Submission by the Australian Nursing and Midwifery Federation

Australian Health Practitioner Regulation Agency (Ahpra) – Draft Revised Recency of Practice and Continuing Professional Development Registration Standards

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Australian Nursing & Midwifery Federation

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Key Points

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country.

2. The ANMF thanks the Australian Health Practitioner Regulation Agency (Ahpra) for the opportunity to provide feedback on the draft revised recency of practice (RoP) and continuing professional development (CPD) registration standards.

Recommendation 1: Retain the current Recency of Practice (RoP) standard

3. The NMBA and Ahpra should retain the current RoP standard of 450 hours over five years. The proposed increase in the RoP requirement from 450 hours over five years to 450 hours over three years represents a substantial policy change without a clearly articulated evidence base demonstrating the need for the change or its likely benefits. The proposal risks over-burdening health professionals, reducing workforce participation, limiting access to health services, and disproportionately disadvantaging nurses and midwives working part-time, in flexible arrangements, or in rural and remote areas. It also has the potential to prevent safe, competent practitioners from maintaining registration.

Recommendation 2: Conduct a comprehensive impact assessment before implementing any changes to the RoP standard

4. The proposed changes may have significant unintended consequences for workforce participation, particularly for women, practitioners with caring responsibilities, those taking parental leave, those with disability or chronic illness, newly graduated nurses and midwives, and nurses and midwives in rural and remote practice. The ANMF also reiterates its longstanding concern that the proposed RoP requirements may constitute indirect discrimination under applicable anti-discrimination legislation. Before implementing any changes, Ahpra and the NMBA should undertake and publish a comprehensive workforce,

equity and legal impact assessment, including consideration of potential indirect discrimination and impacts on workforce sustainability.

Recommendation 3: Retain the current definition of "recent graduate"

5. The ANMF recommends maintaining the current NMBA definition of a recent graduate, allowing graduates up to two years from completion of their approved qualification to seek initial registration without additional RoP requirements. Reducing the exemption period for recent graduates from two years to one year may unintentionally prevent graduates from entering practice where transition has been delayed by financial hardship, English language requirements, parental leave, or other legitimate circumstances. This risks disrupting the pipeline of new nurses and midwives and further exacerbating workforce shortages.

Recommendation 4: Improve consultation processes and profession-specific communication

6. The proposed changes represent significant reforms affecting all registered nurses and midwives, yet consultation materials are difficult to navigate and appear to have been inadequately communicated to those most affected. Ahpra and the NMBA should publish separate consultation documents for each profession; simplify the structure and formatting of consultation materials; clearly explain any colour coding or visual elements through an accompanying legend; and implement targeted communication strategies to ensure all segments of the nursing and midwifery workforce understand proposed changes and their implications.

Recommendation 5: Do not introduce mandatory minimum hours of interactive CPD

7. Retain flexibility in how practitioners meet CPD requirements rather than prescribing mandatory minimum hours of interactive learning. While continuing professional development is fundamental to maintaining safe, evidence-based practice, specifying a minimum of five hours of interactive CPD may reduce flexibility, create unnecessary barriers to compliance, and inadvertently reduce workforce participation.

Recommendation 6: Strengthen employer responsibility for CPD

8. Maintaining professional competence should be a shared responsibility between practitioners and employers. Many nurses and midwives face significant barriers to accessing CPD due to workload, staffing shortages, rostering arrangements, and a lack of employer support. The ANMF recommends the introduction of a formal standard or accompanying guidance requiring employers to provide reasonable support, including protected time and appropriate access to CPD, to enable practitioners to meet registration requirements.

Recommendation 7: Introduce mandatory culturally safe CPD across all registered professions

9. Culturally safe practice is fundamental to high-quality, person-centred healthcare and should be embedded consistently across all regulated health professions. All registered health practitioners should complete mandatory CPD in cultural safety as part of their annual registration requirements.

Recommendation 8: Retain flexibility for return-to-practice requirements

10. Continue to allow National Boards discretion in determining appropriate return-to-practice requirements on a case-by-case basis, rather than introducing arbitrary time limits. The ANMF supports the proposal not to prescribe a maximum period out of practice or mandatory return-to-practice requirements within the registration standard. A rigid time-based approach does not appropriately recognise the diversity of practitioners' experience or individual circumstances.

Introduction

11. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 356,000 nurses, midwives and care-workers across the country.

12. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

13. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

14. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

15. The ANMF thanks the Australian Health Practitioner Regulation Agency (Ahpra) for the opportunity to provide feedback on the draft revised recency of practice (RoP) and continuing professional development (CPD) registration standards.

Consultation questions: Recency of practice registration standard

Question 1 – *Is the proposed revised ROP standard clear and workable in practice? Why or why not?*

16. The ANMF highlights that the proposed revisions to the RoP standard represent a substantive change that could have significant ramifications for all nurses and midwives. Despite this, the consultation appears to have been poorly communicated to those who will be most affected. Ahpra must ensure that clear information about the proposed revisions to both the RoP and CPD standards is communicated effectively to all nurses and midwives and presented in an accessible and understandable manner. This is particularly important for those who may be most impacted but least likely to be aware of the changes, including practitioners who are currently out of the workforce, on parental leave, receiving workers' compensation following workplace injuries, or experiencing difficulty securing employment due to conditions placed on their registration. These practitioners are less likely to receive or engage with consultation updates. Ahpra and the NMBA must be proactive in ensuring that all receive clear and consistent communication regarding the proposal and any implemented changes.

