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Subject:	5TH Edition revised BPF 20 Nov.docx
Attachments:	5TH Edition revised BPF 20 Nov.docx

Good afternoon

Firstly, a huge thank-you to everyone for your time and participation this week with all of the teleconferences in relation to this document.

Please find attached the Draft BPF 5th Edition for your review and welcomed comments of the content and flow. I understand the format may not be perfect and I have been assured that this will be able to be corrected by the publishing team.

Could you please send me feedback and comments by Monday 30 November? The feedback can be sent back either in track changes in the document or by scanned document with hand written comments.

We have a meeting on Wednesday to discuss the distribution for consultation and implementation.

This document has not been sent your EDON yet, but will be next week. Please feel free to discuss this with your EDON.

Regards
Juliet

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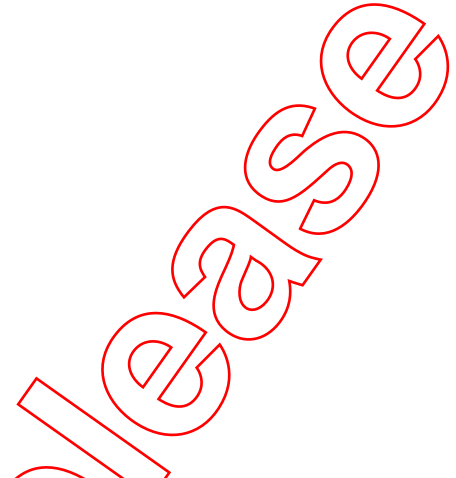
Business Planning Framework

5th Edition

November 2015

DOH-DL 15/16-032 RTI Document 2



Business Planning Framework – 5th Edition

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Introduction

The Business Planning Framework: the tool for nursing and midwifery workload management (BPF) will imminently transition to a Standard, to support safe ratios and workplace provisions. As part of the *Nursing Guarantee – putting patient safety first*, the Government has committed to legislate for safe nurse-to-patient ratios and workload provisions in Queensland's public Hospital and Health Services (HHS).

The complementary objective for this initiative is to transition the BPF into a Standard, to provide a clear message that the number of nurses on a shift is an important aspect to improving patient safety and quality of care. Integral to the Standard, is the emphasis on increasing transparency on health system performance, monitoring and public reporting on compliance with ratios and the BPF.

The BPF provides nurses and midwives with a business planning process to assist in determining appropriate staffing levels to meet patient requirements and evaluate the ongoing performance of the nursing service.

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The BPF provides nurses and midwives with a simple, standardised business planning process, which assists to:

- determine appropriate nursing staff levels and skill mix to meet service requirements
- identify strategies for managing workloads; and
- guide the development of transparent processes to evaluate the efficiency and effectiveness of the service.

Each clinical unit is required to determine its nursing / midwifery requirements to ensure safe, high quality patient care through shift-by-shift assessment of patient demand. Individual patient needs must be met by the appropriate nursing and midwifery resource allocation over the twenty four (24) hour cycle.

The BPF also determines the process for monitoring and acting to ensure these requirements for nursing and midwifery staff are met and most importantly, to ensure patients are receiving the nursing and midwifery care and contact time they need on the shift. These procedures are outlined in the BPF to demonstrate effective responses to unplanned variations to predicted patients' needs or the availability of nursing staff at any time during the day or night, including prompt action to enable an increase or decrease in nursing staff.

Key benefits of the Business Planning Framework

The BPF improves health service delivery by:

- assisting nurses / midwives to plan
- defining goals and objectives
- identifying priorities determining the required human resources (e.g. nursing / midwifery hours, skill mix) and determining other required resources (e.g. technology, equipment etc)
- guiding monitoring and evaluation; and
- promoting the alignment of frontline services with the strategic directions of Queensland Health and Hospital and Health Services.

Principles of the Business Planning Framework

Business planning is a systematic process for examining a ward / unit / service and its environment in order to allocate nursing and midwifery resources to meet the demand in the most appropriate way. The underlying principles in the BPF process promote transparency in consultation, collaboration and negotiation with the nursing and midwifery leadership team and the Hospital and Health Services (HHS) executive team to ensure that current demand for service / activity is matched with the supply of resources.

These principles fall into three key categories aligned with the key stakeholders of a health service: patients, staff and the wider organisation. The principles are:

1. Patient / client focussed
   - applies evidence based models of care and clinical practice
   - meets agreed outcomes and health improvement targets
   - promotes the premises as underpinning delivery of safe, quality health care (accessible, responsive, safe, efficient, sustainable, effective and appropriate).
2. Staff focussed

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- ensures active participation in the planning and management of resources by nursing and midwifery staff to ensure a balanced approach to resource management
- aligns staff numbers and skill mix with service demand to effectively manage workloads
- integrates workforce planning, workforce flexibility, evidence-based practice, competency, requirements and training
- embeds systems for delivering safe, equitable workloads
- clinical environment.

3. Organisation focussed
- ensures alignment and consistency between individual service-based business plans and Hospital and Health Services' strategic direction
- promotes optimal use of resources
- integrates systems to assist staff in decision making
- provides access to timely, accurate and reliable data.

The BPF supports nursing and midwifery service managers to match the supply of nursing / midwifery resources with patient demand to deliver services that provide quality patient care outcomes.

Governance and process influences

Individual nursing and midwifery services within Hospital and Health Services have individual, agreed processes for the planning and reviewing of nursing and midwifery resource requirements. These processes align with the current BPF methodology and National Standards for Safety and Quality, and also promote budget integrity.

The people responsible and accountable for nursing and midwifery staffing follow agreed governance principles to identify and support appropriate staff resources at an organisational and at a ward / unit / service level to ensure safe patient care. These processes are delivered within an overarching governance structure to ensure an integrated, consistent and supported approach to workplace and workforce management, and are influenced by:

- Patient Safety and Quality
- Clinical/Performance Outcomes
- Defensible Business/Workforce Plans
- Accountability Structure
- Approval/Negotiation Processes
- Workload Management → service profiles → strategic / analytical monitoring → determining skill mix
- Consistency and Transparency
- Staff Collaboration

This approach requires 'service profiles' that detail the nature of the demand, including population health profiles and internal, external analyses with comparative analysis and performance metrics. These steps reveal any gaps that indicated service growth or reduction, and what the impacts of these variances maybe on the nursing and midwifery workforce.

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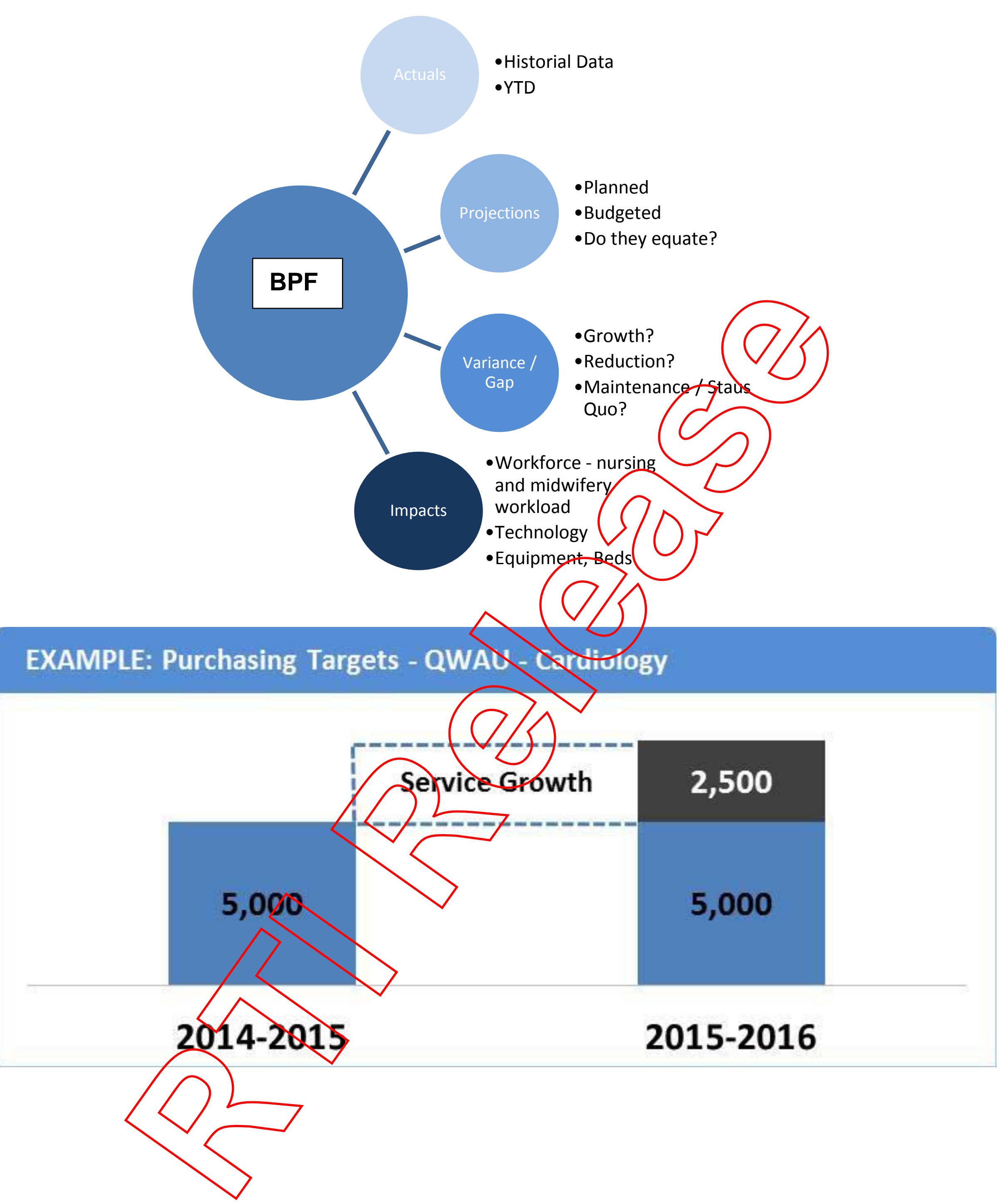
Contemporary BPF



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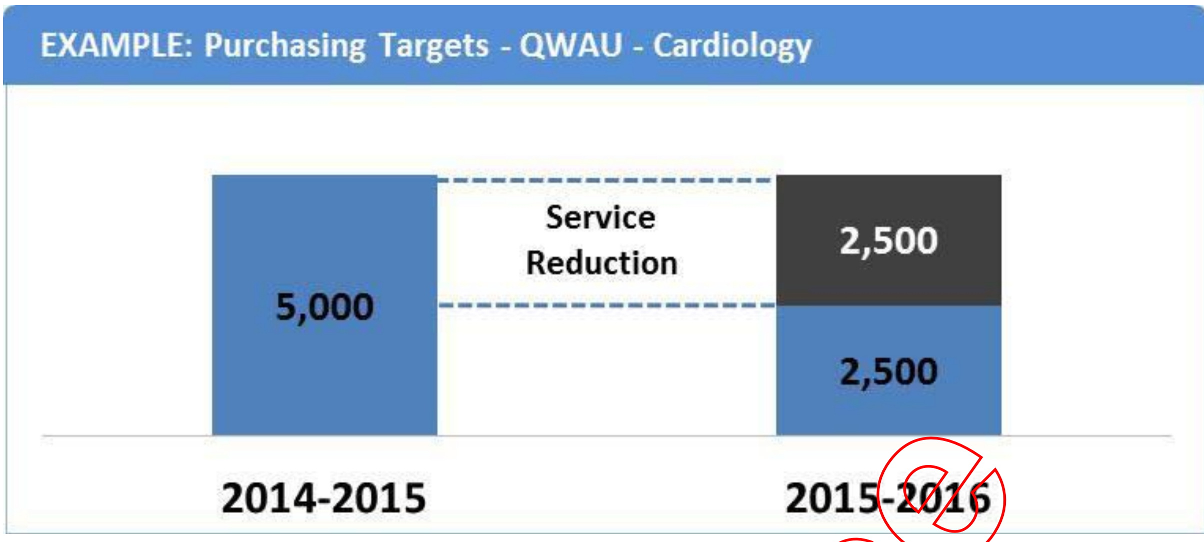

Gap Analysis will indicate that estimates of human resourcing, capital, technology are required. The gap will need to be managed up through the governance structure of the organisation, supported by data wherever possible. This leads to the negotiation process between what the service has planned and should guide the budget negotiations. Optimally, budgeted activity (actuals) equal planned (forecast) activity.

Service profile

Health care services exist in a complex and changing environment and a robust plan assists to meet these challenges. Therefore, the ability to balance service demand and staff supply is essential when planning the long-term viability and sustainability of these services. Frequent monitoring and evaluation of demand indicators such as client acuity and activity is necessary to ensure nursing and midwifery workloads are matching service (patient) demand.

A service profile will identify the nature of the demand, the clinical capability of each facility, service and unit, the resource allocation used to meet current demand and the amount of resources required to meet activity projections for future year/s. The relevant corporate and HHS priorities / strategies need to be reflected in the service profile to align with the HHS service level agreement and the *National Safety and Quality Health Service (NSQHS) Standards.*

When developing the service profile, it is important to document the core demands on the service and consider all influences and variables, particularly in relation to workforce numbers, skill mix profiles and material resources.

A completed service profile:

- describes the demand placed on nursing and midwifery resources
- assists in the planning of service delivery
- identifies the service's purpose, direction, tasks and priorities
- determines the resources utilised to deliver the current services and estimates of resources required to deliver future activity
- provides guidance with monitoring and evaluating service performance.

A service profile is developed annually, based on the financial year, acknowledging adjustments to the profile may be required throughout this time if key factors such as patient / client activity and nursing supply change during this time. The proposed service profile

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determines the current / future state of demand and provides a plan for matching this with resource supply through the collation of relevant data collected from the following analyses:

The external environment includes the following factors:

- Policy/Legal
- Economic
- Social
- Technology
- Research and EBP

The internal environment:

- Structural
- Human Resource Management (HRM)
- Information and Communication Technology (ICT)
- Comparative Analysis

The SWOT reviews:

- Service Strengths
- Service Weaknesses
- Service Opportunities
- Service Threats

Using the initial service profile as a guide, the service area's budget for the financial year is clearly identified and can be readily discussed and negotiated. Once the budget and the level of service is agreed upon and finalised, the initial service profile is recognised as the 'agreed service profile' (keeping in mind the profile may need to be reviewed and amended periodically in line with the budget allocation).

It is important to remember the service profile includes both demand and supply data, and performance metrics of how these can be measured for monitoring and evaluation.

Resource Allocation

Chapter 2 discusses the importance of a BPF approach to resource allocation, and the calculation tools. The calculations to estimate the resources required to meet planned / forecast activity for the following financial year will become simplified as automation replaces the current calculations. Chapter 2 contains the manual calculations, however the corporate/IT systems current recommendation will be updated and linked to the Office of the Chief Nursing and Midwifery Officer's website.

Methods for allocating resources in response to demand are explained and response strategies are provided where the allocation of funds does not balance with identified service requirements in Chapter 3, Reaching a Balance

Reaching a Balance

This third and final stage of business planning analyses the differences between the demand for resources and the actual resources allocated. It allows service area managers, staff and senior management to identify gaps and agree on a resolution. That solution is likely to be one of three potential outcomes:

- change the demand for resources

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- change the investment of resources
- alter the mix of resources to achieve agreed outcomes.

When differences occur, a balance can only be achieved by adjusting either supply or demand, or both. This is discussed further in Chapter 3 and how to negotiate a resolution.

Escalation

When workload issues arise, escalation is necessary when resolutions cannot be found at the local level. These are described in detail in Chapter 4.

Performance metrics

Measuring performance to understand progress is key to understanding the outcomes of the diverse activity within a unit, service, facility and HHS. Chapter 5 describes the importance of nurse sensitive indicators and keeping nursing metrics on the HHS agenda.

The ability to balance service demand and staff supply is essential when planning the long-term viability and sustainability of health services. Frequent monitoring of demand indicators such as client acuity and activity is necessary to ensure nursing and midwifery staffing matches service demands, and the term acuity is used interchangeably with complexity and intensity to identify service demand within health care services. The BPF is the agreed, industrially mandated methodology to ensure safe and sustainable workloads for nurses and midwives. The framework has been a collaborative project between Queensland Hospital and Health Services, the Queensland Nurses Union, Office of the Chief Nursing and Midwifery Officer and the Employee Relations Unit.

The Addenda from the 4th edition BPF on Mental Health; Perioperative; Outpatient and Ambulatory; Primary and Community and Public Health Services remain essential reading for those specific settings undertaking their annual review [hyperlinked]. These documents highlight the importance of any setting considering their annual service profile, the most appropriate model of care and service delivery model to meet service demand and the nursing and midwifery hours required.

The BPF complements (and is not a replacement for) the professional self-regulation and individual accountability for clinical / professional judgment that are integral components of health care. The BPF reinforces the importance of using professional judgement to make decisions appropriate to the circumstances; with the priority of safe, high quality patient care. The key to the BPF's success is empowering the middle management levels to maintain the safety and quality of health care services and budget integrity.

Accordingly, the Nurse Unit Manager, Nursing Director and Director of Nursing have cascading responsibility for developing and implementing the BPF at the 'local' level and are empowered to do so. The BPF provides the management of workload issues, resolution processes and performance metrics. A sound business framework and workload management strategy is essential in delivering quality care and improving patient outcomes in today's complex and dynamic health care environment.

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Chapter 1: Develop a service profile

Action!
Refer to:
Template 1: Service Profile

In a nutshell:
The purpose of this first Chapter of "how to implement the BPF" is to support you in planning through clear identification and articulation of the health needs of your local area. It is not just about looking at the current business model and quantifying the required resources, it is about starting at the very beginning and identifying the aims and objectives of the service ("why are we here?") and assessing the area's current activities for achieving this ("is this the best way to do this?").

Following these steps will inform your human and financial requirements from the demand so that service delivery can meet the appropriate level of care. This means determining supply by allocating the most appropriate resources and is the basis for Chapter 2.

The following points are important considerations when developing a business plan.

Developing a service profile

Service Profile

Demand
based on Population Health data
(Internal, External, SWOT analyses)

Supply
(Calculations and professional judgement determines resources)

Performance Metrics (NSI, Benchmarks, HHS reporting) to monitor and evaluate

Developing a service profile may seem like a daunting task. However, a step-by-step guide is outlined in this chapter with a matching template. By simply following these steps and filling out the template, any service area can readily develop an effective service profile.

This has the interrelated benefits of:

- simplifying the process for service area managers
- ensuring the final service profile is robust and can be used as an effective business planning and budgetary tool; and
- embedding consistency across all health service delivery areas

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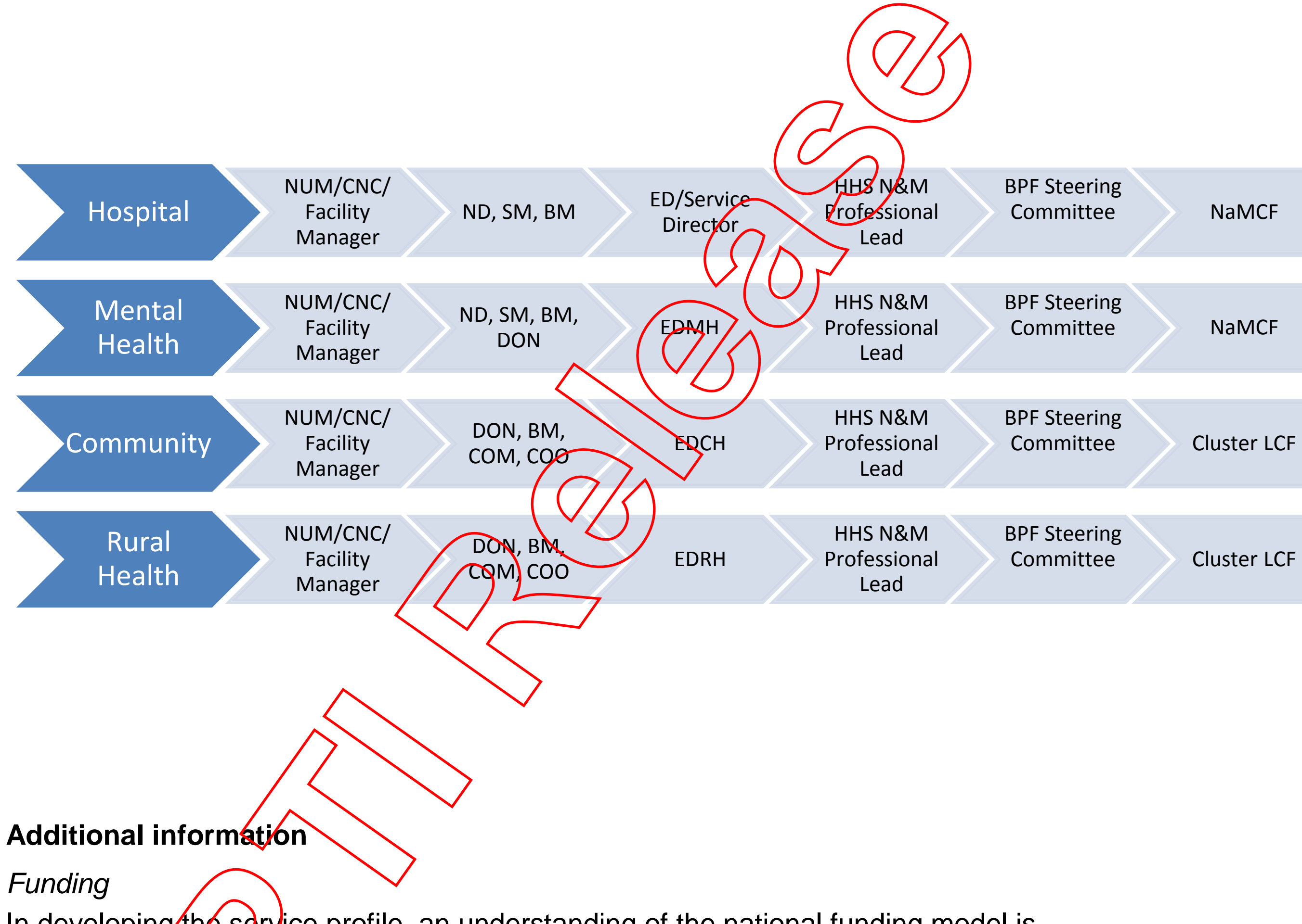
The service profile incorporates Demand, Supply and Performance Metrics that culminate in actuals versus forecast to inform the gap and variances

In developing any business plan, consultation with stakeholders needs to occur. For this initial Chapter, nursing and midwifery staff should actively participate to ensure frontline, on-the-ground information and experience is captured. Also, this participation will lead to a better understanding of the concepts, as well as greater ownership and commitment to the plan by everyone it impacts. The following diagram illustrates an example of the governance processes for different settings within a HHS.



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Additional information

Funding

In developing the service profile, an understanding of the national funding model is beneficial. For more information about how this model works and is implemented on a localised level, refer to Annexure: Understanding the Funding Environment.

Data collection (monitoring)

Health Indicator Sets

The Health Statistics Unit has compiled a list of state and national health-related indicator sets and performance measurement frameworks with links to key information about indicators. Some links for indicator sets are only accessible to Queensland Health staff via the Queensland Health intranet (QHEPS). Please contact hlthstat@health.qld.gov.au https://www.health.qld.gov.au/hsu/collections/dchome.asp

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Guide to completing a Service Profile

To assist you in developing the service profile for your area, additional notes and direction are provided below.

Remember: Queensland Health and Hospital and Health Services (HHS) have strategic plans stating the mission statement and key outcomes to be achieved during the designated timeframe. These should be referred to and links to web pages / documents when developing your service profile.

Service overview

Stating the aim

State the aim of your service in a succinct, broad sentence, describing how your service contributes to achieving the aims and direction of Queensland Health and HHS.

Example: To provide holistic care for cardiology patients, utilising a coordinated multidisciplinary approach, resulting in optimal patient outcomes and a cost efficient service.

Developing objectives

The objectives are statements indicating the key outputs / measurements for the service to achieve. They form a basis for assessing the performance of the organisation. In developing objectives, incorporate any new activities or programs that need to be undertaken and consider past non-achievements of the service.

Ensure the stated objectives are:

- easy to understand
- specific
- realistic and achievable
- time oriented
- outcome focused
- measurable
- prioritised.

Example:

- To implement the reviewed cardiac patient education program within six months.

Describing the present service

When describing the present service (or the service being planned) you may wish to include:

- recognised type of service (e.g. a cardiac service)
- function of the service and location of care delivery.

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Internal environmental analysis

Location and size

Describe the physical environment in which the service exists.

Are there factors that impact on the amount of nursing and midwifery resources required? Examples include:

- remote areas where transport is difficult to obtain can delay the discharges of patients
- the size of the locality services can affect community and outreach services.

Services within the facility

List the services / activities within the facility. Where appropriate, document them in order of priority or operational focus and list the Clinical Services Capability Framework level for each service.

