Mr Kim Snowball  
Independent Reviewer  
Of behalf of the  
Australian Government.

nras.review@health.vic.gov.au

Dear Mr Snowball

Review of the National Registration and Accreditation Scheme for Health Professions.

The New South Wales Nurses and Midwives’ Association welcomes the opportunity to provide advice in relation to the list of questions provided within the review and consultation process regarding the review of the National Registration and Accreditation Scheme for Health Professions (NRAS).

The New South Wales Nurses and Midwives’ Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes assistants in nursing (who are unregulated), enrolled nurses and registered nurses and midwives at all levels including management and education.

The NSWNMA has approximately 59,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

The NSWNMA support the National approach to the regulation of all Health Professionals.

Prior to the establishment of the National Registration and Accreditation Scheme (NRAS), Nurses and Midwives in New South Wales were regulated through the
Nurses and Midwives Board of New South Wales, which had similar responsibilities as the Nursing and Midwifery Board of Australia. Other states and territories also had their own specific registering or licensing arrangements but often had differing legislation and regulation requirements such as endorsements e.g. Immunization. At that time nurses and midwives were required to apply and seek registration or license in each state/territory in which they wished to work.

The establishment of the Nursing and Midwifery Board of Australia, supported by each state/territories Nursing and Midwifery Council has demonstrated efficiency and effectiveness in the provision of a single national database of registrants. Therefore, enhancing public protection by ensuring nurses and midwives practice safely, competently and within an ethical framework. For example prior to the national registration scheme a nurse or midwife who had undergone a disciplinary process within state/territory could register in another state and continue to practice, at times without knowing of previous disciplinary issues.

The National Registration and Accreditation Scheme for Health Professionals and the Nursing and Midwifery Board have achieved a number of specific governance outcomes;

- Titles - consistent nomenclature across the states and territories with the protection of ‘nurse, registered nurse, nurse practitioner, enrolled nurse, midwife and midwife practitioner’ enhances public safety as only those who are registered to use the title. However, the NSWNMA remains concerned that unregulated health care worker (Assistants in Nursing) remain unregulated. The NSWNMA strongly believe this vital role must be regulated in the interest of public safety.
- National Accreditation – the accreditation of undergraduate programs that lead to registration as a nurse or midwife, therefore ensuring consistency in education standards, competency and clinical preparation.
- Registration Standards – implementation of a number of standards which greatly increases governance e.g. Criminal History, English Language Skills Registration, Continuing Professional Development, Professional Indemnity, Recency of Practice.
- Professional Practice Frameworks – implementation of Scope of Practice, Decision Making Framework, Code of Ethics, Code of Professional conduct
- Single registration fee.

National registration and accreditation has clearly contributed to safety and quality of nursing and midwifery practice to our communities.

In relation to the specific questions outlined in the review the following response has adopted the approach undertaken during the recent consultation forums.

1. Accountability and Governance
   1.1 Should the Australian Health Workforce Advisory Council (AHWAC) be reconstituted to provide independent reporting on the operation of the National Scheme?
   1.2 Should the AHWAC be reconstituted to be the vehicle through which any unresolved cross professional issues are addressed?
1.3 Should a reconstituted AHWAC be the vehicle to provide expert advice on threshold measures for entry to the National Scheme to the Health Workforce Ministerial Council?

1.4 Should the proposed reconstituted AHWAC carry responsibility for informing regulators about health workforce reform priorities and key service access gaps?

The NSWNMA supports and believes the reconstitution of the AHWAC to provide independent reporting will enhance public safety. Given that currently within the National Law the AHWAC was intended to fulfil an advisory role, but has not been active, strengthening the role of AHMAC as an independent Council overseeing the operation of the National Scheme will ensure good governance. However it must be recognising that each Health Profession Board is accountable for their performance. It is noted that this is not an additional cost or actual increase in regulation, but should additional funding be required this should be provided by the Federal Government and not through cross-subsidization by any health professional board.