17. The revised RoP standard, in its current multi-profession format, is unclear and the case for cross-profession alignment is not well made. The professions regulated by the National Boards have distinct scopes of practice and professional risks. While greater consistency may assist in understanding among practitioners and reduce administration burden through the standardisation of requirements, this does not, in and of itself, justify identical RoP requirements across all professions. For instance, where a profession already has a minimum RoP requirement, such as the nursing and midwifery professions, it is neither clear why that existing benchmark should be changed nor what evidence has been considered to inform both the decision to change and the specifics of the proposed new standard. If alignment across professions is proposed, the rationale should clearly show that the new standard: 1) improves safety for the public in comparison to the current standard, 2) remains relevant and proportionate to the profession's specific risk profile, and 3) is underpinned by clear, appropriate evidence. In the absence of this, the proposed new standard appears to be

driven by an unexplained prioritisation of administrative optimisation and uniformity over a clear, well-explained, evidence-based need to improve the quality and safety of care and professional practice.

18. It is noted that, in the '*Nursing and midwifery only'* box in '*Appendix B – Registration standard: Recency of practice'*, nurses and midwives are required to complete "450 hours of practice in the previous three years" and "150 hours of practice in the previous 12 months". Notably, these requirements are not separated by "or", as they are for the other professions. It is unclear whether this is a typographical error or reflects an intentional difference in the proposed requirements for nurses and midwives. The ANMF has significant concerns if the latter is intended. Requiring nurses and midwives to meet both requirements would substantially disadvantage the professions by removing the flexibility that the proposed revised RoP standard is intended to provide. In particular, it would significantly affect practitioners who take extended periods of leave, such as parental leave, which is especially relevant in a predominantly female workforce. As outlined later in this submission, such a requirement would place additional pressure on a workforce that is already experiencing significant strain and difficulty in meeting current standards.

19. Further, the '*Nursing and midwifery only*' box in '*Appendix B – Registration standard: Recency of practice'* states that nurses and midwives may meet the standard through the "successful completion of a program or assessment approved by the NMBA". Further clarification is required regarding this provision. In particular, it is unclear what is meant by an "assessment", as the ANMF is not aware of any existing NMBA-approved assessment pathway that enables practitioners to demonstrate recency of practice in this manner. If the inclusion of an assessment pathway reflects a new or proposed mechanism for meeting the RoP standard, this should be clearly explained within the consultation materials. Stakeholders require sufficient information to understand what such an assessment would involve, who would be eligible to undertake it, how it would be administered and assessed, and whether it would be available nationally. Without this information, it is not possible to meaningfully assess the implications, accessibility, or fairness of this proposed pathway.

20. The revised RoP standard introduces a revised definition of 'recent graduate' as "a person who qualified from an approved program of study within *one year* of lodging a complete application for registration". This differs from the current NMBA definition, which describes a recent graduate as "a person applying for registration for the first time whose qualification for registration was awarded not more than *two years* prior to the date of their application". This change is concerning and there are risks of significant unintended impacts that it may have on nurses and midwives entering practice. Reducing the RoP standard exemption for new graduates from two years to one year may result in situations where individuals who have recently graduated, but experienced delays in transitioning to practice due to financial constraints, delays in obtaining English language requirements, or are on maternity leave, are unable to enter the profession. This change may have serious financial implications for these graduates, as well as the potential to disrupt the pipeline of new nurses and midwives, ultimately affecting workforce sustainability. The ANMF strongly opposes this proposal.

21. The draft multi-profession version of the registration standard is difficult to navigate and creates unnecessary confusion. The ANMF strongly recommends that Ahpra and the NMBA publish a separate version of the consultation document for all the professions covered, including nursing and midwifery, to ensure that specific requirements for professions can be easily understood and to reduce the burden associated with participating in consultation. As the largest profession regulated by Ahpra, it is essential that proposed changes are presented in a format that is clear, accessible, and easily understood by nurses and midwives.

22. The use of multiple coloured text boxes (blue, green, grey and purple) further reduces the document's clarity. The purpose of this colour coding is not immediately apparent, and the document does not include a legend or key explaining the significance of each colour. This makes it more difficult for readers to identify which information is relevant to their profession and increases the risk of misunderstanding the proposed changes. The ANMF recommends that the document formatting be simplified and that any colour coding be clearly explained through an accompanying legend or key.

