Submission to

The Review of the

National Registration and Accreditation

Scheme for Health Professions

October, 2014
Introduction

The Queensland Nurses’ Union of Employees (‘QNU’) makes this submission to the Australian Health Ministers Advisory Council (‘AHMAC’) regarding the review of the National Registration and Accreditation Scheme for Health Professionals (‘the Scheme’ or ‘NRAS’).

The QNU represents all categories of workers that make up the nursing workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care. The QNU also retains specialist lawyers to assist it’s members in their dealings with the Nursing and Midwifery Board of Australia (‘NMBA’) and Australian Health Practitioner Regulation Agency (‘AHPRA’).

Our more than 50,000 financial members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU and our membership continues to grow.

The QNU supports the six key objectives and three guiding principles of the Scheme. Whilst the primary purpose of the NRAS is the overall regulation of health practitioners, it must be kept in mind that the application of the scheme to individual practitioners must have clarity and practicality at the ‘coalface’. It must enhance the working relationships of the various disciplines that make up the healthcare team, rather than create confusion and disharmony regarding role definition and scopes of practice.

The QNU takes this opportunity to highlight the fact that assistants in nursing (however titled) (‘AINs’) make up a large proportion of the healthcare team, particularly in aged care, where AINs perform the bulk of the healthcare needs of our older Australians, under the supervision of a registered nurse. Health workforce and training trends indicate that the current and predicted future shortage of registered nurses is being addressed in part by increasing the number of accredited Certificate III and IV qualifications to encourage AINs and allied health assistants to enter or remain in the health workforce in a qualified role. This trend amplifies the need to bring these roles under the umbrella of current regulation, with AINs becoming a ‘third level’ nurse, under the regulatory control of the NMBA.

The administration of the Scheme by AHPRA must also be sufficiently resourced. If this does not occur, no amount of reviews will assist in meeting the objectives and guiding principles of the National Law.
Executive Summary

The QNU makes a number of recommendations that address many of the questions posed by the Independent Reviewer. We also make a number of other recommendations that, although outside the scope of the questions posed, are important issues that we believe must be considered by any review of the NRAS.

We recommend that:

1. The Australian Health Workforce Advisory Council (‘AHWAC’), if reconstituted, should be engaged in various aspects of the operation of the Scheme, not solely as an independent reporter on the Scheme’s efficiencies.

2. Unresolved cross-professional issues should be addressed at the National Board level in the first instance and if resolution is not achieved then referred to the Council of Australian Government’s (‘COAG’) Standing Council on Health.

3. Modern healthcare takes a multidisciplinary approach to the client, is holistic and person-centred. National Boards should collaborate and be proactive in addressing potential cross-professional issues, particularly in the area of assisting health practitioners to understand the scopes of practice of the other regulated health professions. This will help to create innovative models of care and a flexible expansion of scopes of practice, both of which will be essential to meet Australia’s future healthcare needs.

4. A single Health Professions Board for the nine low regulatory professions has high potential to fail to understand the nuances of those various professions and creates an unacceptable situation where practitioners of one profession are casting judgment on practitioners of another profession.

5. Any savings from further efficiencies in the Scheme should first address any resource deficiencies in the administration of the Scheme and then any surplus should be passed on as lower registration fees.

6. With nurses and midwives comprising the largest proportion of health practitioners, nursing and midwifery registration fees must not be used to subsidise the costs of regulation of the other health professions.

7. Assistants in nursing make up a large proportion of the nursing workforce. Trends show that this proportion is increasing. The National Law should be amended to protect the title of ‘Assistant in Nursing’ and a recommendation made to the
National Board that AINs be formally regulated within the nursing and midwifery professions.

8. Notifications should have a single entry point at AHPRA in order to provide consistency in the application of the National Law’s disciplinary provisions across all jurisdictions. Co-regulatory jurisdictions have high potential to create inconsistencies in the application of the National Law, which is contrary to the guiding principles of the Scheme.

9. The notification process must incorporate adequate safeguards for the privacy of the health practitioner who is the subject of the notification and appropriate time frames for the review of interventions, while prudently addressing any desire by a notifier to be kept informed of actions and outcomes.