The appointments to the reconstituted AHWAC are through Ministerial appointment. However, appointments must include expert regulators along with expert clinicians. It is the view of the NSWNMA that nursing/midwifery, medical and other regulated clinical professions should be included. It would be our recommendation that the appointment of clinical experts should be through nomination. Furthermore we believe this is vital given it is suggested that the AHWAC should be the vehicle through which any unresolved cross-professional issues can be addressed. However, the referral pathway should be from National Boards to AHWAC and not instigated by AHWAC.

It would be appropriate for the AHWAC to be the vehicle through which to advise on the threshold of entry measures into the National Scheme. Future entry into the scheme should be based on the Risk to Public Safety and as such the framework provided for risk assessment as outlined in the Council of Australian Governments Best Practice Regulation – A Guide for Ministerial Councils and National Standard Setting Bodies, October 2007.

Given the recent changes by the Federal Government and the closure of Health Workforce Australia it is unclear as to how health workforce reforms and health workforce priorities will be identified and addressed. Past experience has demonstrated a lack of coordination and communication regarding these vital matters. AHWAC could adopt the role of the coordinator to bring together key stakeholders, such as educational provider’s workforce statisticians and regulation boards to collaboratively determine the workforce requirements and national health workforce directions.

2. Future Regulation of Health Practitioners

2.1 Should a single Health Professions Australia Board be established to manage the regulatory functions that oversee the nine low regulatory workload professions?
2.2 Alternatively should the nine National Boards overseeing the low regulatory workload professions be required to share regulatory functions and registration through a single service?
2.3 Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?
2.4 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?
2.5 Should the National Law be amended to recognise those professions that provide adequate public protection through other regulatory means?

The NSWNMA supports the establishment of a single Health Professions Australia Board to oversee the nine low regulatory workload professions. The rationale in supporting this is based on the evidence that this is similar practice to the United Kingdom, the Health and Care Professions Council which is responsible for 17 health related professionals, and in some jurisdictions within Canada. Of course nursing and midwifery is not a low regulated workforce and as such we do not support any changes to the current arrangement for nursing and midwifery.

While it is evident that there are cost efficiencies by combining the nine low regulatory workload professions in one single board these savings should be returned to the registrants through lower fees. Clarification needs to be provided to the professions involved as to the future fee structure to ensure that any professional group within the nine does not experience an increase in fees. At this stage it is unclear as to the membership of the proposed Board and consideration must be undertaken to ensure the smaller health professional groups are able to be adequately represented.

In relation to future proposals for inclusion with the National Scheme as previously outlined achievement should be based on risk to the public and associated cost, again we refer to need for consistency with the Best Practice Regulation. The NSWNMA and Australian Nursing and Midwifery Federation (AMNF) have continually lobbied along with other nursing and midwifery professional groups that Assistants in Nursing/Midwifery (AIN/Ms) however titled, e.g. health care worker/assistants, should be regulated under the National Scheme. Currently AIN/Ms are unregulated. AINMs provide certain aspects of nursing and personal care often to clients in the most vulnerable situations. AINs are a major provider of this care in Aged Care Facilities and Services often caring for clients who are frail, have multiple co-morbidities including physical or psychology impairment. Given that current trend towards a reduced number of registered nurses within some health sectors this places an enormous burden on the remaining registered and enrolled nurses in supervision the care provided by AIN/Ms.

A consultation paper ‘A National Code of Conduct for Health Care Workers’ was released by the Australian Health Ministers’ Advisory Council in March 2014, with the believe that a single Code of Conduct for unregistered health practitioners with enforcement powers would likely deliver the greatest net
public benefit to the community. While appreciating the direction that was provided by the Draft Code of Conduct, the NSWNMA remains gravely concerned that unregulated health workers will continue not to be registered through appropriate standards for educational preparation, competence and scope of practice. The Code of Conduct will not ensure consistency of education, nor ensure that care provided by AIN/Ms will remain within a professional practice framework, leading to potential harm to patients/client, without a reporting framework for breaches in conduct or health related concerns, with the only option being civil law.

The Public Inquiry into the serious failings of the Mid Staffordshire NHS Foundation Trust in the United Kingdom clearly identified the lack of regulation of healthcare workers as significant factor in influencing patient outcomes. The report referred to as the ‘Francis Report’ was released in 2013, strongly suggested in recommendation 209 the registration of healthcare support workers as follows, “a registration system should be created under which no unregulated 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 and/or infirmity) in a hospital or care home setting.”