23. The ANMF are pleased to see that the proposed standards do not include specific requirements for returning to practice after an absence or set a maximum period of time out of practice and leave this for individual boards to determine. As highlighted in the ANMF's prior submission to the NMBA in 2020 on their proposed revised registration standards for recency of practice, we have never supported the rigid adherence to a cut-off period for applicants requesting to re-enter the register after ten years of lapsed nursing and midwifery practice. The 2026 proposed standard, however, continues to rely on NMBA-approved programs and supervised practice as pathways for nurses and midwives who do not meet the RoP hours thresholds with no mechanism for consideration of extenuating circumstances and no exemptions (see below for a section focussed on return to practice programs). The ANMF notes that its 2020 submission documented significant and ongoing barriers to accessing these pathways, including a scarcity of approved re-entry programs in most states and territories, employer reluctance to engage practitioners with conditions on registration, and burdensome NMBA requirements deterring employer participation. These structural barriers have not, to the ANMF's knowledge, been remediated. Ahpra and the NMBA should demonstrate that these pathways are genuinely accessible.

Question 2 – *Does the proposal to require 150 hours of practice in the previous 12 months or 450 hours in the previous three years provide appropriate options for practitioners applying for or renewing their registration, including overseas health practitioners applying for registration in Australia? Why or why not?*

24. The ANMF does not support the proposed change as this represents a significant increase in the recency requirement for nurses and midwives, from 450 hours over five years to 450 hours over three years. As stated above, it is also unclear whether or not nurses and midwives would need to demonstrate 450 hours over five years *and* 150 hours within 12 months. While also allowing for this to be met with 150 hours within the previous 12 months, this would still be challenging for staff who have taken a longer time away from work and/or who cannot amass the required number of hours within a 12-month period. This is an increase in regulatory burden placed on these professions and does not appear to be underpinned by clearly presented evidence. In lieu of evidence to support the proposed

revised RoP standard, we highlight the proposal's potential detrimental impact on nursing and midwifery professionals, particularly given that the increase in expectations may result in some nurses and midwives being unable to maintain their registration. Notably, the discussion paper does not include an analysis of this proposal's potential impact on individual professionals, the broader workforce, or the communities that rely on their care. It is unclear what percentage of the current health professional workforce would not currently meet this new requirement and thus may become ineligible for registration. This is of particular importance in the nursing and midwifery workforce, where there are already significant workforce deficits.[1]

25. The ANMF contests that increasing RoP requirements has the potential to affect hundreds, if not thousands, of nurses and midwives across Australia. ANMF NSW Branch membership data highlights the scale of impact, with 534 enquiries relating to recency of practice, reporting obligations, and registration renewal, including 157 specifically about recency of practice under the current standard. The proposed changes to the standard would directly impact many of the nurses and midwives reflected in these figures. It is important to note that these numbers represent NSW members only. The national impact across Australia would be significantly higher. We are concerned that the proposed RoP will detrimentally impact women in the workforce due to an unequal distribution of caring roles and a longstanding dismissal of health and well-being issues affecting women. The healthcare workforce, and particularly the nursing and midwifery workforce (54% of the total health workforce), is predominantly women (74%).[2] The Australian Bureau of Statistics highlights that caring for children is the number one reason why 44% of women report being unavailable for work, with long term health conditions or disability (10%), short-term illness or injury (9.4%), and caring for ill, disabled, or elderly loved ones (6%) also contributing significantly to why women might often need to take extended breaks from work.[3] A growing body of evidence also highlights the widespread, detrimental, and significant impacts that menopause has for many women, including that 80% of women are impacted by menopause in a moderate to severe way, leading to 37.7% retiring before age 55 and 17% aged 45-64 taking an extended break from work.[4]

26. Nurses and midwives, like the rest of the Australian population, suffer from emotional, physical and psychological concerns, and at times need to take leave and not practice due to physical health, workplace injuries, and mental health issues. Importantly, however, Australian nurses and midwives face significantly higher rates of physical and psychological injuries than the national average.[5] Driven by workplace violence, patient-handling, and severe burnout, the health care and social assistance sector reports the highest number of serious injury claims in the country.[5]

27. Psychosocial hazards at work are also important considerations. These are the "aspects of the design and management of work and its social and organisational contexts that have the potential for causing psychological or physical harm" (International Labour Organization 2016, p. 13).[6] Frequently reported workplace psychosocial hazards include: low job control, poor organisational change management, shift work and unpredictable hours, underuse of skills, remote/isolated work-related violence and aggression, bullying, harassment, role ambiguity, and poor workplace relationships and interactions.[6, 7] Work-related stress is determined by the psychosocial hazards or risks found in the organisation, design or relations of work, and occurs when the demands or expectations of the job do not match the capabilities, resources or needs of the worker. As noted above, people working in the health care and social assistance sector are at a greater likelihood of experiencing these risks. Since 2018, many Australian states and territories have implemented regulations concerning psychosocial hazards, addressing these in work health and safety laws and codes of practice for employers to manage psychosocial hazards. While these regulations sit outside of RoP standards, they are a key element within the context of healthcare professionals' work and consideration of this context is vital in terms of ensuring standards remain evidence-based and appropriate.

28. Changes to the required RoP hours based on insubstantial and uncited evidence is likely to compound the pressures that nurses and midwives already experience that hinder them from taking time away from work when it's required. Likewise, an unfeasibly restrictive standard will also drive health professionals to return to work earlier than is safe, placing both them

and communities they serve at risk. Where ANMF members are unable to meet RoP standards, then, compounded by other work- and gender-related pressures, there is a very real risk that they will instead choose to leave practice entirely, resulting in compounding workforce shortages, reduced community access to care, and poorer health and wellbeing outcomes at both the individual and population levels.

