NRAS submission, NMC, 10 October 2014

The Nursing and Midwifery Council of NSW is strongly supportive of those aspects of the scheme that

- provide a uniform approach to registration and accreditation of health practitioners;
- provide for a national and publicly accessible register of practitioners; and
- allow for nationally consistency in the development of policy around access to drugs and poisons and practise restrictions.

Further work at a national level is required to prioritise standards related to risk and safety rather than less critical policies such as advertising and social media. A focus on improved interdisciplinary collaboration in regulation, education and practise is also required at a national level.

The Council notes that in most cases registration fees have significantly increased on what was levied in NSW prior to the scheme coming into operation. Nevertheless the costs compared to other countries examined in recent research conducted by the Council appear to be reasonable (see attachment 1). The Council is, however, concerned that the process through which the national boards account for their costs is not transparent. As a specific example there are some NSW Councils which receive an arbitrarily determined 30% of the national registration fee paid by practitioners with a principal place of practice in NSW as the complaints handling proportion of the fee. While this amount was the agreed split back in early 2010 when the scheme was being established it does not appear to bear any relation to the ‘on the ground’ reality in relation to the increasing rates of notifications compared to the rate of growth of registrations. For example the Nursing and Midwifery Council has experienced more than 300% growth in complaints compared to the number of complaints received in 2019/10. It is acknowledged that the establishment of the scheme was a massive logistical and financial commitment however now that the registration side of the national scheme appears to be working extremely efficiently, with over 95% of registration renewals occurring on-line. It may be appropriate to revisit the proportion of allocation of funding to complaints management with transparency and appropriate analysis and research.

It is noted that with the recent commencement of co-regulatory arrangements in Queensland, 50% of registered practitioners have a principal place of practice in co-regulatory jurisdictions and over 60% of complaints are generated in those jurisdictions. While no other jurisdiction has made any move towards a co-regulatory set-up it is noted that the Victorian Parliament has made recommendations for co-regulatory arrangements and if those recommendations were taken up, three quarters of practitioners would be covered by co-regulatory arrangements. Some consideration about how the national scheme might evolve to accommodate such developments should occur to allow for this flexibility while maintaining the gains achieved from national accreditation, registration and consistency of standards in areas such as recency of practice, mandatory continuing education; and professional codes and guidelines.

The Council argues that the receipt and management of complaints and notifications best occurs at the state level, allowing for better identification of risks and innovative and collaborative solutions between regulators, state quality and safety organisations, and state health service providers which would be more difficult to achieve at a national level, across

all states, in a consistent fashion. This approach also enables a more expeditious outcome for the notifications process.

Individual jurisdictions would then be at liberty to determine the most effective way to deal with complaints and notifications on a jurisdictional basis. This would allow Ministers to regain input into those matters for which they retain political responsibility whilst ensuring, due to the national arrangements in place for standard setting, registration, and maintenance of the national register, that the progress made by the national scheme is not lost.

If such a model was adopted, provisions would be necessary in each state to allow the efficient transfer of the management of health and performance complaints when a practitioner has transferred to another state before a matter has been finalised (ie in matters where the behaviour of the practitioner may be ongoing, such as where the practitioner continues to suffer from a health disorder or a performance gap). Complaints about conduct which examine past behaviour, e.g. fraud, sexual abuse) would continue to be investigated in the state in which the conduct occurred even when the practitioner is working in another state. Provisions would also be required in each state to allow the transfer of monitoring of conditions to occur in a different state and territory to the one in which they were imposed.

Revision of Objectives and Guiding Principles specified in the Law
A review of the objects and principles of the Law should be considered to determine that they are of continuing relevance and sufficient.

Health services are now typically provided in a collaborative or team model, with overlapping and blurring scopes of practice within the health professions. The relevance of interprofessional collaboration is growing in importance within education and service provision. A World Health Organisation (WHO) report\(^2\) states “Governance mechanisms that establish system-wide standards and support patient safety can be used to embed inter-professional education and collaborative practice within the healthcare system. Many of the governance mechanisms that are enacted throughout the world exist to protect patients and the community. If regulation is too rigid, processes may become fragmented and result in an escalation of costs and additional strain on the health system. Alternately, if regulation is reasonably flexible, opportunities to embed inter-professional education into practice increase”.