Service Structure

- What is the structure of the service?
- What teams are involved in service delivery?
- What are the roles, responsibilities and accountabilities of team members?
- What are the reporting relationships of team members?

Leadership and Management

This is informed by the responses above to service structure.

- Who is accountable for the service?
- What is the governance structure?

Nursing and midwifery structure

Refer to Part A: Service Profile and fill in the table provided, deleting any positions or rows not applicable.

It may also be beneficial to document additional information such as:

- What are the accountabilities of nursing and midwifery staff?
- What impact does the nursing and midwifery structure have on the clinical and non-clinical workload?

Non-nursing support positions

Which other roles are employed by the service and how is the relationship to the nursing/midwifery team structured? Is it a multidisciplinary team? Staff who are not employed by the service, and not rostered exclusively to the service. Eg physiotherapist / occupational therapists, other specialist roles.

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Current model of care

A 'model of care' can be described as a multifaceted concept that broadly defines the way health services are delivered at unit, division or whole of service level. An example of a model of care is the Queensland Health Integrated Mental Health service.
http://qheps.health.qld.gov.au/northwest/mental-health/mentalhealth-home.htm

When documenting the service area's model, ask:

- Is the current model of care aligned to the health care requirements of the local community?
- What are the outcomes for patients / clients?
- Is there good evidence to support the current model of care?
- Does the existing structure support the model of care?
- Are there other models of care preferred in terms of economic effectiveness and patient/client outcomes?

Human Resource Management

Core staff working in the service – categories, scope of practice, skills (What are the categories of core staff working in the service?

- Numbers and FTE indicated separately i.e. 16 FTE = 30 staff - implications for costs of training and workload for completing
- What is the current scope of practice of the clinical staff and what potential opportunities are there to optimise the scope of practice
- Do the competency levels of the staff match patient / client needs? And what is the effect of this context on skill mix?
- Effect of context on skill mix i.e. Grad RN in rural facility cannot be in charge of a facility without sufficient experience.

Teaching and training / development commitments / needs

- What is the teaching role of the service?
- What agreements with universities are in place or under development?
- What is the impact of these agreements? For example: costs, opportunities for funding
- What clinical placements are required?
- What is the impact of these agreements? For example: costs, opportunities for funding
- What structures / processes are in place to support the teaching requirements/ commitments?
- What education imperatives are impacting on the service (eg: demand for undergraduate clinical placement, Regional Training Authorities)
- Are needs likely to change?
- Are there any organisation requirements (eg: % of staff as fire wardens) that require training?
- Insert link to HHS or service education plan

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Mandatory and requisite training

- A HHS is a statutory body under the *Financial Accountability Act 2009* and the *Statutory Bodies Financial Arrangements Act 1982* and is a unit of public administration under the *Crime and Misconduct Act 2001*. HHSs are responsible for ensuring they comply with the legislation as it applies to them.
- Under the *Hospital and Health Boards Act 2011* one of the functions of HHSs is to comply with the health service directives that apply to the HHS. Section 50 of the *Hospital and Health Boards Act 2011* states that a health service directive is binding on the HHS to which it relates. The HHS must also comply with other directives, such as directives applied under the *Public Service Regulation 2008.*
- Relevant legislative compliance is monitored within the Service, at divisional level and by the XXHHS.

Other indirect patient / client care commitments (optional)

What management/administrative responsibilities do team members have?

For example:

- portfolio work (such as NO2 special projects)
- quality improvement activities, accreditation, audits
- research.
- Add in rural and remote themes

Maintenance of pharmacy i.e. pharmacy, ordering, returning/removing expired stock, annual stock take; xray; pulling charts as required; admitting and discharging patients on HBCIS; changing O2 cylinders; attending the morgue; supplying scripts for public patients; supporting videoconference consultations; preparing paperwork for patient retrieval; audits and codes and documentation of such; checking emergency equipment, procedure boxes and retrieval bags; escorting patients to aircraft for retrieval or to Local sonography (e.g. 5 hr round trip) when required; isolating fire alarms and reporting; coordinating discharge into community with community supports; be on call for clinical support as required

Information technology management

Provide an overview of the information technology framework of your service area. Key considerations include:

What information sources and systems are in place? Here is a list which may prompt you?

- Is there sufficient information provided by these systems?
- What access is there to information?
- Who collects / supplies the information?
- How timely and accurate is the information from these systems?
- How reliable / stable are the systems? (e.g. are staff required to input information after periods of downtime?)
- Do staff know what information is available and to how to use that information?
- Do you have telehealth systems in place?

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External environmental analysis

The purpose of this section is to provide a snapshot of the factors, external to your service area (and therefore largely out of your control) which can have a direct impact on your service.

Policy / legal factors

- Commonwealth direction / policies / funding
- Queensland Health direction / policies / funding
- relevant legislation
- licensing organisations
- professional groups
- Industrial groups / issues
- education imperatives

Economic factors

- international / national economy
- public / private interface
- private health care providers
- future capital works planned.

Social factors

Analysing your service area's prevalence of disease and population trends will provide useful insights into the required categories and levels of outpatient and ambulatory health services. Calculating the percentage of potential and known populations at risk will assist in workforce planning and management of nursing and midwifery workloads. Other questions to ask include:

- Is the population young or aging?
- What is the growth rate?
- How diverse is the population?
  - Example: a large non-English speaking population will require the use of interpreter services. Organising and using these services consumes resources, thereby increasing overall nursing or midwifery resources.
- Are the health needs of the community matched with the national and state priorities for health outcomes?
- Community and consumer expectations
  - What does the local community / consumer expect from its health services?
  - Are these expectations realistic and/or deliverable?
  - What is their level of awareness of the health services they require and that are provided?
  - What involvement does the community have in local health service planning?
- Workforce issues
  - Are there enough nurses and midwives with the skills required for your health service?
  - What other workforce recruitment and retention issues are there?

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- Technological factors
  - What is the impact of technology availability on the service?
- Research and Evidenced Based Practice
- What research developments are impacting, or have the potential to impact on services?
- Are you required to participate in State or National data collection? Does this impact upon workloads?

SWOT analysis

A SWOT analysis is a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in delivering a service in consultation with staff in the service / unit.

It involves identifying the internal and external factors that are favourable and unfavourable to the service area and can assist in identifying when and where additional resources may be required or better allocated to achieve greater effectiveness.

A SWOT analysis can assist in moving from a 'business as usual' position to a stronger focus on true work priorities.

- **Strengths**

These are internal characteristics of your services area that give it an advantage over others.

- **Weaknesses**

There are internal characteristics that place your service area at a disadvantage relative to others.

- **Opportunities**

These are external elements that your service area could exploit to its advantage.

- **Threats**

These are external elements that could cause challenges or difficulties for your service area.

A common practice for documenting a SWOT analysis is tabular as shown below. You may wish to follow this method in the service profile.

	Helpful	Harmful	
Internal (and largely controllable)	**Strengths** • characteristic • characteristic • characteristic	**Weaknesses** • characteristic • characteristic • characteristic	Typically happening now
External (and largely uncontrollable)	**Opportunities** • characteristic • characteristic • characteristic	**Threats** • characteristic • characteristic • characteristic	Typically happen in future
	Increase	Reduce	

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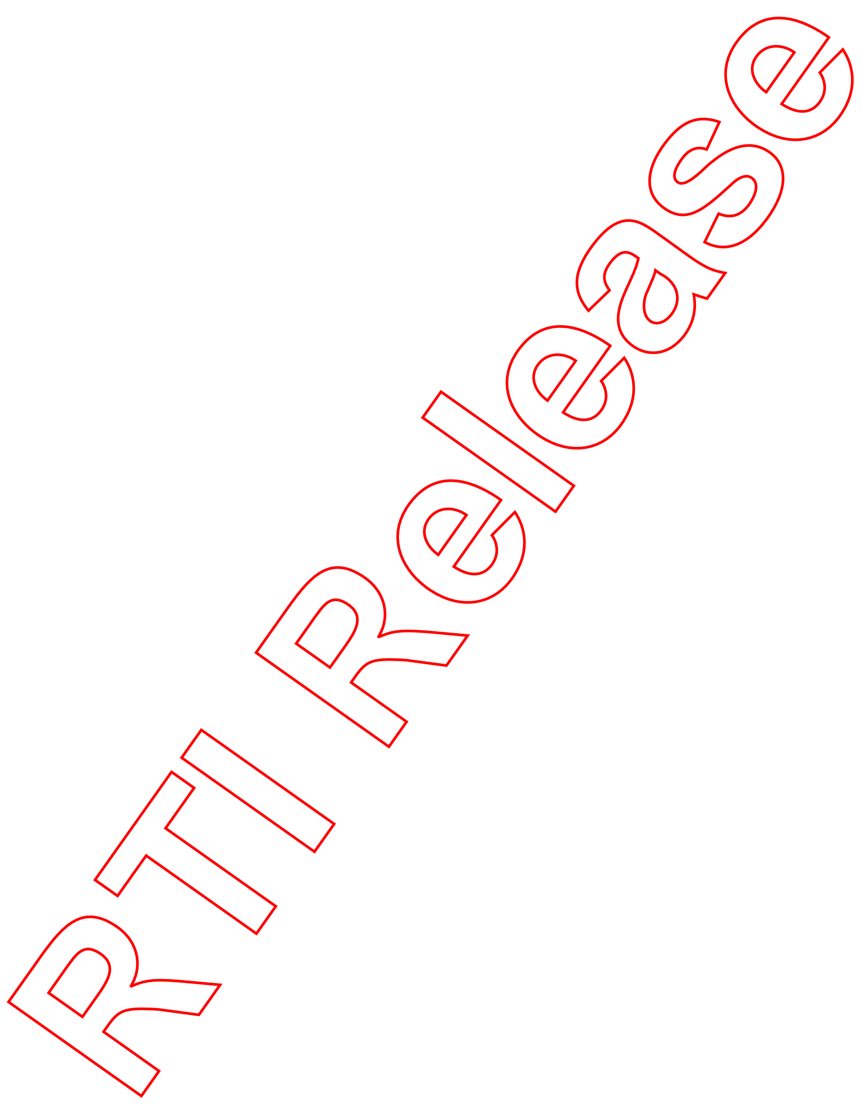
Significant achievements in the past 12 months

Consider the significant achievements that have occurred throughout the past twelve months. Reflect upon these and refer to the information collated within the internal, external and SWOT analysis as part of this framework to assist in the identification and projection of priority areas for service improvement for the oncoming financial year.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Comparative analysis

ACTUALS

Patient / Client activity

- Identify and discuss patient client activity, consider in context to previous financial year activity and impact upon nursing and midwifery workloads
- Major DRGS / OOS
- Patient/client complexity and acuity
- Patient/client activity: Identify and report upon key activity data relevant to the service. Activity to consider are have a direct relation to nursing and midwifery workloads, **NB: Not all activity metrics are relevant to all services.**

(Listed below are examples/suggestions for reporting of YTD activity demand, consider what activity/activities of demand best represent the type of services provided and add or delete where appropriate)
Patient / Client activity

▪

▪ Number of separations ▪ Weighted Activity Units ▪ Total occupied bed days (fractional) ▪ Average occupancy ▪ Occasions of service ▪ Emergency department presentations vs admissions ▪ Numbers per triage category ▪ Number of operating theatre sessions / complexity ▪ Operating minutes	▪ Number of day surgery cases ▪ Home visits occasions of service ▪ Number of births ▪ Retrievals ▪ Back-transfers ▪ Number of births: vaginal / caesarean ▪ Number of group sessions, numbers of attendees at group sessions ▪ Number of units of activity in Central Sterilising Departments

Table xx: Activity factors

Top Ten DRG					
No.	**DRG**	**Description**	**ALOS**	**Peer Group Ave**	**Variance**
1					
2					
3					
4					
5					
6					

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7					
8					
9					
10					

Fractional Bed Days		
Month	Total	Ave.
Oct		
Nov		
Dec		
Jan		
Feb		
Mar		
Apr		
May		
Jun		
Jul		
Aug		
Sep		
Total		

Emergency Department Presentations							
Month	Cat 1.	Cat 2.	Cat 3.	Cat 4.	Cat 5.	Total	Weekly Ave.
Oct							
Nov							
Dec							
Jan							
Feb							
Mar							
Apr							
May							
Jun							
Jul							
Aug							
Sep							
Total							

Occasions of Service								
Month	OOS 1	OOS 2	OOS 3	OOS 4	OOS 5	OOS 6	Total	Weekly Ave.
Oct								
Nov								
Dec								
Jan								
Feb								
Mar								
Apr								
May								
Jun								
Jul								
Aug								
Sep								
Total								

Ward Occupancy (Nurse Dependency System)

Insert your Nurse Dependency trends and highlight any particular issues.

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Performance

Financial performance

Financial performance against budget allocation, report the information in the table below and provide a brief description on the influencing factors of the budget variance. These factors need to be considered in the determination of nursing resources.

Cost centre	*YTD Actual*	*YTD Budget*	*YTD Budget Variance*
Labour			
Non labour			
Total Performance			

Identify and discuss nursing and midwifery labour performance indicators and influencing factors associated with negative trending outcomes for the financial YTD.

Trends may be occur on a daily, weekly, monthly, annual, seasonal or other regular basis.

Factors in trends to be considered include:

- why they exist
- how they occurred
- the degree of change
- the relationship among the changes.

Trends can indicate:

- increasing or decreasing activity at a steady rate
- fluctuations due to seasonal factors areas that require further investigation and action, for example, increasing sick leave.

Activity factors need to be monitored and reviewed as activity is one of the measures of organisational performance. While the listed measures are the major ones to be considered on a whole of organisation basis, within individual services, there may be other types of activity that need to be reviewed.

Therefore, each unit should develop a minimum data set which is a listing of the factors considered to be important indicators of workload for that particular service. For example, the information collected in the operating room will be different from a surgical ward or a community health service.

Workforce data from Queensland Health Decision Support System (DSS) is considered an important source of information and is used to support decision making in developing BPF service profiles. However DSS data does not delineate productive hours into direct and indirect clinical hours.

Availability of comparative data will support n/m leaders to make informed decisions related to adjusting nursing and midwifery workloads, staffing levels and skill mix.

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Reliable, standardised, accurate and timely operational management information is crucial given current efficiency measures. Robust workload data facilitates n/m leaders to effectively plan, deliver, monitor and evaluate the services provided. Duffield RBWH

Nursing / Midwifery Labour Performance Indicators				
YTD Sick Leave	YTD Casual	YTD Overtime	YTD Agency	YTD Vacancy
(%)	(% of productive hrs)	(% of productive hrs)	(% of productive hrs)	FTE

re

Identify and discuss nursing and midwifery labour YTD FTE and skill mix demands for external escorts and patient specialling where relevant to the service.

Patient specialling

Are there procedures that indicate a patient will need specialling post operatively or an assumption that a percentage of patients have a cognitive impairment and may require 1:1 care? What grade of nurse on average does your behavioural versus clinical specialling? Professional judgement should be used and skill mix dependant on acuity. Ad hoc basis maybe difficult to allocate budget, historical data may inform whether or not it should be recruited to.

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
TOTAL												

Patient escorts and retrievals

Is there a percentage of the patients in your service that will need escort/retrieval? What grade of nurse on average does your behavioural versus clinical? Professional judgement to be used and skill mix dependant on acuity. Ad hoc basis maybe difficult to allocate budget, historical data may inform whether or not it should be recruited to.

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
TOTAL												

Nurse sensitive indicators

Consider what Nurse Sensitive Indicators are applicable to your service. Report in the table below the incident rates, these may be dependent on the setting of the service. At the system level, incident rates are adjusted to the Service Level Agreement financial penalties.

It is imperative that the nursing and midwifery resources determined for clinical service delivery are considered in the context of local reported clinical incident types given the variances across clinical environments.

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Clinical incidents

Incident type	SAC1	SAC2	SAC3	Total No.	OBD	Rate
Falls						
Medication incidents						
Pressure injuries						
Blood transfusion						
Infection rate						

Resource Allocation

Reviewing the current health workforce allocations will allow some longitudinal benchmarking. For the forthcoming financial year, depending on whether activity targets are a growth, reduction or maintenance of current service levels. This current state analysis allows for a workforce reassessment that aligns with the forecasted activity for the service, and assists the service in determining if more, less or the same resources are required.

Nursing resource allocation

Priorities for next 12 months

Annual activity targets set by Queensland Health (outlined in the service agreement) need to be factored into forecasting. Once the data has been analysed, activity levels can be estimated for the following year. It is important to record assumptions made during the forecasting.

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FORECAST (PLANNED/PROJECTIONS)

- Baseline (previous year)

Actuals - Budgeted = Variance

- Estimated Future Activity - Targets

Forecast Activity or Estimated Future (Health Service) Activity (EFA) Methodology

http://qheps.health.qld.gov.au/ppb/docs/hsram/efa_methodolgy20152016_v1.pdf

A key component of healthcare purchasing negotiations is to set activity targets for each Hospital and Health Service (HHS). Estimated future (health service) activity (**previously referred to as "assessment of health service need"**) has played an informing role in the development of service agreements for both 2012–13 and 2013–14.

For the 2014–15 service agreements, priorities in terms of investment were identified based on a comparison of levels of activity purchased in 2013–14 against the estimated future activity for 2016–17. It is expected that a similar approach will be adopted for the 2015-16 service agreements.

The starting point for establishing activity targets is the assessment of estimated future activity. For the 2015-16 three year Service Agreements, 2016–17 estimated future activity is being used as a "target end point" to inform the allocation of resources. As such estimated future activity is not being provided for the interim years. In most cases, the Service Agreement activity targets relate to HHSs as a whole; therefore, estimated future activity has not been assessed for individual facilities.

Estimated future activity has been assessed by:

- service stream:
- – Acute Inpatient;
- – Interventions and Procedures;
- – Outpatients;
- – Emergency Care;
- – Sub and Non-Acute;
- – Mental Health, and

Other Activities.

- Hospital and Health Services of treatment, plus Mater Health Services (public only, Mater Children's Hospital will be allocated to Children's Health Queensland);
- Hospital and Health Services of residence (where possible);
- both adults and children (where possible);
- with a relevant level of service type detail for each stream (e.g. SRG for Inpatients, Tier 2 Clinic for Outpatients, Triage Category for Emergency)

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FORECAST

Nursing Resource Determination

Defining activity in specialty areas

In some specialty areas where nursing activity is not measured using the Nursing Hours Per Patient Day (NHPPD) model, additional consideration may have to be given to the definition or measurement of activity. The principles of the BPF can be applied in a clinical area using an agreed unit of activity. Some units of activity that may apply, other than NHPPD include

- number of separations (discharges, transfers, deaths)
- weighted separations
- total occupied beds
- average occupancy
- occasions of service
- emergency department presentations
- numbers per triage category
- number of theatre sessions
- day surgery cases
- outpatient occasions of service
- number of births
- retrievals
- home visits
- client separations
- number of group sessions
- number of clients attending group sessions
- operating minutes

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Nursing Resource Determination
<INSERT YEAR>

Step 1: Calculate Average Productive NHPPD or NHPOS or NHPUA

Average Nursing Hours per Patient Day =	Total Annual Productive Hours / Total Activity (FBD's/OOS/UA)
Average NHPPD/NHPOS/NHPUA=	5.89 (example)

Step 2: Determine the Weekly Nursing Hours

Weekly Nursing Hours =	**Total Annual Productive Nursing hours/52 weeks**

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Weekly Nursing Hours =	52 992/52 weeks (example)
Weekly Nursing Hours Total =	1019 hrs

Step 3: Develop Master Staffing Roster Profile

Proposed Master Staffing Roster Profile is developed within **WorkMAPP** workforce planning system. Roster Profiles include direct and indirect hours as allocated to position ID. Once finalised attach a copy of the Roster Custom Report to this document. NB: (Proposed Service Profiles) The weekly hours determined in step three must equal the weekly hours total in the WorkMAPP Roster. (Agreed Service Profiles) The WorkMAPP Roster Total FTE must equal the Rostered FTE in the BPF excel spreadsheet.

Step 4: Confirm Direct Care Shift Profile

(Example)

Direct Care Shift Profile						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
8.0 : 7.0 :3.0	8.0 : 7.0 :3.0	8.0 : 7.0 : 3.0	8.0 : 7.0 : 3.0	8.0 : 7.0 : 3.0	7.0 : 7.0 : 3.0	7.0 : 7.0 : 3.0

Step 5: Confirm Notional Nurse Patient Ratio

(Example)

Notional Nurse Patient Ratio – Direct Care Hours				
Shift	**Resourced Beds**	**Nursing Hours**	**Nursing Headcount**	**Nominal Ratio**
Day	24	64	8	1:3
Evening	24	56	7	1 : 3.4
Night Shift	24	24	3	1:8

Summary

In finalisation of the Service Profile document consider the significant achievements that have occurred throughout the last twelve months. Reflect upon these and consider the information collated within the Internal, External and S.W.O.T analysis to assist in the identification and projection of priority areas for service improvement for the oncoming financial year.

Significant Achievements in the last Twelve Months

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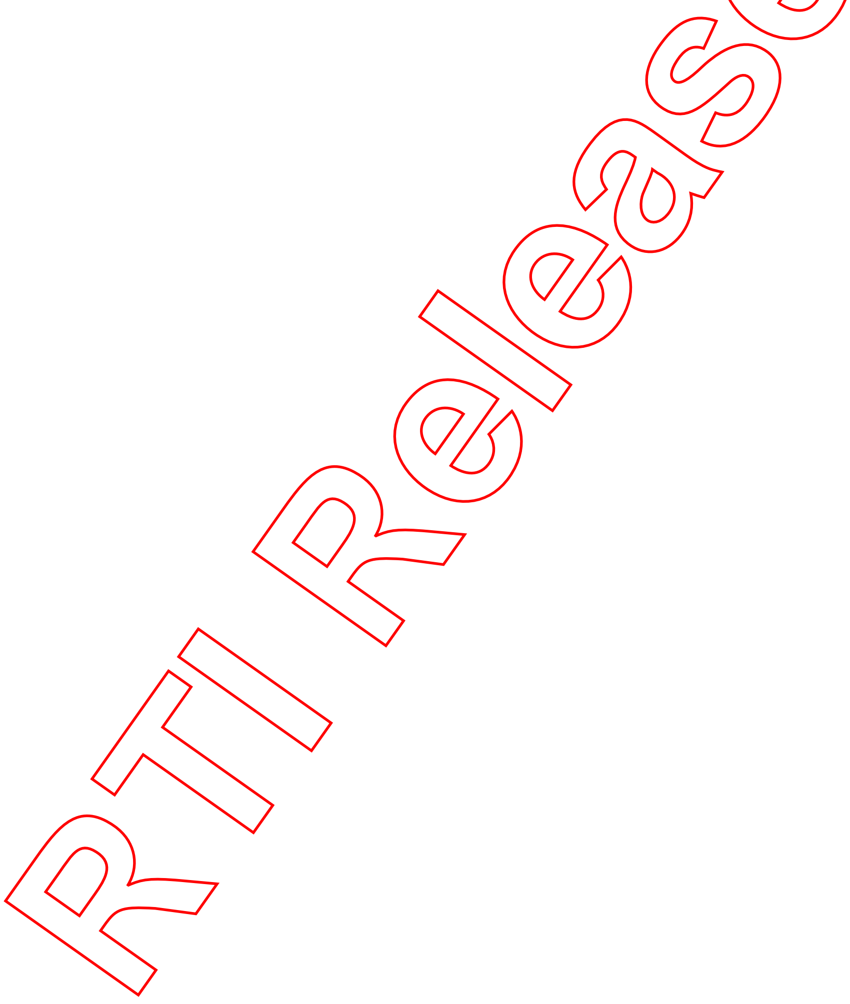
Approval

Once your template has been completed and finalised, use it for discussions and negotiations with your relevant supervisors and senior managers and have them sign off the document, as outlined in the BPF Introduction.

Service Improvement Business Case

A service improvement business case is required to be submitted for 2016-17 to support service delivery changes: See the template at Appendix 2 for an example, however each HHS may have a different template, and templates may differ depending on the amount of additional funding required.



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Chapter 2: Calculations of Nursing and Midwifery resources

Action!

- Complete calculations under the Guide

In a nutshell:

This second Chapter of business planning focuses on estimating the nursing and midwifery resources required to meet activity based on the service profile (Chapter 1). The estimation process is simplified by tools and information that help convert the identified demand requirements into actual dollars. Methods for allocating resources in response to demand are explained and response strategies are provided where the allocation of funds does not balance with identified service requirements.

Defining

Remember: Always refer to the service profile when calculating the resource allocation, taking into account any negotiations that have occurred at a local level and the unique environmental characteristics of your service area.

- Establish the total nursing and midwifery resources allocation required:

  (i) Calculate total annual productive nursing/midwifery hours required to deliver service.

  (ii) Determine skill mix / category of nursing / midwifery hours.

  (iii) Convert productive nursing/midwifery hours into full-time equivalents.

Finance will determine the operating budget and complete the following, but it is important for nursing and midwifery line managers to understand how the following calculations:

Calculate non-productive nursing/midwifery hours according with nursing and midwifery award entitlements.