10. The National Law focuses the National Boards on the health, performance and conduct of individual practitioners. The National Law should be amended to make provision for National Boards to intervene where deficiencies in the safety and quality of healthcare service delivery have been identified.

11. The current processes for credentialing nurses and midwives are not uniform and they are not scrutinised by an independent entity. The Accreditation Authority for nursing and midwifery should be directed to accredit programs that lead to nurses and midwives being credentialed practitioners, with such programs then being referred to the National Board for approval.

12. That Accreditation Authorities remain independent, be accountable to AHMAC and be directed to engage fully in the capacities afforded to them under the provisions of the National Law. This must include the assessment and accreditation of all postgraduate programs of study that lead to any additional qualification, recognition or benefit for a practitioner within that health profession.

**Accountability**

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

The operation of the AHWAC has been enabled by the Scheme since its inception. Given that AHWAC has not met for some years and the Ministerial Council has not had reason to refer to the AHWAC for advice, one would question the usefulness and cost-benefit of re-establishing the AHWAC. If AHWAC’s function was only to independently report to the AHMAC on the Scheme’s key performance indicators, that function could be better and
more appropriately performed by an entity with demonstrable skill in data collection and independent reporting.

AHWAC should not be reconstituted if only to provide independent reporting on the operation of the Scheme. Other potential functions of a reconstituted AHWAC have been identified further in this submission.

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

Cross-professional issues should be addressed in the first instance by the relevant National Boards. The National Law prescribes that the AHWAC must be a seven-person council, which could consist of as few as three health practitioners, and must be chaired by a person who has not been a health practitioner for at least five years.

If any cross-professional issues could not be resolved at National Board level, it is difficult to foresee how such complex issues could be resolved by the AHWAC, given the potential lack of clinical expertise on that entity.

In our view, unresolved cross-professional issues should not be referred to AHWAC, but should be referred by the relevant National Boards directly to the COAG Standing Council on Health. The COAG can then resolve to make a determination on the unresolved issue, or seek expert advice for further consideration.

Modern healthcare takes a multidisciplinary approach to the client, is holistic and person-centred. Practitioners from varying health professions are constantly interacting with one another in the provision of care. Additionally, some practitioners must provide care with limited resources and without the support of practitioners from other professions. From the practical perspective, all of this provision of care must also be done within various industrial frameworks and limitations. An understanding of the scopes of practice of other professions and how one’s own scope of practice can be expanded to assist other professions, or is limited by regulation, is essential.

National Boards should not be silos, they should collaborate and be proactive in addressing potential cross-professional issues, particularly in the area of assisting health practitioners to understand the scopes of practice of the other regulated health professions. This will help to create innovative models of care and a flexible expansion of scopes of practice, both of which will be essential to meet Australia’s future healthcare needs.
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.

The posing of this question indicates a failure to fully appreciate the importance of the expert knowledge that is relevant to the individual health profession, being knowledge that cannot be assumed by practitioners of any other profession.

Only nurses know what nurses really do and only nurses are authorised to make a judgment on what nursing is. The same applies to midwives and midwifery. Our view is that this principle would be the same for each health profession. For this reason, it would not be appropriate to have practitioners of one profession casting judgment on the regulation of a differing health profession.

As such, it would not be professionally acceptable to have a single Health Professions Board managing the regulatory functions on nine distinct health professions.

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.

For the same reasons as in the answer to Question 3, it would not be professionally acceptable or appropriate for the members of one profession to be casting judgment on the registration requirements or standards of professional conduct of a different profession.

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

Should option 1 or 2 be established, although in our view they should not be, any savings achieved should first address any resource deficiencies in the administration of the Scheme’s registration and notifications processing by AHPRA. Any surplus after those deficiencies have been addressed should be returned to the registrants in the form of reduced registration 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?

Reducing the risk of harm to the public is the primary objective of the National Law. In our view, this objective cannot be achieved when a large proportion of the ‘hands-on’ nursing care of the public is performed by unregulated healthcare workers such as AINs. To achieve
this threshold, AINs should be formally included in the regulatory framework for nursing, which will not only create accountability, but also provide clarity in the working relationships within the multidisciplinary healthcare team.