Notifications, where inter-professional issues arise, already occur and are challenging to manage within a single profession regulatory framework. There are practitioners with registration in multiple professions, or a single complaint may relate to a number of different practitioners in different professions with shared decision making responsibility. The Council recommends that inter-professional collaboration be emphasised in the objectives of the Law not only to promote collaboration at the regulatory level but also at the education and service level.

The Law should also provide for the efficient interdisciplinary management of complaints where more than one profession is involved and has shared decision making processes. As the Nursing and Midwifery Council consists of two professions it can currently efficiently manage cases which relate to both those professions. It is much more complex when a case

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relates to a nurse who is also a pharmacist, or a nurse who is also a psychologist which sometimes require two separate panels to consider the case and on some occasions can result in very different outcomes with no clear explanation as to why the results differ.

The principles specified in the Law should also be extended to include provide a stronger framework and guidance. The Professional Standards Authority (PSA)\textsuperscript{3} identifies the following principles as well as others:

- Patient and public centred and independent
- Risks to public safety is regularly reviewed and regulators are be responsive to change
- Targeted and proportionate according to the problem and the level of risk

**Discussion Points**

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

   Yes. The reconstitution of AHWAC would provide a useful mechanism for reporting on those parts of the National Scheme that are embodied in the National Boards and AHPRA as well as those parts of the scheme that have less visibility such as the development of a sustainable and responsive health workforce.

   The model suggested by the discussion paper mirrors the model in the UK provided by the PSA which:

   a. conducts regular review of the Professional Boards organizations, structure, process and outcomes in key areas: governance, guidance and standards, education and training; and registration and fitness to practice
   b. Reports and makes recommendations to government
   c. Conducts research and shares and disseminates good practice knowledge.

   Points A and B would provide both the Ministers and the public some reassurance that the Boards and AHPRA are functioning effectively. It is less likely to be able to address decisions by adjudication bodies which may be more lenient and therefore pose a risk to public safety.

   Although not noted in the discussion document, the PSA also reviews all final decisions for Fitness to Practise formal hearing decisions for the 9 regulators. This is an important function, particularly where Boards take a predominantly governance role, and the decision making about individual cases generally occurs at the level of independent committees or panels. Consistency is much more difficult to achieve with increasing numbers of individuals involved in decision making, particularly when considered across professions.

   The PSA have power to appeal decisions which have been made by a Board’s committees and are considered too lenient. Another important reason for reviewing

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final decisions is to improve the overall quality of the regulators’ processes and the decisions made by their committees. This is done by the PSA sharing, with regulators the ‘learning points’, which are identified during the reviews. The PSA has noted a reduction in the number of decisions referred to court over recent years, which suggests the quality of decisions has improved as a result of the shared learning in this area. The PSA also carries out an audit of the initial stages of the UK regulators’ fitness to practise processes, looking at random samples of the decisions made by each regulator to close a case without referral to a formal hearing of a Fitness to Practise committee. The frequency of audits, of each regulator, varies according to an assessment of the relevant risks, with each regulator being audited at least once every three years. This is undertaken to ensure that the regulators’ decision-making processes are effective.

It may be useful to consider processes which would allow all the functions of the PSA to be incorporated within the national framework in some fashion, not necessarily all by AHWAC.

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

Yes. As discussed earlier the importance of interprofessional collaboration is increasing. The WHO\(^4\) states that interprofessional collaboration in education and practice will play an important role in mitigating the global health workforce crisis. Interprofessional education is a necessary step in preparing a collaborative health workforce that is better prepared and sufficiently flexible to respond to local health needs. Regulatory mechanisms to support interdisciplinary complaints within complex systems of health provision as well as models for accrediting models of interprofessional education and related curricula are necessary.

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.**

To determine the best structure for regulation, the functions, powers, actions and the responsibilities of each level of the structure must be identified (i.e. board, committees, support staff) and when and how the professions will be represented in the structure. This information is required to determine if the use of a single health professional board would be effective and efficient. There is insufficient information provided in the discussion document about the proposed model to be able to make an informed comment. This work ought to be undertaken to determine the best way forward.