29. In terms of specifying particular cut-off periods applied within a RoP standard, it appears that there is currently very limited empirical evidence for a minimum duration of practice to maintain professional competence. A 2023 systematic review of evidence on the RoP standard for regulated health practitioners in Australia found no evidence identifying a minimum number of practice hours required to maintain competency, other than reference to an unpublished 1994 study of Texas nurses.[8] International jurisdictions that also specify practice hours for nursing and midwifery registration, such as New Zealand and the United Kingdom, also appear to lack a clear rationale for their selection of practice hour requirements.

30. The proposed requirements of 150 hours of practice in the previous 12 months and/or 450 hours in the previous three years do not appear to be grounded in clear or strong empirical evidence. In the absence of a clearly articulated evidence base for this proposed change and in-depth consideration of the potential impacts of the change on the workforce, the ANMF does not support the proposed RoP standard and advocates for the maintenance of the status quo. We recommend the retention of 450 hours of practice over five years to be maintained.

Question 3 – *Does the requirement for practitioners moving to a new area of practice (e.g. non-clinical to clinical) to ensure they have sufficient training and/or qualifications to achieve competency in the new area adequately protect the public and align with public expectations of registered health practitioners?*

31. As highlighted in the ANMF's prior submission to the NMBA in 2020 on their proposed revised registration standards for recency of practice, the reference to 'clinical' and 'non-clinical' practice has the potential to create confusion amongst the nursing and midwifery

professions. The terms are additional terminology that are not required. Nurses and midwives should not be required to repeatedly demonstrate that they possess sufficient training or qualifications to achieve competency in a new area of practice. Nursing and midwifery are professions that rely heavily on practical, on-the-job training. Expectations that practitioners should gain skills independently before entering a new role are not realistic. In practice, nurses and midwives are typically supported through orientation, education and supernumerary time before working independently in a new area. It is extremely difficult, if not impossible, for a nurse or midwife to achieve both the necessary education and competency prior to commencing a new role. This expectation is already embedded within existing scope of practice frameworks and the nursing and midwifery standards. By design, nursing and midwifery are professions with broad, adaptable scopes and diverse skill sets. The current standards clearly outline practitioner responsibilities for assessing and working within their scope of practice. Given these established safeguards, there is no justification for introducing additional regulatory requirements.

Question 4 – *What additional explanatory material or resources would help practitioners understand and comply with the standard?*

32. Nurses and midwives recognise the importance of maintaining clinical competence to support safe, high-quality care. Ahpra should develop evidence-based resources with clear, explicit explanations of how the standard contributes to community member and workforce outcomes. This would better strengthen its legitimacy and perceived value and demonstrate how recency of practice relates to quality and safety outcomes.

33. For nursing and midwifery, profession-specific challenges have also been identified regarding the application of the RoP standard, including uncertainty about which activities could be counted towards RoP hours.[9, 10] Aphra must engage with the NMBA and the nursing and midwifery professional bodies to develop a range of nursing and midwifery-specific explanatory materials to ensure that any implemented changes are clearly communicated, operationally explained and justified, and made easily accessible, such as online and in workplaces. Such work must guide practice and include explicit definitions, worked examples,

an additional paragraph or fact sheet specific to new graduates and internationally qualified nurses and midwives, and clarification of common areas of confusion to support consistent interpretation and application across the workforce.

34. The proposed change represents a notable shift in expectations for nurses and midwives, increasing the recency requirement from 450 hours over five years to 450 hours over three years and/or 150 hours within the previous 12 months. The proposed change may have unintended impacts on segments of the nursing and midwifery workforce, particularly those working part-time or casual roles, or those who have experienced career interruptions.

35. The ANMF does not support the proposed changes to the RoP standard for nurses and midwives, however if the proposed change is realised, Aphra and the NMBA must ensure targeted communication is received and understood by all segments of the workforce, including nurses and midwives, to ensure that poorly communicated decisions do not inadvertently result in nurses and midwives no longer meeting their registration requirements or being put in situations where they might need to risk their own safety and wellbeing and that of others, such as working when they are unwell, to meet RoP requirements.

36. Nurses and midwives are already required to meet a range of professional obligations, including CPD (see below), maintaining up-to-date clearances, and adhering to various regulatory and employer requirements. The revised RoP standard should be designed and implemented in a way that does not introduce unnecessary administrative burden. To support this, there should be clear expectations, streamlined processes, and practical guidance on how practitioners can efficiently demonstrate compliance. Consideration should also be given to aligning documentation requirements with existing systems where possible, to minimise duplication. Further, employers must be required to provide appropriate and flexible supports to ensure that health professional staff are able to meet their RoP requirements without compromising their health, safety, or ability to maintain an appropriate work-life balance.

Question 5 – *Will the proposed ROP requirements help support access to health services while maintaining public protection? Please describe.*

37. The ANMF is concerned that the proposal has the potential to decrease access to health services. These measures are far more likely to deter skilled professionals from returning to practice, accelerating the loss of experience our health system cannot afford. The proposed changes do not facilitate access to a sustainable health workforce; rather, they risk disadvantaging the predominantly female nursing and midwifery workforces, those in flexible working arrangements, and those in rural and remote areas. This RoP proposal could particularly impact nurses and midwives' access to concurrent parental leave, making it more challenging to manage work life balance (see Question 2 and Question 6).

