that further breaches would not be tolerated.

Despite taking no additional action in relation to the practitioner, the QBMBBA again amended the grounds of their referral for disciplinary proceedings to QCAT on the basis of non-compliance. This second amendment occurred two months after the first amendment and took four weeks to file with QCAT.
Other than requesting a response from the practitioner, there is no evidence that AHPRA took any action in relation to the eight additional breaches of the practitioner’s chaperone conditions identified in the third review of the practitioner’s compliance.

The QBMBBA did, however, amend the grounds for referral to QCAT on a third occasion, in this instance as a result of the practitioner’s alleged forgery of letters that attempted improperly to influence persons involved in the QCAT proceedings and personal injury proceedings commenced by the practitioner. The QBMBBA considered the alleged forgery at an out-of-session meeting two months after AHPRA received the allegedly forged letters, and the amendment of the grounds for referral was filed with QCAT within one week.

I formed the view that:
- the decision by AHPRA not to escalate the case to recommend imposing more stringent conditions or taking any other immediate action (such as suspending the practitioner’s registration) in response to the second and third instances of breaches, despite previous communication to the practitioner that no further breaches would be tolerated, was not appropriate and was inconsistent with their earlier communication to practitioner.
- filing of amendments with QCAT, to the grounds for AHPRA’s referral for disciplinary proceedings, was not always timely.

5.2 Recommendations

I recommend that:

1. AHPRA adopt a clear transparent pyramid approach to regulating compliance that clearly outlines the hierarchy of responses from least restrictive to most restrictive for particular categories of non-compliance.
2. AHPRA outline in their hierarchy of responses clear sanctions for the late submission and non-submission of self-reported compliance data by practitioners.
3. AHPRA and the QBMBBA, including its committees, consider changes to their decision making processes to streamline decision making, including establishing timelines.
4. Decisions by AHPRA and the QBMBBA to take no further action in response to non-compliance with conditions should be accompanied by clear documented reasons for the decision and a plan to manage any outstanding risk associated with continuing non-compliance.

See AHPRA’s response to the recommendations in section 6.3 of this report.
6. Conclusion

6.1 Health Ombudsman’s comments

In summary, based on the information provided to me by AHPRA, and examined at the time of this case review, it would appear that:

- evidence of breaches of chaperone conditions on more than a dozen occasions were available to AHPRA with the submission of the practitioner’s first self-reported data i.e. within six weeks of conditions being imposed
- if AHPRA had analysed the self-reported data as it became available, AHPRA could have identified the breaches of chaperone conditions and QB MBA could have taken action within two months (rather than the ten months it took for the first evidence to go before the QB MBA)
- no sanctions were imposed by the QB MBA despite evidence of substantial non-compliance with conditions by the practitioner across a considerable period of time
- despite evidence of the practitioner’s non-compliance with the conditions imposed on his registration on at least 191 occasions across a two year period, it required evidence of forgery for the practitioner’s registration to be suspended.

This case review has identified a number of opportunities for improvement in the monitoring of practitioners’ compliance with conditions imposed on their registration by AHPRA and the QB MBA.

I have formed the view that the processes followed by AHPRA and the QB MBA during their monitoring of the practitioner’s compliance with the conditions imposed on his practice, including their decisions, do not meet reasonable expectations for high quality and timely compliance monitoring.

It is difficult to reconcile the progression of this case with the obligation on AHPRA and the national board to protect the public by taking timely and necessary action.

In response, I have made ten key recommendations to enhance AHPRA and the QB MBA’s monitoring of practitioners’ compliance with conditions imposed on their registration.

6.2 Recommendations

I recommend that:

1. AHPRA develop and document a clear, detailed compliance monitoring plan for each practitioner that has conditions imposed on their registration. Where practicable, this plan should be progressed in parallel with the development of the conditions to be applied to the practitioner’s registration.

