Australian Nursing & Midwifery Federation

Submission to: Review of the National Registration and Accreditation Scheme for health professions

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Introduction

Established in 1924, the Australian Nursing and Midwifery Federation (ANMF) is the largest professional and industrial organisation in Australia for nurses and midwives, with Branches in each State and Territory of Australia. The core business of the ANMF is the professional and industrial representation of our members and the professions of nursing and midwifery.

With a membership of over 244,000 nurses, midwives and assistants in nursing, our members are employed across all health and aged care settings in urban, rural and remote locations, in both the public and private sectors.

The ANMF takes a leadership role for the nursing and midwifery professions by participating in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The Federation espouses a nationally consistent approach to the regulation of nurse and midwives is essential. We fully support the role of the Nursing and Midwifery Board of Australia (NMBA) in providing for protection of the public through its registration and accreditation approval activities legislated under the *Health Practitioner Regulation National Law 2009* (the National Law). In particular, the ANMF upholds the core role of the NMBA of "ensuring that any person who is registered is safe and competent to practice".

Built into the implementation of the National Registration and Accreditation Scheme (NRAS) for the health professions was a process for review three years post-establishment of the Scheme. The ANMF welcomes this review of NRAS which demonstrates accountability to the public of regulatory and accreditation mechanisms established for their protection. We are confident the review will provide an opportunity to highlight significant achievements in both the regulation of health professionals and the accreditation of their education programs. As the Australian Health Practitioner Regulation Agency (AHPRA) Annual Report 2011/12 records: *AHPRA undertook the largest ever renewal in Australia when more than 333,000 nurses and midwives renewed their registration in May 2011*.[1] This indicates the enormity of the exercise engaged in by AHPRA in implementing the national registration scheme.

From the introduction of the NRAS the ANMF was aware, through our state and territory Branches, of difficulties encountered by some members in their registration processing interactions with AHPRA. The registration and accreditation components of the Scheme are now working well for the nursing and midwifery professions. The Scheme is still relatively young in terms of establishment and thus there are areas where processes could be streamlined and efficiencies gained. Acknowledgement should be given to the achievements and areas working well should not be compromised in the effort of making adjustments to those parts of the Scheme which are lesser developed.

Background

Since its inception, the ANMF has been a strong supporter of regulation for nurses and midwives in Australia. The regulatory framework includes registration of individual nurses and midwives, and, accreditation of programs leading to registration or endorsement. The framework provides mechanisms for protection of the public receiving health, midwifery and aged care services.

Given the size of our membership, ANMF members can be found providing clinical care in all settings where health, midwifery and aged care is delivered, across all geographical areas. The nursing and midwifery professions have the widest reach into the Australian community of all health professionals. The ANMF therefore has a genuine interest in all aspects of care delivery by health professionals, and, in common with our members, has a particular concern for safeguarding the public for whom they provide care.

Our union has worked diligently over past years, along with other nursing and midwifery stakeholders, to develop nationally agreed standards and codes to govern nurses' and midwives' practice. The essential nationally agreed professional standard is that the individual nurse or midwife is able to demonstrate that she/he meets relevant professional standards for practice.

Although the nursing and midwifery professions had some well-established nationally agreed Australian Nursing and Midwifery Council standards, codes and guidelines prior to the introduction of NRAS, until 2010 we were regulated under eight separate pieces of legislation. This created cost and mobility imposts for nurses and midwives wishing to move across jurisdictions, as well as for overseas nurses and midwives seeking employment and travel in this country. In addition, there was variation across the country on legislation and regulation governing nursing and midwifery practice.

Nursing and midwifery achievements

National registration and accreditation

The ANMF considers the enactment of legislation to introduce the NRAS for the health professions has had a significant and positive impact on our two professions – nursing and midwifery. The overriding aim of the national Scheme has been to introduce consistency, and a shared understanding of terminology, across the country in relation to regulation of health professionals. The intention to simplify processes and terminology is essential not only for the health professionals themselves, but also, and critically, to reduce confusion for consumers of health and aged care services about the codes, guidelines and standards applying to health professionals.

The essential areas where commonality has been achieved through national registration and accreditation are: titles, database of registrants, registration fees, registration standards, professional practice framework, and, accreditation.

Titles: with the advent of national registration we now have consistent nomenclature across the states and territories. The protected titles for nursing and midwifery under the National Law are: nurse, registered nurse, nurse practitioner, enrolled nurse, midwife, midwife practitioner. The inclusion of 'nurse' as a protected title across all jurisdictions is an important element, we believe, in protecting the public. Given the plethora of unregulated health and aged care workers across acute care, primary health care, community and aged care sectors, it is critical that the public remains aware of who is a 'nurse' and who is not – that is, who practices within a professional practice framework to provide safe, competent care and who is providing care outside of those mechanisms instituted for public protection. This is now a shared understanding across all states and territories under the NRAS. Likewise, the terminology and protected titles of 'registered nurse' and 'enrolled nurse' under National Law, provide for a clear differentiation of roles and legislated responsibilities, a shared understanding of terminology across the country, for the profession, and greater clarity for consumers of health and aged care services and the general public.