Question 6 – *Would the proposed ROP requirements result in any negative or unintended impacts for individuals or groups? If so, please describe the impact and who may be affected.*

38. As explained above, the nursing and midwifery workforce is predominantly female, and this has important implications for how practitioners engage in paid work and meet regulatory requirements. Many nurses and midwives are employed in part-time, casual, or agency roles to better accommodate caring responsibilities. Women comprise 67 per cent of part-time workers and are nearly three times more likely than men to use flexible working arrangements to manage caring responsibilities, including care for children and older family members.[11] These patterns are particularly pronounced among single mothers, who often face additional barriers to workforce participation due to the absence of shared caregiving responsibilities. Due to taking on additional caregiving responsibilities, there is an increasing reliance on employment arrangements that offer flexibility but not necessarily stability or predictability. This creates a potential barrier to meeting the RoP standard, where clinical hours are dependent on employer rostering practices or irregular shift availability. Due to an employer's unwillingness to provide additional hours, otherwise capable and committed practitioners may be unable to satisfy the standard despite remaining willing to work and maintain constant engagement across the year. Loss of registration will mean loss of income, disruption to career progression, and heightened financial stress for practitioners and their

dependents. The proposed changes to the RoP framework may disproportionately affect workers with caring responsibilities and may unintentionally contribute to workforce attrition. This is likely to be compounded in rural, regional, and remote areas where access to alternative supports (including childcare and other caring services) is poorer.

39. Childcare responsibilities after maternity leave are a significant source of stress for nurses and midwives returning to work, with many extending leave within the current allowance of up to 24 months to mitigate this.[12] This can leave too little time to meet RoP requirements, creating an unfair conflict between leave entitlements and workforce re-entry requirements. This can create significant work-life imbalance and work-family conflict, impacting upon nursing and midwifery wellbeing. Further, the proposed RoP standard contends with breastfeeding guidance under WHO and UNICEF, which recommends breastfeeding up to two years of age.[13] This guidance can be difficult to meet in busy clinical settings, where practitioners often feel rushed or guilty about taking lactation breaks,[12] and a reduced RoP period may further discourage breastfeeding and undermine sustainable return-to-work pathways.

40. The proposed RoP requirements may also inadvertently and disproportionately affect dual-registered nurses and midwives, particularly those working in rural and remote settings, resulting in substantial consequences if there is a change to the current standard for nurses and midwives. In these contexts, dual registrants are often essential due to their broader scope of practice across both nursing and midwifery settings and the cited impracticality of employing separate nursing and midwifery staff within small communities. For example, a dual registrant in a small community may primarily provide general nursing care while also being available to deliver midwifery services when required. In such settings, the opportunities to provide maternity care across the birth and post-partum care continuum could be limited due to a relatively low number of births, which may limit opportunities to accrue sufficient midwifery hours. As such, practitioners could be at risk to maintain their RoP component of their dual registration, thereby reducing local access to maternity care and disrupting continuity of care for community members. This creates a disproportionate

burden on practitioners in rural and remote areas, who may be required to independently source additional clinical opportunities, often without employer support, funding, or the ability to travel, to maintain their registration. While the importance of maintaining competence is not disputed, regulatory settings must account for the practical realities of service delivery in these contexts.

41. Changes to the definition of recent graduate, reducing the timeframe from two years to one year from lodging a complete application for registration, will have significant implications for early career nurses and midwives. This change risks excluding individuals who have completed their qualifications but experienced delays in entering the workforce, such as due to financial constraints, caregiving responsibilities (including maternity leave), or the time required to secure employment. This will result in disruption to the pipeline of new nurses and midwives, ultimately impacting workforce sustainability. This impact will be most pronounced among internationally qualified nurses and midwives (IQNMs), where meeting English language testing (ELT) requirements can take over one-year. This can result in IQNMs having unnecessary conditions placed on their registration, further hindering their ability to enter practice.

42. In response to the above issues, the ANMF recommend that Ahpra and the NMBA issue a statement that employee-initiated flexibility should be accommodated by employers to ensure there isn't disproportionate impact to those with protected attributes in meeting the RoP standard. At present, the responsibility is largely placed on individual practitioners to track, document, and ensure they meet the required RoP hours. However, this expectation does not adequately reflect the realities of many employment arrangements within the health workforce. In practice, many nurses and midwives have limited control over their working hours and schedules. Importantly, for our members engaged in casual, part-time, or agency-based employment may be constrained where their ability to meet practice hours is contingent upon the availability of shifts where they work. This also puts nurses and midwives in a position that they might be forced to take on multiple jobs in order to make up the number of shifts needed to maintain their RoP. In these contexts, practitioners cannot

independently guarantee that they will meet RoP requirements, despite making reasonable efforts to remain compliant. This issue is further compounded for dual registrants, who, under the current NMBA approach, are required to meet the registration standards as a nurse and as a midwife individually. It is unclear if this is to apply under the revised RoP standard. If it is, this would require dual registrants to complete 900 hours of practice within three years or 300 in 12 months per registration across both nursing and midwifery practice to maintain dual registration. Achieving this balance can be especially challenging when practitioners rely on employers to allocate shifts across both disciplines. In many cases, employers may not prioritise or facilitate this distribution of work. Without this standard, there may be an increase in attrition rates, which affects workforce sustainability and consumer access to care services.