2. AHPRA provide the practitioner with a documented compliance plan at the commencement of monitoring that clearly states:
   a. the conditions imposed on the practitioner’s registration
   b. the methods and data that will be used to monitor and assess compliance with each of the conditions (including the rationale for each)
c. reporting requirements, including the format, content and specific due dates for any self-reported compliance data, including if these are one-off or ongoing requirements

d. processes for communication by the practitioner to AHPRA of routine self-reported compliance data and any immediate reporting of significant monitoring issues

e. the frequency of assessment of compliance

f. a description of actions that would constitute non-compliance with a condition

g. a description of responses to non-compliance, including likely or actual penalties for breaches, relative to their severity

h. that adjustments to the monitoring plan may occur in response to any changes in the level of risk and, if this does occur, it will be communicated to the practitioner.

3. AHPRA work with Medicare to establish processes that provide AHPRA with more timely access to data for compliance monitoring purposes.

4. AHPRA develop and adopt a clear, risk-based compliance monitoring framework that provides a consistent set of principles and directions on:
   a. undertaking risk assessments of monitoring cases
   b. the choice of monitoring methods and activities, including the data that will be used to monitor specific conditions by categories of conditions
   c. the frequency and extent of monitoring activity by categories of conditions.

5. AHPRA’s compliance monitoring framework ensures that:
   a. self-reported data is assessed at intervals that allow for the early identification of non-compliance
   b. independent data for verification of the accuracy of self-reported data is obtained and assessed at intervals that allow for early identification of non-compliance.

6. AHPRA review their processes for counting and categorising breaches of conditions to ensure more accurate measurement and reporting of the extent and nature of any non-compliance.

7. AHPRA adopt a clear, transparent pyramid approach to regulating compliance that clearly outlines the hierarchy of responses from least restrictive to most restrictive for particular categories of non-compliance.

8. AHPRA outline in their hierarchy of responses clear sanctions for the late submission and non-submission of self-reported compliance data by practitioners.

9. AHPRA and the QBMB, including its committees, consider changes to their decision making processes to streamline decision making, including establishing timelines.

10. Decisions by AHPRA and the QBMB to take no further action in response to non-compliance with conditions should be accompanied by clear documented reasons for the decision and a plan to manage any outstanding risk associated with continuing non-compliance.
6.3 Summary of Australian Health Regulation Practitioner Agency’s response to the recommendations

Recommendation 1: AHPRA develop and document a clear, detailed compliance monitoring plan for each practitioner that has conditions imposed on their registration. Where practicable, this plan should be progressed in parallel with the development of the conditions to be applied to the practitioner’s registration.

AHPRA’s response stated:

- ‘In November 2013 AHPRA deployed the monitoring module within Pivotal (registrant management software) …. That deployment included the publication of the Monitoring and Compliance Procedure Manual (the manual) ….. The manual deals with all stages in the monitoring and compliance process including the development and maintenance of the monitoring plan ….’

- ‘Since introduction of the module and the manual, all practitioners with registration restrictions (conditions and undertakings) in Queensland have had a monitoring plan developed and maintained. The monitoring plan serves multiple purposes, including:’
  - defining the activities that are to be performed to monitor each restriction
  - establishing when these activities will occur
  - outlining what information is expected to be received and
  - communicating to the registrant and other involved parties their responsibilities with respect to the restrictions.’

- ‘The aim of the plan is to ensure that each restriction is appropriately monitored and that the expectations for specific events such as reports are set and understood by all parties.’

- ‘Compliance staff are required to be consulted to inform the development of restrictions being recommended to decision makers to ensure the form of the restrictions enables effective monitoring. This cannot always be achieved given the nature of independence in decision making by Committees, Boards, Panels and Tribunals. To address this issue AHPRA has under development a national restrictions library which will be available for use in the development of recommendations and by decision makers in determining the form of a restriction. The library will supplement and replace the state based bank of conditions that exist in Queensland. In this regard the library will contain restrictions that have been developed and tested and are fit for purpose …, clearly defined … and able to be monitored …’
Recommendation 2: AHPRA provide the practitioner with a documented compliance plan at the commencement of monitoring that clearly states:

- the conditions imposed on the practitioner’s registration
- the methods and data that will be used to monitor and assess compliance with each of the conditions (including the rationale for each)
- reporting requirements, including the format, content and specific due dates for any self-reported compliance data, including if these are one-off or ongoing requirements
- processes for communication by the practitioner to AHPRA of routine self-reported compliance data and any immediate reporting of significant monitoring issues
- the frequency of assessment of compliance
- a description of actions that would constitute non-compliance with a condition
- a description of responses to non-compliance, including likely or actual penalties for breaches, relative to their severity
- that adjustments to the monitoring plan may occur in response to any changes in the level of risk and, if this does occur, it will be communicated to the practitioner.