National database of registrants: For the nursing and midwifery professions, 1 July 2010 marked a critical moment in history when, for the first time in Australia, all nurses and midwives became registered on a central national database. This database contains relevant registration information on every single nurse (registered and enrolled) and midwife, registered to practice in Australia. This database is publicly available, which of course includes employers, and prospective employers of health professionals, as well as the general public.

The national database means professional and industrial bodies and policy makers now receive far more accurate and timely information, direct from the database (through the NMBA) with which to determine nursing and midwifery workforce projections and planning.

Another advantage of the national database is that undergraduate students of nursing and midwifery programs are also entered on the national register, adding to the accuracy of being able to forecast supply and demand for the nursing and midwifery workforce.

Registration fees: with national registration there is now a common registration fee amount. This enables mobility of nurses and midwives around the country, and reduces the cost to one registration where once a registration fee was required to be paid in every state/ territory in which a nurse or midwife practiced.

Registration standards: the implementation of NRAS under the National Law has introduced a suite of nationally applicable registration standards for nurses and midwives, some of which are also common across the regulated health professions. Over and above the national database and common registration fee achieved through the NRAS is the fact that nurses and midwives across the country are now governed by the same standards for their practice. These standards are as follows:

- Criminal History Registration Standard (common across regulated health professions);
- English Language Skills Registration Standard (common across regulated health professions);
- Continuing Professional Development Registration Standard
- Nursing and Midwifery Professional Indemnity Insurance Arrangements Registration Standard
- Nursing and Midwifery Recency of Practice Registration Standard
- Endorsement as a nurse practitioner registration standard
- Registration Standard for Eligible Midwives

In addition, there are standards for practice (formerly competency standards) for registered and enrolled nurses, midwives, nurse practitioners and eligible midwives, which prescribe the minimum standard for practice as a nurse or midwife.

Having common standards for nurses and midwives across Australia provides a greater level of confidence for these professionals themselves, when working together, but also increased transparency for other health professional colleagues and the public receiving care.

Professional practice framework: Registered and enrolled nurses and midwives have their practice governed by a professional practice framework which assures protection of the public. The development of this national framework with nationally applicable standards, codes and guidelines, has been the result of the NRAS. The professional practice framework now includes consistency in the following:

- registration;
- education standards;
- professional practice standards;
- scope of practice;
- a decision-making framework;
- code of ethics;
- code of professional conduct;
- professional boundaries; and
- other relevant registration standards relating to:
    - continuing professional development,
    - criminal history checks,
    - English language skills,
    - recency of practice, and
    - professional indemnity insurance arrangements.

National accreditation: Until 2010, accreditation of programs leading to registration as a nurse or midwife was undertaken by the state/territory nursing regulatory bodies. This led to variation in requirements for education programs across Australia. With the advent of NRAS, the Australian Nursing and Midwifery Accreditation Council (ANMAC) was established as the national accreditation body responsible for developing and monitoring accreditation standards for the curricula of all nursing and midwifery pre-registration programs.

National accreditation of education programs has brought a greater level of consistency to the content of undergraduate programs for registered nurses and midwives in the university sector; as well as much needed standardisation to the qualification level, role and scope of practice for enrolled nurses in the Vocational Education and Training (VET) sector. This was particularly pertinent to the achievement of uniformity in medicines management education and other areas of the scope of practice for all enrolled nurses. This national uniformity in accreditation standards extends to programs leading to endorsement of Nurse Practitioners and Eligible Midwives.

The establishment of national accreditation brings greater assurance of the standard of education of graduands of nursing and midwifery preparatory programs, for prospective employers.

While there is now a cost incurred for accreditation of programs assessed under ANMAC, which wasn't imposed in all instances under the state/territory system, this cost reflects the processes involved in developing and maintaining accreditation standards and assuring rigorous assessment to ensure quality curricula. Education providers now have assurance of a process of assessment which is nationally agreed, is more rigorous, provides consistency for all programs assessed, and a longer period of accreditation status (five years as compared with a previous variable of two to five years). Just as registrants pay a registration fee to be able to practice nursing or midwifery, education providers pay an accreditation fee to be able to provide education programs to nurses and midwives.

The ANMF understands that ANMAC is continually monitoring and evaluating its accreditation functions. As a relatively new entity, this on-going evaluation includes streamlining of cost structures for accreditation services provided to education providers.

The ANMF supports the submission made to the NRAS review by the Health Professions Accreditation Councils' Forum, which details the important role of accreditation councils in ensuring consistency of standards for health professional education.

Benefits of national registration and accreditation

In addition to the advantages of national registration and accreditation to the nursing and midwifery professions as outlined above, the list below provides a summary of other benefits.