  (iv) Convert non-productive nursing/midwifery hours into full-time equivalents.

  (v) Add productive and non-productive full-time equivalents together and convert into financial resources

  (vi) Allocate nursing/midwifery hours to service requirements.

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Guide to calculations

Estimating the nursing and midwifery resources required will provide a framework for allocating and controlling nursing resources. Determining the nursing and midwifery resource estimates can occur once the following activities have been undertaken:

- analysis of nursing hours per unit of activity used in the past
- analysis of trends in patient acuity data
- identification of levels of forecasted activity
- comparative analysis with similar services
- consultation with staff providing the services – the staff who deliver the services have the professional judgement, knowledge and experience to advise on the level of resources required to deliver care.

The annual resource allocation for nursing or midwifery includes all labour expenditure (i.e. salaries and wages) for nursing or midwifery staff, including productive costs (and non-productive costs (such as annual and sick leave) explained in detail in the following section.

Calculating the Total Nursing and Midwifery resource allocation required

A summary of the multipliers are located on each BPF staffing profile and are used to calculate the total workforce required to meet clinical activity.

The BPF multipliers are calculated using a standardised methodology and are based on the Nurses and Midwives Award 2012 (Queensland Health, 2012 – hyperlink to new award once available).

BPF Staffing Profile - Multiplier Methodology	
BPF Multiplier	**Calculation**
Productive Direct FTE	NHPPD x Bed Capacity x Occupancy x days of service
Productive Indirect FTE	NHPPD x Days per week x weeks per annum/1976
Mandatory Training FTE	Minimum 5 days per headcount plus an additional 6 days for all new starters per headcount
Professional Development FTE (paid)	Award entitlement for all permanent employees grade 3 and above working > 16 hours per fortnight. Full time employees entitled to 24 hours per annum (pro rata for part time employees).
Training and Conference Leave (including travel time) (paid) Optional	Based on average of training and conference leave accessed over the last three years (please note includes average travel time accessed)
Sick Leave (paid)	Based on average of sick leave accessed over last three years
Sick Leave (unpaid) ***Include?***	Based on the average of unpaid sick leave accessed over the last three years
Family Leave (paid) ***Check correct title***	Based on average of family leave accessed over the last three years
Maternity Leave (paid)	Based on average of maternity leave accessed over the late three years

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Other Leave paid	Based on average of other leave accessed over the last three years
Unpaid Leave (FTE)	Based on average of unpaid leave accessed over the last three years. This calculation is included to measure flexible resources required to meet the BPF needs of each Service Line.
Recreational Leave FTE	Based on award entitlement, 6 weeks per FTE for three shift rotating workers, 5 weeks per FTE for non-shift work employees
Long Service Leave	Based on average of long service leave accessed over the last three years

Queensland Health has developed electronic tools to assist with the process of developing the total nursing and midwifery resource allocation required to meet project activity. However it is important to understand the principles and the methodology behind these calculations so that estimations and allocations are applied consistently across service areas.

A total nursing and midwifery resource estimates incorporate both productive and non-productive components, which are defined as follows:

- **Productive hours** - contribute to patient care and include both *direct clinical* and *indirect clinical hours*.

  Direct clinical hours - activities directly related to care provided to the patient / client such as planning and assessment of care, and documentation.

  Indirect clinical hours - activities undertaken which benefit the patient / client while not in direct contact with them, including education and training on the clinical unit, mandatory competence attainment, quality improvement activities, portfolio activities, performance appraisal and unit orientation time.

  Total productive hours = direct clinical hours + indirect clinical hours

- **Non-productive nursing hours** - are employment entitlements which do not involve patient / client care, such as annual and sick leave. They are often referred to as 'on-costs'.

Converting total hours into full-time equivalent (FTE) staffing resources

There are six steps in establishing the total annual resource estimates for nursing and midwifery to meet planned activity and inform the annual operating budget. The nursing hours calculated are considered in terms of averages for a specific period. The steps are:

1. Calculate total productive nursing and midwifery hours
2. Calculate total annual productive nursing and midwifery hours required to deliver services
3. Determine skill mix categories of the required hours
4. Convert productive hours into full-time equivalent (FTE)
5. Calculate non-productive hours
6. Convert FTE into dollars

Professional judgement is recognised that is a valid criterion for deeming a definitive staffing level of nurses and midwives as being safe. The total nursing and midwifery resources required to meet the approved service requirements must be able to be determined and validated by completing:

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(a) service analysis and profile

(b) analysis of historical nursing/midwifery hours per unit of activity and sufficiency in meeting service demand

(c) analysis of trends in activity data

(d) forecast level of activity

(e) comparative analysis with similar services

(f) consultation with staff delivering services.

Step Approach for Determining Required Nursing FTE

Calculate Productive Hours

- Need to calculate HPPD / HPOS.
- Need to calculate nursing hours worked.

How to calculate HPPD / HPOS:

Method 1

This method is easiest if you have a stable consistent acuity level of patients within unit, or similar OPD clinic session times.

Identify number of nursing hours worked for past financial year (data from Trend or Necto). Do not forget to include casual, overtime, special and escort hours within your calculation of house worked. Plus, identify occupied bed days or occasions of service.

Calculation

$$\frac{\text{Nursing hours worked}}{\text{Total occupied bed days of occasions of service}} = \text{HPPD / HPOS}$$

Method 2

This method is used if you have a unit with diverse acuity: So HPPD will alter with DRG.

Example:

DRG	Average no of nursing hours	No of occupied bed days	Total no of hours
D1gZ	3	500	1500
Dg2Z	4	250	1000
D9k1	5	100	500
TOTAL		**850**	**3000**

Calculation

$$\frac{3000}{850} = 3.5 \text{ HPPD}$$

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(Examples for residential aged care, peri operative community child health, emergency, mental health will be provided at end of document).

Calculate Productive Hours

Productive hours = Direct plus indirect hours

Direct hours relate to nursing activities that contribute to patient care including documentation.

Indirect Hours include activities required for patient but does not require direct contact with patient (i.e. education/training on ward, quality activities and unit orientation).

Calculation NHPPD
x
Total occupied bed days = productive hours (Direct + Indirect Hours).

Calculation 3.5
x
850 = 2975 productive nursing hours
(Note productive hours can also be obtained from TrendCare or NECTO).

Determine Skill Mix

Break annual productive hours into a weekly figure.

Calculation 2975
52 = 57 hours per week
Note: this example is utilising small numbers to explain a concept, and generally numbers in reality will be greater.

Determine skill mix within the 57 hours:

- Grade 6 16hrs per week
- Grade 5 24 per week
- Grade 3 17 per week

Note: if you have minimal safe staffing; this is where you would state that you have minimum of 2 staff per 8hr shift = 16x3 - 48hr x7= 336 hrs per week (provide rationale for minimal safe staffing).

- CN 168hrs
- RN 168hrs
- EN 0hrs

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Only the positions (e.g. grade 7 or clinical facilitators) may not be included in the calculations if they are additional to productive hours, unless they provide a direct care or run a clinic.

Convert Productive Hours to FTE

Total productive nursing hours per week/38 = FTE equivalent

Example 1 7hr per week / 38 = 0.18FTE

Example 2 336 hrs per week / 38 = 8.8 FTE
Note: if you are calculating a part time FTE equivalent that works .3 shifts per week = 24hrs / 38 = 0.63 FTE.

Calculate Non-Productive FTE

Majority of these costs are automatically calculated with semi-automated tool. This is for information purposes.

Determine annual leave requirements:

- Is annual leave to be built into resource allocation
- If your annual leave percentage is less than 1 FTE, you need to manage your leave with placing casual staff on temporary contracts, or increasing part time contracts to cover annual leave (agency staff are not encouraged to backfill annual leave).

Determine sick leave:

- This should be based on last year's state average.

Determine Mandatory training;

- Currently there is an agreed 11 days for new staff and 5 days for existing staff (However, health services may negotiate a standard based on previous year usage and/or other determined factors. This is currently under negotiation within XXHHS and until told otherwise please utilise the standard 5/11 day ratio.

Professional development leave:

- 3 days per headcount > 16 hours per fortnight

On costs:

- Penalty allowances etc are determined by a percentage
- A nurse works 52 weeks x 38 hours = 1976

  To calculate 1 day (7.6 hour as percentage):
  (7.6 / 1976 = 0.0038)
  Multiply x 100 = 0.38 % N.B: only works at FTE percentage level, not at headcount level

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Add Productive FTE with Non-Productive FTE to Determine Resource Estimates required to meet activity

This step is calculated automatically within the semi-automated tool

Example:

	Required hrs per week	Weekly FTE	Required hours per year/1 FTE	Yearly FTE
Grade 7	38	1	1786	1.11
Grade 6	168	4.42	1748	5.00
Grade 5	365	9.6	1748	10.86
Grade 4	112	2.95	1748	3.26
Grade 3	112	2.95	1748	3.26
TOTAL	**795**	**17.92 FTE**	**8778 Hours**	**23.49 FTE**

Determine Seasonal Demand

Month

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	TOTAL
OBD	100	200	200	400	400	500	500	400	300	200	200	200	**3700**
%	2.7	5.4	5.4	10.8	?	?	?	?	?	?	?	?	**100%**
Req NHPPD	4	4	4	5									
Total hrs req	**400**	**800**	**800**	**2000**									

Week

Surgical Ward (agreed example HPPD 4)

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Pt days	20	30	28	25	25	15	10
Hrs req per day	80	120	112	100	100	60	40

Calculation Pt days x HPPD = hr required per day.

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Additional Examples for Determining HPPD/HPOS within Specialty Areas

Residential Aged Care (Utilise residential classification scale)

Data to be obtained from QHERS or NECTO.

RCS Categories	1	2	3	4	5	6	7	8	**TOTAL**
Ward 1	3	5	6	2	0	1	1	0	**18**
Ward 2	6	10	4	5	1	2	0	0	**28**
Total no of residents	9	15	10	7	1	3	1	0	**46**
Her per cat calc	3.86	3.3	2.79	1.86	1.29	1.28	1.28	1.28	
Total res x hrs per cat	34.74	49.5	27.9	13.02	1.26	5.4	1.28	1.28	**134.42**

Indicated nursing hours per day = 134.42 / = 2.9 hours per resident day.

No of residents = 46

Short Stay

- Base on top 5 DRG utilise method 2 of HPPD calculation
- Or Fixed staffing model:

*** All patients who episode of care is deemed appropriate for admission to short stay / obs ward must have their admission data captured in both EDIS and HBCIS at the time of short stay admission*

Please Select Staffing Model → Fixed — NB: Select N/A if no designated Short Stay unit available

Occupancy = — NB: Occupancy should be adjusted to reflect actual Short Stay usage

Total Available Beds = 8 — NB: Maximum number of beds / spaces available (not funded beds)

Using Fixed Staffing Model

Position	*Hrs / Wk*	*Wks / Year*	*FTE*
CN			0.00
RN	336	52	8.84
EN			0.00
AIN			0.00
			0.00
			0.00
			0.00

Total productive FTE: **8.84**

* Caution Required as staffing Short Stay Units may be absorbed or extracted from Core Business Staffing numbers depending on activity levels and may be a source of over budgeted FTE

Total Hrs Required (Year) = 17472

Therefore....

NHPPD x Beds x Occ% should equal (=) 47.868493

Therefore....

NHPPD = 5.9836

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Community / Mental Health / Child Health

- Data to be obtained from QHERS for occasions of service.
- Productive hours from Trend and NECTO.

Calculation Nursing hours worked divided by occasions of service:

$$\frac{20000}{4000} = 5 \text{ HPOS}$$

Hospital In The Home (HITH)

- Data to be obtained from QHERS for occasions of service.
- Productive hours from Trend and NECTO.

Top 5 DRG (Method 2)

Day Surgery

- 5 day Service
- Operating hours 7-5

NHPPD: Total productive hours / obd

CSSD

- Average Nursing hours per CSSD Tray 2.87hrs
- Average nursing hours per CSSD loan tray 1.2;

Calculate number of CSSD Loads and multiply by above denominators.
Add together to provide with required nursing hours.

Compare this with historical productive nursing hours to determine if nursing hours meet demand.

Theatre

- Minimum staffing as per acorn standards;

Determine productive hours as per recovery calculation determining theatre session lengths in time multiplied by number of theatre.

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- Number of theatres: 2
- Operating minutes plus down time for cleaning and preparation of cases
- Number of working days per year: 242
- No of nursing staff per operating room: 3.5
- Annual meal relief required: if sessions do not stop for lunch: 30min per staff; 91.5

Annual productive hours: No x operating rooms x no x operating hours x no of working days x no of staff annual meal relief = 2x 9x242x 3.5 + 91.5 = 15337.5 productive hours

-

Divide annual productive hours by 52 to determine weekly productive hours = 295hrs

295 divided by 38 = 7.76 Productive FTE

Recovery

- Data to be obtained from ORMIS, NECTO, TrendCare and QHERS

Number x hours opened per day 0800-2000- 12hrs (if your recovery does not run at 100% occupancy) you can calculate no of hours required for service per week and divide x 5 or 7 (5day service or 7 day service0 to determine an average daily number)

If your Recovery works on 2 x 4 hour sessions per day for three days per week and 1 3 hour session on 2 days per week; your calculated hours would be based on 8x 3 + 2x 3= 30 hours per week divided by 5 days = average hrs per day = 6hrs
No of working days per year (242) closed for 14 days at xmas
No of staff (1 per operating room (plus 1 runner) (Note this is for staffing recovery only.
(Note if you only have one operating room running at one time then staffing would be 2.

Total productive hours:
Average daily session hours x working days per year (Subtract any compulsory closure days from 365 to establish working days and subtract weekends if not a 7 day service. X by number of staff required = Productive hours)

6   x 242 x 3= 4356productive hours

Divide annual productive hrs to hrs per week- 4356/ 50 (52- 2 weeks for compulsory xmas closure) = 87.12 hours
Divide weekly hours x 38 to determine FTE-   187.12/38-=2.29FTE

Mental Health

- Data to be obtained from CIMHA, QHERS and NECTO

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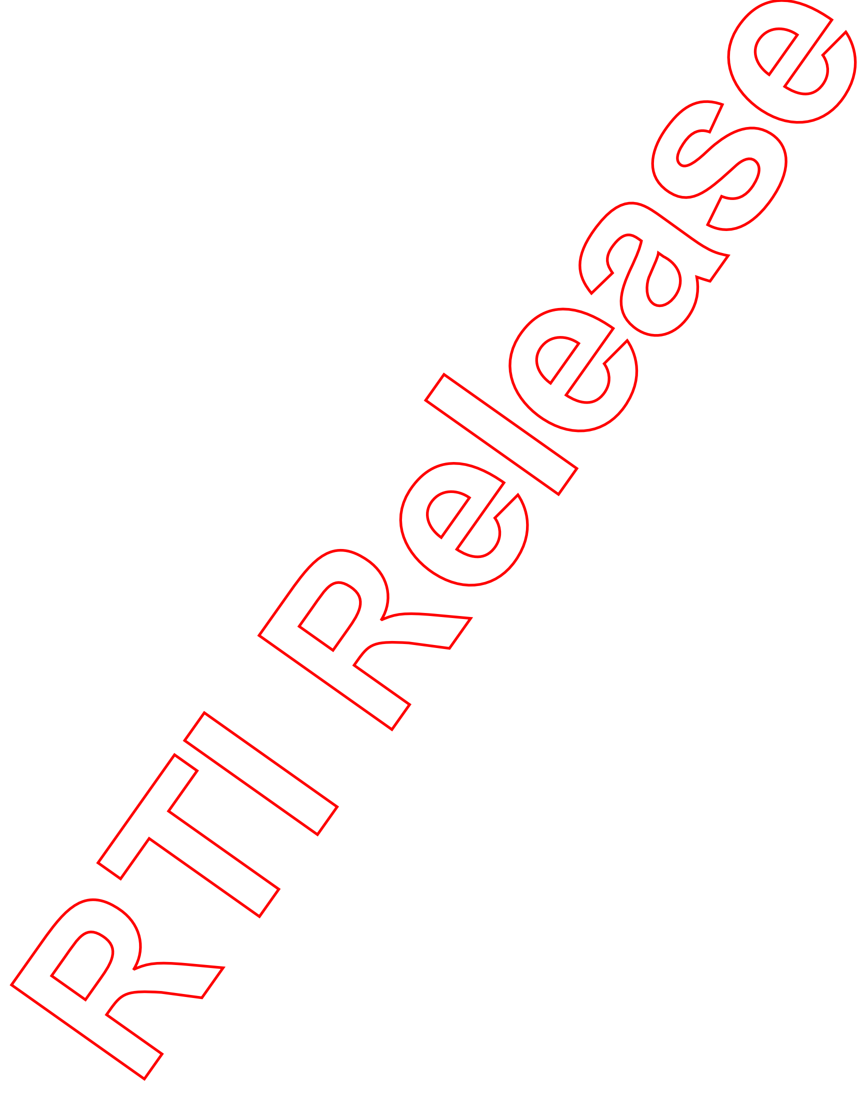
-

Inpatient unit: Top 5 drg model (Method 2)
Outpatient dept: utilise total nursing hours divided by total occasions of service= HPPD

Emergency Department

- Data to be obtained from EDIS, QHERS, TrendCare and NECTO

http://qheps.health.qld.gov.au/nmoq/workforce/documents/BPF_ED_calc_tool_.xls



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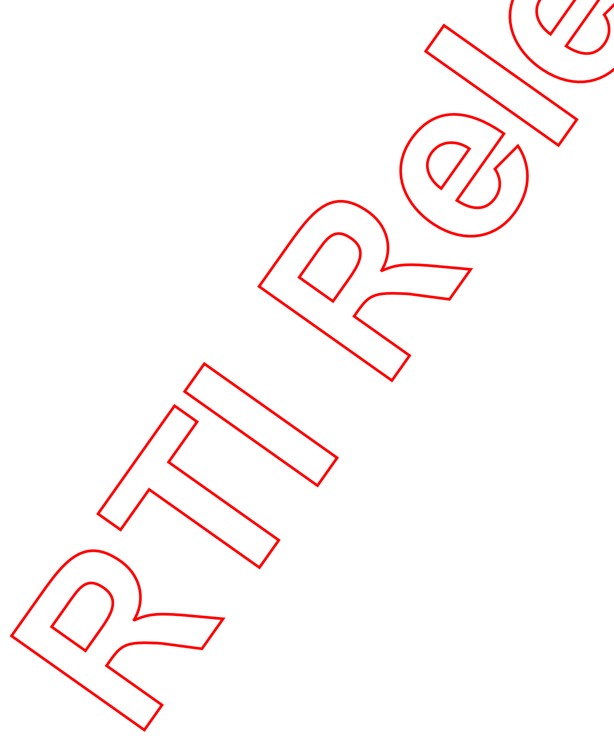
Rostering

Nursing and midwifery rostering

Nursing and midwifery rostering practices support provision of high quality health care that meets the patient's needs whilst also meeting the requirements of the organisation and employees. Effective rostering juggles work / life balance issues, understanding the skill set required, professional nursing and midwifery judgment, compliance with Industrial awards, legislation and policy, prevention of fatigue in employees, cultural and generational considerations and legal implications within a framework that promotes fairness and equity.

The Service recognises the need to consider accrued leave when employing new staff members; with the aim to negotiate that excess leave be taken prior to employment. Additionally, when staff are seconded to the Service, leave accrued during the secondment is rostered to be taken prior to completion of the contract.

Rostering practices for nurses and midwives employed in the Service should conform with 'The Principles of Best Practice Rostering: Queensland Health Guidelines' (2012). This document can be located http://qheps.health.qld.gov.au/schsd/docs/edu/tmd/20064.pdf



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Chapter 3 - Reaching a balance

In a nutshell:

This third stage of business planning focuses on analysing the differences between the demand for resources and the actual resources allocated. It allows service area managers, staff and senior management to identify gaps and agree on a resolution. That solution is likely to be one of three potential outcomes:

- *change the demand for resources*
- *change the investment of resources*
- *alter the mix of resources to achieve agreed outcomes.*
- *An agreement by the nursing / midwifery leader and staff is required in order to meet demand by varying staffing levels if demand changes. When there is an excess of staff, predesignated list of activities that are enabled or disabled depending on the workload management status.*

Exercising professional judgement

- Advocating for the provision of safe, quality care is one of the most important activities that you as a nurse or midwife can undertake to protect yourself and your patients, clients or residents.
- Professional nursing judgement is a process that requires decision making based on critical reflection, evaluation and clinical expertise in order to resolve issues, problems and dilemmas. When you exercise your professional judgement on what constitutes safe workloads you are advocating for your patients and keeping yourself and them safe.
- It is essential you, as a nurse or midwife, are confident in asserting your professional judgement as this is the tool of accountability for your interventions and care. In Queensland Health, nurses' and midwives' professional judgement is accepted as a valid method for determining safe workloads.
- Professional judgement in health involves practitioners in finding not the right answer (which probably does not exist in the absolute sense), but in deciding what is best in the situation they find themselves. When exercising professional judgment the nurse / midwife must take into account all the aspects, even though some of them seem to be unimportant.
- The background of professional judgment is formed of the specialist's knowledge, technical skills, competence, experience and abilities. Besides these essential characteristics, documentation is very important and must be able to defend the opinion. See http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/scope-of-practice.aspx for the 'A national framework for the development of decision-making tools for nursing and midwifery practice'. *http://www.nursingmidwiferyboard.gov.au/search.aspx?q=decision%20making%20framework*

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Data Analysis

The analysis of workforce data alongside other information such as activity and clinical outcomes can assist greatly in identifying and allocating resources because it enables assessment of the effectiveness of those allocated resources. For example, monitoring the use of nursing and midwifery hours / occasion of service and expenditure will help to explain variances.

Duffield et al (2006) reaffirms the importance of determining a measure for nursing and midwifery workload in a standardised manner and establishing a relationship to retention and patient and staff safety, which are of state and national concern.

Strategies to evaluate and address an imbalance of supply and demand

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Strategies to evaluate and address an imbalance of supply and demand

A systematic approach to planning the nursing and midwifery operating resource estimates allows the service area manager to identify, clarify and document the many issues impacting on the allocation. The ultimate aim of the BPF process is to achieve a balance between supply and demand, but it also helps to quickly identify imbalances when:

- service demand is greater than the supply of resources, or
- supply of resources is greater than service demand.

When differences occur, a balance can only be achieved by adjusting either supply or demand, or both.

Managing variances

- *Unfavourable variances* ***(demand exceeds supply)***

Reasons for unfavourable variances may include increased activity or costs that were overlooked during the service planning, or unforeseen due to unpredictable changes to the working environment. It is important to determine whether the resource t allocation is sufficient to meet the demand so that this can be remediated in future. Unfavourable variances may be addressed by any of the strategies listed in the previous section, '*Strategies to address an imbalance of supply and demand*'.

- *Favourable variances* ***(supply exceeds demand)***

Favourable variances could bring unwanted repercussions which is why it is important to investigate their cause. Obvious reasons may be that activity is less than predicted or efficiencies have been made. However, savings may also have been made by under-staffing, which could lead to a decrease in the quality of service.

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Strategies for managing emergent situations

Emergent situations will arise such as:

- unexpected sick leave of staff members who are unable to be replaced
- unplanned activity e.g. increased number of inpatients, higher acuity.

Using the flow sheet in Chapter 4, nurses and midwives within clinical work units can, in consultation with their supervisor, identify strategies for managing workloads in the short-term to address roster deficits or inefficiencies related to patient care, acuity, staffing, skills mix and safety needs. It is essential in these situations that safety for patients and staff is the priority.

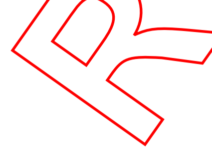
Strategies for managing temporary vacancies

Traditionally, casual pool staff and agency staff have been employed on temporary contracts to backfill temporary vacancies created (but not limited to) by industrial instrument leave entitlements such as long service leave, maternity and parental leave, parental work agreements, approved leave without pay, long-term sick leave and staff secondments. These vacancies can have a significant impact in a team and may result in:

- instability of staffing in work units
- variable skills mix
- increased workloads
- increased need for preceptor support and training of temporary staff
- decreased staff morale
- increased sick leave
- increased costs.

Ultimately this can impact on the effective management of nursing and midwifery workloads. Existing practices of backfilling by temporary contracts of external / casual pool staff, or managing the unfilled shifts on a daily basis with agency staff, additional part-time shifts or overtime, can be inefficient when looking at the long-term impact on the service.

Each HHS will individually need to investigate and establish a strategy to managing temporary / permanent vacancies with consideration of complexity of the service.