3. Complaints and Notifications

3.1 What changes are required to improve the existing complaints and notifications system under the National Scheme?
3.2 Should the co-regulatory approach in Queensland, where complaints are managed by an independent ombudsman, be adopted across all States and Territories?
3.3 Should there be a single entry point for complaints and notifications in each State and Territory?
3.4 Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?
3.5 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?
3.6 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?
3.7 At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?
3.8 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?

New South Wales (NSW) operates within a co-regulatory system. This model ensures that there is an independent investigator and decision making relating to disciplinary matters, while keeping registration decisions relating to management of nurses and midwives with an ongoing health, performance or conduct issue separate. In NSW complaints are managed by the Health Care
Complaints Commissions who may refer findings to the Nursing and Midwifery Council in NSW while notifications are managed through the Nursing and Midwifery Council.

In the initial stages of the implementation of the National Scheme a number of issues were and some continue to be experienced;

- Lack of timeframe for management of notifications, (the HCCC has a 60 day timeframe to assess complaints).
- Poor communication regarding the referral pathways for complaints and notifications
- Current notification form on the APHRA website is confusing and includes complaints, which can result in delays to the issue being referred to the appropriate body for management.
- Inappropriate timeframes for registrants to respond to issues or requests for information.
- Lack of feedback to a complainant when the matter does not proceed to a disciplinary process
- Disparity regarding information provided to registrants by APHRA officers.

It must be acknowledged that increased efforts have been made by the National Board to address concerns especially regarding the increase in the Notifications committee to meet twice each month. However, there needs to be further education and clarification as to the roles of the Nurses and Midwifery Council in NSW and Health Care Complaints Commission along with the streamlining of the framework and tools available on the APHRA website.

While the NSWNMA fully supports the co-regulation system and acknowledges that throughout the country two (2) other states also have co-regulation processes which are slightly different to NSW. It must be stated that the recent change within Queensland has just been implemented and evaluation of the process has not yet been undertaken. We agree that co-regulation is the appropriate model for consistency across the states along with ensuring each state/territory has a mechanism in which their respective Health Ministers are informed about the status of complaints and notifications within their jurisdictions. Overall the current system in NSW work well and we strongly advocate maintaining the current situation and that it is implemented across the states and territories.

While a single point of contact for all complaints relating to services and practitioners would be an effective and appropriate mechanism, however it must be acknowledged that complaints and notifications are different. Generally complaints in NSW are managed by the HCCC while the majority of notifications are received and managed by APHRA and the National Boards. APHRA and National Boards must be solely responsible for the management of notifications. Should a single point of contact be the preferred model then
the NSWNMA would be concerned should this result in an increased time
delay in complaints and notifications being forwarded to the appropriate body
for investigation.

Performance measures and realistic timeframes should be determined as
clearly articulated for both the complainant/notifier and registrant. While
registrants are expected to respond to requests within a specific timeframe,
which as stated previously are often extremely short, it is particularly unfair on
registrants. Similar expectations are not expected of National Boards. The
HCCC has a mandated time of 60 days to assess a complaint.

National boards should have flexible powers to adopt alternative dispute
resolution. This could work well in the case of minor disciplinary actions and
infringements arising to enable negotiation between the board and, notifier
and practitioner. In NSW the HCCC provides an assisted resolution service
“the Resolution Service” in some circumstances which follows the principles of
ADR. National Boards could adopt a similar process.

Once a practitioner has achieved the requirements of their notations arising
from adverse findings / disciplinary process then the National Board should
remove any conditions applied to the registrant. At the latest this should be
removed by the next registering period. Registrants should also be provided
with evidence of the removal. The NSWNMA is aware that in other Countries
the registering authority may have set a mandatory period prior to the removal
of any notations e.g. in Ontario, Canada the mandatory period is at least six
(6) years. The NSWNMA does not support this view and believe maintaining of
notations or conditions after the registrant has achieved the required activities
could lead to further unnecessary damage to the registrants reputation.