National registration and accreditation contributes to the safety and quality of care provided by nurses and midwives for the Australian community through:

- Common governing legislation for the regulated health professionals: the *Health Practitioner Regulation National Law* 2009 (the National Law),
- Mandatory registration standards: criminal history record checks; advertising; professional indemnity insurance arrangements; English language skills, recency of practice
- Notification of conduct, health or performance of a registered health practitioner by members of the public, other health professionals, employers, and health complaint entities in the jurisdictions
- A national database, which provides for:
    - a central point for data
    - consistency in registration data; titles; terminology
    - transparency for the public with access to the database
    - employers to be able to track registration status of employees; and, of potential employees
    - a database of students of nursing and midwifery undergraduate programs
    - the generation of timely information on nurses (registered and enrolled) and midwives registration status
    - the generation of national statistical data for nursing and midwifery workforce projection and planning purposes
    - access to more accurate nursing and midwifery data for policy formulation and planning purposes
    - a risk management process regarding registered practitioners who may be attempting to avoid detection in relation to misconduct or unacceptable practice standards, or where there are impairment issues

- The facility to assign health professional identifiers for the national personally controlled electronic health records scheme, aiming to streamline information communication between health professionals and consumers of health and aged care
- Removal of the need for cross-border arrangements, especially for nurses and midwives who live in cross-border towns/cities, or those who cross borders for emergency or other types of retrieval work
- Movement of nurses/midwives around the country in the event of national disasters
- Overseas nurses and midwives wishing to work in Australia: central point for registration, and easier to travel and work around the country
- Greater facility for monitoring of nurses and midwives as they move around the country, including those from overseas working in Australia. Allows easier monitoring of health professionals and detection by prospective employers of those for whom official complaints have been lodged on conduct, health or performance.

Specific issues of concern

Regulation of assistants in nursing

Assistants in Nursing (AINs) and personal care assistants (PCAs) are employed in, and are a significant part of, the health and aged care systems. They undertake aspects of direct nursing and personal care, but, unlike nurses and midwives, AINs (however titled) are not regulated. Given the purpose of regulation is protection of the public it is difficult to understand how a significant part of the health and aged care workforce remains unregulated. The ANMF contends AINs should have been included in the national registration and accreditation scheme as they, like registered nurses, midwives and enrolled nurses provide care, and in doing so, have the potential to pose significant risk to the public. It is essential that AINs, as health care workers, are safe and competent to practice and thus we raise this issue in the context of the review of the NRAS. It is the view of the ANMF that AIN regulation must occur within the current nursing and midwifery regulatory framework.

We are aware that AINs do not consistently work under the supervision and delegation of registered nurses and therefore there is no mechanism for accountability and consequently protection of the public.

Currently, there is a lack of consistency in standards of educational preparation, competence and employment arrangements for these workers for whom regulated nurses share care responsibilities and who they are often supervising and supporting. Similarly, AINs are providing health care to people of all ages who are ill, or injured, and for many who are frail often with multiple co-morbidities as well as diminished independence of physical or psychological causation. This domain has long been recognised as ‘nursing’ and therefore must be regulated under the NRAS.

Consideration must be given, therefore, to the risks posed to the recipients of health and aged care, in the same way the risks are considered in relation to the health and aged care provided by nurses. The AIN workforce is scattered across numerous care environments: increasingly in all units of hospitals, residential aged care facilities, community health and welfare services, home care services, primary care settings, and disability services, to name but a few.

The fact that AINs are not regulated means their direct care is undertaken outside of a professional practice framework. There is no mandatory minimum educational preparation, no requirement for continuing professional development, no standards of competence to practice, no codes of conduct or codes of ethical behavior, no identified scope of practice, no policies on social media usage, no process for mandatory notification of conduct or health impairment issues, and no legal boundaries to the practice of AINs, other than civil law.

The vulnerability of the people who are cared for in the health and aged care systems produces an inherent potential for harm in the delivery of their care. A comprehensive regulatory framework is in place to manage this risk for most groups of health workers, especially those responsible for direct care and treatment. Incongruously, this framework currently excludes AINs – a large and growing section of the health and aged care workforce.

The wider public has a level of trust with regard to who cares for their relatives or friends in health and aged care facilities and in the community. The public has a right to know that persons caring for family or friends are fit and proper persons, which is a standard required of any regulated health professional. It is acknowledged that AINs are required to have a National Police Certificate if employed in aged care. However, an employer is not required to report any other matters in relation to fitness and propriety that fall outside criminal conduct, to any regulatory body, and as such there is no capacity or obligation to investigate the matter to determine if the public is at risk, or to take action, if such a finding was justified.

Exposure by AINs to the aged and those with a disability is no different to the regulated professions, such as nursing, physiotherapy and medicine, where it is acknowledged that regulation is needed to protect the public by way of determining educational standards, practice standards and codes of conduct and ethics.