43. The ANMF notes that in its 2020 submission it raised detailed legal concerns that the then proposed incremental RoP hours structure would constitute indirect discrimination towards women under anti-discrimination laws applicable across all jurisdictions where Ahpra and the NMBA operate, on the basis of sex/gender, pregnancy, breastfeeding, and parental/carer responsibilities.

44. To illustrate, a nurse who takes 18 months of parental leave and returns to work at 0.5 Full Time Equivalent (FTE) would need to accumulate 450 hours in the remaining 18 months of the three-year window or/and 150 hours in 12 months; achievable only with consistent work and no further interruptions, a precarious position for someone managing infant or family care. Under the previous five-year standard, the same practitioner would have had three years to accumulate 450 hours on return. Where a second parental leave occurs within the window, as is common, the burden compounds further. With a tighter window disproportionately disadvantaging women who exercise their legal right to extended parental or carer leave. Ahpra should publish its anti-discrimination assessment of this proposal before finalisation.

Consultation questions: Continuing professional development registration standard

Question 1 – *Is the proposed revised CPD standard clear and workable in practice? Why or why not?*

45. The ANMF recognises the importance of the CPD standard in supporting practitioners to maintain current knowledge and skills in line with the need to ensure the delivery of evidence-based care. Ongoing education and learning are fundamental to a registrant's practice. It is an essential element to guide safe, high-quality care, and uses acquired knowledge gained from CPD to consolidate an individual's practice and to implement change or evolving clinical practices, newer evidence, skills, and technologies. While there is some evidence supporting the general need for CPD as a mechanism to promote professional competence and improve patient outcomes,[14] there remains a lack of evidence identifying an optimal quantity/duration or structure of the CPD required to achieve these outcomes.[15] As with the RoP standard, the absence of a strong evidence base makes it difficult to assess the potential adequacy and impact of the proposed CPD standard. Without clear data linking specific CPD conditions and thresholds to improved practitioner performance or patient outcomes, there is a risk that requirements may be viewed as arbitrary rather than an evidence-informed standard which could influence both views regarding the legitimacy of the standard as well as compliance.

46. The ANMF recommends that any CPD standard must be accompanied by a directive from the NMBA on employers to ensure the workforce is supported to meet the standard. As it is the responsibility of the health professional to maintain compliance with the CPD standard to undertake their roles, it must be the responsibility of the employer to ensure that their employees are effectively and appropriately supported to achieve this. To ensure that CPD requirements are met, employers must have a clear responsibility to ensure their workforce is supported and provided with sufficient opportunities to engage in high-quality CPD in a way that does not impinge on their rights to work-life balance. This includes funded CPD entitlements, provision for backfilling positions while staff undertake CPD, awarding

scholarships and bursaries, subsidising the cost of CPD, offering a range of high-quality workplace-based CPD activities that support accessible learning, and implementing other initiatives to facilitate participation and relieve costs on individuals.

47. Research demonstrates that engagement in CPD and improved learning outcomes are strongly linked to a supportive work environment.[16, 17] The development of rules around this expectation on employers would improve the visibility of the workplace's support for ongoing learning and professional development and assist in actively engaging, attracting, and retaining staff.

48. In relation to CPD, of particular concern is the proposal that education, training, mentoring, or supervision required by the Board or a tribunal does not count towards CPD. This approach raises issues of fairness, clarity, and proportionality. It is likely to disproportionately impact vulnerable practitioners and does not appear to be supported by a clear evidence base. It risks operating as a punitive measure, creating additional barriers for practitioners seeking to re-enter the practice rather than supporting their safe and effective return to the workforce. Practitioners who have conditions placed on their registration are required to meet the costs associated with mandated education and training. These requirements are typically completed outside of paid work hours, and in many cases, practitioners may not have ongoing employment due to the conditions imposed. Additional burdens can include travel to attend face-to-face education and limited access to flexible learning options. Prior to undertaking this education, practitioners are also required to develop a learning plan that identifies gaps in their practice and outlines how these will be addressed, further demonstrating a structured and reflective approach to professional development. The financial and time burden associated with meeting-imposed education conditions is substantial. For example, a practitioner required to complete Board-imposed education in medication administration and calculations with an assessment component may need to attend a six-hour face-to-face course, complete approximately 21 hours of online learning modules, undertake practice assessments equating to an additional six hours and sit a three hour live examination requiring a 100% pass mark. In total, this represents approximately 36

hours of focused learning for a single condition. Despite its clear relevance to maintaining and improving clinical competence, this learning would not be recognised as CPD under the proposed changes. Excluding such education from CPD requirements creates inequitable outcomes, as practitioners who are already shouldering significant financial and personal burdens would be required to undertake additional CPD at their own expense. This imposes a double burden and risks discouraging skilled and experienced practitioners from remaining in, or returning to, the workforce, particularly in a context of ongoing workforce shortages.