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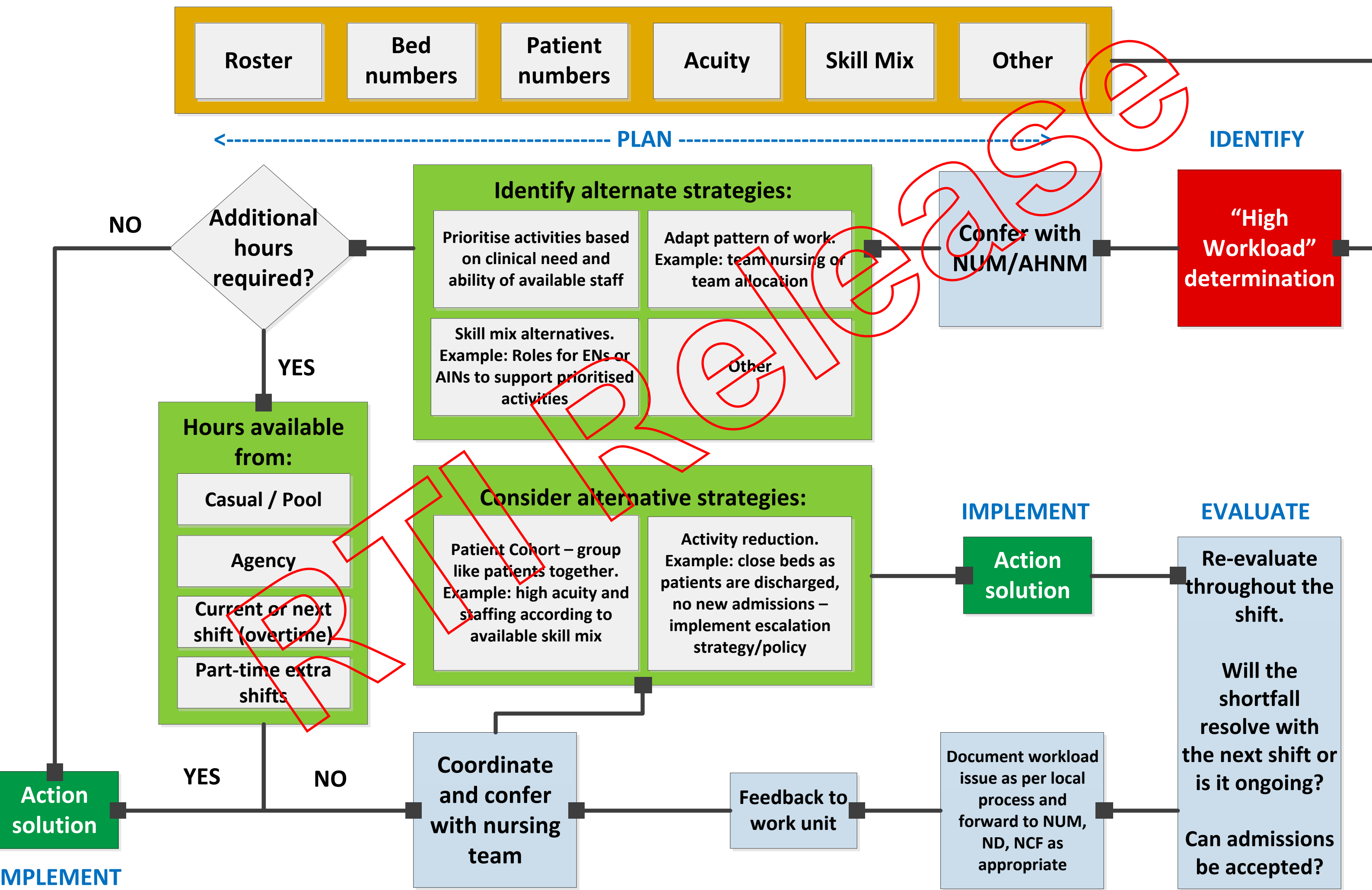
BUSINESS PLANNING FRAMEWORK

Management of Emergent Situations



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Suggested strategies	
When service demand is greater than the supply of resources *Hospital and Health Boards (Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015* will mandate ratios of 1:4, 1:4, 1:7 commencing 1 July 2016. The ratios will be implemented in a phased approach, with only prescribed acute wards and facilities in the public health sector having to comply with ratios.	***When the supply of resources is greater than service demand***
The environmental analysis identifies factors impacting on service demand. While changes to any of these may reduce demand, the following strategies should be considered: • nursing / midwifery team to clearly identify capabilities with the available staff • replacing nursing / midwifery staff with like for like skill mix as a first priority • changing patient mix • exploring improved support services • improving bed utilisation / bed reductions • exploring alternate funding sources • prioritising clinical / work unit activity • exploring opportunities for efficiencies • reviewing indicators – patient / client, staff, quality.	When an over-supply of resources has been identified, the following strategies should be considered: • reduce nursing / midwifery hours • approve leave • review flexibility of core roster • review nursing / midwifery practices • re-direct allocated nursing / midwifery hours • increase services • agreed activity list (eg: audits; training; review documents)

Finalising the service profile

Once the initial service profile is completed, it will be used during discussions and negotiations for financial year budget allocation. Once the agreed budget and the level of service is finalised and agreed, the 'proposed service profile' should be reviewed and amended accordingly to ensure the profile reflects the available resources and service priorities. The final document is recognised as the 'Agreed service profile' and should be signed off by senior nursing / midwifery management and the Chief Finance Officer. See Flowchart on next page.

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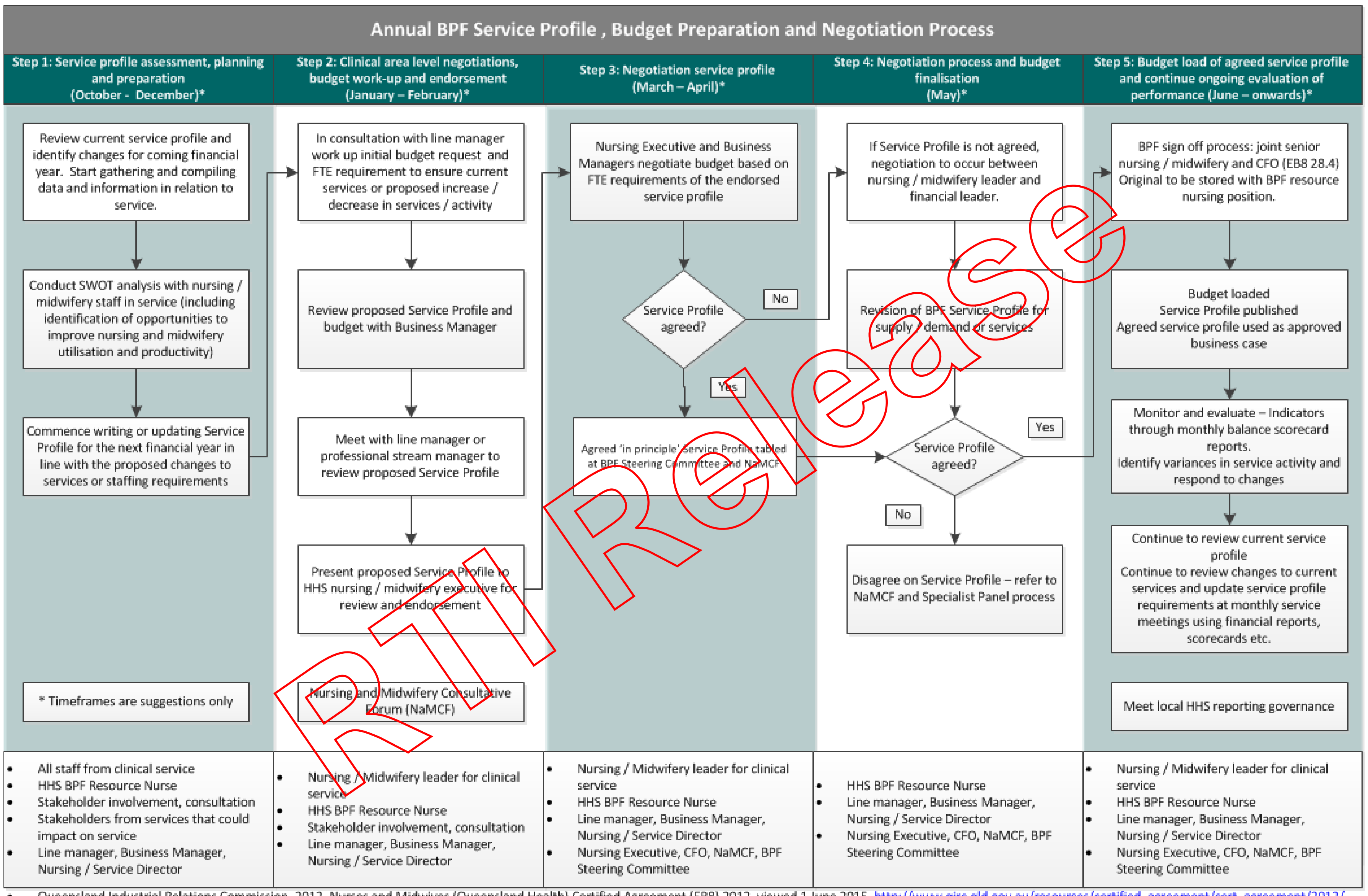

- Queensland Industrial Relations Commission, 2012, Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012, viewed 1 June 2015, http://www.qirc.qld.gov.au/resources/certified_agreement/cert_agreement/2012/ca105_2012.pdf
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- Queensland Health, 2008, HR Policy B5: Nursing Workload Management, Queensland Health, Brisbane, viewed 1 June 2015, http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-180.pdf

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Chapter 4 – Escalation

Action!

- See Nursing and Midwifery Workload Management Process (FUTURE STATE)
- See Nursing and Midwifery Workload Management Specialist Panel Referral Process

In a nutshell:

This fourth Chapter of the BPF Manual looks at the importance of a mandated escalation pathway when the differences between the demand for resources and the actual resources allocated cannot be resolved. It allows nursing / midwifery managers, staff and senior management to agree on a resolution.

Workload management issue escalation process (for nursing and midwifery award 2015)

The process of escalation for identified workload management issue must be:

Step 1
The workload issue is identified by nurse/midwife and raised immediately at the service level.
The line manager or after-hours nurse/midwife manager immediately investigates workload issue identified and implements actions (including implementing service agreed low priority strategies) to resolve the identified issue or mitigate risk to patient safety and prevent reoccurrence.

Step 2
If the workload issue cannot be resolved at the service level at Step 1, it is to be escalated to the Nursing/Midwifery Executive team. The Nursing/Midwifery Executive team will review the identified issue and implement further actions to resolve or mitigate risk to patient safety and prevent re-occurrence, within 7 days of the workload issue being identified. A detailed summary of all resolved issues will be tabled at the Nursing and Midwifery Consultative Forum (NaMCF).

Step 3
If the workload issue cannot be resolved at Step 2, the NaMCF will review the identified issue and recommend actions to resolve or prevent re-occurrence of the identified issue.

If there is a workload management issue identified as critical to patient safety, an extraordinary NaMCF can be requested.

A report outlining identified issues and outcomes from each monthly NaMCF must be provided to the Chief Executive and the patient quality and safety committee.

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Step 4
If the workload issue cannot be resolved at Step 3, a specialist panel must be convened by the Hospital and Health Service within 7 days of the NaMCF meeting, to review the identified workload issue and recommend actions to resolve or mitigate risk to patient safety and prevent re-occurrence of the identified issue.

The recommendations of the specialist panel meeting must be published within 3 days. The recommendations of the specialist panel meeting will be implemented by the relevant Hospital and Health Service within the timeframes set by the specialist panel.

Step 5
If the workload issue cannot be resolved and recommendations not agreed to at Step 4, the matter is to be referred within 7 days from the specialist panel meeting to the Queensland Industrial Relations Commission for assistance and if necessary arbitration.

Communication and Reporting
The line manager provides communication to staff affected by the identified workload issue on the actions taken.

The Nursing/Midwifery Executive team will communicate to all affected staff on the actions taken and to be taken to address identified workload issue within three days of convening Specialist Panel meeting.

The Nursing/Midwifery Executive team must provide a thematic summary of identified workload issues and actions to the Hospital and Health Services Patient Quality and Safety Committee and Executive Committee to endorse recommendations if required.

Compliance measures

All performance reporting frameworks must be evidence based, align with national clinical and safety standards for health services and be documented within local service agreements.

The report on workload issues deemed to impact patient safety, including matters that fail to comply with the escalation timeframes, are tabled at Hospital and Health Service Nursing and Midwifery consultative forums at least monthly.

Reports that monitor the correlation between the identified workload issue and the key performance indicators, including patient safety measures and quality of services are to be tabled at Hospital and Health Service Nursing and Midwifery Consultative Forums at least quarterly and made available to the Chief Executive (Queensland Health) for the purposes of public reporting.

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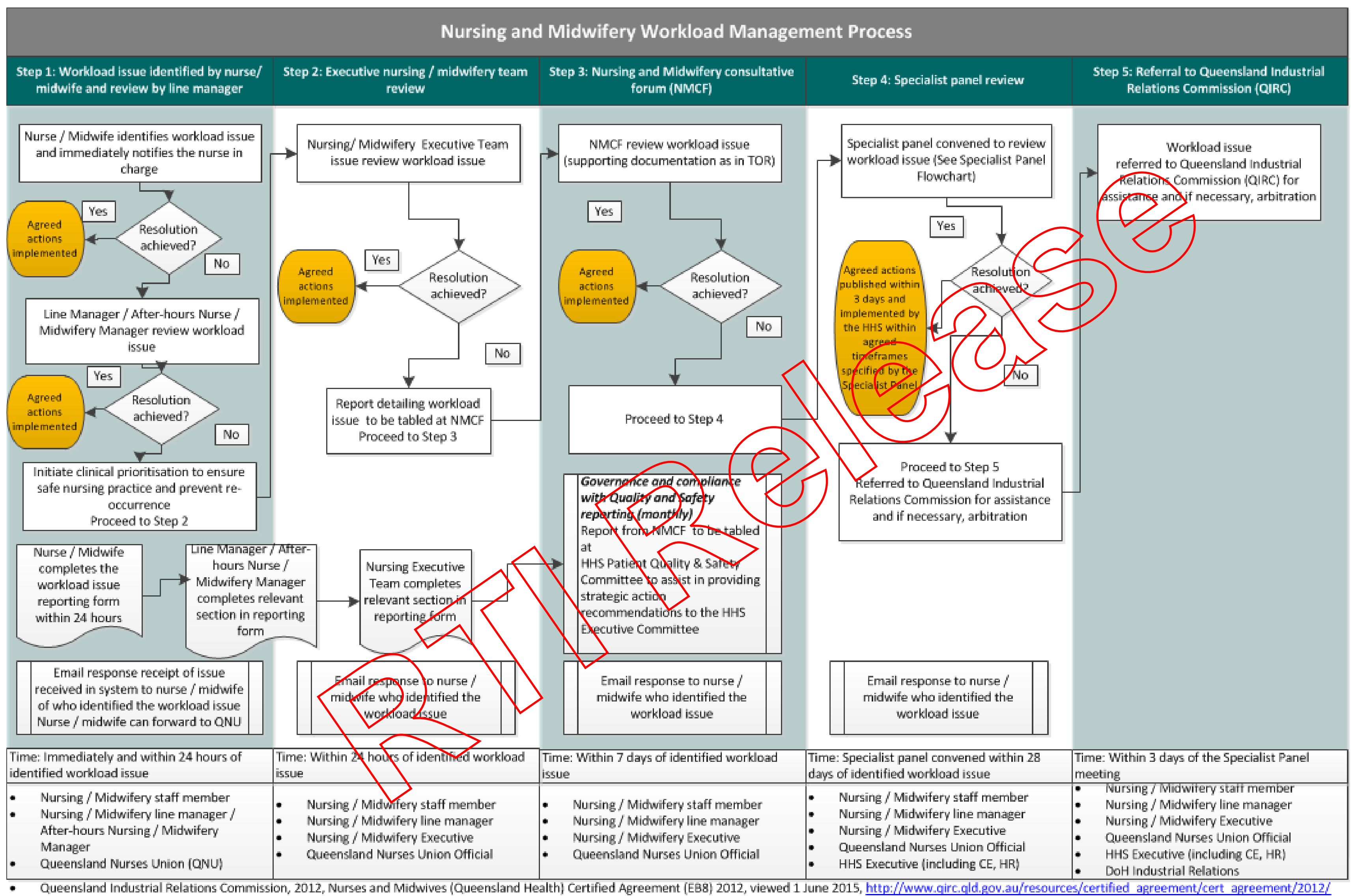

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- Queensland Industrial Relations Commission, 2012, Queensland Health Nurses and Midwives Award – State 2012, view 1 June 2015, http://www.qirc.qld.gov.au/resources/pdf/awards/q/q0090_swc13.pdf
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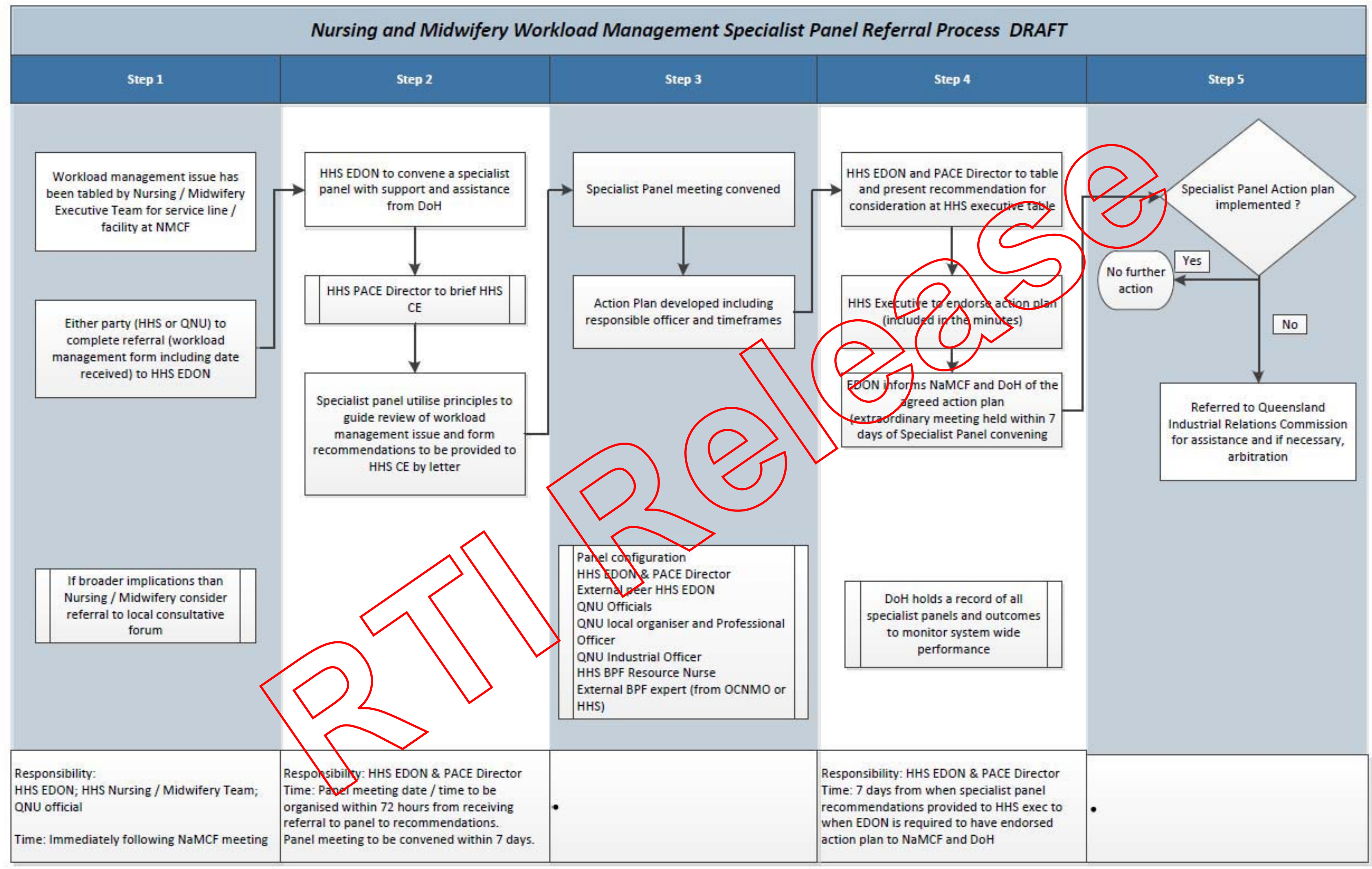

Sources:

- Queensland Industrial Relations Commission, 2012, Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012, viewed 1 June 2015, http://www.qirc.qld.gov.au/resources/certified_agreement/cert_agreement/2012/ca105_2012.pdf
- Queensland Industrial Relations Commission, 2012, Queensland Health Nurses and Midwives Award – State 2012, view 1 June 2015, http://www.qirc.qld.gov.au/resources/pdf/awards/q/q0090_swc13.pdf
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Chapter 5 – Performance Metrics

Action!
Refer to: Office of the Chief Nursing and Midwifery Officer website for updates and links on metrics and anayltics

In a nutshell:
This fifth Chapter of the BPF Manual looks at the importance of monitoring the unit, service, facility and HHS performance. The language in the area of performance metrics can often be confusing as the words monitor, evaluate, performance, evidence-base, benchmarking and best practice are often used simultaneously or interchangeably. This chapter also defines these terms and attempts to provide a broader overview of how the balance of supply and demand may affect the safety and quality of patient care indicators. Changes in these indicators may reflect suboptimal outcomes, poor resourcing decisions and provide evidence that may be able to be used to advocate the appropriate levels of nursing resources.

The primary objective of the Australian health care system over the last few decades has been the improvement of population health resulting from the use of efficient and cost-effective health care interventions. Evaluation is a central function for improving the health system's performance and is based on immediate objectives such as improving safety, efficacy, and appropriateness and on long term outcomes such as life expectancy.

Activities, disciplines and methods that are available to identify, implement and monitor the available evidence in health care are called 'best practice', and health care has been and is still working towards this continuous improvement for quality. The four disciplines: clinical research, clinical epidemiology, health economics and health service research develop an evidence base to inform best practice. The different disciplines are related to each other in three 'domains': (a) input (b) dissemination / implementation and (c) monitoring / outcome. These provide evidence on (a) the (potential) effects of health care interventions and policies (b) on ways to implement them; and (c) on ways to monitor their actual outcome.

Best practice, synonymous with **benchmarking**, is referred to as a process-oriented concept to achieve improvements within individuals, agencies or settings over time, and therefore related to quality (Perleth, M et al). Best practice is the best way to identify, collect, evaluate, disseminate and implement information as well as **monitor the outcomes** of health care interventions for patients / population groups and defined indications or conditions. Information is required on the best available evidence on **safety, efficacy, effectiveness, cost-effectiveness, appropriateness,** social and ethics values and quality of health care interventions and the process of obtaining this information has become a discipline known as **evaluation.**

There are many different types of evaluation (design, impact, process, outcome, formative to name several), however measurement is centric to all types and includes the **robust collection and analysis of qualitative and quantitative data to answer specific questions and undertake comparison.** Simplistically, if you are going to measure efficacy of yoga as exercise to lower blood pressure, a baseline of the subject's blood pressure using

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a sphygmomanometer before and then after they perform yoga over a number of weeks is a method of **monitoring**. Monitoring generally means to be aware of the state of a system, to observe a situation for any changes which may occur over time, using an appropriate measuring device. There are many measuring devices to take a range of metrics, including instruments such as validated questionnaires that are tools to measure more nebulous concepts such as patient satisfaction or consumer engagement.

The term '**metrics'** is often applied to these **measurements** and in the future as health care information is collected into integrated computerised systems, data linkage will enable the emerging field of **analytics and metadata** to provide the discovery and communication of meaningful patterns in data. Health care is rich with recorded information and electronic systems capable of collecting and collating this data are emerging in Queensland, as analytics relies on the simultaneous application of statistics, computer programming and operations research to quantify performance.

Effectiveness - the degree to which something is successful in producing a desired result; success. When talking in terms of efficacy versus effectiveness, effectiveness relates to how well a treatment works in the practice of health care, as opposed to efficacy, which measures how well treatment works in clinical trials.

Efficacy is the capacity for beneficial change (or therapeutic effect) of a given intervention (for example a drug, medical device, surgical procedure, or a public health intervention). If efficacy is established, an intervention is likely to be at least as good as other available interventions, to which it will have been compared. Comparisons of this type are typically made in 'explanatory' randomized controlled trials, whereas 'pragmatic' trials are used to establish the effectiveness of an intervention.

A Key Performance Indicator **(**KPI**) is a measurable value that demonstrates how** effectively a company is achieving key business objectives. **Organisations use** KPIs **to evaluate their success at reaching targets.**

The Performance Management Reference Guide (http://www.premiers.qld.gov.au/publications/categories/guides/perf-manage-framework.aspx) provides examples of developing performance indicators for the difference measures of activity, process, input, quality or access/equity that may be relevant to and retained for your agency's internal monitoring. http://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/

The Hospital and Health Service Performance Management Framework (https://publications.qld.gov.au/dataset/e1c2648f-eb8e-4e7f-a0d7-42604cd9212f/resource/94ce3c3b-59dd-44d4-8d3c-ada71f6379bc/download/sd2hhspmf1415.pdf) explains key performance indicators, targets and tolerances.