AHPRA’s response stated:

- Practitioners are as a matter of course sent an initial monitoring letter. This was reviewed in August 2014 and now is a far more structured document that articulates the practitioner requirements separated by restriction category and includes a copy of the schedule of restrictions. Information sheets are also sent relating to high risk restriction categories that include information in relation to what may ensue if a breach of restrictions or a failure to provide monitoring information occurs. This includes the restriction categories of chaperonage, supervision and restrictions not to practice. These information sheets …were implemented in August 2014 and are sent with the notice of decision.’

AHPRA also undertook in their response to:

- ‘... review the initial monitoring correspondence to implement further changes including:
  - the methods and data that will be used to monitor and assess compliance with each of the restrictions (including the rationale for each)
  - a description of the actions that would constitute non-compliance with a restriction based on the nationally agreed critical compliance events … and

more detail about the potential outcomes for a breach of a core restriction vs an operating
Recommendation 3: AHPRA work with Medicare to establish processes that provide AHPRA with more timely access to data for compliance monitoring purposes.

AHPRA’s response stated:

- ‘… in June 2014 the CEO formally requested assistance from the Department of Human Services (DHS) for access to Medicare data … Two lines of action have been progressed by DHS and AHPRA following this formal request, as follows:
  - development of a formal data exchange agreement has been progressed and
  - negotiations for the classes of data to be accessed, the timeframes for responses and an escalation process were initiated for both compliance and investigation purposes.’

With respect to the formal data exchange agreement, AHPRA advised me that the agreement is in the form of a Deed with the DHS. This deed covers matters such as specified timeframes for the provision of data sets by the DHS to AHPRA, and a requirement that if the requested data is not able to be provided by DHS to AHPRA within the expected timeframes, that AHPRA be promptly notified, including proposed alternative delivery date.

In their response AHPRA also advised me that, through the governance group established under the Deed, AHPRA is negotiating the provision of data on the basis of the following priorities:

- **Critical** – Where there is an immediate threat, contact can be made by phone to the Information Release contact officer by the AHPRA Officer to request an immediate response
- **High** – Response will be provided by Information Release within five working hours
- **Priority** – Response will be provided by Information Release within 10 working days
- **Routine** – Response will be provided by Information Release within 30 working days with the exception of requests for PBS scripts and older than five year data which may take longer.

AHPRA’s response also stated:

- ‘Given the time it has taken to gain clear agreement from DHS, use of an alternate data source is being investigated involving accessing Medicare claims data direct from medical practices. If confirmed as viable, this method of data collection will be introduced as a standard compliance tool for medical practitioners as soon as possible. Queensland has initiated a local policy for monitoring chaperone restrictions which now require the provision of practice billing data and includes an early reconciliation of this data against the chaperone log. On receipt of the Medicare data a reconciliation of this with the chaperone log is also completed.’
Recommendation 4: AHPRA develop and adopt a clear, risk-based compliance monitoring framework that provides a consistent set of principles and directions on:

a. undertaking risk assessments of monitoring cases
b. the choice of monitoring methods and activities, including the data that will be used to monitor specific conditions by categories of conditions
c. the frequency and extent of monitoring activity by categories of conditions.

AHPRA’s response stated:

- ‘The National Director, Compliance is responsible to progress policy, procedure, innovation and effective reporting in this functional area of regulation. An overarching strategy for the compliance function strongly anchored in risk management has been developed and endorsed. This strategy is as follows:

  - The role of AHPRA’s compliance function is, on behalf of the National Boards, to monitor health practitioners and students with imposed registration restrictions or where their registration has been suspended or cancelled. This role is consistent with the requirements of the National Law (links to Regulatory Principle 1).

  - The purpose of monitoring health practitioners and students is to manage risk and protect the public by regularly confirming they are complying (or identifying non-compliance) with the restrictions which are designed to ensure they continue to provide health services safely and of an appropriate quality. In the case of suspensions and cancellations it is to confirm that the health practitioner has ceased practising the profession or that the student has ceased clinical practice (links to Regulatory Principles 2&3).