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

In our view, the regulation of all health practitioners must be consistent, under one framework, and not be fragmented by processes that will vary from profession to profession. Co-regulatory jurisdictions might exist for the purpose of dealing with complaints (notifications), but the threshold regulatory requirements must remain consistent and cost-effective for all health practitioners. Healthcare professions that protect the public through other regulatory means should strive to attain the criteria required under the National Law and become included in the Scheme.

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?**

In the event that this review recommends the reconstitution of the AHWAC, then this body would be the appropriate vehicle to advise AHMAC, provided that expert advice on the particular health profession was sought and provided. Such advice would need to be profession-specific and include the threshold criteria for protecting the public in the provision of healthcare by that profession.

We take this opportunity to advise the Independent Reviewer that the NMBA would be the appropriate entity to advise AHWAC on the threshold measures for the entry of AINs under the Scheme.

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

Queensland is now a co-regulatory jurisdiction for the purpose of dealing with complaints and notifications, since 1 July 2014. The co-regulatory roles of both the Office of the Health Ombudsman (‘OHO’) and AHPRA are still in the early development stages and we expect greater clarity to be achieved as OHO processes further develop.

At present, notifications of a serious nature are retained by the OHO and those that are less serious are referred to AHPRA and, in the case of notifications about nurses or midwives, to the NMBA for adjudication. In our view it is too early to make a judgment on the efficacy of co-regulatory arrangements in Queensland due to the lack of reliable data.
10. Should the co-regulatory approach in Queensland, where complaints are managed by an independent commissioner, be adopted across all States and Territories?

Our primary concern with the co-regulatory approach is the potential lack of consistency with other jurisdictions in dealing with notifications due to the fact that AHPRA, the national administrator of the Scheme, does not have control over the assessment and investigation of notifications in Queensland.

Given that the OHO can take immediate action on notifications about nurses or midwives, we are also concerned that the NMBA, the national expert in nursing and midwifery regulation, and the Queensland Board of the NMBA, do not have the opportunity to provide that expert advice for all notifications about nurses or midwives.

One of the guiding principles of the Scheme is for the Scheme to be administered in a fair and consistent way. The existence of co-regulatory jurisdictions creates high potential for inconsistencies in the application of the National Law across jurisdictions, which is contrary to its guiding principles.

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?

We are aware that AHPRA in Queensland has instituted performance measures to improve the handling of notifications and the timely outcomes of Queensland Board and National Board decisions. If these performance measures are realistic and achievable then, in our view, they should be adopted nationally. Once such key performance indicators being met, the entry point for notifications should be with AHPRA. Further, given that prior to the OHO, senior AHPRA Officers had discretion to refer notifications to a National Board for immediate action, we suggest that, if AHPRA returns to being the single entry point for notifications, then the AHPRA Director of Notifications should have the delegated authority to refer matters to the OHO when appropriate.

Queensland’s *Health Ombudsman Act 2013* has also created a negative licensing scheme for unregulated healthcare workers such as AINs. However, although the OHO has capacity to issue prohibition orders on AINs, it has not yet published a Code of Conduct for AINs to refer to as guidance for their practice. In any event, the Code of Conduct is not a mandatory element of practice and is only applied once the AIN has been the subject of a complaint, therefore does not provide the public with any form of proactive safety.
Hence, we reiterate our view that, in order to provide consistency and fairness in the handling of complaints against nursing staff and for the protection of the public when receiving nursing care, AINs should be brought under the umbrella of regulation within the national Scheme, with the NMBA providing the expert advice on the thresholds for imposing mandatory ethical and professional conduct by AINs within the nursing and midwifery professions.

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?

Most often, the notifier is a recipient of healthcare and not a health professional of the same discipline as the care provider. As a result, the notifier will not have the requisite knowledge of the profession to fully understand and appreciate how decisions and outcomes are arrived at.

The current process provides the notifier with the result of the decision-making by the National Board and, if disciplinary action was taken against the practitioner, refers the notifier to the relevant statements on the public register. This creates an appropriate balance between the practitioner’s right to privacy and the rights of the notifier, particularly when the investigation and assessment elicits a practitioner with impairment. Any failures in the current process could potentially be attributable to a lack of sufficient human resources for AHPRA to manage notifications in a timely manner.