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.**

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\(^4\)Framework for Action on Interprofessional Education (WHO 2010)
http://whqlibdoc.who.int/hq/2010 /WHO_HRH_HPN_10.3_eng.pdf?ua=1
The NSW Councils acknowledge that over 95% of complaints in the national scheme are generated by 5 of the 14 professions. This situation is replicated in NSW (which is part of the national scheme) where 96% of complaints are made about those 5 professions and only 4% about the remaining 9 professions. In fact, three professions (medicine, nursing & midwifery, and dental) account for over 85% of complaints alone.

The Councils do not however consider that the total number, or proportion, of complaints should be the sole consideration of the need for a dedicated Board or Council. In this respect, it is noted that on a per 1,000 practitioner basis there are more complaints about a number of professions (including chiropractic and podiatry) than there are about nursing and midwifery. The Councils are of the view that the primary consideration in this respect should be the potential harm that can arise from unprofessional or unethical conduct by a member of the profession, or from a practitioner’s impairment or poor performance.

The Nursing and Midwifery Council is aware that the midwifery profession would like to see a separate Board established for midwives. The Nursing and Midwifery Council do not believe that this proposal is cost effective and would result in substantial costs in fees due to the small registration base. The Council recognises the importance of having midwives making decisions about midwifery practise described in complaints. If the model of regulation which combines professional boards is selected, The Council recommends that the provisions of the Law require that when a complaint is received about practitioner in a specific profession that a representative of the profession is involved in the assessment of the complaint. As stated previously when the Council receives health complaints and performance complaints about practitioners who are both a nurse and a midwife, the membership of the panel that considers the complaint is selected to ensure that both nursing and midwifery are represented on the panel.

The Nursing and Midwifery Council is of the view that there must be appropriate profession specific input in the decision-making processes when dealing with regulatory matters to minimise risk and harm and as stated earlier, greater flexibility is necessary to achieve inter-professional assessment when that is required.

In terms of streamlining and efficiency it is noted that NSW already has in place arrangements whereby secretariat and administrative functions are shared across a number of Councils. The services provided to 10 Councils (the 9 low volume professions plus psychology) are shared in 3 teams. Further streamlining of these functions into a single team may be a valuable exercise. However, if this approach is taken care is needed to ensure that the smaller professions, and those newly admitted professions with less mature systems are not swamped by the larger and more established professions. Criteria and processes would need to be put in place which would allow for fair and equitable funding of professional specific projects as cross subsidisation is likely to be unavoidable.
5. **Should the savings achieved through shared regulation under options 1 or 2 be returned to registrants through lower fees?**

While returning savings to registrants is an option, another option is to utilise those savings to develop the scheme and to more quickly bring the consolidated professions into regulatory alignment with all others, for example by driving accelerated development of sophisticated performance and health management systems.

Alternatively under the option promoted above of devolving responsibility for managing complaints and notifications to jurisdictions the savings generated from consolidation would be best utilised to fund effective local systems that are responsive to patient and consumer complaints.

If such improvements are not made utilising these funds, the funds should be returned to registrants through lower fees.

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?**

Yes – with clear criteria about the risks assessed.

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

Where public protection is already provided by regulations further regulation is not required.

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?**

Yes.

9. **What changes are required to improve the existing complaints and notifications system under the National Scheme?**

The Councils consider that the co-regulatory system that applies in NSW provides a suitable approach to managing complaints and notifications. The NSW system provides for multiple points of entry, AHPRA, the Councils and the Health Care Complaints Commission (HCCC), but in doing so requires that all complaints/notifications be dealt with by the Councils and the Commission in a consultative manner.

The Councils and the Commission are locally accountable and responsive to the Minister for Health and/or the NSW Parliament. In addition the NSW arrangements ensure profession specific input at all points from the initial consultation on a
complaint through to membership of the disciplinary tribunal or other body, thereby helping to ensure that regulatory decisions have the imprimatur of the profession and are accepted.

As stated earlier, greater flexibility to assess interprofessional complaints is required.

10. **Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?**

The Councils are observing developments in Queensland with interest, however it is far too early to assess whether or not the approach that is being taken in Queensland will be successful and, if so, translatable into other jurisdictions.

It is also noted that significant decision making power rests within the Ombudsman’s office without the obligation for profession specific input. It is unclear whether this may undermine the integrity of those decisions within the regulated professions.