  - The compliance function is not therapeutic, rehabilitative or pastoral in nature. Compliance staff support health practitioners and students in complying with registration restrictions, however it is ultimately the individual health practitioner’s or student’s responsibility to ensure they comply.

  - On identifying potential or actual non-compliance compliance staff will assess the risk that this presents and respond in ways that are proportionate to manage the risk and protect the public, including any required escalation to a National Board (links to Regulatory Principles 5&6).’

AHPRA’s response also stated that AHPRA ‘has an extensive policy development agenda by category of restrictions. … Each policy developed will include:

- the monitoring methods and activities to be undertaken, including the data that will be used to monitor specific restrictions and

- the frequency and extent of monitoring activities to be undertaken.’

AHPRA also stated in their response:

- ‘[they are] well advanced in the development of Compliance Key Performance Indicators (KPIs) and a risk based reporting framework. To ensure that Compliance KPIs have an emphasis on risk management as well as on measures of efficiency and timeliness the KPIs have been closely integrated with risk based monthly reporting.'
Four key KPIs have been endorsed nationally as the key measures of performance.

Risk based reporting is anchored in the concept of 'critical compliance events' which if occurring may result in the public being exposed to the risk that the registration restrictions were designed to prevent. Introducing this concept is necessary to ensure nuanced reporting that is not overwhelmed by the 'noise' of low level or technical non-compliance.

In their response, AHPRA explained that there were several steps in risk based reporting to enable values to be applied and extracted for reporting purposes. AHPRA provided details of these steps in an attachment and outlined the monthly reports being proposed for development. Their response went on to say:

‘The reports for deployment of the risk based reporting framework are currently being tested with the objective of implementation from April 2015. Implementation will be supported by a national training program for compliance staff. In the interim, Queensland has implemented local policies on high risk restriction categories including chaperone restrictions that provide a minimum expectation of monitoring officers and the expected activity if there is a suspected breach. In addition Queensland has implemented compliance status reporting from July 2014 for medical practitioners and from October 2014 for nurses, midwives, dentists and psychologists.’

Recommendation 5: AHPRA’s compliance monitoring framework ensures that:

a. self-reported data is assessed at intervals that allow for the early identification of non-compliance

b. independent data for verification of the accuracy of self-reported data is obtained and assessed at intervals that allow for early identification of non-compliance.

AHPRA’s response stated:

The KPI and risk based reporting framework will require compliance status reviews to be undertaken at least monthly for conduct, health and performance restrictions and quarterly for restrictions related to suitability/eligibility … Each compliance policy developed will identify the independent data sources to be utilised in monitoring the restriction and assessment will be required consistent with KPI requirements … in the interim, Queensland has implemented local policies on high risk restriction categories including chaperone restrictions that provide a minimum expectation of monitoring officers and the expected activity if there is a suspected breach.

In addition, Queensland has implemented compliance status updates reporting from July 2014 for medical practitioners and from October 2014 for nurses, midwives, dentists and psychologists to ensure more timely reporting of concerns to delegates of the National Boards.’
Recommendation 6: AHPRA review their processes for counting and categorising breaches of conditions to ensure more accurate measurement and reporting of the extent and nature of any non-compliance.

AHPRA’s response stated:

- ‘AHPRA has an ongoing program of work in this area. In Queensland (since July 2014 for medicine and October 2014 for other professions) each of the local decision makers receives compliance status updates at each of their meetings. These updates provide an overall picture of compliance and monitoring cases, listed as either non-compliant, suspected non-compliant, pending compliance (where information is pending but still within the required timeframe) and compliant. These updates enable at-a-glance reporting of the overall compliance picture and measurement of the current status of the compliance program in Queensland.

- In September 2013, AHPRA implemented templates for agenda papers and compliance audit table, which assists compliance officers to document occasions and categories of potential breaches to then report to Boards and Committees. The compliance audit table lists all of the practitioners with restrictions and associated analysis and commentary on the practitioner’s compliance and/or non-compliance.

- As part of the implementation of this template, the compliance officer is also required to conduct regular reviews of each practitioner’s file including upon each occasion of receipt of evidence (or non-receipt of evidence). These templates have assisted in reporting to Boards and their delegates on the extent and nature of any non-compliance.