In our view, this is sufficient transparency for notifiers regarding the result of the notification. However, there could be additional capacity for the notifier to be fully informed of the process at key milestones in that process, including anticipated time frames, so that they remain cognisant of the sometimes lengthy nature of an assessment and investigation and can appreciate the need to afford the health practitioner due process, privacy and natural justice.

In the event that the Independent Reviewer recommends additional and flexible powers for national boards to undertake alternative dispute resolution strategies, such a process should provide the Board with discretion to determine, on a case by case basis, the appropriateness of such a strategy for that matter.
15. At what point should an adverse finding and the associated intervention recorded against a practitioner be removed?

Current regulation requires the Board to set a time frame for the review of undertakings and conditions which, depending upon the nature of the conditions, is generally 12 months. There is also capacity within the National Law for the practitioner to make application for a review of their undertakings or conditions.

To enhance these current provisions, in our view it would be appropriate for any Board encumbrances upon a practitioner’s registration to also be reviewed by the practitioner’s AHPRA case manager at each annual renewal of registration.

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 clarity that the testimonial must not be placed on, or included within, the advertisement created or approved by the practitioner. Testimonials are a common tool used by consumers to make choices on health care services and could be placed on any individual’s social media website without the practitioner’s knowledge. It is an unreasonable burden to require nurses and midwives to search websites to identify if any person receiving their care has appended their advertisement onto a webpage and provided written feedback that may constitute a testimonial.

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

In our view it is essential for AHPRA and the National Boards to monitor and provide consistent 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 QNU considers that a national code of conduct for unregistered health practitioners is not in the best interests of public safety.
In our view 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 licensing 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') 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.”

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 QNU supports the professional regulation of health practitioners in the public interest. In pursuit of this objective the QNU and its national federation the ANMF have 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.

In our view, amending the existing Health Practitioner Regulation Law Act 2009 in each state and territory 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.

The QNU 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 by incorporating AINs into the regulated nursing family, with consistent minimum standards developed by the National Board.
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?

Western Australia provides a complete exemption for treating practitioners not to make notifications regarding practitioners in their care; however Queensland’s exemption is only a partial exemption in that the exemption only applies if there is no professional misconduct or no impairment which places the public at substantial risk of harm.

It is an unfortunate reality that many practitioners who suspect they have an impairment will think twice before seeking treatment for fear of being the subject of a notification and thereby putting their career and earning capacity at risk. There must be consistent capacity within the National Law of each state and territory that does not deter impaired practitioners from seeking treatment.

In our view, all jurisdictions should have an exemption clause identical to that which provides a complete exemption as in Western Australia’s National Law.

In addition to the exemption, the National Law should also prescribe, perhaps in the definitions, that if an impaired practitioner is taking leave from work to seek treatment and/or recover then, by virtue of the fact that they are not practising the profession whilst on leave, the public is not being put at risk and therefore they do not meet the threshold of a mandatory notification.

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?

In our view, if the National Boards and Accrediting Authorities had the resources to assist in the development of a flexible and responsive health workforce, there would already be serious discussions taking place with stakeholders regarding regulating AINs and accrediting appropriate courses of study that would permit a qualified AIN to be included within the nursing and midwifery regulatory framework.

Given current health workforce predictions, AHPRA and the National Boards must become increasingly involved in workforce development in order for minimum standards to be developed for all persons engaged in healthcare that will protect the public from harm. Many of the 14 professions have unregulated workers that assist them in the provision of
care. All such workers should be under the regulatory umbrella, otherwise the primary objective of the National Law will not be fully realised.

Of serious concern to the QNU is the current trend for some nursing and midwifery Colleges and Associations to offer credentialing services, through a fee-based assessment, and the use of that credentialled status by employers as an incentive for promotion. There is no uniformity or independent scrutiny of the credentialing process.

In our view, for the safety of the public and consistency in quality, the NMBA must address this issue by ensuring that credentialing assessments or qualifications delivered by nursing or midwifery colleges or associations are accredited by ANMAC prior to be offered to practitioners.

With regard to the National Boards meeting the objectives of the Scheme, one flaw in the National Law is that it focuses the National Boards on the health, performance and conduct of individual practitioners. There is no capacity for National Boards, arguably the national experts in safeguarding the public from poor quality healthcare, to assess the overall safety and quality framework as a whole.