11. **Should there be a single entry point for complaints and notifications in each State and Territory?**

As noted above the Councils consider that the approach in NSW, whereby there are multiple points of entry to the system, but mandatory consultation and consistency in management of complaints provides a valuable approach. The Councils do not consider that a single point of entry would improve the system. In NSW notifications may be made to the councils, HCCC or AHPRA. This flexibility is appropriate providing the communication of notifications is timely and effective (which in the majority of cases it is). Having several points for notifications will tend to capture more notifications rather than less because notifiers are likely to have an imperfect understanding the regulatory system. There can also be roadblocks and delays when there is a single entry point. Of course, there needs to be clear communications mechanisms between the multiple points to ensure effective sharing information.

12. **Should performance measures and prescribed timeframes for dealing with complaints and notifications be adopted nationally?**

When establishing prescribed timeframes, it is important to identify and resolve any systems issues impacting on timeframes. NSW is developing a range of performance indicators and timeframes, but there is sometimes a lag between identifying the issues and providing resources to address them over which the Council sometimes has little control because of bureaucratic processes.

The number of complaints received by the Nursing and Midwifery Council has increased over 300% since the beginning of national regulation in July 2010. The timeframes must be realistic and attainable with sufficient resources to manage the volume of complaints. It should also be recognised that complaints and notifications are all different, albeit sometimes in very subtle ways, and that prescribing hard and inflexible timeframes does not guarantee that matters will be handled effectively and
in fact, can sometimes have the opposite result. The Council receives a number of cases where both impairment and performance issues are evident and these cases frequently require a longer assessment period. On occasions, the Council also receives a ‘run’ of serious matters requiring immediate action. To ensure that these high risk complaints are appropriately dealt with in a timely fashion, these matters are prioritised and the assessment of less serious matters may be delayed. Another factor which may influence timeframes is the processes used to examine the complaint. For example, a medical assessment usually requires less time than an investigation.

The current timeframes identified by the HPCA in NSW and AHPRA nationally significantly differ and appear to be somewhat arbitrarily chosen. Consideration of risks should be a factor in developing time frames as should fairness to the complainant and the practitioner in knowing how long the process is likely to take, and to enable them to prepare and organise their own activities.

The Council’s research identified several boards and colleges which had timeframes for the management of complaints. For example, the College of Nursing in Ontario has the following process:

Once a matter has been filed as a complaint for investigation, the College’s committee is required to dispose of the investigation within 150 days. If the committee has not disposed of a complaint within the time period specified it must provide the complainant and practitioner with written notice of that fact and provide an expected date of disposition which is not more than 60 days. If after this period the complaint has not been disposed of, the Health Professions Appeal and Review Board (the Board) must be notified of the reasons for the delay, and the complainant and practitioner are advised of a further 30 day extension. If, after that period, the committee has not disposed of the complaint, the member and complainant are advised that an extension of time of another 30 days is provided and the Board informed of the reasons for the delay. The practitioner, or the complainant, may make an application to the Board to consider the delay. If an application is made to the Board, the Board may take one of the following actions:

1. direct the committee to continue the investigation
2. make recommendations the Board considers appropriate to the committee
3. investigate the complaint.

In practise, the Board has never used its power to investigate nurses and it is reported that it has little resources to do so.

An important element in the process described above is informing the practitioner and complainant at regular intervals providing them with information about the

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progress and expected completion time and reasons for any delay. There is also an opportunity for the practitioner to appeal to an independent body after a specified period of time. The outcomes of the appeal are less clear in a protective jurisdiction as public protection requires that a complainant be appropriately investigated. In the event that a third party is required to complete the investigation further delay is likely. In NSW, and other states, the complainant and the practitioner are able to make an administrative complaint about delays in process to the regulator, and if necessary to the Ombudsman. The Ombudsman may address the issues of the delay – but the management of the assessment and investigation of the complaint remains with the investigator.

In summary, the Council considers that:

- timeframes should be set on the basis of risk, relevant process, available resources and fairness, and reviewed on a regular basis;
- quarterly data on duration should be reviewed by the regulator to identify and if necessary address process and systems issues – this data may be published for the sake of transparency and public interest;
- the practitioner and complainant should be notified of the progress of the complaint at regular intervals but these timeframes should not be so onerous as to add a burden on the regulator and further delay outcomes;
- complainants and practitioners already have an avenue to complain about administrative delays.