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Why performance management matters

> ***Performance management** is considered to be the system, which integrates organisational strategic management, performance information, evaluation, performance monitoring, assessment and performance reporting.*
>
> (OECD, Working Definitions, 2002)

The Queensland Government Performance Management Framework (PMF) is designed to improve the analysis and application of performance information to support accountability, inform policy development and implementation and create value for customers, stakeholders and the community. The PMF enables a clear line of sight between planning, measuring and monitoring results and public reporting.

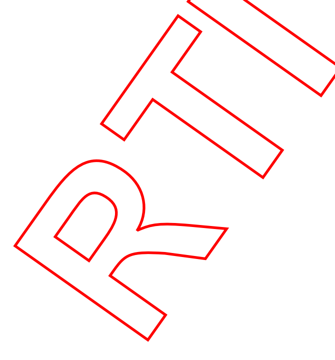
The updated Queensland public sector guide reflects the continuous improvement of the Queensland public sector agencies in performance management.

Opportunities exist for agencies to continuously improve organisational performance to better meet the government's broad objectives for the community. This guide establishes the minimum requirements for agencies in relation to performance management.

Measuring performance is the means of reviewing the overall effectiveness, efficiency and appropriateness of the **inputs, outputs and outcomes of the allocation of resources**. It involves the evaluation of **both financial and non-financial results.**

In evaluating performance, actual results may be compared with:

- **planned indicators, measures and activity targets**
- **previous results**
- **the performance of other services, either internal or external to the organisation.**



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Principles of Nursing Metrics

It is essential that performance metrics are important, scientifically sound, useable and feasible. Useability relates to the extent to which intended audiences can understand results and are likely to find them useful in decision making, while feasibility relates to the ability to obtain quality data in a timely manner with a demand on resources that is proportionate to the benefits. Griffiths et al (2008) determined that good nursing-specific metrics should be:

TABLE12: Determinants of a good nursing indicator

Measurable using existing data and at a reasonable cost	**Evidence based and linked to important outcomes**
Able to inform remedial action	**Sensitive to nursing – the sensitivity should be evidenced and there should be substantial variability associated with nursing practice**
Recognised as important to nurses, managers and the public	**Risk-adjusted to compare performance in different settings**
Recognised as being the responsibility of nursing staff	**One that minimises the risk of a 'perverse incentive' (where improving performance on the indicator detracts from overall performance)**

The biggest challenge lies in striking the right balance between the data collection burden and the need to ensure that performance metrics represents broad achievement of the goals of nursing processes that deliver these goals. The more metrics that are collected the greater the data collection burden, however the danger on focusing on a few narrowly defined metrics lies in the creation of perverse incentives where maximising performance on metrics detracts from overall performance.

Patient Experience

Part of the challenge in developing meaningful nursing metrics is how to incorporate patient feedback and views into the system. Nursing is essentially a patient centred activity with a significant qualitative component. The use of interactive and intuitive patient experience questionaries could provide a straightforward metric to be incorporated into the current Nursing Performance Scorecard.

This feedback provides an understanding of the needs and expectations of patients, and a reliable measure for the hospital's performance in delivering patient-centred care. The program is embedded in all areas of the hospital and fully supported by the leadership team. It educates staff on the issues that matter most to patients. Key features include a Consumer and Community Engagement Committee with staff from each hospital service working in partnership with consumers to develop a sustainable framework. Hospital departments have taken the program a step further, developing their own engagement activities specific to

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individual service needs with the goal of improving patient safety, experience and outcomes. The RBWH framework empowers and encourages staff and consumers to work together to contribute, develop, learn, be innovative and creative in the delivery of patient-centred care.

The below metrics should be considered as a means of capturing patient experience with the Queensland Health environment:

- % of complements received as a proportion of total feedback received
- % of complaints about nursing care as a proportion of total complaints received.

Satisfaction with nursing is among the most widely used nursing outcome measures and is a major determinant of overall satisfaction scores. There are a plethora of instruments for patient-reported outcome measures available, including PROMS and provide patients opportunities to assess their treatment outcome, they warrant consideration for evaluation of specific nursing interventions or narrowly focused nursing services.

Nurse Sensitive Indicator Tool and Reports

The State-wide Nurse Sensitive Indicator (NSI) reporting tool delivers a series of useful and relevant reports to help Queensland Health (QH) adult facilities to analyse, trend, monitor, compare and/or benchmark the care delivered by nurses.

These reports can be used to develop quality improvement initiatives which support the delivery of patient safety and care.

The NSI tool features 63 NSIs under 9 in-hospital sub categories including:

- reported falls clinical incidents
- reported pressure injuries clinical incidents
- reported medication administration clinical incidents
- reported blood transfusion clinical incidents
- health care associated staphylococcus aureus bacteraemia
- hand hygiene compliance
- nursing agency
- nursing skill mix
- nursing sick leave

The reports are generated from corporate QH systems and include Decision Support System, Prime CI, Queensland Health Statistic Centre and the Centre for Health care Related Infection Surveillance and Prevention.

For further information about the NSI tool and reports, please view the frequently asked questions or contact the Project Team.
http://qheps.health.qld.gov.au/nmoq/profession/nsi_about.html

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Nursing Performance Scorecard

The Nursing and Midwifery Office, Queensland (NMOQ) has developed a nursing performance scorecard to assist with reporting and monitoring trends across public nursing and midwifery services. The scorecard is interactive and enables a review of multiple interrelated measures across skill mix, sustainability, productivity and quality *(Queensland Health, 2014).* A snapshot of the scorecard is presented below:

Nursing Performance Scorecard – KPI attributes

Skill Mix	Sustainability	Productivity and efficiency	Quality
Workforce Profile - Total Workforce (Headcount) Workforce Profile – Clinical Workforce (Headcount) Nursing Skill Mix (FTE) Registered Nurse Skill Mix (FTE) Internal-External Skill Mix	Age Profile Age Profile by Skill Mix Fractional FTE Rate by Age Average Age Graduate Employment Graduate FTE Rate Leave Profile Leave Over Limit FTE Leave Over Limit of Total Nursing Percentage Leave Over Limit Value Banked RDO FTE Banked RDO Percentage Banked RDO Value Workcover rates Turnover rates	Agency Rate Casual Rate Overtime Rate EB8 Efficiency Nursing Cost per WAU WAU Profile	Reported Blood Transfusion Incidents Reported Medical Administration Incidents / 1,000 per patient day/s Reported Hospital Acquired Falls Reported Hospital Acquired Pressure Injuries

(Queensland Health, 2014).

The above scorecard metrics should be used as Key Performance Indicators and considered from the three principles of business planning (patient, staff and organisation). An updated version of the scorecard will be provided to each HHS every six months. Keep in mind that the Nursing Performance Scorecard is an indicative tool only and input from nursing and midwifery executive at a service level is required to fully interrogate data to make meaningful analysis.

In 2014, the Office of the Chief Nursing and Midwifery Officer performed analysis to provide a clear illustration of the inter-relationship between workforce metrics and nurse sensitive clinical safety and quality metrics and the impact these factors have on perceived nursing efficiency. Data analysed suggested that the reduction of clinical incidents associated with falls and medication administration incidents; and optimal resourcing of Grades 1-2 and 3-4 staff (i.e. appropriate skill mix) are where the greatest efficiency gains are likely to be achieved.

Further challenges exist to develop metrics that inform decision making systems that are dynamic with congruence between available nurse skill and patient demand using skill matching of both permanent and agency staff.. Such metrics and systems have the potential to prevent clinical compromise to patients and at the same time promote fiscal responsibility.

The below section details specific metrics that should be considered for inclusion in the current NMOQ Performance Scorecard. The outlined metrics have been included due to

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their compliance with the above determinants outlined in Table 12. While metrics cannot provide a complete picture or a complete solution, they can provide a powerful mechanism to incentivise quality by making the contribution of nursing more visible within the healthcare system.

There are a variety of reporting methods:

- Balanced Scorecard / Dashboard
- Strategic Plan KPI progress reports
- Cost Centre Management reporting (suites of reports are provided to cost centre managers to support effective and timely evaluation of performance at the operational level):
- DSS Necto finance and variance reports
- full-time equivalent (FTE) Reports
- overtime reports
- absenteeism reports
- payroll reports
- KPI reports, financial and non-financial
- workforce efficiency report
- agency and locum usage report.
- number of clinical incidents

The balanced scorecard is a strategic planning and management system that is used extensively in business and industry, government, and nonprofit organizations worldwide to align business activities to the vision and strategy of the organization, improve internal and external communications, and monitor organization performance against strategic goals. It was originated by Drs. Robert Kaplan (Harvard Business School) and David Norton as a performance measurement framework that added strategic non-financial performance measures to traditional financial metrics to give managers and executives a more 'balanced' view of organizational performance. While the phrase *balanced scorecard* was coined in the early 1990s, the roots of the this type of approach are deep, and include the pioneering work of General Electric on performance measurement reporting in the 1950's and the work of French process engineers (who created the *Tableau de Bord* – literally, a "dashboard" of performance measures) in the early part of the 20th century.Kaplan and Norton describe the innovation of the balanced scorecard as follows:

The balanced scorecard retains traditional financial measures that tell the story of past events, an adequate story for industrial age companies for which investments in long-term capabilities and customer relationships were not critical for success. These financial measures are inadequate, however, for guiding and evaluating the journey that information age companies must make to create future value through investment in customers, suppliers, employees, processes, technology, and innovation. Kaplan & Norton:1996

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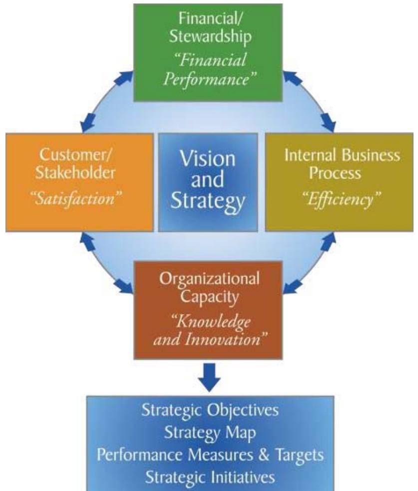

The balanced scorecard comprises four perspectives, and metrics should be developed to collect and analyse data relative to each of these four perspectives:

- Learning and Growth
- Business Process
- Customer
- Financial.

Balanced scorecards and dashboards provide a succinct summary capturing the information most relevant to effectively monitor a facility or health service's performance against strategic goals and established performance measures. Balanced scorecards and dashboards include a range of indicators to manage and measure both financial and non-financial data that is compared to a target value within a single concise report.

A dashboard is where all data and metrics are collated and presented as useful information for the organisation. A dashboard is created by using metrics and Key Performance Indicators (KPIs). In essence, a dashboard is a multilayered performance management tool that enables organisations to measure, monitor and manage business activity by using both financial and non-financial measures. The dashboard provides analysis into the progress of the organisation toward achieving each defined objective. A dashboard comprises a toolset of visual displays that provide timely, relevant information in an easy to understand format, utilising multiple sources of existing data, and displays information in real time required to inform daily decisions that help drive process improvement (VisionEdge Marketing, 2007). See http://qheps.health.qld.gov.au/hsu/dashboards/dbhome.htm and click on the various collections to see dashboards as described above.

Setting tolerances and targets

Consideration should be given to establishing tolerances and targets for relevant metrics contained in the current Nursing Performance Scorecard. Establishing and incorporating tolerances and targets in combination with a traffic light system (similar to what is contained in the current QLD Health DSS dashboard) within the scorecard would allow HHS and/or facilities to see what is acceptable, what needs action, and how urgently action is needed.

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Benchmarking

Benchmarking is the process of comparing the cost, cycle time, productivity, or quality of a specific process or method to another that is widely considered to be an industry standard or best practice. Essentially, benchmarking provides a snapshot of business performance and assists in understanding actual performance in relation to a particular standard. This often results in a business case for making changes in order to improve services. Benchmarking is used most often to measure performance using a specific indicator (cost per unit of measure, e.g. WAU) resulting in a metric of performance that is then compared to others.

"Best practice benchmarking" or "process benchmarking", is a process in which organisations evaluate various aspects of their processes in relation to best practice, usually within a peer group defined for the purposes of comparison. This then supports organisations to develop plans on how to make improvements or adopt best practice, usually with the aim of increasing some aspect of performance. Benchmarking may be a once only event but is often treated as a continuous process in which organisations continually seek to challenge their practices. **BPF communities of practice** (CoP) between HHS share successes and learn from each other's lessons learnt, evidence and stories.

Types of benchmarking

Process benchmarking	The organisation focuses its observation and investigation of business processes with a goal of identifying and observing the best practices from one or more benchmarks from other organisations. Activity analysis will be required where the objective is to benchmark cost and efficiency.
Financial benchmarking	Performing a financial analysis and comparing the results in an effort to assess an organisation's overall competitiveness.
Performance benchmarking	Allows an assessment of competitive position by comparing products and services with those of target facilities.
Product benchmarking	The process of designing new products or upgrades to current ones. This process can sometimes involve reverse engineering which involves deconstructing products to find strengths and weaknesses.
Strategic benchmarking	Involves observing how others compete. This type of benchmarking is usually not industry specific, meaning it is preferable to observe other industries.
Functional benchmarking	A facility will focus its benchmarking on a single function in order to improve the operation of that particular function.

Benchmarking can be undertaken internally within the organisation or externally with other organisations. When benchmarking, it is best to select other units / facilities / organisations with similar characteristics of:

- role delineation / Clinical Services Capability (Framework)
- casemix
- activity.

In analysing the use of nursing and midwifery resources, it is important that where there are differences in the benchmark results, the analysis of the differences be carefully considered.

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The analysis should particularly focus on:

- skill mix / category of nurses and midwives
- support services
- team structure / numbers (other than nursing).

Conclusions

An emphasis on the quality of nursing care and keeping quality high on the agenda of Hospital and Health Service management is vital for the improvement of nursing. In this respect nursing metrics may be both important and effective. Metrics could allow nurses to regain control of nursing quality. It seems likely that to achieve this goal, measurement and analysis of nursing care outcomes will become more important. For this to be meaningful, the outcomes measured need to be consistent and sensitive, and have the ability to be measured without detracting from the core role of nursing, that is, providing high quality care to patient

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TEMPLATE

Business Planning Framework

Service Profile

Document Approval

Name:

____

Nurse Unit Manager

Date:

Name:

____

Service Director / Nursing Director / Director of Nursing

Date:

Name:

____

XXHHS Nurse Manager, Business Planning Framework

Date:

Name:

____

XXHHS Executive Director of Nursing and Midwifery

Date:

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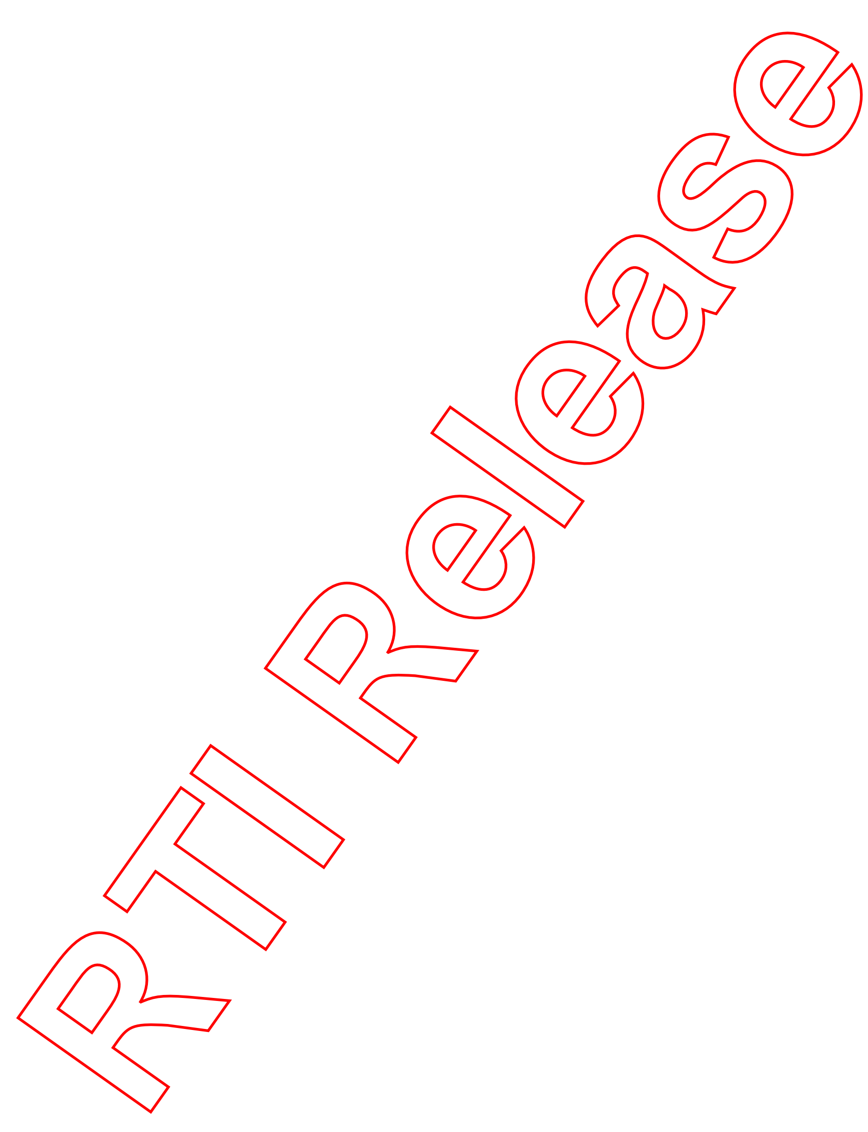
Service Profile Document Control

Version	Date	Prepared by	Comments

**Drafts should use format vX.1 (eg. start at v0.1). Final versions should use format vX.0 (eg. v1.0).*



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Service Overview

Service Name

Aim

Objectives

The key objectives of our Service are:

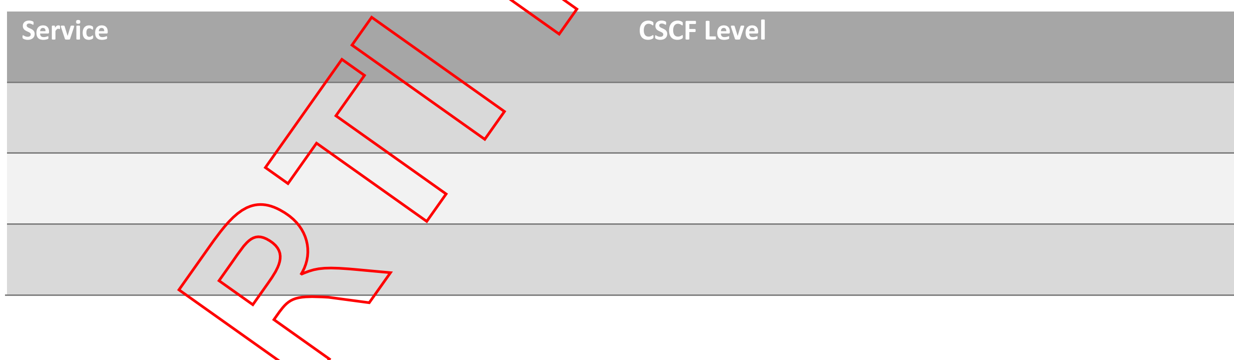
Describe the Present Service

Internal Environmental Analysis

Location and Size

Services within the Facility

The Service capability is assessed against the Queensland Department of Health Clinical Services Capability Framework for Public and Licensed Private Health Facilities (v3.1) and is documented in the XXHHS Service Agreement xxxxxxxxxxxxx.



Service	CSCF Level

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Service Structure

The service and unit structures provide transparent lines of accountability and responsibility.

Leadership and Management

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Staffing Structure

Nursing / Midwifery Structure:

(Copy and paste Excel Table – table below is an example or copy and paste WorkMAPP Cost Centre Structure)

Nursing Officer Grade	Position Name	Position ID	Cost Centre	Productive FTE	% of Workforce = Skillmix	Temp (T) or Perm (P)	Roles & Responsibilities	Proposed FTE
Nurse Grade 10	Director of Nursing							
Nurse Grade 9	Nursing Director Assistant Director of Nursing							
Nurse Grade 8	Nurse Practitioner							
Nurse Grade 7	Clinical Nurse Consultant Nurse Unit Manager Nurse Manager Nurse Educator Nurse Researcher Public Health Nurse, and Midwifery equivalents							
Nurse Grade 6-7A	Associate/Advanced Practice role							
Nurse Grade 6	Clinical Nurse							
Nurse Grade 6	Clinical Midwife							
Nurse Grade 5	Registered Nurse							
Nurse	Registered Nurse							

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Grade 5	Midwife (only)							
Nurse Grade 5	Registered Nurse (Graduate)							
Nurse Grade 4	Enrolled Nurse Advanced Practice							
Nurse Grade 3	Enrolled Nurses							
Nurse Grade 2	Undergraduate Student Nurses / Midwives							
Nurse Grade 1	Assistant in Nursing							
	Total			**0.00**				

Non-Nursing Support positions Support Staff

- Staff who are not employed by the service, and not rostered exclusively to the service. Eg physiotherapist / occupational therapists, CNC specialist roles.

Position level	Position Name	Position ID	Cost Centre	Productive FTE	% of Workforce = Skillmix	Temp (T) or Perm (P)	Roles & Responsibilities	Proposed FTE
	Total			**0.00**				

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Current Model of Care

Human Resource Management

Core staff working in the service

Teaching and training/development commitments/needs

Clinical Support Base activities

Information Technology / management:

Information Technology (clinical and management)

Information Management

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External Environmental Analysis

Policy/Legal Factors	
Economic Factors	
Social Factors	
Technology Factors	
Research and Evidenced Based Practice	

S.W.O.T Analysis

Strengths to build on • Strength is a distinctive competence of the service	
Weaknesses to address • A weakness is a deficiency that limits the performance of the service	
Opportunities to take advantage of • An opportunity is a factor external to the service that presents an area of potential for the service	
Threats to neutralize • A threat is an unfavourable factor in the external environment	

Comparative Analysis

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ACTUALS

Patient / Client activity

Top Ten DRG					
No.	DRG	Description	ALOS	Peer Group Ave	Variance
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Fractional Bed Days		
Month	Total	Ave.
Oct		
Nov		
Dec		
Jan		
Feb		
Mar		
Apr		
May		
Jun		
Jul		
Aug		
Sep		
Total		

Emergency Department Presentations							
Month	Cat 1.	Cat 2.	Cat 3.	Cat 4.	Cat 5.	Total	Weekly Ave.
Oct							
Nov							
Dec							
Jan							
Feb							
Mar							
Apr							
May							
Jun							
Jul							
Aug							
Sep							
Total							

Occasions of Service								
Month	OOS 1	OOS 2	OOS 3	OOS 4	OOS 5	OOS 6	Total	Weekly Ave.
Oct								
Nov								
Dec								
Jan								
Feb								
Mar								
Apr								
May								
Jun								

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Jul								
Aug								
Sep								
Total								

Performance

Financial Performance Calender Year (to date)			
Cost centre	Actual	Budget	Budget Variance
Total Performance			

Nursing Labour Performance Indicators Calender Year (to date)				
Sick Leave (%)	Casual (%)	Overtime (%)	Agency (%)	Vacancy (FTE)

Patient Specialling													
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Hours													

Patient Escorts													
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Hours													

Nurse Sensitive Indicators

Clinical Incidents				
Incident Type	SAC 1	SAC 2	SAC 3	Total No.
Falls				
Medication Incidents				
Pressure Injuries				
Blood Transfusion				
(insert other relevant)				

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Forecast

Nursing Resource Determination 2016-2017

**Nursing Resource Determination
2016-2017**

Step 1: Calculate Average Productive NHPPD or NHPOS or NHPUA

Average Nursing Hours per Patient Day =	Total Annual Productive Hours / Total Activity (FBD's/OOS/UA)
Average NHPPD/NHPOS/NHPUA=	

Step 2: Determine the Weekly Nursing Hours

Weekly Nursing Hours =	**Total Annual Productive Nursing hours/52 weeks**
Weekly Nursing Hours =	
Weekly Nursing Hours Total =	

Step 3: Develop Master Staffing Roster Profile

Insert master roster profile

Step 4: Confirm Direct Care Shift Profile

(Example)

Direct Care Shift Profile						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
8.0 : 7.0 :3.0	8.0 : 7.0 :3.0	8.0 : 7.0 : 3.0	8.0 : 7.0 : 3.0	8.0 : 7.0 : 3.0	7.0 : 7.0 : 3.0	7.0 : 7.0 : 3.0

Step 5: Confirm Notional Nurse Patient Ratio

(Example)

Notional Nurse Patient Ratio – Direct Care Hours				
Shift	**Resourced Beds**	**Nursing Hours**	**Nursing Headcount**	**Nominal Ratio**
Day	24	64	8	1:3
Evening	24	56	7	1 : 3.4