The body of knowledge and subsequent role and scope of AIN work is embedded in nursing. There are currently national curricula at Australian Qualifications Framework (AQF) Certificate III level offered by Registered Training Organisations in Australia, which have had significant nursing input to their design. However, the fundamental flaw in the process is that there is no requirement for any consistent application of these curricula by education providers, nor is it mandatory to complete these qualifications for employment within the health or aged care sectors. These courses could be the basis for nationally agreed and applied educational requirements specific to the area of AIN work that are used to form a scope of practice. The resultant newly developed AIN standards for practice could then be used as the benchmark for practice consistency throughout Australia.

Consequently, AIN courses would be required to meet accreditation standards set by the ANMAC and endorsed by the NMBA. These standards would be based on the framework for current standards for accreditation of nursing and midwifery courses leading to initial registration. In doing so, there would then be a consistent level of attention to safety and quality issues across the curricula for those delivering nursing care, from currently regulated registered and enrolled nurses, through to AINs.

The ANMF contends existing regulatory boundaries could and should be reframed to include the AIN, an important health and aged care support worker. Regulating AINs is an essential step that must be taken for community protection, safety and quality, and workforce flexibility and mobility. Given there is existing infrastructure to accommodate the regulatory framework required for AINs, this also makes sound economic sense.

Nursing and Midwifery Board

The ANMF is aware of recent discussion by some midwifery stakeholders with the aim to separate the NMBA into two Boards – one for nurses and one for midwives. The ANMF does not support this proposition. This proposition to establish two separate Boards was canvassed prior to the introduction of the NRAS and was rejected. There is no evidence of significant change that would suggest this position has altered. At June 2014, the total number of registered midwives was 35,062.[2] Of this total, 90.8% (31,832) are dual registered as a nurse and midwife. The Federation has more than 19,000 midwife members and they are predominantly dual registered.

We are acutely aware from the review consultation paper the smaller and low regulatory workload Boards are generally required to pay considerably higher registration fees than are nursing and midwifery. The large numbers within the nursing and midwifery professions allows for one of the lowest registration fees. A separate midwifery board would have small numbers of registrants and thus would realistically (from the evidence presented on page 74) attract a significantly higher registation fee for midwives to support its operations. Given the vast majority of midwives are dual registered as both nurses and midwives, presumably there would be a new requirement for them to pay two fees, one for initial application, and one annually for renewal of registration, for each of the two disciplines as a nurse and as a midwife. We consider the impact on our members financially should they be required to pay two registration fees could not be countenanced, as we see no justifiable regulatory gain for a potentially considerable financial impost.

Of concern too is that should dual registrants be financially disadvantaged, they may decide to cease registration as a nurse or as a midwife. This action would have the unwanted and dire consequence of reducing the numbers of registered nurses and midwives available to the Australian community. There would be particular impact in rural and regional communities across the country, where a health service may need to employ dual registered nurses and midwives as their annual birth rate is not sufficient to support the employment of registered midwives only.

The ANMF experience of current AHPRA audit processes has verified for us that a significant overlap exists between the nursing and midwifery professions. There is no evidence to suggest that the regulation of midwifery as a separate profession by an autonomous Board will improve regulation of the profession or safety of the public. It is the view of the ANMF that adherence to the standard regulatory procedures utilised in nursing has enhanced the clarity of the roles and responsibilities of midwives. The ANMF believes this will be diminished if a separate Board were to be established.

NMBA and ANMAC have successfully reviewed midwifery registration standards and course accreditation standards utilising the same frameworks as those in place for nursing. The flexibility available within existing regulatory processes is evidenced by those pertaining to Eligible Midwives and Private Practice Midwives. These practitioners are accommodated within specific regulatory arrangements within existing frameworks.

The ANMF is concerned that some dual registrants may well discontinue their midwifery registration if the costs become burdensome, thereby reducing the numbers of midwives available to the Australian community.

From the consultation paper regulatory workload appears to be assessed according to numbers of registrants in the profession and/or numbers of notifications. On that basis midwifery, separated from nursing, would logically be considered a low regulatory workload profession. The Federation is gravely concerned that should there be a separation of Boards, midwifery could well be included in the proposed new board for the low regulatory workload professions. This would lead to a serious dilution of the voice of the profession of midwifery at a governance level, which we could not support.

Given the numbers of dual registered nurses and midwives the ANMF holds the position that a separate midwifery Board would not serve to improve public safety, registration oversight nor efficiency gains.

Notifications

As identified previously, there are many achievements of the NRAS for both health professionals and the public. However, it is clear from the previous reviews of the Scheme and this review, the notifications process requires significant improvement. There appear to be a number of issues impacting on the effective management of the notifications process. What is unclear, however, is whether the poor outcomes for notifications are due to AHPRA and the National Boards experiencing difficulties in managing this component of the Scheme, or, if the process is just too complex and unwieldy, with unrealistic expectations.