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?

The Councils consider that maximum transparency is always important and valuable, although a balance also needs to be struck with individual privacy. The Council supports the publication of disciplinary decisions from Tribunals and Professional Standards Committees (and the equivalent interstate bodies) where those bodies conduct their proceedings in public. The Councils also support the public of information about outcomes and practitioners where such public is in the public interest.

The Councils do not support the routine publication of disciplinary decisions where proceedings are not conducted in public, and do not believe that decision documents from the various health and performance programs should be made public. The rationale for rejecting the publication of health and performance proceedings is that the relevant programs, irrespective of the manner in which they are run, are focused on rehabilitation, education and improvement. However the Council would not object to de-identified summaries of cases being published. Other jurisdictions in Canada and the US provide a de-identified one paragraph description of the case, the issues considered and the broad outcomes of the case. The Nursing and Midwifery Council in New South Wales published de-identified case histories for the benefit of the professions and general readership via e-newsletters.
It should be noted that the information desired by various notifiers may differ. For example, patients may want information about what happened, why it happened and what will prevent it happening again, whereas employers may want more technical information and specific information about practice conditions. Both the notifier and the practitioner will require transparency about the criteria used to assess the complaint and the outcomes.

Methods used to improve transparency implemented in the UK are the development and publishing of ‘guidelines’ and ‘indicative sanctions’\(^7\), explaining the context in which different types of conditions or suspensions etc might be used and the reasons for imposing such conditions. These guidelines are not prescriptive. The Council acknowledges the need to make assessable the criteria and processes used in the assessment and management of complaints to consumers, practitioners, education providers and employers.

Finally, it is reasonable that notifiers be provided with information about the issues considered by the Council and the reasons for its decision. The Council also requires practitioners are open, honest and complete in their responses to complaints, but they may be less likely to do so if there is a fear of possible civil litigation when full details to their response is provided to a complainant, who may subsequently use this information to mount a civil case against them. A greater willingness for practitioners to provide open disclosure to the complainant would be possible if the practitioner’s responses were protected and not able to be used in civil cases.

**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?**

Alternative dispute resolution (ADR) is usually seen as a tool to resolve civil disputes between parties. However, disputes between notifiers and health professionals are not merely civil disputes as they may have a significant public interest component. ADR could be useful to resolve notification issues provided the possible outcomes of ADR processes have the capacity to reflect the wider public interest.

The option of complaint resolution is available in NSW and is managed during the assessment phase by the HCCC. Serious matters are not referred to resolution and the HCCC consult with the professional councils prior to ADR occurring. Furthermore, both the complainant and the practitioner must agree to resolution for ADR to occur. The Commission stays involved by providing a Resolution Officer to assist the parties to negotiate a resolution of the complaint.

These functions are most appropriately managed by health complaints entities. The National Boards (and the NSW Councils) are professional regulators; they are not consumer complaints bodies. The inclusion of a power for National Boards to resolve

matters by consent may see the Boards seeking to resolve complaints about fees and similar matters which are outside the scope of public protection.

The Council acknowledges that there may be some confusion about the role of the Boards and the Councils in the management of complaints for public protection and safety rather than 'complaints resolution', ie ameliorating the impact that the practitioner’s behaviour has had on the complainant. The Boards and the Councils need to do more work in increasing consumers’ understanding of the purpose and primary focus of the complaints management. In this respect it is vital to understand that the regulatory system and the complaints process are designed to protect the public and to maintain public, employer and political confidence in the registered professions. This confidence can only be maintained in circumstances where important decisions and the processes behind them are transparent (discussed under section 13). Improving the willingness for practitioners to provide open disclosure may also assist in resolving complaints for individual complainants.

15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

Conditions and, in National Board jurisdictions, undertakings are placed on practitioners' registration for the protection of the public. The logical extension therefore would appear to be that such public protection measures should be removed at that point where the public no longer need to be protected. This point will be different in every case and a review mechanism that assesses the need for protection and to assess risk is the appropriate mechanism to determine if that point has been reached.