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Night Shift	24	24	3	1:8

Summary

Significant Achievements in the last Twelve Months

Priorities for Service Improvement 2016 - 2017

Attachments

- **Proposed Service Profile**

References

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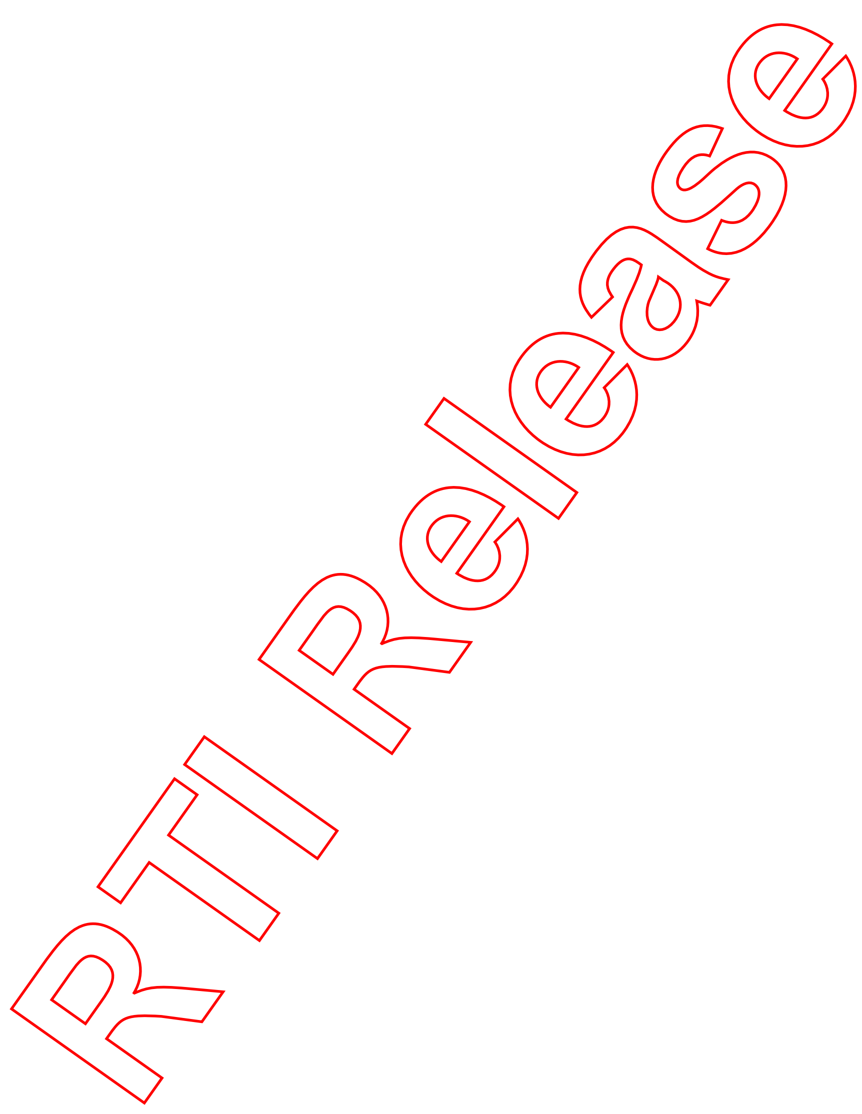
- Service Improvement Business Case

A service improvement business case is required to be submitted for year - year to support service delivery changes:

☐ Yes

☐ No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TEMPLATE
Service Profile & Budget Negotiation Formal Agreement (optional)

- Sign off needs to occur by the designated nursing / midwifery leaders and Chief Finance Officer. This signed document needs to be tabled at the local governance meeting.
-

Ward / Unit Name: ______________________

Hospital & Health Service: ______________________

Service Group: ______________________

Financial Year Period: ______________________

Agreed

NHPPD		:		Beds	@		% Occupancy
NHPOS		:		Daily OOS	@	100	% Occupancy
NHPUA		:		Daily UoA	@	100	% Occupancy

	Proposed FTE	Budgeted FTE	Agreed FTE*	% of total agreed FTE	Agreed FTE inclusions					Total budget $
					Base	A/L	S/L	MDT	PDL	
NUM					100%					
CNC					100%					
CN					100%					
RN					100%					
GRAD					100%					
SIN					100%					
AIN					100%					
Total										

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*Agreed FTE is the total FTE allowable to be recruited to without formal application to increase FTE with the relevant Nursing & Service Group Directors. This number would match and be reportable using Panorama DSS

Note: comments / details of discussions may be documented on the reverse of this page as necessary

Approval

This is to certify that negotiations have occurred as per the Business Planning Framework and agreement has been reached in regards to the nursing resource requirements outlined above.

Service Director	Nursing Director	Business Service Manager	Nurse Unit Manager
Date:	Date:	Date:	Date:

☐ Budget provided to NUM / Line Manager

☐ Service Profile provided to Nursing BPF Resources for publishing

Discussion Details / Notes

It is expected that this document is completed and signed by all relevant stakeholders

by 30 June each year

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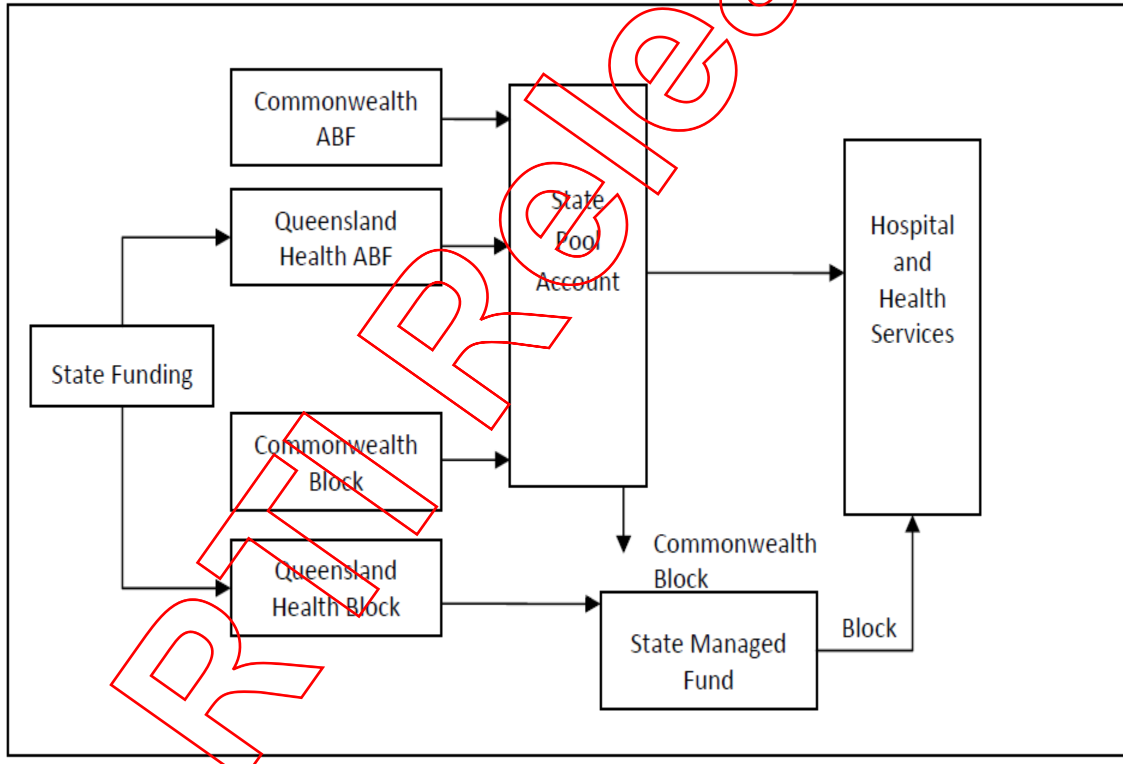
Annexure 1: BACKGROUND - Understanding the funding environment

COAG agreed, out-of-session in August 2011, to the National Health Reform Agreement, which aim to deliver major reforms to the organisation, funding and delivery of health and aged care. The Agreement sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health care system.

The reforms aim to achieve better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for our health system into the future through increased Commonwealth funding. This new agreement gives effect to the commitment made by COAG on 13 February 2011, and in doing so, supersedes the National Health and Hospitals Network Agreement and the Heads of Agreement on National Health Reform.

Figure 2: Funding flows under the National Health Reform Agreement



Under the National Health Reform Agreement, the Commonwealth is providing an extra $16.4 billion, through to 2019-20, for public hospitals. Under the Agreement, a component of the National Health Reform funding is identified as public health funding, to be paid by the Commonwealth into the National Health Funding Pool, and from there to state or territory health departments:

Aligning the Business Planning Framework with the funding system

When developing and then negotiating budgets based on your Business Planning Framework's service profile, it is beneficial to understand the wider financial framework

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your service area operates. In Queensland, service agreements are negotiated between the Queensland Health System Manager (Department of Health) and each of the Hospital and Health Services (HHSs). The service agreement determines the type and number of services provided by HHSs and the funding that the Department of Health provides for the provision of these services.

- Activity Based Funding (ABF) for larger public hospitals – where funding flows to local Hospital and Health Services according to the type and number of services they provide, based on a Queensland base price (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf) for each type of service.

Independent Hospital Pricing Authority

The Independent Hospital Pricing Authority (IHPA) is an independent agency established under Commonwealth legislation as part of the National Health Reform Agreement (NHRA) signed by the Council of Australian Governments (COAG) in August 2011.

The IHPA:

- sets the National Efficient Price (NEP), the National Efficient Cost (NEC), and the price weights based on national data provided by the state and territory governments
- determines the Activity Based Funding model
- uses the National Hospital Patient Costing Standards http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/costing-standards-lp

The National Hospital Patient Costing Standards aims to provide direction for hospital patient costing through the development of standards for specific elements of the costing process and reporting requirements. It provides the framework and guidelines to regulators, funders, providers and researchers that submit data to the National Hospital Cost Data Collection (NHCDC).

It is important that costing data conforms to the costing standards outlined in the document to meet the Council of Australian Governments (COAG) requirement for national consistency. This will also allow any relevant cost studies to consistently and reliably reflect the changes in hospital output prices and clinical practice in public and private sectors.

IHPA works in partnership with the National Health Performance Authority and Australian Commission on Safety and Quality in Health Care to ensure that pricing, quality and performance measures for public hospitals are complementary and facilitate a strong national framework for the delivery of public hospital services.

Two key measures developed from this work are the NEP and the NEC.

The NEP, the NEC and the National Weighted Activity Unit (NWAU) are determined annually by the IHPA. The NWAU is the unit of measure of the ABF system. Each year, IHPA publishes a draft Pricing Framework for Australian Public Hospital Service – a key policy which helps guide the NEP and NEC.

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IHPA receives activity data from each jurisdiction on a quarterly basis. This data includes inpatient admissions, emergency department presentations and outpatient appointments as well as a range of mental health and rehabilitation services.

- For more information visit:
  - National Health Performance Authority - measures performance http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/home-1
  - National Health Funding Body – provides the funds from the Commonwealth http://www.nhfb.gov.au/

Efficient price determination

(NEP) = $4993

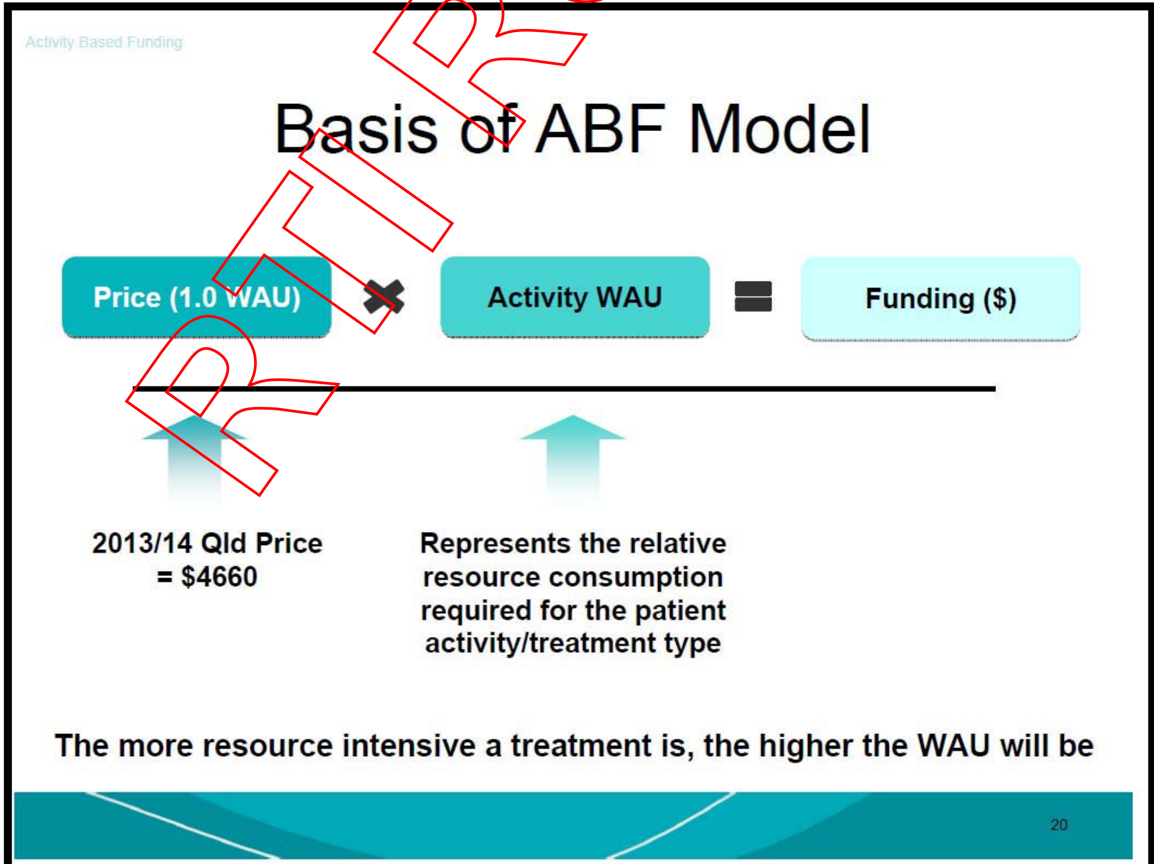
(QEP) =$4660

Reason for difference is:

- Corporate overheads
- Site specific grants
- Clinical education and research.
  - For more information visit: http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/national-efficient-price-determination-lp

Cost weights and trim points

Weighted Activity Units, or cost weights, are used to measure patient care. They are a standardised ratio of the average resource requirements for treating a patient and represent the complexity of a care type and how much it costs to deliver it



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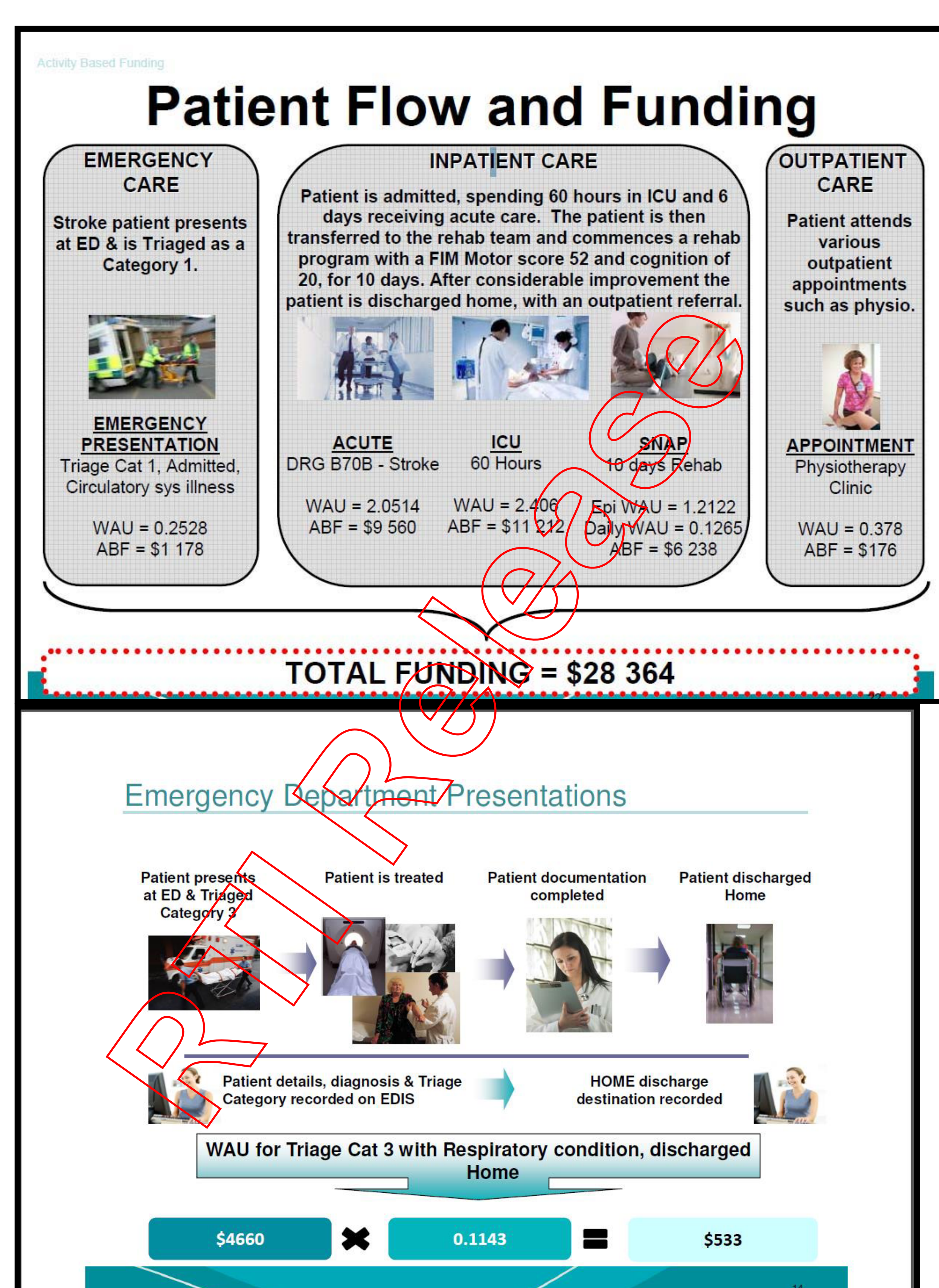

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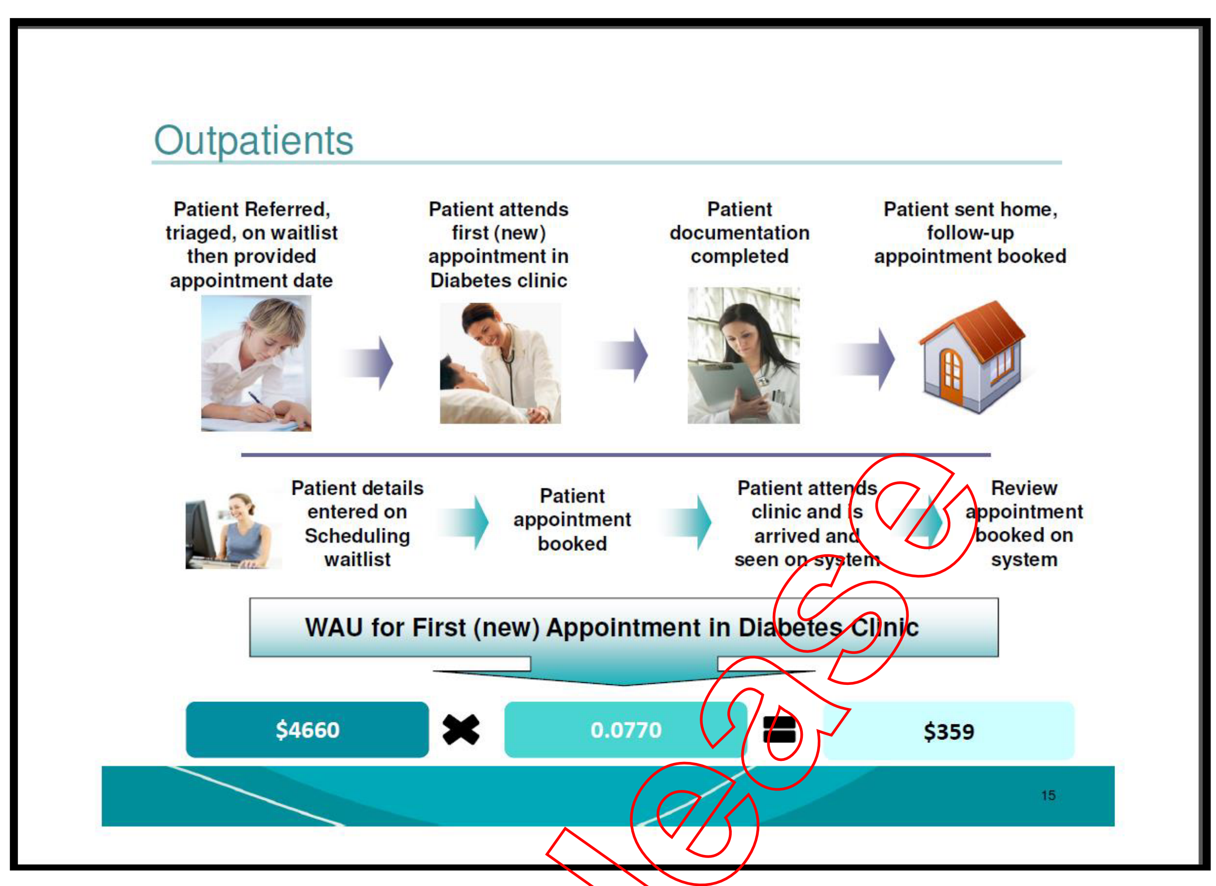

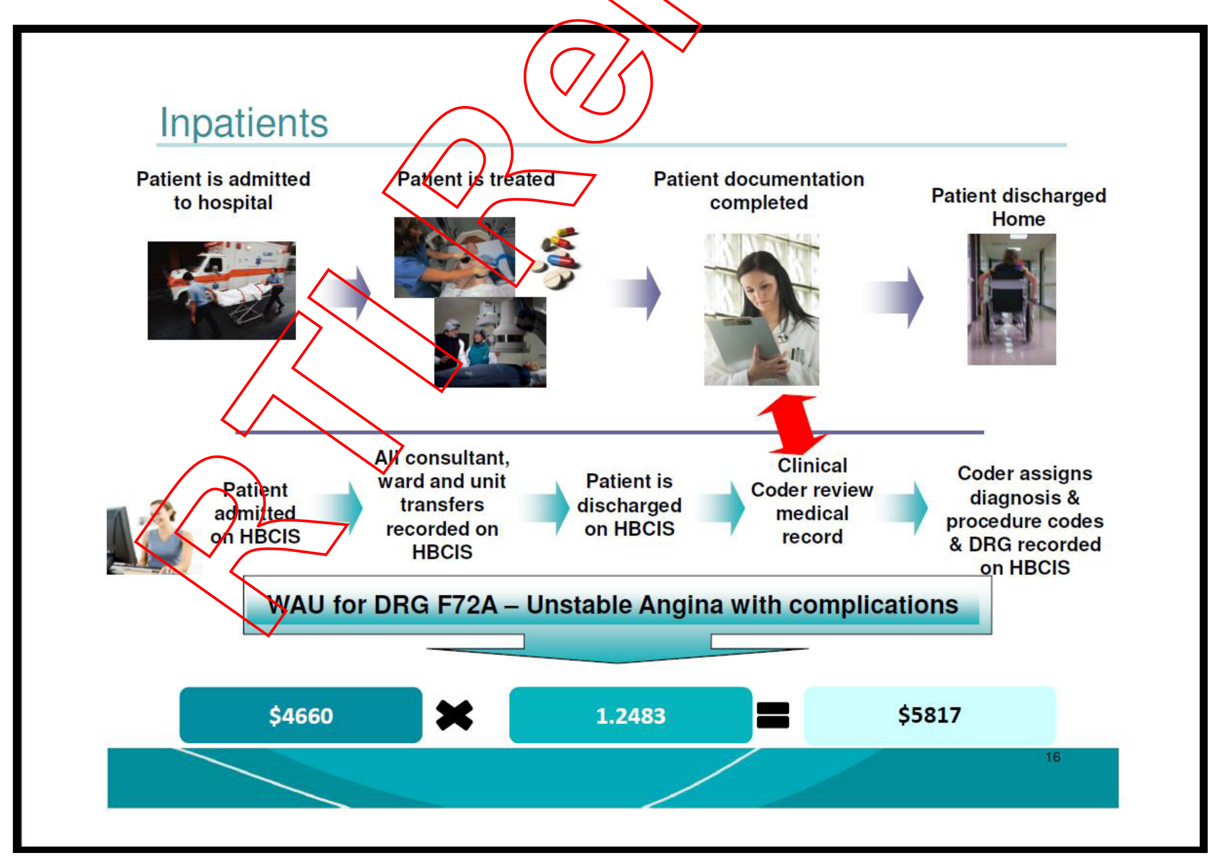

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- For more information visit:

http://qheps.health.qld.gov.au/abf/home.htm
http://qheps.health.qld.gov.au/nmoq/workforce/documents/ABF_Overview.pdf

- A block funding approach for small and regional hospital services – where funding is provided by historic block funding, based on the hospital's intention to treat patients (availability).
http://www.publichospitalfunding.gov.au/national-health-reform/funding-what

Cross-border activity based funding

When a resident of one state receives hospital treatment in another state, the 'resident state' compensates the treating or 'provider state' for the cost of that care via a 'cross-border' payment.