The ANMF recognise notifications as an essential area of the NRAS to assist in protection of the public. We therefore want the system to be timely, fair, and consistent with the National Law. As higlighted earlier in this submission the ANMF has provided ongoing support for the NRAS and its ability to provide consistency for regulation and accreditation, around the country. However, the current notification system is variable across jurisdictions. The New South Wales and Queensland notification processes, and the difference in Western Australia with mandatory notifications, have all contributed to this inconsistency.

The ANMF is concerned this review of the NRAS is using notifications as the trigger to potentially unravel a system which is in the most part delivering on its requirements. The ANMF agree there are potential efficiencies to be made in some areas of the National Scheme, with notifications of most concern, and subsequently believe it should be the main focus of the review.

It is most concerning to the ANMF that the driver for change to the structure of National Boards is based on the premis of workload generation from notifications. In the review consultation paper (pages 8 and 9) the regulated professions are divided into ‘higher regulatory workload’ professions and ‘lower regulatory workload’ professions. This appears to be largely based on the notifications workload and does not consider the practices and risk to the public of the profession nor the registration or accreditation requirements. Using notifications as the basis for significant change is to be cautioned.

The ANMF is also concerned with the focus on potential savings being a key motivation for change in the Scheme. Some of the proposed changes suggest a savings amount although the actual figures have not been provided. It is unclear how the proposed savings have been identified. The ANMF is concerned that the focus on efficiency gains to be made by wholesale change to NRAS will come at a cost to the aspects of the system that currently work well.

Comments on review questions

1. Should the Australian Health Workforce Advisory Council be reconstituted to provide independent reporting on the operation of the National Scheme?

It is difficult to support the reconstitution of the Australian Health Workforce Advisory Council without having a deeper understanding on how it would be reconstituted and funded. It is also unclear as to why this would be seen as adding value to the process.

The ANMF recognise the benefit of one national body responsible for assessing the functions of the regulators working under the National Law, against established key performance indicators. It is important to consider whether this could be managed within the current established structure by adding clear and transparent key performance indicators and outcome based assessment.

Adding another bureaucratic layer to a system that is already complex and at times ponderous, may hinder processes rather than improve efficiency.

The ANMF can see significant benefit of a national body providing a direct link with health workforce reform and the NRAS. This link would enable collaboration on future health workforce reform, planning and safe implemention.

It is essential that the NMBA continue to have funding authority to enable the Board's access to revenue for nursing and midwifery regulation. The ANMF has held a firm position since the inception of the Scheme that there be no cross subsidisation of other health professionals by nursing and midwifery, or any further increase in registration fees to fund another bureaucratic layer. Any additional funding requirements should be funded by government.

2. Should the Health Workforce Advisory Council be the vehicle through which any unresolved cross-professional issues are addressed?

It is unclear what is referred to as unresolved cross-professional issues as there was no detail provided, nor is it clear as to what the current process is or how it has failed.The accreditation authorities could consider cross professional issues in relation to education.

3. Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions? Estimated cost saving $11m per annum.

4. Alternatively, should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions of notifications and registration through a single service? Estimated cost saving $7.4m pa.

Although ranking low in notifications, nursing and midwifery are not considered 'low regulatory workload' professions. The ANMF would not support this option for the nursing and midwifery professions should they ever be considered 'low regulatory workload'. We would be concerned if governance representation at National Board level is provided by those outside of the nursing and midwifery professions.

In relation to question 4, if supported by the nine professions potentially being affected by the change, the option of sharing regulatory functions of notations and registration through a single service may be more efficient. The ANMF would not accept a situation where professional standards of practice or education, accreditation of courses or professional issues are being decided by a National Board without context of the nursing and midwifery professions. This principles surely applies to other professional groups. The ANMF refer this question to the nine professions who would be effected by this change.

5. Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?

The ANMF defers to the nine affected professions to comment.

6. Should future proposals for professions to be included in the National Scheme continue to require achievement of a threshold based on risk to the public and an associated cost benefit analysis?

The ANMF supports the current criteria used as a threshold, which is based on risk to the public.

Under this current process, statutory registration would only be introduced where:

(a) it was supported by a majority of jurisdictions; and

(b) it could be demonstrated that the occupation's practice presents a serious risk to public health and safety which could be minimised by regulation.

However, how this is measured needs to be defined. Health care workers providing direct care to the public regardless of setting clearly should be included in the regulatory framework. Given the main thrust of the NRAS is to achieve a transparent and consistent health care workforce, to refuse to regulate certain groups who provide healthcare is only confusing to the public and leaves them vulnerable. A perfect example of this is the personal care worker employed in the aged care setting who is currently unregulated yet works alongside regulated health professionals. To the consumer this is not a clear differentiation and can lead to misleading expectations of the role.

The question of the proposed associated cost benefit analysis clearly depends on the tools used to measure this and must include, not just the cost of the provision of the regulation, but also the cost of non-regulation and any resultant consequences.

Each health profession also needs to be individually assessed and their nuances considered. Further, the criteria needs to be interpreted and applied consistently to all health care workers.

