Public consultation on draft revised registration standards and relevant guidelines

19 May 2014

Responses to consultation questions

Please provide your feedback as a Word document (not PDF) by email to podiatryconsultation@ahpra.gov.au by close of business on 14 July 2014.

Stakeholder Details

Organisation name
Contact information *(please include contact person's name and email address)*
Kerry May

Your responses to the consultation questions

Registration standard: Recency of practice (ROP) *Please provide your responses to any or all questions in the blank boxes below*
1. From your perspective how is the current Recency of practice registration standard working?
As it currently stand the definition of practice is; "Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. Practice in this context is not restricted to the provision of direct clinical care. It also includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on the safe, effective delivery of services in the profession" As more podiatrists move into health administration, where they are required to have a health professional qualification and use it to support their health administrator work, it needs to be clearer that this definition stands and is adequate to maintain registration along with the relevant professional development requirements.

Registration standard: Recency of practice (ROP)

Please provide your responses to any or all questions in the blank boxes below

2. Is the content of the draft revised registration standard helpful, clear, relevant and more workable than the current registration standard?

It is clear regarding the clinical requirement by detailing a minimum hour's worked requirement; however, it actually muddies the waters more regarding non-clinical Podiatrists. If a Podiatrist is in a Health Administrator role (Director of Allied Health, Program Manager) and this role is full time there would be limited capacity to meet the clinical hour requirement for registration as it is proposed. By placing a clinical hours requirement on recency of practice it is essentially saying the current standard is null and void in regards to non-clinical practice that had previously been considered as contributing to maintaining registration as practice "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."

3. Is there any content that needs to be changed or deleted in the draft revised registration standard?

Yes, if there is an hourly clinical minimum then it should only be related to Podiatrists in clinical roles, not non-clinical roles, and/or it should be a smaller hourly requirement (along the lines of the nursing registration requirements – see below) to make it workable for all Podiatrists.

4. Do you have any comments on the minimum practice requirements in the draft revised registration standard?

There should either be delineation between clinical and non-clinical roles OR as previously, all roles that require a base health professional degree and utilise it as part of the delivery of their role, should have those hours count towards recency of practice.

22. Do you think that the following alternative for minimum hours of practice would be better? (i.e without the option of 150 hours in the 12 month period prior to applying for registration or renewal of registration). Please provide the reason for your answer:

    - *450 hours of practice in the three year period prior to applying for registration or renewal of registration*

It makes no difference regarding my points above – I think it is a lot of hours compared to our counterparts on other disciplines. I would suggest that comparison with other registered professions such as nursing may be helpful – they have a requirement for 20 hours of clinical practice (that can include PD) each year to maintain registration – senior nurses report that this is realistic, achievable and enables them to maintain their clinical contact.

23. Is there anything missing that needs to be added to the draft revised registration standard?

No.

24. Do you have any other comments on the draft revised registration standard?

It is important that the current definition of practice stands: "Practice means any role, whether remunerated or not, in which the individual uses their skills and knowledge as a health practitioner in their profession. Practice in this context is not restricted to the provision of direct clinical care. It also

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includes using professional knowledge (working) in a direct non-clinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on the safe, effective delivery of services in the profession" or there will a risk of loss of senior Podiatrists from the Podiatry leadership community, a loss of knowledge, mentoring, coaching and volunteer work that would be felt deeply in a small professional group such as Podiatry.
25. Do you think that that the current review period of at least every three years should be maintained or would an alternative period be appropriate e.g. five years, with the option to review earlier if the need arises?
Three years is reasonable, but may not take into account where people have consecutive maternity leave that can run to 6+ years.
26. Do you have any comments on the draft *Guidelines about recency of practice*?
I believe it is not relevant to the changing face of Podiatry – we are increasingly occupying senior and health administrator roles, yet wish to maintain our links to our profession like our Medical and Nursing partners. Mandating 150 clinical hours per year will not support this, and will probably see experienced Podiatrists moving away from the profession as it will be too difficult to maintain the clinical requirements. This would be a loss in experience, but also in mentoring and coaching of the future leaders of Podiatry, as well as a risk to the many volunteer roles we take on at a state and national level. It is a personal matter of pride that I am a Podiatrist by background, and I believe I would not only be saddened to have to cease being a Podiatrist if this clinical hour requirement came into action but it would also remove me from my ongoing role within my profession in mentoring and supporting up and coming Podiatry leaders. I use my clinical knowledge every day in my Director of Allied Health role to support decisions around serviced delivery. Any changes to the recency of practice requirements should be reflective of the more modern role of the Podiatrist in the broader scope of the health community.

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