49. The ANMF recommends that nationally consistent CPD on Aboriginal and Torres Strait Islander Peoples cultural safety be a mandatory requirement across all professions. CPD focused on Aboriginal and Torres Strait Islander Peoples cultural safety and culturally safe care in general must be delivered to all health professionals to ensure services are accessible and care is provided in a culturally safe manner. This is particularly important in delivering on commitments such as Closing the Gap. Responsibility for ensuring this training is provided must be placed on employers, and it must be made available across all workplaces. This could be achieved by the Federal Government funding the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) to deliver yearly updated nationally mandated cultural safety training to all health workers in all sectors that counts towards CPD hours.

Question 2 – *Should a minimum amount of interactive CPD (e.g. peer discussion, virtual mentoring, case review) be required? If yes, is five hours per year appropriate?*

50. The ANMF does not support the proposed requirement for a minimum of five hours of interactive CPD. While the broad intent of promoting engagement and professional development is understood, there is limited evidence to demonstrate that mandating a specified number of interactive learning hours improves learning outcomes or professional practice for nurses and midwives. Further, the proposal lacks clarity about what constitutes 'interactive learning' and how compliance would be demonstrated, creating unnecessary administrative burden for an already stretched workforce. The requirement may also disproportionately disadvantage nurses and midwives working in regional, rural, and remote

areas, as well as those in busy clinical settings, where opportunities to participate in scheduled interactive learning activities are often limited. Many practitioners in these contexts rely on online and self-directed learning because it provides the flexibility to undertake CPD at times and locations that accommodate shift work, family responsibilities, and demanding clinical workloads. Mandating interactive learning risks reducing this flexibility without clear evidence that it leads to better professional outcomes.

Question 3 – Is the requirement for an additional 10 hours of CPD for practitioners with technical and/or profession-specific skills (e.g. endorsement for scheduled medicines) appropriate? Why or why not?

51. For nurses and midwives with an endorsement, the requirement for an additional 10 hours of CPD already exists under the NMBA. While the intent of this requirement, to support the maintenance of competence, clinical capability, and safe practice in advanced practice roles, is well understood, the basis for setting the additional CPD requirement at 10 hours per year is not clearly articulated. In particular, there appears to be limited evidence demonstrating why 10 hours is the appropriate threshold, how this amount of CPD contributes to maintaining competence in endorsed practice, or whether it is associated with improved consumer safety, quality of care, or health outcomes. A more transparent evidence base linking the required number of hours to measurable professional and consumer benefits would strengthen the rationale for retaining this requirement, support greater confidence in its effectiveness, and encourage practitioners to meet this requirement.

52. The feasibility of meeting the additional CPD requirement must also be considered in light of access to relevant CPD opportunities, which can vary significantly depending on an individual's practice setting, geographic location, employer support, and availability of education providers. As a result, the ability of practitioners to meet CPD obligations should not rest solely with the individual. Employers have a critical role in supporting workforce capability and should be responsible for providing, facilitating, or funding access to appropriate CPD opportunities that are directly relevant to endorsed practice. This is particularly important in rural, regional, and resource-constrained settings, where access to

specialised education may be limited. Without adequate employer support and sufficient availability of relevant CPD activities in paid time, compliance with additional CPD requirements may become burdensome and may not achieve the intended objective of enhancing practitioner competence and improving consumer outcomes.

Question 5 – What additional explanatory material or resources would help practitioners understand and comply with the standard?

53. If the change regarding the requirement for 'interactive learning' is put in place, supporting material regarding the specifics of this requirement, the activities that can be counted towards this requirement, and the evidence required to demonstrate that this learning was 'interactive' is required.

54. As with the RoP standard, the multiprofessional approach attempts to cover too many disciplines within a single document, resulting in a lack of clarity, coherence and practical usability for nurses and midwives. To ensure accuracy, relevance and ease of interpretation, we strongly recommend the development of a separate, profession-specific document for nursing and midwifery.

Question 6 – Will the proposed CPD requirements help support access to health services while maintaining public protection? Please describe.

55. The ANMF suggests that the proposed CPD requirements may inadvertently reduce access to practitioners, particularly in rural and remote areas (see Question 7). Increasing regulatory barriers for nurses and midwives will undermine, not enhance, access to care. These measures are far more likely to deter skilled professionals from returning to practice, accelerating the loss of experience our health system cannot afford. The proposed changes do not facilitate access to a sustainable health workforce; rather, they risk disadvantaging the predominantly female nursing and midwifery workforces.

Question 7 – Would the proposed CPD requirements result in any negative or unintended impacts for individuals or groups? If so, please describe the impact and who may be affected.