Given this criteria and for all the reasons outlined in the preamble of this submission, the ANMF takes a firm position that AINs should be regulated under the National Scheme by the NMBA. AINs are engaged in direct care activities and therefore have potential to cause harm.

The ANMF strongly supports regulation of all health care workers who are engaged in direct physical and psychological care.

7. Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?

The ANMF cannot support hybrid processes of regulation. We contend there must be a consistent regulatory system. We argue that all health professions should be included under the National Law for consistency. 'Other regulatory means' serve to fragment the system and are retrospective. These 'other regulatory means' only come into play once a complaint is made or the public has been harmed.

The community is the ultimate beneficiary of the regulatory system through the provision of safe health care. Health care is already a complex world through which the public are required to navigate and therefore it is critical that the public have a clear understanding of the system for addressing their concerns about the conduct or practice of a health care worker. This is only achievable through a single scheme. It is unreasonable to expect the 'average' user of health care services to comprehend a piece-meal approach to regulation that may see them having to notify a health care professional under the NRAS (for example, a nurse, doctor or physiotherapist) but also having to make a separate complaint through a professional body not currently covered by the NRAS (for example, a social worker or dietitian). Any move to formalise 'other regulatory means' will not contribute to the community's understanding of the health care system and does not meet the community's 'common sense' test. Recognising professions not currently under the NRAS through 'other regulatory means' may assist the professions concerned, but creating a new process for the public's protection will not actually assist the community it is suppose to serve due to the confusion it is likely to create.

8. Should a reconstituted Australian Health Workforce Advisory Council be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

If the Australian Health Workforce Advisory Council was to be reconstituted it would seem reasonable for this Council to be the vehicle to advise on threshold measures for entry into the National Scheme. However, it would be preferable to have an established threshold that does not require the establishment of another committee to make recommendation for entry into the NRAS. It would be important to ensure there are not overlapping functions of the Council with the Office of Best Practice Regulation, but rather a more coordinated and efficient process. Of most concern is that whomever is responsible for the provision of expert advice on threshold measures takes into account the views of health professions when interpreting and implementing the criteria of public risk and associated cost benefit.

9. What changes are required to improve the existing complaints and notifications system under the National Scheme?
10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?
11. Should there be a single entry point for complaints and notifications in each State and Territory?
12. Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?

13. Is there sufficient transparency for the public and for notifiers about the process and outcomes of disciplinary processes? If not, how can this be improved?
14. Should there be more flexible powers for National Boards to adopt alternative dispute resolution, for instance to settle matters by consent between the Board, the practitioner and the notifier?
15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

A single point of contact for all complaints relating to health services and practitioners in each state and territory jurisdiction is a practical and transparent way to initially manage the difficulties of assessing a complaint and identifying where it should be managed.

The ANMF supports AHPRA and the National Boards being the only entity to complete relevant notifications for health practitioners. AHPRA, in all states and territories apart from NSW and recently Queensland, have developed infrastructure to manage notations through human resource expertise and database systems that document and manage processes. These systems enable registrant's information to flow between registration and notification. A disconnect with states and territories managing notifications separately, would appear wasteful and creates further inconsistencies. The process of notification needs to be brought back to be managed wholly and solely by AHPRA and the National Boards.

Some are seeing the newly implemented co-regulatory approach in Queensland is potentially an option for improving notations and complaints management. The ANMF is concerned this process is in its infancy and outcome data has not been provided nor assessed. It would be unwise to change a system for notifications whose introduction was known to be complex and fraught with difficulties, which is now predominantly settled, to a new approach in the absence of identified learnings and outcomes.

Clear and consistent performance measures with realistic prescribed timeframes for managing complaints and notifications by AHPRA and the National Boards is recommended by the ANMF. This would ensure transparency for the notifier and the health practitioner. It would also provide clear expectations for AHPRA and the National Boards. A more flexible and streamlined approach to managing notifications, clear reporting lines and appropriate resourcing is important for the success of this change. If this is achieved it will serve to protect the public as notifications will reach the public register in a timely manner.

Where an adverse finding and the associated interventions are recorded against a practitioner, the ANMF support the decision about when this is removed being made by the state and territory boards of the NMBA. Conditions imposed should be immediately removed once they have been met and reviewed by the Board. Any delay imposes an unfair impost on the practitioner.

The ANMF do not believe there is any benefit to providing an historical disciplinary history for the public record. If the Board is satisfied that the initial concern has been resolved this should be sufficient. Clearly the Board will be aware of past issues should there be a reoccurrence, which would then be a consideration in their next deliberations. We do not believe there is any evidence to suggest detail of conditions should be included for longer periods of time. In addition, particularly where health issues have been raised, to provide historical information could be detrimental to the health of the practitioner and, in fact, prevent practitioners who are well from gaining employment.

16. Are the legislative provisions on advertising working effectively or do they require change?

The legislative provisions on advertising are reasonable, with the exception of testimonials. The National Law needs to provide clear instruction on this aspect of advertising. Testimonials are a common tool used by consumers to make choices on health care services. Nurses and midwives should not be required to search websites to identify if any person receiving their care has provided written feedback that may constitute a testimonial.