However, it is clear that this is a very difficult issue that has generated significant debate within the professions and the broader community. The 14 NSW Councils are unable to reach a consensus on this point and in fact within individual Councils themselves there is often a lack consensus.

Furthermore the current practice in relation to conditions and reprimands is not consistent.

The register publishes practice conditions but does not identify whether conditions on practice are imposed as a result of ‘disciplinary’ or ‘non-disciplinary’ action, even when they are imposed following an agreement by the practitioner as is the case for Impaired Registrants Panels and the acceptance of undertakings in other states – this is important information both for practitioners and employers. Practitioners, who have ‘non-disciplinary’ conditions, may experience stigma because they may be inaccurately perceived to have had ‘disciplinary’ action.

Reprimands can only be ordered by a Tribunal or Professional Standards Committee (ie a ‘disciplinary’ panel). There is no policy indicating the duration that reprimands should be published. Therefore when a person has a reprimand, a search of the register will indicate they have had disciplinary action even after the conditions have been removed. But, if a registrant has not been reprimanded as part of disciplinary
action; and disciplinary conditions have been removed, there is no indication on the register of previous disciplinary action. This is inconsistent.

Furthermore, all disciplinary decisions are publicly available even after the conditions have been removed, but are provided on a different webpage to the register. So when conditions are removed from the register, information about disciplinary action is available (but difficult to find unless you know about the specific case).

Further discussion and debate is required about public safety and rights to have access to information about current and previous disciplinary action; namely whether or not:
- conditions related to non-disciplinary action should be distinguished from those which have been imposed because of disciplinary action;
- links to the disciplinary decision documents should be available on the register webpage;
- information about previous disciplinary actions should be available to the public after the action has been completed and if so, for what duration should a reprimand and the fact that disciplinary action has occurred, remain on the register.

Research into recidivism and the time period when the majority of recidivism is most likely to occur after an initial complaint occurs may inform how long reprimands and the fact that disciplinary action has occurred remain on the register. It may be that decisions about whether something remains on the register should be made in relation to the level of risk (e.g., number of complaints ever made, seriousness of the finding, likelihood of repeat behaviour).

It is also recommended that published decisions are linked to the register webpage.

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

No comment.

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

The Council believes it would be appropriate to make birthing practices (except in unexpected emergency situations) a protected practice for medical practitioners with and midwives throughout Australia because of the risks associated with childbirth without a suitably trained attendant available.

Protected practices should be the same throughout Australia as when this is not consistent an individual will move to another jurisdiction and may commence practising outside their scope of 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 HCCC currently has a code of conduct for unregulated workers and this has been effective in prohibiting practitioners who do not comply with the code.

Any introduction of a national code of conduct should also include prosecution provisions if the code is not met.

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 Council does not support any narrowing of the matters that are to be notified under the mandatory notification provisions nor the practitioners or bodies that are required to report. The exemption of treating professionals creates a real potential for serious injury to the public which may have been prevented by mandatory notification. There is an analogous requirement of mandatory notification by treating practitioners in child welfare legislation.

The Nursing and Midwifery Council considers that mandatory reporting requirements for employers should be extended. An employer must report when they have terminated a practitioner’s employment or privileges for reasons of misconduct, incompetence or incapacity which are grounds for a complaint under the law; or when the employer intended to do this, but the practitioner resigned first. That is, the employer must have a duty to report when following a grievance, an employer accepts resignation in lieu of termination, or makes another agreement with the practitioner for behaviour which is grounds for a complaint. These reports must be made within a specified time frame following the action taken by the employer and provide the reasons for termination, resignation or restriction of practice.

This will assist in identifying the more serious complaints and if multiple mandatory reports by different employers are made over time, it will make it is easier to identify and investigate a pattern of complaints about performance, identify and remediate these at an earlier stage.

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?

The Councils note that a significant part of the National Registration and Accreditation Scheme and the intergovernmental agreement was concerned with access to services and the development of a flexible and responsive health workforce. Many of these matters seem to have been lost in the transition from state based regulation to national regulation which has focused on the immediate issues of registration and complaints and notification handling.
The modification of the national scheme as proposed above by the Councils, with complaints and notification returning to jurisdiction specific management, would allow national resources and attention to focus on these important and longer term matters rather than the immediate concerns of addressing individual complaints and practitioner failings.