In our view, the National Law should be amended to make provision for National Boards to contribute to the development of a safety and quality framework in healthcare and to intervene where deficiencies in the safety and quality of healthcare service delivery has been identified.

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

In our experience, the NMBA is acutely aware of key workforce priorities and service gaps through its associations with academic and service providers. However, if AHWAC was reconstituted, it could be the vehicle for all National Boards to engage in round-table discussions on measures that could address workforce priorities and service gaps, particularly regarding the development and implementation of innovative models of care and interdisciplinary cooperation.

The QNU is also concerned that, although there is a national safety and quality framework for health organisations, lack of transparency in reporting and compliance mechanisms may reduce the effectiveness of these measures.

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?

The Australian Nursing and Midwifery Accreditation Council (‘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 that the National Board, 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 and sustainable option for providers to offer.

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

The QNU believes the current process for assessment and supervision of internationally qualified nurses and midwives (‘IQNM’) needs improvement. Recent appeals have required AHPRA and the NMBA to undertake considerable review of their IQNM assessment processes. New policies and procedures were introduced without consultation with the professions and an implementation period ensued which did not include a grandfather clause.

We acknowledge this is a complex area and recognise that AHPRA and the NMBA are working hard to rectify anomalies with the assessment of IQNM. However, there were many nurses and midwives who were caught up in recent the change of IQNM policy where, now that it has been reversed, they have suffered considerable financial and personal detriment, primarily due to the disconnect between the ANMAC assessment of nursing and midwifery migration requirements and the AHPRA assessment of minimum requirements to meet registration standards.

This disconnect created an issue where IQNMs receiving approval from ANMAC have migrated to Australia only to find their applications for nursing registration refused by the NMBA due to them not meeting minimum educational standards. Some of this distress
could have been circumvented if consultation with the professions and relevant stakeholders had taken place. It is essential that relevant stakeholders are invited to engage in consultation regarding changes in regulator policies or procedures which will have significant impact on practitioners.

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

Yes. The appointment of the Chair of the National Board should always be made upon merit in a process that is fair, equitable and transparent to all applicants. In our view it is essential that the Chair of the NMBA be a practitioner member.

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 ensure 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 work plan requirements with no cross subsiding funding between functions.

The nursing and midwifery professions are represented in the governance 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.

In our view, the proposed amendments are not controversial and will provide greater direction for regulators in their dealings with both the profession and the public. However, we do emphasise that the decisions regarding notifications that are clearly not relevant, such as those included in the proposed amendments to section 151, should be delegated by the National Board to a senior AHPRA Official in order to expedite those notifications that must be assessed and considered by the Boards.
The QNU believes that there is one essential amendment that has not been considered by the Review. That is to amend section 113 of the National Law to include the title of ‘Assistant in Nursing’ as a protected title for the nursing and midwifery professions. This could be the first step in bringing unregulated workers who assist in the provision of nursing care under the regulatory umbrella held by the NMBA.

**Conclusion**

The transfer from state-based regulation of health practitioners to a National Regulation and Accreditation Scheme was a tremendous achievement and definitely in the interests of both practitioners and the public. The continuation of the Scheme is strongly supported by the QNU.

However, we submit that the Scheme could be improved in a number of key areas that are of relevance to nurses and midwives.

This review is a prime opportunity to enhance the protection of the public in their receipt of healthcare in a number of ways, not the least of which would be recommending that the National Boards take immediate steps to incorporate a wider range of healthcare practitioners within the regulatory framework.

The inclusion of AINs within the nursing and midwifery frameworks is an essential step, not only for the protection of the public, but for the long term flexibility and sustainability of the future healthcare workforce.

The system of receiving and assessing notifications can also be streamlined in a way that affords satisfaction to the notifier regarding the process, but also protects the rights of the practitioner. It is also essential that impaired practitioners are not deterred in any way from seeking treatment for fear of being the subject of a notification by their treating practitioner.

However, no amount of reviews or the streamlining of Scheme processes will be successful if AHPRA is not provided with sufficient human and material resources to enable it to perform its functions in an efficient, effective and timely manner.

The QNU makes this submission to the Independent Reviewer in the interests of the improvement of the Scheme for nurses and midwives and to extend our offering of assistance in any further consultations.