- Clearly delineating critical compliance events into technical and substantive breaches will assist in more accurate measurement and reporting of the extent and nature of any non-compliance. This work aligns within Recommendation 7 below around adopting a hierarchy approach for categories of non-compliance …’

Recommendation 7: AHPRA adopt a clear, transparent pyramid approach to regulating compliance that clearly outlines the hierarchy of responses from least restrictive to most restrictive for particular categories of non-compliance.

AHPRA stated in their response to this recommendation an interest in working with my office to explore the development of such a pyramid as the basis of the matrix discussed in Recommendations 2(f) and (g).

AHPRA’s response to this recommendation also stated:

- ‘In the interim, since the implementation of the Health Ombudsman Act, AHPRA and the Boards routinely advise your office of breaches of conditions that would meet the threshold for professional misconduct or where another ground for suspension or cancellation exists …’.

Recommendation 8: AHPRA outline in their hierarchy of responses clear sanctions for the late submission and non-submission of self-reported compliance data by practitioners.

AHPRA’s referred to their previous responses to recommendations 2 and 7 in response to this recommendation.
Recommendation 9: AHPRA and the QBMBA, including its committees, consider changes to their decision making processes to streamline decision making, including establishing timelines.

AHPRA’s response to this recommendation made reference to their earlier comment in recommendation 5, namely that:

- ‘Queensland has implemented compliance status updates reporting from July 2014 for medical practitioners and from October 2014 for nurses, midwives, dentists and psychologists to ensure timelier reporting of concerns to delegates of the National Boards.’

AHPRA further advised:

- ‘[They] continue to work closely with the QBMBA to refine those reports and to ensure more timely reporting of concerns to delegates. Significant changes have been made to the structure of the committees of the QBMBA also. Monitoring and compliance reporting has traditionally been dealt with only by the Board. On the basis of this recommendation, I propose to work with the Notification Committees of the QBMBA to ensure they have appropriate delegations to take on primary responsibility for dealing with concerns about monitoring and compliance activities. AHPRA is also reviewing the structure of our compliance team in Queensland to ensure that we have the most appropriate mix of officers and a more streamlined escalation process for high-risk matters or concerns about non-compliance.’

Recommendation 10: Decisions by AHPRA and the QBMBA to take no further action in response to non-compliance with conditions should be accompanied by clear documented reasons for the decision and a plan to manage any outstanding risk associated with continuing non-compliance.

AHPRA’s response stated:

- ‘Noted. AHPRA and the Boards in Queensland have embarked on significant activity to improve the detailing of decisions and actions over the past 18 months … which has had a significant effect in this area.’

6.4 Health Ombudsman’s final comments

I have formed the view that AHPRA’s submission demonstrates in-principle support for the ten recommendations made in this report.

As stated previously, it should be noted that since 2012 (the time at which monitoring of the case on which this review is based commenced) AHPRA has undertaken and continues to undertake considerable action at both the state and national levels to improve their compliance monitoring processes and systems.

AHPRA’s submission outlines a suite of significant initiatives to improve the consistency, timeliness and effectiveness of AHPRA’s compliance monitoring and management capabilities that began after the case on which this report is based came to AHPRA’s attention. I consider that AHPRA (and the QBMBA), through these recent state and national initiatives, has in effect commenced implementation of many of the recommendations in this report. While there continues to be considerable work to be done by AHPRA, I anticipate that, if fully implemented and sustained, these initiatives will achieve positive outcomes in registrant’s health service delivery and ensure adequate strategies are implemented to manage identified risks in registrant monitoring.
AHPRA stated in their submission an interest in working with me to progress specific actions against a number of the recommendations, in particular the development of a matrix of practitioner actions that constitute non-compliance with the conditions imposed on their registration, with a corresponding hierarchy of responses to the non-compliance, from least restrictive to most restrictive.

I welcome the opportunity for our two agencies to work collaboratively and have accepted AHPRA’s invitation to work with the National Director, Compliance and the Manager, Compliance (Qld) on these matters.