56. Nurses and midwives work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations, meaning they may be disproportionately and inadvertently affected by the proposed CPD requirements, specifically where there is an expectation for a defined proportion of CPD to be 'interactive learning' with other practitioners. While the increased availability of online learning may help to mitigate some geographic barriers around access to education, the concerns outlined in response to Question 2 regarding the accessibility and practicality of interactive learning are likely to be more pronounced in rural and remote contexts. In some workplaces, there can be limited staffing levels, reduced workforce flexibility, and constrained access to relief or backfill arrangements, which already place significant pressure on service delivery. As a result, the requirement to attend scheduled, group-based, or facilitated learning activities is often operationally difficult, particularly where services are small, geographically isolated, or operating with minimal staffing. Even where interactive CPD opportunities are available virtually, participation may still be constrained by roster rigidity, competing clinical demands, and the need to maintain safe minimum staffing levels. Consistent with the issues described in response to Question 2, the requirement for interactive learning risks compounding existing workforce pressures, particularly in rural and remote areas.

Return to Practice

57. While this consultation does not explicitly address return to practice requirements, leaving this to the individual Boards to determine, the ANMF notes that nurses and midwives already face significant systemic barriers when attempting to return to practice. These challenges are likely to be intensified by the proposed changes to the RoP standard and the revised definition of 'recent graduate'. In particular, there is a limited availability of supervisors for Pathway 1 and a shortage of NMBA-approved re-entry programs for Pathway 2. Given these existing constraints, any changes that make it more difficult to meet RoP requirements or

that shorten the exemption period for recent graduates are likely to increase demand for these pathways, further exacerbating current systemic barriers, and affecting the number of nurses and midwives able to practice.

58. Regarding Pathway 1, while some supportive initiatives exist to assist practitioners, these are limited and can be difficult to access. Practitioners are often required to apply and interview for positions, disclose their supervision conditions, and be selected as the preferred candidate before they can access any financial or program support. Registration conditions requiring supervision can also significantly reduce employment opportunities, as employers may prefer candidates without such conditions, even where experience and qualifications are equivalent or greater. This may discourage practitioners from returning to practice, particularly where they are unlikely to meet the increased RoP requirements set out in this proposal.

59. In relation to Pathway 2, the availability of approved courses of study is limited, particularly for midwives, and there are currently no dedicated programs for Enrolled Nurses (ENs). For ENs who do not meet the recency requirements, this may mean having to complete their diploma again within a three-year period in order to remain in the profession, creating a significant time and financial burden. Where programs are available, the cost is often prohibitive, with the Australian College of Nursing re-entry program costing $17,482 and other universities charging more than $8,000. Nurses and midwives who have recently returned from consecutive maternity leave, carer leave, workers' compensation leave, or cultural leave may already have experienced reduced income, and being unable to work due to increased RoP requirements is likely to force some to seek employment elsewhere.

60. The proposed changes to the RoP also do not adequately account for practitioners progressing through regulatory processes, who are at particular risk of falling outside RoP requirements due to factors beyond their control. Regulatory timeframes commonly extend from one to two years and may include complaints handling, investigations, assessments, and the imposition of conditions on registration. Once conditions are applied, particularly

those requiring supervision or workplace-based assessment, practitioners often face significant barriers to securing employment, further limiting their ability to maintain or regain recency. Reducing the time to meet the RoP requirement would only increase this risk.

61. The draft RoP standard also lacks clarity and flexibility in how individual circumstances, including different forms of leave, will be assessed in relation to return to practice. Reducing the recency period to three years, in the absence of clear, flexible and proportionate consideration of individual circumstances that is supported by evidence, risks disproportionately impacting vulnerable practitioners, including those with caring responsibilities or those transitioning toward retirement after decades of service. This may have unintended consequences for workforce participation and retention.

62. In March 2023, the NMBA updated its *Policy: Re-entry to practice* allowing nurses and midwives out of practice for 10 to 15 years to undertake a shorter, six-month NMBA-approved re-entry program (Pathway 2) instead of the previously mandated university assessment that often took over 12 months. This extended time frame, from 10 to 10-15 years, recognised the need for flexibility to support practitioners who step away from the workforce. Tightening the RoP standard to a three-year timeframe would have the opposite effect, reducing the number of nurses and midwives able to return to practice and, in turn, limiting access to healthcare for the community.

Conclusion

63. The ANMF appreciates the opportunity to provide feedback to Ahpra on the proposed revised RoP and CPD registration standards. The ANMF does not support the proposed changes presented by Ahpra, particularly the proposed shift from 450 hours in five years to 450 hours in three years, changes to the recent graduate definition, and the proposal for specified 'interactive' CPD hours. These changes represent a significant increase in regulatory burden on nurses and midwives that is not supported by a clearly articulated or independently verifiable evidence base. The nursing and midwifery workforce is already under significant pressure, and any changes to registration standards must be clear based on

evidence and carefully calibrated to avoid inadvertently driving workforce attrition, particularly among women managing caring responsibilities, dual registrants in rural and remote settings, and practitioners managing health conditions.

64. Should Ahpra move forward with this revision, the ANMF urges Ahpra and the NMBA to publicly release the evidence base that would be required to justify any future change to the nursing and midwifery RoP standard, including an independent anti-discrimination assessment of the proposal, a workforce impact analysis, and a realistic audit of the accessibility of re-entry and supervised practice pathways.

65. The ANMF remains committed to constructive engagement on registration standards that are evidence-based, equitable, and proportionate, and that enable nurses and midwives to practise safely while supporting a sustainable workforce.

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