- For more information visit:

http://www.publichospitalfunding.gov.au/national-health-reform/funding-what

- Nationally consistent classifications and data collection for hospitals.
  - For more information visit:

http://qheps.health.qld.gov.au/abf/html/002-how-fund-calc.htm

Figure A: Health System Performance Reporting

- Nationally consistent classifications and data collection for hospitals.
  - For more information visit:

http://qheps.health.qld.gov.au/abf/html/002-how-fund-calc.htm

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Funding models - Different payment systems from the Australian and International Health Care systems

Type	Description	Advantages	Disadvantages
Block Funding (still used for small and regional Australian public hospitals)	Traditional approach by government often based on historical levels of funding.	• simple to develop • simple to administer • budget and expenditure are predictable • can supplement other funding - target specific areas	• limited accountability • lack of transparency • no incentive to promote efficiency • does not promote equity
Population based funding	Payment for anticipated activity based on population. Based on measures of expected health need.	• aims to distribute funding equitably based on population need • can be simple to implement and understand • budget allocation and expenditure are predictable • service providers must understand their community and can promote them providing health promotion and prevention programs to remain financially viable	• selecting and measuring the right population measure may be difficult • may not result in equitable access due to service configuration and efficiency • health services with good reputations may attract patients from outside their area and be financially disadvantaged • not suitable for funding specialist and statewide services
Fee for service (primary health care and private specialists in Australia funded by Medicare and co-payment by consumer)	Funding provided on a per service basis. Common price per service.	• transparent and easy to measure output • funding level closely related to cost • removes incentives to reduce service delivery (e.g. no pressure to discharge patients early)	• may not result in equitable access to services • may provide incentives to over service • may provide incentives to select 'profitable' patients • may discourage innovation and efficiency gains
Casemix (ABF) Public hospitals in Australia	Health services are reimbursed for provision of patient care based on the type and mix of the patients treated. A set amount is paid to the provider based on the relative cost of the group to which the patient is classified.	• funding is transparent based on measurable outputs • promotes accountability • promotes technical efficiency • promotes innovation • financial risk is shared between the purchaser and the service provider	• requires significant infrastructure to establish i.e. classification, reporting, governance • funding does not necessarily equal cost • may provide incentives to select 'profitable' patients • may provide incentives to provide fewer services than what is clinically appropriate
Bundled payments Used by HMOs in the US and Primary Care Trusts in the UK	Episode based payment with reimbursement for provider bundled into a single, comprehensive payment that covers all of the services involved in a patients care. Focuses on specific conditions, such as those with defined time frames, defined services or based in specific care settings.	• goal is to improve population health, boost the patient experience and reduce costs • promotes control cost, integrates the care and restructure of the delivery of care • shares financial risk between funder and provider	• difficult to set prices – and if inappropriate price funding allocation will be inefficient • may promote providers selecting 'profitable' patients and providing fewer services than what is clinically appropriate

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Glossary

Terms	Proposed definition / description	Evidence reference / link
Acuity	The term acuity is used interchangeably with the complexity and intensity to identify service demand within outpatient and ambulatory health care services. Also known as client acuity	
ADO	Accrued Day Off (ADO) means a day accrued as a result of the method of working ordinary hours where employees are rostered off on various days of the week during a particular work cycle.	http://www.qirc.qld.gov.au/resources/pdf/awards/q/q0090_swc13.pdf
Benchmarking	Benchmarking is a way of measuring performance against a similar-sized service to identify how to improve.	http://www.business.qld.gov.au/business/starting/market-customer-research/benchmarking-business
Business plan	Referring to the HHS Strategic / operational plans.	http://www.health.qld.gov.au/services/default.asp
Casemix	Casemix is a generic term for a method of classifying the activities that health services deliver. It is a description of the mix and type of patients treated in a hospital. Casemix may be defined as an information tool involving the use of scientific methods to build and make use of classifications of patient care episodes. The term may be taken to refer to both: • the number and types of patients treated • the mix of bundles of treatments, procedures and so on provided to patients.	What is Casemix Funding
Client acuity	Within the BPF, the term client acuity is used interchangeably with complexity and intensity to identify service demand within health care services.	
Client complexity	A measure used to assist nurses and midwives in identifying and planning the resources required to meet the care demands of consumers.	
Clinical costing system	In brief, the clinical costing system does the following: • takes financial and patient information from feeder systems (e.g. DSS, Payroll, HBCIS) • organises financial information and patient utilisation into departments • costs products at department level • assigns products and costs to patients.	http://casemix.health.qld.gov.au/CC/costing.html
Clinical Service Capability Framework (CSCF)	The Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3.1 (CSCF v3.1) has been developed as a result of a review of version 3.0 which was released in 2011. The responsibility for implementing, monitoring, complying with and notifying changes in service levels in public health facilities will rest with Hospital and Health Service Chief Executive Officers. It is a classification of the capability a facility has to provide a service. For example, if a hospital has no orthopaedic surgeon then it does not have the capability of providing orthopaedic surgery.	http://www.health.qld.gov.au/cscf/
Cost Centre	A cost centre is an area where the costs for all services for a particular unit or setting are allocated.	http://qheps.health.qld.gov.au/financenetwork/financial_policy/docs/FMPM/fmpm_appendices.pdf
Diagnosis-related groups (DRGs)	A patient classification system used in Australia that groups similar diagnosis and procedure types together. This information is used to provide a meaningful and consistent way to clinically assess the types of treatment received and to inform activity costing processes for the purposes of activity based funding models, patient costing and benchmarking.	http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf http://qheps.health.qld.gov.au/abf/home.htm
Direct nursing / midwifery hours	The nursing / midwifery hours used to support direct care to patients / clients.	

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Terms	Proposed definition / description	Evidence reference / link
Episode of care	The period of admitted patient care between a formal statistical admission and a formal or statistical separation, characterised by only one care type. An admission may be 'statistical' in that the patient changed from one type of admitted patient to another (between any two of acute, rehabilitation, palliation, or non-acute) without being separated from the hospital.	LINK 1: http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf LINK 2: DSS casemix glossary
External environmental factors	Factors that are generally outside of the control of the business. This may include political decisions, technological changes, market demographics and competitor behaviour.	http://www.business.qld.gov.au/business/starting/market-customer-research/swot-analysis/example-swot-analysis
Fixed costs	Costs which do not change as volume changes.	Nil available
Forecast	A prediction of some future value e.g. activity levels, acuity levels, nursing and midwifery hours required.	Nil available
Fractional bed day	Actual hours a bed is occupied.	
Full-time equivalent (FTE)	The number of employee hours (paid, unpaid or contracted hours) divided by the Award standard hours per fortnight.	http://qheps.health.qld.gov.au/financenetwork/financial_policy/docs/FMPM/fmpm_appendices.pdf
Appointed FTE	Number of FTE that are appointed / used against established positions.	http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/procedures/fte_budfte_paper.pdf
Approved FTE	Number of FTE that are approved, and have been established within the payroll system. A position, for example, may be generic to five staff who are all setup against one position as represented in a position occupancy report.	-
Budgeted FTE	Positions that are captured when developing the annual budget for the respective business unit. Budgeted FTE are the funded positions that are likely to be filled during the financial year. Budgeted FTE includes overtime and external FTE.	http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/procedures/dis_bfte_upl_ins.pdf
Hospital and Health Service (HHS)	A HHS is a statuary body with a Hospital and Health Board, accountable to the local community and the Queensland Parliament.	http://www.health.qld.gov.au/health-reform/
Indirect nursing / midwifery hours	Indirect clinical hours - activities undertaken which benefit the patient / client while not in direct contact with them, including education and training on the clinical unit, mandatory competence attainment, quality improvement activities, portfolio activities, performance appraisal and unit orientation time.	
Internal environmental factors	Factors that are generally internal to the business and therefore can be influenced by the business. This may include: funding that is available, resources / staff and current processes.	http://www.business.qld.gov.au/business/starting/market-customer-research/swot-analysis/example-swot-analysis
MOHRI Occupied FTE	MOHRI stands for – Minimum Obligatory Human Resource Information. It is a Whole of Government (WoG) methodology for producing an Occupied FTE value sourced from the QHealth payroll system data for reporting and monitoring. The data reported is based on the cost centre that the position is assigned to in payroll. MOHRI FTE is calculated by dividing the contracted employee hours into the award standard hours that the employee should work.	http://dss.health.qld.gov.au/dss/docs/MOHRI_Occupied_FTE_and_Headcount_explanation.pdf
MOHRI Occupied FTE (Diagram)	Refer to diagram in link	http://dss.health.qld.gov.au/dss/docs/explanation_diagram_mohri_vs_qh_fte.pdf
Non-productive nursing and midwifery hours	Paid, non-worked hours where the employee is not physically contributing to patient care. This can also be measured through a non- productive FTE and includes annual leave, sick leave, paid parental leave, work cover leave.	
Nurse Sensitive Indicator (NSI)	Nurse Sensitive Indicators (NSI) capture nursing contributions to health care outcomes through collecting process, structure and outcome measures such as workforce and patient outcome indicators.	http://qheps.health.qld.gov.au/nmoq/profession/nsi_about.htm

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Terms	Proposed definition / description	Evidence reference / link
Nursing and midwifery hours per patient day	The average nursing and / or midwifery hours per unit of activity for hospital inpatients.	
Nursing and midwifery hours per occasions of service	The average nursing hours per unit of activity for ambulatory patients (e.g. Emergency Department, outpatients).	
Occasions of services	Any examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit or a health service facility.	
Occupied bed day (OBD)	The occupancy of a hospital bed by an inpatient for up to 24 hours.	http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf
Operating expenses	The costs associated with the operations of the service. This includes all overhead, fixed and non fixed costs.	
Patient Dependency System (PDS)	A system that classifies patients according to the intensity of nursing / midwifery care needs and therefore indicates the amount of nursing hours required.	http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf
Productive nursing and midwifery hours	Productive hours are the hours that an employee is paid for which directly contribute to patient care. When measured through FTE, this includes base salary and wages, overtime and recall. In the Business Planning Framework, the definition of productive hours also includes study and training leave. It is important to note that from a financial perspective study and training leave are measured as non-productive FTE.	Only reference is in BPF documents
QH FTE	Internal QH mechanism for measuring FTE. It is reported based on the cost centre the employee is paid from in payroll and may NOT be the same as the cost centre assigned to the position worked in. QH FTE is calculated by dividing the actual hours worked into the award standard hours that the employee should work.	http://qheps.health.qld.gov.au/financenetwork/financial_policy/docs/FMPM/fmpm_appendices.pdf
Scorecards	Scorecards are a collection of management reporting tools used to measure the performance or a respective business area or unit against the objectives outlined within the operational plan or service level agreement.	http://dss.health.qld.gov.au/dss/docs/scorecard_intro.pdf
Service agreements	An agreement between Queensland Health and each HHS. It explains how funding is allocated and provides details about HHS performance and includes a protocol for managing concerns about performance when they arise.	http://www.health.qld.gov.au/hhsserviceagreement/default.asp
Service profile	Describes the role and function of a service.	http://www.health.qld.gov.au/services/default.asp
Skill mix	Skill mix refers to the diversity of the skill sets and training required to meet patient needs.	
Staffing plan	A document which identifies the numbers and categories of staff members required for patient / client care	
Standard FTE	Standard FTE is the performance reporting FTE for Queensland Health (QH) and is a key performance indicator in the Queensland Health Scorecard. Standard FTE includes all paid hours, including overtime, sick leave, special leave and maternity leave with pay. It excludes unpaid, long service and recreation leave. Penalties and back pays do not result in the production of an FTE figure and therefore are not included in any FTE calculations.	-
Strategic plan	Strategic Plan for Department of Health, HHS & individual hospitals, streams, divisions, units	http://www.health.qld.gov.au/about_qhealth/strat_plan/12-16/
SWOT analysis	A SWOT analysis is a tool for documenting internal strengths (S) and weaknesses (W) in your business, as well as external opportunities (O) and threats (T). You can use this information in your business planning to help achieve your goals. To work out if something is an internal or external factor, ask yourself if it would exist even if your business didn't. If it would, then it's an external factor (e.g. new technology).	http://www.business.qld.gov.au/business/starting/market-customer-research/swot-analysis

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Terms	Proposed definition / description	Evidence reference / link
Variance	A variance is defined as any difference to the proposed	
Variance analysis	Investigation into the reasons for any differences between the actual results and the expected / forecast results. • For example, variance analysis is conducted to explain differences between the planned nursing hours and the actual nursing hours used within the rostered period or the actual expenditure against the forecast expenditure for the month.	
Weighted Activity Units (WAU)	Value applied to the activity of hospitals that denotes the amount of resources used. The greater the WAU, the higher the resource usage.	http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf
Year-to-date	A measure of the position from the start of financial year to the current date. Used to inform financial reporting for example to give an indication of the performance to date.	

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Natalia Rosenblatt

From: Juliet Graham
Sent: Wednesday, 25 November 2015 2:46 PM
To: Ben Ballard; Paolo La Penna; Renee Woodfield; Colleen Glenn; Glynda Summers; Sandy Munro; Lorraine Mathison; Robyn Fox; Barbara Geddes; Craig Hulme; Desley Horn; Glenn Hokin; James Shattock; Jeff Dippel; Jeffrey Souter; Jillian Richardson; Juliet Graham; Lisa Champion; Lorraine Mathison; Lynne Cameron; Maryanne Humphries; Michelle Eley; Neil Pratt; Rachelle Cooke; Rohan Harbert; Tarryn Mullavey; Ann McCorquodale; Anne Gagie; Ben Archdall; Ben Hackwood; Cathie Nesvadba; Damien Lawson; Denise Brewster-Webb; Denise Wilds; Diana Schmalkuche; Frances Harlow; KarenJ Berry; Katherine Stock; Luke Robinson; Mary Wheeldon; Nikki Goodwin; Paula Longbottom; Sandy Jamieson; Sarah Howarth; [redacted]@qnu.org.au; Susan Freiberg; Trish Smith; Wendy Hoey
Cc: Susan Margaret Krimmer; OCNMO_Corro; Frances Hughes; Francis Price
Subject: BPF 5th edition draft version 3
Attachments: BPF 5TH Edition DRAFT v3 20151120.docx

Good afternoon

Thanks for attending the teleconference meeting this afternoon.

Please find attached the BPF manual 5th edition version 3 for review.

The agreed timeline is below. Please let me know if these timeframes are not a reflection of what was discussed. I have not put the "escalation process" due dates on the time line as I will not have them agreed until the meeting this afternoon. (Update to be provided tomorrow)

Activity	To Whom	Date to be Send Out	Date to be Sent Back
Version 3	BPF Network	20/11/15	3/12/15
Version 3	BPF Strategic WG	24/11/15	3/12/15
Version 4	EDONM Forum	7/12/15	14/12/15
FINAL DRAFT	EDONM Forum, BPF Resource Network, BPF Strategic Group, CE & HR & DoH ER department and professional editor	16/12/15	
WEB CONTENT	OCNMO	TBA	

To provide feedback on BPF document, please feel free to either provide in a tracked changes document; scanned document with feedback or I am more than happy if you would like to make an appointment in my diary and we can go over your feedback over the phone.

Thanks in advance.

Regards
Juliet

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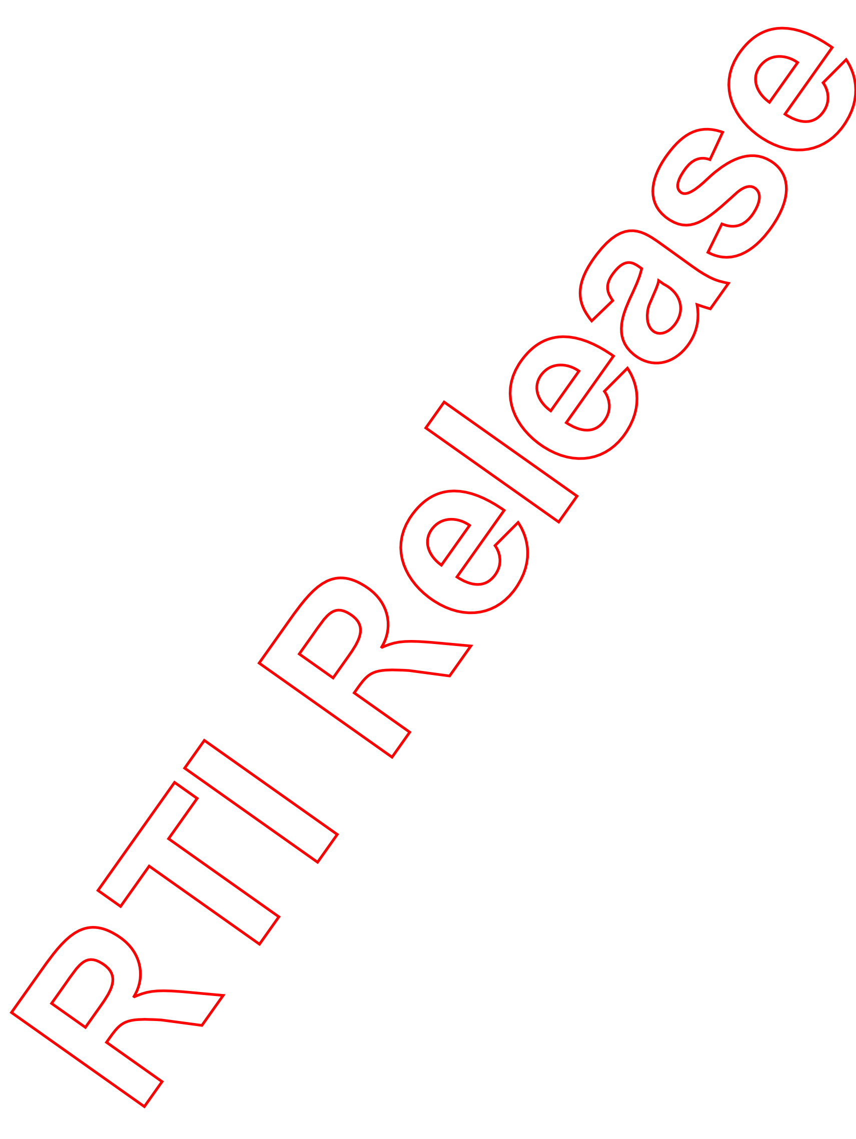
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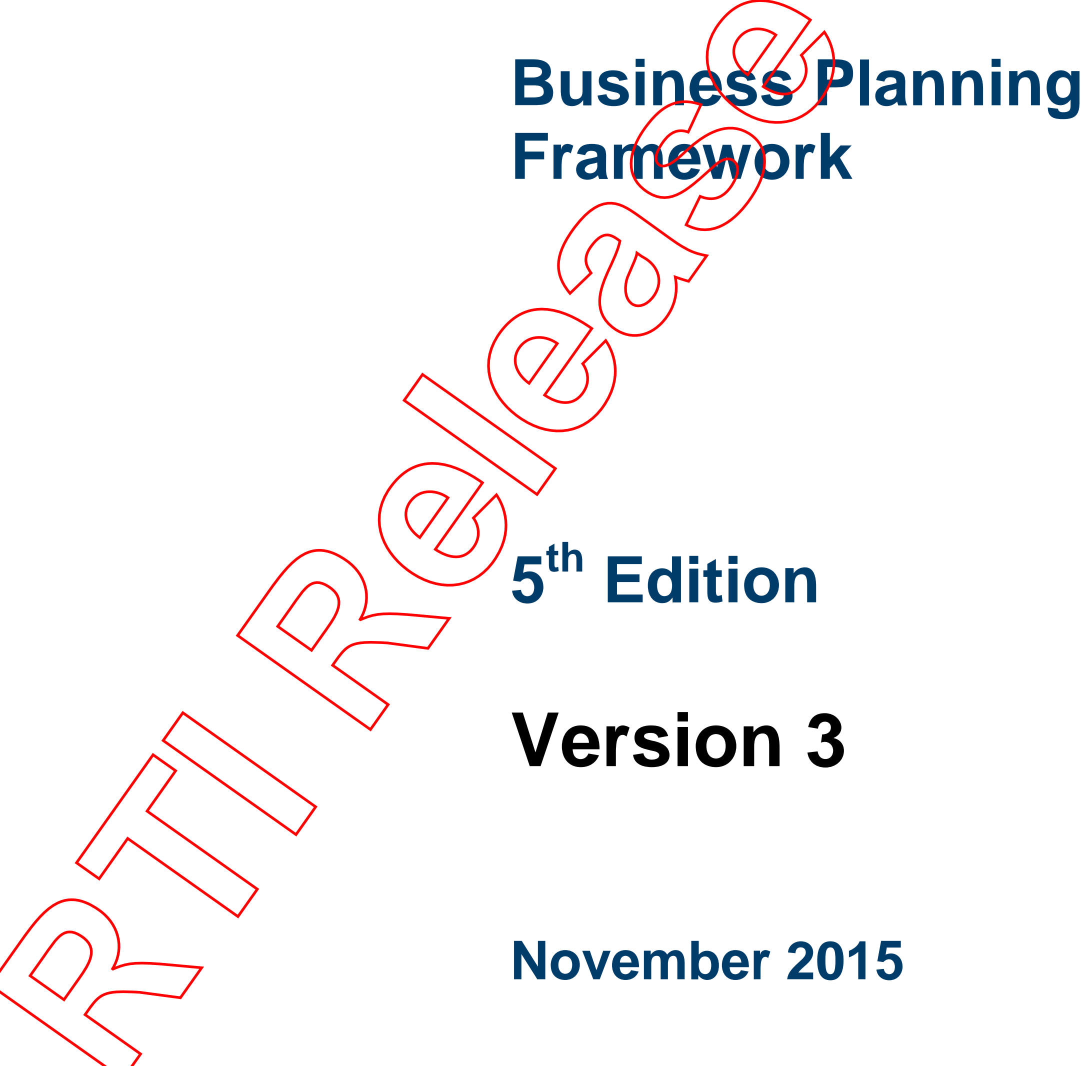

Business Planning Framework

5th Edition

Version 3

November 2015

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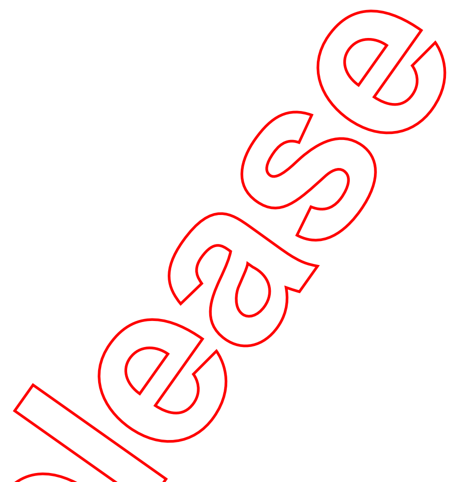

Business Planning Framework – 5th Edition

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Introduction

The Business Planning Framework: the tool for nursing and midwifery workload management (BPF) will imminently transition to a Standard, to support safe ratios and workplace provisions. As part of the *Nursing Guarantee – putting patient safety first*, the Government has committed to legislate for safe nurse-to-patient ratios and workload provisions in Queensland's public Hospital and Health Services (HHS).

The complementary objective for this initiative is to transition the BPF into a Standard, to provide a clear message that the number of nurses on a shift is an important aspect to improving patient safety and quality of care. Integral to the Standard, is the emphasis on increasing transparency on health system performance, monitoring and public reporting on compliance with ratios and the BPF.

The BPF provides nurses and midwives with a business planning process to assist in determining appropriate staffing levels to meet patient requirements and evaluate the ongoing performance of the nursing service.

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The BPF provides nurses and midwives with a simple, standardised business planning process, which assists to:

- determine appropriate nursing staff levels and skill mix to meet service requirements
- identify strategies for managing workloads; and
- guide the development of transparent processes to evaluate the efficiency and effectiveness of the service.

Each clinical unit is required to determine its nursing / midwifery requirements to ensure safe, high quality patient care through shift-by-shift assessment of patient demand. Individual patient needs must be met by the appropriate nursing and midwifery resource allocation over the twenty four (24) hour cycle.

The BPF also determines the process for monitoring and acting to ensure these requirements for nursing and midwifery staff are met and most importantly, to ensure patients are receiving the nursing and midwifery care and contact time they need on the shift. These procedures are outlined in the BPF to demonstrate effective responses to unplanned variations to predicted patients' needs or the availability of nursing staff at any time during the day or night, including prompt action to enable an increase or decrease in nursing staff.