I will continue to meet with AHPRA on an ongoing basis to exchange information, develop ways to strengthen co-regulatory responsibilities and discuss AHPRA’s progress in implementing the recommendations outlined in this report. I am mindful that AHPRA is a national organisation with responsibilities across all states and territories. As a result, I acknowledge the importance of addressing common regulatory challenges while recognising the issues that are specific to Queensland.

Ongoing monitoring of the implementation of the recommendations

I intend to request quarterly reports from AHPRA on the status of the initiatives currently underway to improve AHPRA’s compliance monitoring and management capabilities, as well as any other steps taken by AHPRA to implement the recommendations. These reports may be supplemented by targeted assurance or audit activities undertaken by my office.

It is my intention to publish an update on progress achieved by AHPRA on the implementation of the recommendations six months after publication of this report.
## Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full name</th>
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<tbody>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>HQCC</td>
<td>Health Quality and Complaints Commission</td>
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<tr>
<td>IAC</td>
<td>Immediate Action Committee</td>
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<tr>
<td>MBA</td>
<td>Medical Board of Australia</td>
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<tr>
<td>OHO</td>
<td>Office of the Health Ombudsman</td>
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<tr>
<td>QBMBAA</td>
<td>Queensland Board of the Medical Board of Australia</td>
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<tr>
<td>QCAT</td>
<td>Queensland Civil and Administrative Tribunal</td>
</tr>
</tbody>
</table>
Appendix A – Immediate action registration conditions imposed on practitioner May 2012

1. The practitioner must not consult, assess, examine or treat any female person without a chaperone being present at all times, who is at least 18 years of age and meets at least one of the following criteria:
   a. Either a person that has accompanied the patient to the consultation.
   b. Any other individual with the consent of the patient including a member of staff.
   c. An adult guardian.

2. At the time of the consultation, assessment, examination or treatment of any female person the practitioner must record the full name of the chaperone in the patient's clinical record.

3. The practitioner must maintain a patient log/chaperone report to be completed in indelible ink at the time of the consultation, assessment, examination or treatment of any female person, which must contain:
   a. The date and time of the consultation;
   b. The name of the patient;
   c. The full name of the chaperone;
   d. The chaperone's signature confirming they were present during the entire doctor - patient interaction.

4. The patient/chaperone report must be forwarded to the Board by the practitioner at the end of every month.

5. The practitioner authorises representatives of the Board to inspect, take or copy patient clinical records, log books, appointment diaries and/or patient log/chaperone report, at such time or times as the Board shall determine, for the purpose of monitoring compliance with the conditions imposed on the practitioner's registration.

6. The practitioner will provide a monthly statutory declaration that they have complied with the Board's requirements and the conditions of their registration.

7. The practitioner must provide the Board with all clinical records of patients nominated by the Board, at such time or times as the Board shall determine, for the purpose of monitoring compliance with the conditions imposed of in writing by the Board.

8. The practitioner must authorise insurance funds and Medicare Australia to provide information to the Board about his treatment of patients for the purpose of monitoring conditions imposed on the practitioner's registration.

9. The practitioner must notify in writing, any current and any future employers, CEO (or equivalent) of any health care facility where he works, and colleagues he works with of the conditions imposed on the practitioner 's registration within seven days of their imposition (or prior to commencing any future employment).
10. The practitioner must provide the Board with a list of name of employers, CEO’s (or equivalent), and persons to whom he has notified of the conditions imposed on his registration.

11. The practitioner must notify the Board of any and all changes in their practice, such notification to include the name and address of any employer, partner or person for whom or with whom the practitioner is working, and the address from which the practitioner is practising.

12. The practitioner authorises representatives of the Board to contact and exchange information with each employer and hospital or facility where he works, at such time or times as the Board shall determine, for the purpose of monitoring compliance with the conditions imposed on the practitioner’s registration.

13. The existence and the details of these conditions will be entered in the Board’s National Public Register in accordance with section 225(k) of the Health Practitioner Regulation National Law Act 2009.

14. All cost and expenses in relation to the terms set out in these conditions are to be at the practitioner’s expense.

15. The practitioner will provide to the Board any documentary evidence required by these conditions, within the timeframes specified.

16. Failure to comply with these conditions may be a ground for health, conduct or performance action against the practitioner.