17. How should the National Scheme respond to differences in States and Territories in protected practices?

The ANMF considers it is essential for AHPRA and the National Boards to monitor and provide advice to states and territories in regard to protected practices. Early intervention will offer a nationally consistent approach to practice issues and enable the regulator to pre-empt and contribute to discussions which will impact on professional practice.

18. In the context of the expected introduction of a National Code of Conduct for unregistered health practitioners, are other mechanisms or provisions in the National Law required to effectively protect the public from demonstrated harm?

The ANMF considers that a national code of conduct for unregistered health practitioners is not the best mechanism to serve the interest of public safety.

The ANMF believes that this form of negative licensing is a high risk, retrospective mechanism. The scheme only comes into play when a complaint has been made against an unregulated health worker. Under this scheme the patient/resident/client has already been harmed. In our view, the fundamental flaw of negative licencing is that it does not mitigate the significant potential risk to the public.

The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry in the United Kingdom (the Francis Report),[3] was handed down in February 2013. The evidence gathered by this Inquiry showed clearly that for many patients the most basic elements of care were neglected. Recommendation 209 of this report stated:

> *A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability or infirmity) in any hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents.*

ANMF acknowledge that this recommendation is yet to be implemented however the importance of the recommendation and the underpinning protection to the public should not be ignored.

Given the findings of the Francis Report, the importance of regulation of the health workforce cannot be ignored.

Negative licensing is in glaring contrast to the approach taken by the NMBA, under the NRAS.

The ANMF supports the professional regulation of health practitioners in the public interest. In pursuit of this objective the ANMF has lobbied, over a number of years, for the professional regulation of workers engaged in the delivery of nursing services and nursing care in the health, community and aged care sectors. This should be undertaken by the NMBA.

The Federation contends amending the existing *National Health Practitioner Regulation Law Act* 2009 to incorporate the regulation of all current unregulated groups of health practitioners, in a similar manner to currently regulated health practitioners, is the only safe course of action.

To establish a two tier system will be very confusing to the public in general and more specifically where these health care practitioners (regulated and unregulated) work/are employed in the same setting and with the same patients/clients. This presumably would also require the establishment of an additional body to process any complaints in relation to non-compliance issues with the National Code of Conduct. The consideration of applying a prohibition on a practitioner that is not regulated, not registered or is not to be found in the public arena (a public register) is not providing any semblance of public protection and it is unclear under what legislation this could occur.

The ANMF strongly supports regulation of all health workers who are engaged in direct physical or psychological care. We urge this review to recognise the inherent risk of negative licensing for this cohort of health workers, and subsequent importance of a proactive approach to public protection.

19. Should the mandatory notification provisions be revised to reflect the exemptions included in the Western Australian and Queensland legislation covering health practitioners under active treatment?

The ANMF would support option two - a change to mandatory notifications to be in line with Western Australia and Queensland to exempt health practitioners under active treatment. In the absence of this revision it serves as a deterrent to health practitioners with health issues seeking active and ongoing treatment.

Practitioners should feel safe in seeking remedy to any health issues without fear of adverse actions. Many practitioners do have illnesses or health conditions that they responsibly manage and take time off from work as appropriate in order to return to health. With the above mentioned revision, practitioners may be more likely to seek assistance at an earlier point of time. This exemption will not prevent a mandatory report should the health practitioner continue to practice in an unsafe manner.

20. To what extent are National Boards and Accrediting Authorities meeting the statutory objectives and guiding principles of the National Law, particularly with respect to facilitating access to services, the development of a flexible, responsive and sustainable health workforce, and innovation in education and service delivery?

21. Should a reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key health service access gaps?

AHPRA and the National Boards could have far greater involvement in discussions about health workforce reform priorities and key health service requriements. Currently there is minimal dialogue between those in government responsible for workforce reform and the regulator. Graduate nurse unemployment rates are one example of a consequence of this disconnect. Across the country, education providers are producing significantly more graduate nurses than available employment positions. This dire situation is impacted by the number of nurses being registered, and those being employed from overseas. Bringing all the relevant stakeholders, including the regulators, together to discuss workforce issues such as this is imperative to in some way devising possible solutions. If AHWAC was reconstituted, it could be the body to bring together regulators and other stakeholders in the professions to identify and manage issues in the workforce. However, it should not predetermine the actions to be taken by the AHPRA and the National Boards, as the regulator must remain independent of AHWAC.

ANMAC, as the accreditation authourity for nursing and midwifery, is meeting the needs of these flexible and responsive professions. Their includion in co-ordinated consultation with those in government responsible for workforce rerform would be also be recommended.

22. To what extent are Accrediting Authorities accommodating multidisciplinary education and training environments with coordinated accreditation processes or considering future health practitioner skills and competencies to address changes in technology, models of care and changing health needs?