There is a concern that as Health Workforce Australia no longer exists, the closer attention to the risks associated with workforce issues is required to ensure early identification of risks occur and are managed. A process to bring the different relevant groups together, including service providers and education providers, to assist with planning negotiation and agreements is required.

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

Yes (see response to discussion points 1 and 2).

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?

The Nursing and Midwifery Council is unable to comment on what is currently occurring but as previously discussed, it agrees with the WHO report about the importance of this area in the current health care provision context and the need to have a framework to guide it. There are currently a limited number of interdisciplinary education programs

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

The experience of the Councils is that inexperience in practice rather than the level of qualification, is a better indicator of complaints about a practitioner’s performance. The Councils’ broad experience therefore does not suggest that a constant increase in the base level of qualification will deliver benefit to consumers.

The Council has had a number of complaint cases relating to new graduates. A forum was held with education providers and service providers to discuss the issues. Some of the issues raised in the forum were:

- Although the faculty may fail a nursing/midwifery student in a particular course, they are sometimes successful on appeal. It was reported that the universities did not necessarily place the same level of importance as accreditation and registration bodies on some criteria used to determine successful completion of a course or a qualification.
• Faculties were required to provide students with “reasonable adjustments” during their courses and assessments when nursing and midwifery students have disabilities. The reasonable adjustments permitted by the universities sometime exceed those that are available in the work place. There is on occasions, a disconnect between the capabilities achieved on completion of the nursing/midwifery qualification and those required for the practise.

• Some education facilities debated that it was the responsibility of the registration authority to determine that an individual with a qualification has the capability to be a registered health professionals. Students in other degree courses receive reasonable adjustments and some students use their nursing and midwifery qualification for reasons other than registration.

• In a small number of cases a person with a qualification in nursing and midwifery may not possess the capabilities required to practise. To prevent this occurring some (but not all) universities have introduced a policy relating the inherent requirements. In the case where it is determined that inherent requirements cannot be met with reasonable adjustments, the University staff can provide guidance regarding alternative study options to nursing or midwifery.

• It may be appropriate for regulation authorities to request from education providers about the reasonable adjustments provided to individuals and the reasons they were required.

• Inherent capabilities for the practise of a profession may also be specified in a registration standard and/or accreditation standard to ensure all universities take them into account.

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

The Nursing and Midwifery Board of Australia is the appropriate organisation to determine that the qualification meets the standards required for registration.

The Council’s perception is that overseas trained practitioners may be overrepresented in complaints and notifications. That said there has been a lack of research in this area and the perception may in fact not be supported. In addition if the Councils’ perception is supported by the research there may be a range of factors, other than educational factors, that are in play. These may include communication and cultural factors as well as the possibility of a higher propensity for consumers to complain about overseas trained practitioners.

The Council would be willing to discuss collaborating in future research in this area.

25. Should the appointment of Chairperson of a National Board be on the basis of merit?
Yes the process must be based on merit and be transparent.

Given the role of the national boards with the professions it is critical that the Chairperson has the confidence of the profession. This may be achieved when the Chairperson is a respected member of the profession or alternatively an individual who has a thorough understanding, knowledge, experience and engagement with the profession.

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?

Those Councils who have direct experience of the accreditation process consider that the current arrangements work well and that the division of functions and arms-length arrangements between National Boards and accreditation authorities should be maintained.

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

Again those Councils with direct experience of the accreditation functions consider that the current oversight, review and appeal mechanisms are appropriate. The one comment that has been made is that greater involvement of academics in the accreditation process might streamline the processes.

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

There is also significant support amongst the Councils for revisiting a number of the key definitions used within the scheme in order to achieve greater consistency in approach between national law jurisdictions and co-regulatory jurisdictions.

1. Commonwealth Reforms to Freedom of Information Legislation
   Nil comment

2. Tabling of Regulations
   Nil comment

3. Statutory protection for health practitioners reporting serious offences to police
   This would be appropriate to ensure reports were made. The provision should include serious offences rather than indictable offences to capture more crimes in the provision.