17. The conditions will remain in force until the earlier of the following occurs:
   a. The decision is set aside on appeal; or
   b. The conditions are removed by the Board.
Appendix B – Monitoring timeline May 2012 to May 2014

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare data received</td>
<td>May 2012</td>
</tr>
<tr>
<td>142 potential breaches identified</td>
<td></td>
</tr>
<tr>
<td>Correspondence to practitioner seeking comment on potential breaches</td>
<td></td>
</tr>
<tr>
<td>NFA notice to practitioner</td>
<td>Mar 2013</td>
</tr>
<tr>
<td>Request for Medicare data</td>
<td></td>
</tr>
<tr>
<td>Compliance report considered at PPSC</td>
<td></td>
</tr>
<tr>
<td>PPSC recommended IAC take immediate action</td>
<td></td>
</tr>
<tr>
<td>IAC resolved to refer breaches to QCAT and impose further conditions</td>
<td></td>
</tr>
<tr>
<td>Submission from practitioner in response to potential breaches</td>
<td>Mar 2013</td>
</tr>
<tr>
<td>Conditions imposed</td>
<td></td>
</tr>
<tr>
<td>First request for Medicare data</td>
<td>Mar 2013</td>
</tr>
<tr>
<td>Monitoring and compliance officer assigned</td>
<td></td>
</tr>
<tr>
<td>Correspondence to practitioner outlining reporting requirements</td>
<td></td>
</tr>
<tr>
<td>Show cause notice to practitioner</td>
<td>Apr 2013</td>
</tr>
<tr>
<td>Show cause response from practitioner</td>
<td></td>
</tr>
<tr>
<td>IAC final decision to take no further action (s173(2)(A))</td>
<td>Nov 2013</td>
</tr>
<tr>
<td>Compliance report prepared</td>
<td>Nov 2013</td>
</tr>
<tr>
<td>Request for Medicare data</td>
<td>Nov 2013</td>
</tr>
<tr>
<td>Medicare data received</td>
<td>Nov 2013</td>
</tr>
<tr>
<td>Additional 8 potential breaches identified</td>
<td>Nov 2013</td>
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<tr>
<td>Request for Medicare data</td>
<td>Apr 2014</td>
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<tr>
<td>Medicare data received</td>
<td>Apr 2014</td>
</tr>
<tr>
<td>Additional 41 potential breaches identified</td>
<td>Apr 2014</td>
</tr>
<tr>
<td>Submission from practitioner in response to potential breaches</td>
<td>Mar 2014</td>
</tr>
<tr>
<td>Practitioner sent forged letters to board and notifier’s lawyers</td>
<td>Mar 2014</td>
</tr>
<tr>
<td>QCAT hearing – registration suspended for two years</td>
<td>Mar 2014</td>
</tr>
<tr>
<td>Correspondence to practitioner seeking comment on further potential breach</td>
<td>May 2014</td>
</tr>
<tr>
<td>Submissions received from chaperoines</td>
<td></td>
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</tbody>
</table>

Case review by the Health Ombudsman
Managing practitioner compliance with conditions of registration
Appendix C – Initial Australian Health Practitioner Regulation Agency correspondence to practitioner

Re: Conditions of registration

I am an Inspector appointed under section 239 and an Investigator appointed under section 163 of the Health Practitioner Regulation National Law Act 2009 (the National Law) to carry out inspections and/or investigations as directed by the ten National Boards, including the Medical Board of Australia (the Board).

I have been directed to monitor your compliance with the following conditions imposed on your registration as a medical practitioner in Australia:

1. The practitioner must not consult, assess, examine or treat any female person without a chaperone being present at all times, who is at least 18 years of age and meets at least one of the following criteria:
   a. Either a person that has accompanied the patient to the consultation; or
   b. Any other individual with the consent of the patient including a member of staff; or
   c. An adult guardian.

2. At the time of the consultation, assessment, examination or treatment of any female person the practitioner must record the full name of the chaperone in the patient’s clinical record.

3. The practitioner must maintain a patient log/chaperone report to be completed in indelible ink at the time of the consultation, assessment, examination or treatment of any female person, which must contain:
   a. The date and time of the consultation;
   b. The name of the patient;
   c. The full name of the chaperone;
   d. The chaperone’s signature confirming they were present during the entire doctor-patient interaction.