23. What relationship, if any, is required between regulators and educational institutions to ensure the minimum qualification for entry to professions remains available?

ANMAC, as the accreditation authority for the nursing and midwifery professions is meeting the needs of a flexible and responsive profession. Further co-ordinated consultation with workforce reform would be useful.

ANMAC already undertakes genuine discussions and consultation with the nursing and midwifery professions, which includes education providers, about the standards for accreditation of courses leading to registration and endorsement. ANMAC has developed a strong working relationship with education providers. It would be beneficial to the professions if the National Board and ANMAC continue to endeavour to work closely together to achieve a seamless process of registration and accreditation

It is essential the regulator, both the National Board and ANMAC, and education providers maintain a productive working relationship. These entities need to be connected with open dialogue to produce a quality, sustainable nursing and midwifery workforce. The regulators need to continue to engage with education providers to ensure what is being proposed is feasible and will be an attractive option for providers to offer.

24. How effective are the current processes with respect to assessment and supervision of overseas trained practitioners?

The ANMF recognises the current process for assessment and supervision of internationally qualified nurses and midwives needs improvement. Recent appeals have required AHPRA and the NMBA to undertake considerable review of their assessment processes. New procedures were introduced without consultation with the professions and an implementation period ensued which did not include a grandfather clause. The ANMF acknowledges this is a complex area and recognises AHPRA and the NMBA are working hard to rectify and justify their process. However, there are many nurses and midwives who have been caught up in this change. A disconnect between the migration and registration requirements continues to compound the issue. Some of this distress could have been circumvented if consulting with the professions had taken place. Further co-ordinated work needs to be completed in this area through consultion with the professions, to ensure the needs of nurses and midwives are addressed.

25. Should the appointment of Chairperson of a National Board be on the basis of merit?

The ANMF support the appointment of the Chairperson for a National Board being based on a process that is fair and equitable. It is essential the Chairperson of the NMBA continues to be a practitioner member.

The ANMF also recommends an additional protected position is created for a National Board practitioner member to represent Aboriginal and Torres Strait Islander nurses and midwives.

26. Is there an effective division of roles and functions between National Boards and accrediting authorities to meet the objectives of the National Law? If not, what changes are required?

27. Is there sufficient oversight for decisions made by accrediting authorities? If not, what changes are required?

Accreditation authorities are independent bodies and therefore are able to make their own decisions. The reporting requirements against the quality framework for accreditation functions ensures accreditation authorities are meeting their obligations under the National Law and the responsibilities of the contract of their engagement.

The relationship between the accreditation authority and AHPRA and National Boards needs to be transparent with clear contractual expectations and reporting requirements. The funding for accreditation authorities should be based on workplan requirements with no cross subsiding funding between functions.

The nursing and midwifery professions are represented in the governence structures for ANMAC which provides professional oversight for decisions and recommendations made to the NMBA.

28. The review seeks comment on the proposed amendments to the National Law.

The ANMF are not opposed to any of the proposed amendments to the National Law. However, the Federation strongly recommends amendment to include Assistants in Nursing (however titled) as a protected title and practice under the National Law.

Conclusion

The ANMF was a strong advocate for the move to a national registration and accreditation scheme for the nursing and midwifery professions, in particular, and more broadly, for all health professions in Australia. Since the introduction of the National Registration and Accreditation Scheme on 1 July 2010, the Federation has continued support for this Scheme, managed by the Australian Health Practitioner Regulation Agency (AHPRA). This support is due to our contention that there are significant advantages provided by the Scheme for facilitating safe, competent care to the Australian public.

The implementation path from state/territory based registration to national registration has not been seamless. The ANMF is aware, through our state and territory Branches, of difficulties encountered by some members in their registration processing interactions with AHPRA. Given our commitment to the success of this important scheme, however, the ANMF continues to work with AHPRA and the NMBA, on issues which have had the potential to undermine the credibility of the national Scheme.

The implementation of the national Scheme has brought clear and tangible benefits to the Australian public through consistent registration standards and improved monitoring and management of registrants, particularly those who are unable to practice safely. However for the Scheme to be truly effective, the body that administers the Scheme, AHPRA, needs to ensure that it is adequately resourcing essential components of regulatory work. This resourcing must include not only additional and properly trained personnel for the timely management of registrant matters, but also provide the capacity for state/territory offices of AHPRA to collaborate to a greater extent, so that the procedures regarding registration and notifications can be applied consistently across all state and territory jurisdictions.

We forward the information and advice contained in this submission as our contribution to the progression and enhancement of the NRAS for the health professions.

References

1. Australian Health Practitioner Regulation Agency (AHPRA). 2012. *AHPRA Annual Report 2011/12.* Available from the AHPRA website at: http://www.ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx

2. Nursing and Midwifery Board of Australia. 2014. Nurse and Midwife Registrant Data: June 2014. Available from the NMBA website at: http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

3. Francis, Robert. Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary. London: The Stationery Office, 2013. Available at http://www.midstaffspublicinquiry.com/