4. COAG Standing Council on Health
   Nil comment

5. Other amendments
   - section 149 (Prelim assess)
In NSW all matters must be consulted with the HCCC

- **section 151 (When a NB may decide to take no further action)**
  No comment

- **section 167**
  Notification of the outcome of an investigation to the complainant and the registrant is reasonable

- **section 177**
  As above advising the complainant of the decision that no further action is required following an assessment is reasonable

- **section 180**
  The timeframe appears to be reasonable. However what occur if the practitioner does not meet his or her obligations under the law to advise of the offences?

6. **Commencement of registration**

7. **Multiple registration subtypes including limited registration**
  No comment

8. **Contravention of undertakings**
  Contraventions of undertakings should be considered in the same light as contravention of conditions

9. **Information on the Register**
  The rationale for this proposed amendment is not clearly explained. It is unclear the circumstances in which a third party might seek to have information suppressed from the register and the factors that might be considered in such a case. For example, might a practitioner’s spouse or child be able to request that conditions on registration are suppressed due to their potential to cause embarrassment?

  The Councils note that the public register serves an important function in providing information to the public and consider that considerably more detail is required before this proposed amendment can be properly considered.

10. **Conditions on registration**
  Provisions are required to allow the Councils in NSW to review conditions on registration. The current process is confusing to both the registrant and employers, has added risks and does not allow for the efficient monitoring or management of registrants with conditions on their registration. When a practitioner moves, the jurisdiction in Australia to which he or she has transferred should be able to accept the monitoring of the matter and be able to review the conditions or undertakings as well take any action specified in the conditions such as the approval of courses and supervisors etc.
The Councils are strongly supportive of the proposed amendments to sections 125 (2)(b), 126 (3)(b) and 127 (3)(b) to allow co-regulatory jurisdictions to change a condition imposed by an adjudication body in a National Board jurisdiction. In fact the Councils consider these amendments to be essential.

These amendments will significantly improve the management of those practitioners with National Board conditions or undertakings who have principal place of practice in a co-regulatory jurisdiction.

11. **Abrogation of right against self-incrimination**
   The Councils note that an equivalent provision exists in NSW Law and support its extension to National Board jurisdictions.

12. **Notice requirement at section 180**
   Notice of action taken by the Board should be provided to a practitioner.

13. **Appealable decisions**
   There should be a consistent time period for the request of an appeal in all jurisdictions of 28 days following a decision.

14. **Obtaining information from other government agencies**
   Investigators should be able to collect information from government agencies during the course of an investigation.

15. **Notice of a decision to take action**
   It is important that agencies employing practitioners as well as service providers where the practitioner is working is aware of any restrictions on registration.

**Other issues**
Clear provisions are required for the transfer of open complaints to other states and territories when practitioners move to ensure the efficient finalisation of matters eg need to distinguish between:

- complaints related to health and performance (where assessment of current health and performance is required) should occur in the jurisdiction they have moved to allow the matter to be efficiently assessed eg health assessment or performance assessment without returning to the original state in which the issues were identified and
- complaints related to conduct or serious matters which require investigation of past behaviour and therefore should remain with the state in which the behaviour or conduct occurred.
### Financial and other resources 2012/13

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<tr>
<th></th>
<th>NSW</th>
<th>UK</th>
<th>IRELAND</th>
<th>NEW YORK</th>
<th>ILLINOIS</th>
<th>CNO</th>
<th>CRNBC</th>
<th>NZ Nurse</th>
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<tr>
<td>Registrants</td>
<td>96,269</td>
<td>673,567</td>
<td>66,888</td>
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<td>982</td>
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<tr>
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<td>$70</td>
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<td>Revenue</td>
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<tr>
<td>Proportion spent on professional conduct/fitness to practise in 2012/13</td>
<td>50%</td>
<td>76%,</td>
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<td>unknown</td>
<td>unknown</td>
<td>20%</td>
<td>10%</td>
<td>26%</td>
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<td>(only function is the management of complaints) does not include cost of HCCC</td>
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<tr>
<td>Staff</td>
<td>15 + indirect shared staff (eg IT and financial)</td>
<td>440-480</td>
<td>44</td>
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<td></td>
<td>4 direct staff to support the Board of nursing + shared staff Office of the Professions</td>
<td>2 direct staff to support the Board of Nurses + shared staff Division of Professional Regulation</td>
<td>200</td>
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