4. The patient/chaperone report must be forwarded to the Board by the practitioner at the end of every month.

5. The practitioner authorises representatives of the Board to inspect, take or copy patient clinical records, log books, appointment diaries and/or patient log/chaperone report, at such time or times as the Board shall determine, for the purpose of monitoring compliance with the conditions imposed on the practitioner’s registration.
6. The practitioner will provide a monthly statutory declaration that they have complied with the Board’s requirements and the conditions of their registration.

7. The practitioner must provide the Board with all clinical records of patients nominated by the Board, at such time or times as the Board shall determine, for the purpose of monitoring compliance with the conditions imposed or in writing by the Board.

8. The practitioner must authorise insurance funds and Medicare Australia to provide information to the Board about his treatment of patients for the purpose of monitoring conditions imposed on the practitioner’s registration.

9. The practitioner must notify in writing, any current and any future employers, CEO (or equivalent) of any health care facility where he works, and colleagues he works with of the conditions imposed on the practitioner’s registration within 7 days of their imposition (or prior to commencing any future employment).

10. The practitioner must provide the Board with a list of name of employers, CEO’s (or equivalent), and persons to whom he has notified of the conditions imposed on his registration.

11. The practitioner must notify the Board of any and all changes in their practice, such notification to include the name and address of any employer, partner or person for whom or with whom the practitioner is working, and the address from which the practitioner is practising.

12. The practitioner authorises representatives of the Board to contact and exchange information with each employer and hospital or facility where he works, at such time or times as the Board shall determine, for the purpose of monitoring compliance with the conditions imposed on the practitioner’s registration.

13. The existence and the details of these Conditions will be entered in the Board’s National Public Register in accordance with section 225(9) of the Health Practitioner Regulation National Law Act 2009.

14. All cost and expenses in relation to the terms set out in these Conditions are to be at the practitioner’s expense.

15. The practitioner will provide to the Board any documentary evidence required by these Conditions, within the timeframes specified.

16. Failure to comply with these Conditions may be a ground for health, conduct or performance action against the practitioner.

17. The conditions will remain in force until the earlier of the following occurs:
   a. The decision is set aside on appeal; or
   b. The Conditions are removed by the Board.

I particularly note that you must not consult, assess, examine or treat any female person without a chaperone being present at all times and that clause 1 of your conditions details who that chaperone can be.

In accordance with clause 2 of your conditions, you must record the full name of the chaperone in the patient’s clinical record.
Clause 3 of your conditions requires you to maintain a patient log or chaperone report that must be completed in indelible ink at the time you consult, assess, examine or treat any female person. What needs to be recorded in that log / report is also specified in clause 3 of your conditions. In that regard, I have included, with this correspondence, a log / report template that you may wish to use.

As per clause 4 of your conditions, you must forward your log / report to me at the end of every month. Your log / report should reach me by no later than the 7th of every month.

In accordance with clauses 5 and 6 of your conditions, could you please forward to me, also by the 7th of every month, a copy of your appointment diary for the previous month along with your monthly statutory declaration.

In accordance with clause 8 of your conditions, could you please forward to me by 26 June 2012, your written authority to the Board authorizing insurance funds and Medicare Australia to provide information to the Board about your treatment of patients.

Clause 9 of your conditions requires you to notify in writing, any current and future employers, CEO (or equivalent) of any health care facility where you work; and colleagues you work with of the conditions imposed on your registration. For your assistance, I have included, with this correspondence, a template form for your use when notifying those relevant people. In accordance with clause 10 of your conditions, you must provide a list of the names of those people you notify of the conditions imposed on your registration. In that regard, I look forward to receiving your detailed list by 26 June 2012.

The Board expects you to be proactive in managing your Conditions. It is not my role to remind you of your obligations. However, should you require further information regarding these matters, please do not hesitate to contact me either by telephone on [number] or by email at [email address].

Yours sincerely,

[Signature]

Enclauses:
1. Log / Report Template
2. Information and Acknowledgement Form Template

[Logo]
Australian Health Practitioner Regulation Agency
G.P.O. Box 9958 | Brisbane QLD 4001 | www.aphra.gov.au