The mandatory notification provisions should be revised to reflect the
exemptions included in Western Australia and Queensland Legislation.
However, as pointed out at the NSW Health Consultation Forum the criteria
that must be met for the exemption would mean it wouldn’t be a mandatory
notification. A recent study published in the Medical Journal of Australia
http://www.mja.com.au/journal/2014/201/7/mandatory-reports-concerns-
about-health-performance-and-conduct-health, showed that three doctors saw
mandatory notifications as a barrier to seeking treatment and stated “Although
Australia’s mandatory reporting regime is in its infancy, our data suggest that
some of the adverse effects and manifest benefits forecast by critics and
supporters respectively, have not materialised. Further research should
explore the variation in notification rates observed, evaluate the outcomes of
reports and test the effects of the mandatory reporting law on whistleblowing
and help-seeking behaviour” This would suggest that there wouldn’t be any
clear danger in providing an exemption.
4. Other Issues.

4.1 Are the legislative provisions in advertising working effectively or do they require change?

The legislative provisions and guidelines published on the AHPRA website relating to advertising are fair, clear and acceptable however testimonials are not addressed. Clear instructions relating to this aspect of advertising need to be developed and included within the National Law. Testimonials appear to be a common communication method by consumers to make choices on a variety of services including health care. The NSWNMA strongly believe that nurses and midwives should not be required to undertake websites searches to identify if any person receiving their care has provided written feedback that may constitute a testimonial.

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

The NSWNMA acknowledges that overseas trained nurses and midwives must meet the minimum educational preparation requirement. However, recent changes in procedures have resulted in many nurses in the process of seeking registration in Australia not meeting the educational preparation requirement at the level of Bachelor or having their skills and competence recognised. Therefore this is a major concern especially for nurses entering through migration. The changes to the process and standards were introduced without any consultation with the profession. As there remain numerous unresolved issues regarding overseas nurses’ further consultation must be undertaken to enable the profession to develop appropriate and affordable opportunities for overseas nurses and midwives to obtain additional educational preparation in a seamless manner.

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

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

The Australian Nursing and Midwifery Accreditation Council (ANMAC) on behalf of the National Board, undertake stakeholder discussions and consultation with the nursing and midwifery professions. Through this arrangement educational providers participate in the development of the standards for accreditation of courses leading to registration and endorsement. This has forged strong, productive and effective relationships.
The NSWNMA fully supports this working relationship and views that this close alignment between the National Board and ANMAC must continue to ensure the links between accreditation and registration remain strong.

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

Accreditation authorities are and must be independent bodies with accountability and responsibility for their decision making. Therefore as such are expected to report against the quality framework for accreditation. This process ensures accreditation authorities meet their obligations under the national law as outlined in their contract of engagement. The funding and contractual expectations must be transparent and based on a performance agreement and appropriate workplan.

4.6 Should the appointment of chairperson of a National Board be on the basis on merit?

While the NSWNMA supports the appointment of the Chairperson for a National Board being based on merit it is vital that the chairperson has a expert knowledge of the regulatory framework as well as a practitioner within the profession. The process of appointment must be in line with best practice and a fair and equitable process.

In relation to the positions on the National Board the NSWNMA recommends that there is a protected position for a practitioner representative from the Aboriginal and Torres Strait Islander nurses. Furthermore we believe there should also a professional representative from a nursing and midwifery industrial organisation.

Again I would like to reiterate that the NSWNMA promotes the national registration and accreditation scheme not only for the nursing and midwifery professions, but for all health professionals. Health professionals now have consistent standards for registration and the ability to work seamlessly across the nation. Our communities have the right to be cared for and treated by health professionals that are appropriately prepared through accredited education programs, are competent and practice within an ethical framework.

Thank you for the opportunity to provide our submission into the review of the National Registration and Accreditation Scheme for health professions.
Should require any further information or clarification please do not hesitate to contact Mark Kearin, Professional Officer, on 02 8595 1234 or by email mkearin@nswnma.asn.au.

Yours sincerely

BRETTE HOLMES
General Secretary