Key benefits of the Business Planning Framework

The BPF improves health service delivery by:

- assisting nurses / midwives to plan
- defining goals and objectives
- identifying priorities determining the required human resources (e.g. nursing / midwifery hours, skill mix) and determining other required resources (e.g. technology, equipment etc)
- guiding monitoring and evaluation; and
- promoting the alignment of frontline services with the strategic directions of Queensland Health and Hospital and Health Services.

Principles of the Business Planning Framework

Business planning is a systematic process for examining a ward / unit / service and its environment in order to allocate nursing and midwifery resources to meet the demand in the most appropriate way. The underlying principles in the BPF process promote transparency in consultation, collaboration and negotiation with the nursing and midwifery leadership team and the Hospital and Health Services (HHS) executive team to ensure that current demand for service / activity is matched with the supply of resources.

These principles fall into three key categories aligned with the key stakeholders of a health service: patients, staff and the wider organisation. The principles are:

1. Patient / client focussed
   - applies evidence based models of care and clinical practice
   - meets agreed outcomes and health improvement targets
   - promotes the premises as underpinning delivery of safe, quality health care (accessible, responsive, safe, efficient, sustainable, effective and appropriate).
2. Staff focussed

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- ensures active participation in the planning and management of resources by nursing and midwifery staff to ensure a balanced approach to resource management
- aligns staff numbers and skill mix with service demand to effectively manage workloads
- integrates workforce planning, workforce flexibility, evidence-based practice, competency, requirements and training
- embeds systems for delivering safe, equitable workloads
- clinical environment.

3. Organisation focussed
   - ensures alignment and consistency between individual service-based business plans and Hospital and Health Services' strategic direction
   - promotes optimal use of resources
   - integrates systems to assist staff in decision making
   - provides access to timely, accurate and reliable data.

The BPF supports nursing and midwifery service managers to match the supply of nursing / midwifery resources with patient demand to deliver services that provide quality patient care outcomes.

Governance and process influences

Individual nursing and midwifery services within Hospital and Health Services have individual, agreed processes for the planning and reviewing of nursing and midwifery resource requirements. These processes align with the current BPF methodology and National Standards for Safety and Quality, and also promote budget integrity.

The people responsible and accountable for nursing and midwifery staffing follow agreed governance principles to identify and support appropriate staff resources at an organisational and at a ward / unit / service level to ensure safe patient care. These processes are delivered within an overarching governance structure to ensure an integrated, consistent and supported approach to workplace and workforce management, and are influenced by:

- Patient Safety and Quality
- Clinical/Performance Outcomes
- Defensible Business/Workforce Plans
- Accountability Structure
- Approval/Negotiation Processes
- Workload Management → service profiles → strategic / analytical monitoring → determining skill mix
- Consistency and Transparency
- Staff Collaboration

This approach requires 'service profiles' that detail the nature of the demand, including population health profiles and internal, external analyses with comparative analysis and performance metrics. These steps reveal any gaps that indicated service growth or reduction, and what the impacts of these variances maybe on the nursing and midwifery workforce.

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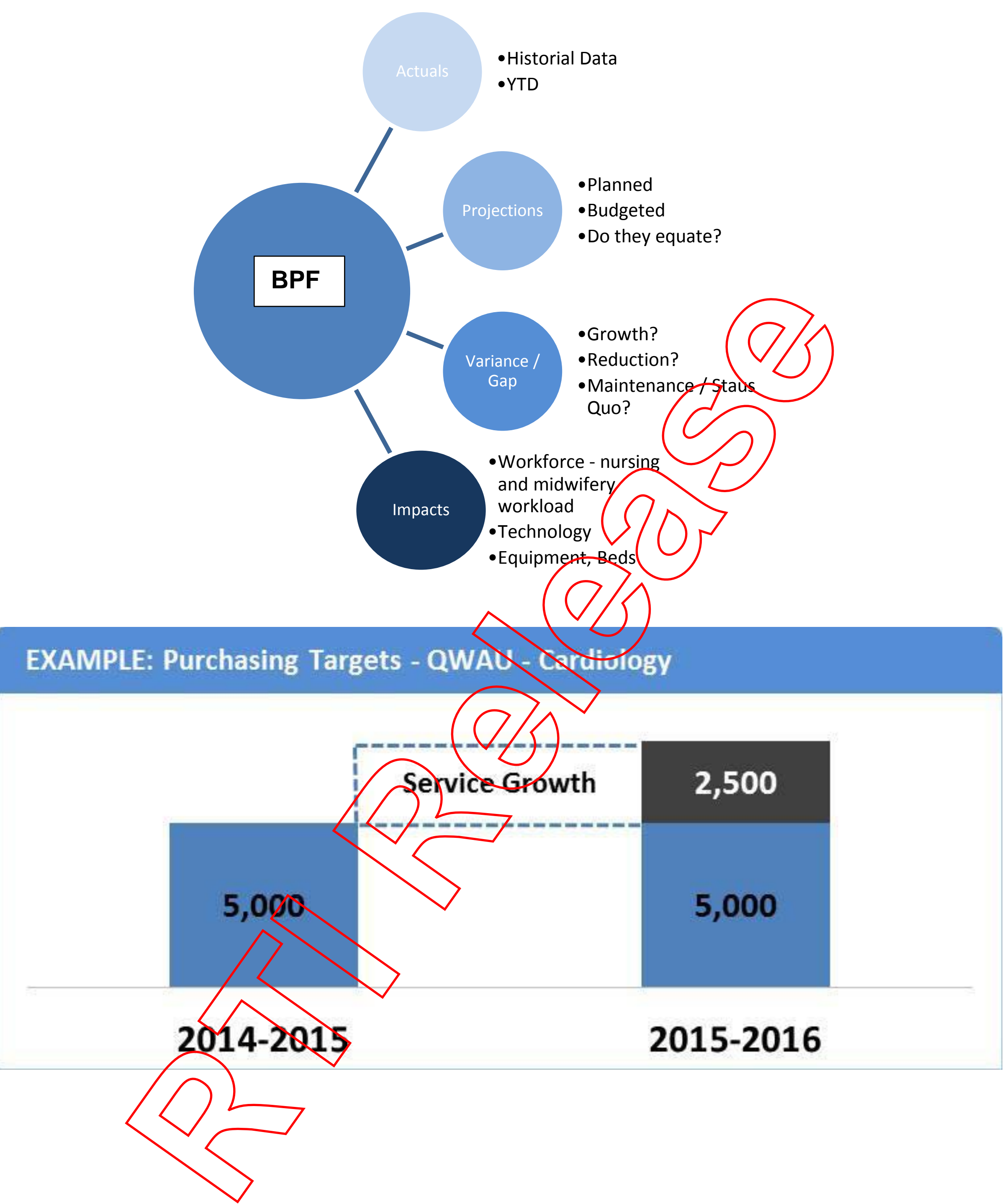
Contemporary BPF



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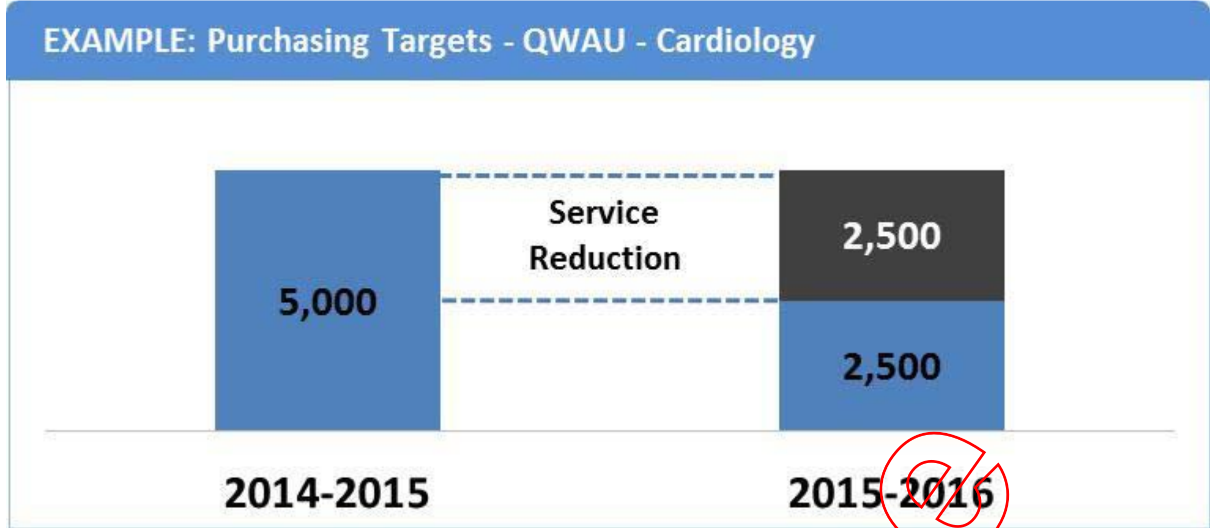

Gap Analysis will indicate that estimates of human resourcing, capital, technology are required. The gap will need to be managed up through the governance structure of the organisation, supported by data wherever possible. This leads to the negotiation process between what the service has planned and should guide the budget negotiations. Optimally, budgeted activity equal planned (forecast) activity.

Service profile

Health care services exist in a complex and changing environment and a robust plan assists to meet these challenges. Therefore, the ability to balance service demand and staff supply is essential when planning the long-term viability and sustainability of these services. Frequent monitoring and evaluation of demand indicators such as client acuity and activity is necessary to ensure nursing and midwifery workloads are matching service (patient) demand.

A service profile will identify the nature of the demand, the clinical capability of each facility, service and unit, the resource allocation used to meet current demand and the amount of resources required to meet activity projections for future year/s. The relevant corporate and HHS priorities / strategies need to be reflected in the service profile to align with the HHS service level agreement and the *National Safety and Quality Health Service (NSQHS) Standards.*

When developing the service profile, it is important to document the core demands on the service and consider all influences and variables, particularly in relation to workforce numbers, skill mix profiles and material resources.

A completed service profile:

- describes the demand placed on nursing and midwifery resources
- assists in the planning of service delivery
- identifies the service's purpose, direction, tasks and priorities
- determines the resources utilised to deliver the current services and estimates of resources required to deliver future activity
- provides guidance with monitoring and evaluating service performance.

A service profile is developed annually, based on the financial year, acknowledging adjustments to the profile may be required throughout this time if key factors such as patient / client activity and nursing supply change during this time. The proposed service profile

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determines the current / future state of demand and provides a plan for matching this with resource supply through the collation of relevant data collected from the following analyses:

The external environment includes the following factors:

- Policy/Legal
- Economic
- Social
- Technology
- Research and EBP

The internal environment:

- Structural
- Human Resource Management (HRM)
- Information and Communication Technology (ICT)
- Comparative Analysis

The SWOT reviews:

- Service Strengths
- Service Weaknesses
- Service Opportunities
- Service Threats

Using the initial service profile as a guide, the service area's budget for the financial year is clearly identified and can be readily discussed and negotiated. Once the budget and the level of service is agreed upon and finalised, the initial service profile is recognised as the 'agreed service profile' (keeping in mind the profile may need to be reviewed and amended periodically in line with the budget allocation).

It is important to remember the service profile includes both demand and supply data, and performance metrics of how these can be measured for monitoring and evaluation.

Resource Allocation

Chapter 2 discusses the importance of a BPF approach to resource allocation, and the calculation tools. The calculations to estimate the resources required to meet planned / forecast activity for the following financial year will become simplified as automation replaces the current calculations. Chapter 2 contains the manual calculations, however the corporate/IT systems current recommendation will be updated and linked to the Office of the Chief Nursing and Midwifery Officer's website.

Methods for allocating resources in response to demand are explained and response strategies are provided where the allocation of funds does not balance with identified service requirements in Chapter 3, Reaching a Balance

Reaching a Balance

This third and final stage of business planning analyses the differences between the demand for resources and the actual resources allocated. It allows service area managers, staff and senior management to identify gaps and agree on a resolution. That solution is likely to be one of three potential outcomes:

- change the demand for resources

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- change the investment of resources
- alter the mix of resources to achieve agreed outcomes.

When differences occur, a balance can only be achieved by adjusting either supply or demand, or both. This is discussed further in Chapter 3 and how to negotiate a resolution.

Escalation

When workload issues arise, escalation is necessary when resolutions cannot be found at the local level. These are described in detail in Chapter 4.

Performance metrics

Measuring performance to understand progress is key to understanding the outcomes of the diverse activity within a unit, service, facility and HHS. Chapter 5 describes the importance of nurse sensitive indicators and keeping nursing metrics on the HHS agenda.

The ability to balance service demand and staff supply is essential when planning the long-term viability and sustainability of health services. Frequent monitoring of demand indicators such as client acuity and activity is necessary to ensure nursing and midwifery staffing matches service demands, and the term acuity is used interchangeably with complexity and intensity to identify service demand within health care services. The BPF is the agreed, industrially mandated methodology to ensure safe and sustainable workloads for nurses and midwives. The framework has been a collaborative project between Queensland Hospital and Health Services, the Queensland Nurses Union, Office of the Chief Nursing and Midwifery Officer and the Employee Relations Unit.

The Addenda from the 4th edition BPF on Mental Health; Perioperative; Outpatient and Ambulatory; Primary and Community and Public Health Services remain essential reading for those specific settings undertaking their annual review [hyperlinked]. These documents highlight the importance of any setting considering their annual service profile, the most appropriate model of care and service delivery model to meet service demand and the nursing and midwifery hours required.

The BPF complements (and is not a replacement for) the professional self-regulation and individual accountability for clinical / professional judgment that are integral components of health care. The BPF reinforces the importance of using professional judgement to make decisions appropriate to the circumstances; with the priority of safe, high quality patient care. The key to the BPF's success is empowering the middle management levels to maintain the safety and quality of health care services and budget integrity.

Accordingly, the Nurse Unit Manager, Nursing Director and Director of Nursing have cascading responsibility for developing and implementing the BPF at the 'local' level and are empowered to do so. The BPF provides the management of workload issues, resolution processes and performance metrics. A sound business framework and workload management strategy is essential in delivering quality care and improving patient outcomes in today's complex and dynamic health care environment.

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Chapter 1: Develop a service profile

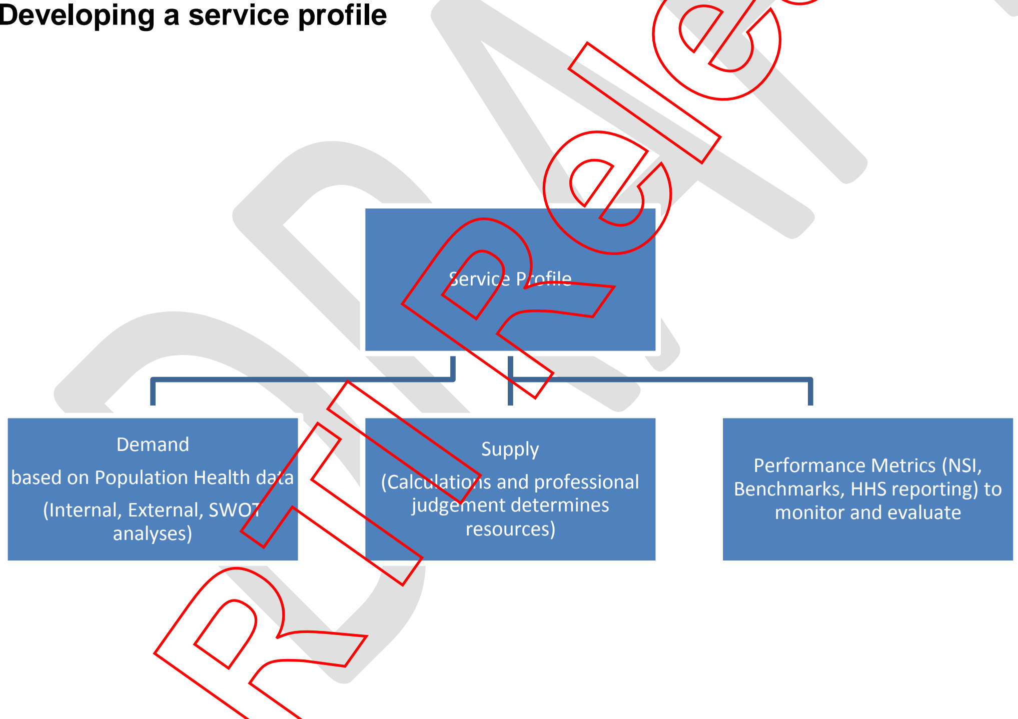
Action!
Refer to:
Template 1: Service Profile

In a nutshell:
The purpose of this first Chapter of "how to implement the BPF" is to support you in planning through clear identification and articulation of the health needs of your local area. It is not just about looking at the current business model and quantifying the required resources, it is about starting at the very beginning and identifying the aims and objectives of the service ("why are we here?") and assessing the area's current activities for achieving this ("is this the best way to do this?").

Following these steps will inform your human and financial requirements from the demand so that service delivery can meet the appropriate level of care. This means determining supply by allocating the most appropriate resources and is the basis for Chapter 2.

The following points are important considerations when developing a business plan.

Developing a service profile



Developing a service profile may seem like a daunting task. However, a step-by-step guide is outlined in this chapter with a matching template. By simply following these steps and filling out the template, any service area can readily develop an effective service profile.

This has the interrelated benefits of:

- simplifying the process for service area managers
- ensuring the final service profile is robust and can be used as an effective business planning and budgetary tool; and
- embedding consistency across all health service delivery areas

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The service profile incorporates Demand, Supply and Performance Metrics that culminate in actuals versus forecast to inform the gap and variances

In developing any business plan, consultation with stakeholders needs to occur. For this initial Chapter, nursing and midwifery staff should actively participate to ensure frontline, on-the-ground information and experience is captured. Also, this participation will lead to a better understanding of the concepts, as well as greater ownership and commitment to the plan by everyone it impacts. The following diagram illustrates an example of the governance processes for different settings within a HHS.

Hospital	NUM/CNC/ Facility Manager	ND, SM, BM	ED/Service Director	HHS N&M Professional Lead	BPF Steering Committee	NaMCF
Mental Health	NUM/CNC/ Facility Manager	ND, SM, BM, DON	EDMH	HHS N&M Professional Lead	BPF Steering Committee	NaMCF
Community	NUM/CNC/ Facility Manager	DON, BM, COM, COO	EDCH	HHS N&M Professional Lead	BPF Steering Committee	Cluster LCF
Rural Health	NUM/CNC/ Facility Manager	DON, BM, COM, COO	EDRH	HHS N&M Professional Lead	BPF Steering Committee	Cluster LCF

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Additional information

Funding

In developing the service profile, an understanding of the national funding model is beneficial. For more information about how this model works and is implemented on a localised level, refer to Annexure: Understanding the Funding Environment.

Data collection (monitoring)

Health Indicator Sets

The Health Statistics Unit has compiled a list of state and national health-related indicator sets and performance measurement frameworks with links to key information about indicators. Some links for indicator sets are only accessible to Queensland Health staff via the Queensland Health intranet (QHEPS). Please contact hlthstat@health.qld.gov.au https://www.health.qld.gov.au/hsu/collections/dchome.asp

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Guide to completing a Service Profile

To assist you in developing the service profile for your area, additional notes and direction are provided below.

Remember: Queensland Health and Hospital and Health Services (HHS) have strategic plans stating the mission statement and key outcomes to be achieved during the designated timeframe. These should be referred to and links to web pages / documents when developing your service profile.

Service overview

Stating the aim

State the aim of your service in a succinct, broad sentence, describing how your service contributes to achieving the aims and direction of Queensland Health and HHS.

Example: To provide holistic care for cardiology patients, utilising a coordinated multidisciplinary approach, resulting in optimal patient outcomes and a cost efficient service.

Developing objectives

The objectives are statements indicating the key outputs / measurements for the service to achieve. They form a basis for assessing the performance of the organisation. In developing objectives, incorporate any new activities or programs that need to be undertaken and consider past non-achievements of the service.

Ensure the stated objectives are:

- easy to understand
- specific
- realistic and achievable
- time oriented
- outcome focused
- measurable
- prioritised.

Example:

- To implement the reviewed cardiac patient education program within six months.

Describing the present service

When describing the present service (or the service being planned) you may wish to include:

- recognised type of service (e.g. a cardiac service)
- function of the service and location of care delivery.

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Internal environmental analysis

Location and size

Describe the physical environment in which the service exists.

Are there factors that impact on the amount of nursing and midwifery resources required? Examples include:

- remote areas where transport is difficult to obtain can delay the discharges of patients
- the size of the locality services can affect community and outreach services.

Services within the facility

List the services / activities within the facility. Where appropriate, document them in order of priority or operational focus and list the Clinical Services Capability Framework level for each service.

Service Structure

- What is the structure of the service?
- What teams are involved in service delivery?
- What are the roles, responsibilities and accountabilities of team members?
- What are the reporting relationships of team members?

Leadership and Management

This is informed by the responses above to service structure.

- Who is accountable for the service?
- What is the governance structure?

Nursing and midwifery structure

Refer to Part A: Service Profile and fill in the table provided, deleting any positions or rows not applicable.

It may also be beneficial to document additional information such as:

- What are the accountabilities of nursing and midwifery staff?
- What impact does the nursing and midwifery structure have on the clinical and non-clinical workload?

Non-nursing support positions

Which other roles are employed by the service and how is the relationship to the nursing/midwifery team structured? Is it a multidisciplinary team? Staff who are not employed by the service, and not rostered exclusively to the service. Eg physiotherapist / occupational therapists, other specialist roles.

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Current model of care

A 'model of care' can be described as a multifaceted concept that broadly defines the way health services are delivered at unit, division or whole of service level. An example of a model of care is the Queensland Health Integrated Mental Health service. http://qheps.health.qld.gov.au/northwest/mental-health/mentalhealth-home.htm

When documenting the service area's model, ask:

- Is the current model of care aligned to the health care requirements of the local community?
- What are the outcomes for patients / clients?
- Is there good evidence to support the current model of care?
- Does the existing structure support the model of care?
- Are there other models of care preferred in terms of economic effectiveness and patient/client outcomes?

Human Resource Management

Core staff working in the service – categories, scope of practice, skills (What are the categories of core staff working in the service?

- Numbers and FTE indicated separately i.e. 16 FTE = 30 staff - implications for costs of training and workload for completing
- What is the current scope of practice of the clinical staff and what potential opportunities are there to optimise the scope of practice
- Do the competency levels of the staff match patient / client needs? And what is the effect of this context on skill mix?
- Effect of context on skill mix i.e. Grad RN in rural facility cannot be in charge of a facility without sufficient experience.

Teaching and training / development commitments / needs

- What is the teaching role of the service?
- What agreements with universities are in place or under development?
- What is the impact of these agreements? For example: costs, opportunities for funding
- What clinical placements are required?
- What is the impact of these agreements? For example: costs, opportunities for funding
- What structures / processes are in place to support the teaching requirements/ commitments?
- What education imperatives are impacting on the service (eg: demand for undergraduate clinical placement, Regional Training Authorities)
- Are needs likely to change?
- Are there any organisation requirements (eg: % of staff as fire wardens) that require training?
- Insert link to HHS or service education plan

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Mandatory and requisite training

- A HHS is a statutory body under the *Financial Accountability Act 2009* and the *Statutory Bodies Financial Arrangements Act 1982* and is a unit of public administration under the *Crime and Misconduct Act 2001*. HHSs are responsible for ensuring they comply with the legislation as it applies to them.
- Under the *Hospital and Health Boards Act 2011* one of the functions of HHSs is to comply with the health service directives that apply to the HHS. Section 50 of the *Hospital and Health Boards Act 2011* states that a health service directive is binding on the HHS to which it relates. The HHS must also comply with other directives, such as directives applied under the *Public Service Regulation 2008.*
- Relevant legislative compliance is monitored within the Service, at divisional level and by the XXHHS.

Other indirect patient / client care commitments (optional)

What management/administrative responsibilities do team members have?

For example:

- portfolio work (such as NO2 special projects)
- quality improvement activities, accreditation, audits
- research.
- Add in rural and remote themes

Maintenance of pharmacy i.e. pharmacy, ordering, returning/removing expired stock, annual stock take; xray; pulling charts as required; admitting and discharging patients on HBCIS; changing O2 cylinders; attending the morgue; supplying scripts for public patients; supporting videoconference consultations; preparing paperwork for patient retrieval; audits and codes and documentation of such; checking emergency equipment, procedure boxes and retrieval bags; escorting patients to aircraft for retrieval or to Local sonography (e.g. 5 hr round trip) when required; isolating fire alarms and reporting; coordinating discharge into community with community supports; be on call for clinical support as required

Information technology management

Provide an overview of the information technology framework of your service area. Key considerations include:

What information sources and systems are in place? Here is a list which may prompt you?

- Is there sufficient information provided by these systems?
- What access is there to information?
- Who collects / supplies the information?
- How timely and accurate is the information from these systems?
- How reliable / stable are the systems? (e.g. are staff required to input information after periods of downtime?)
- Do staff know what information is available and to how to use that information?
- Do you have telehealth systems in place?

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External environmental analysis

The purpose of this section is to provide a snapshot of the factors, external to your service area (and therefore largely out of your control) which can have a direct impact on your service.

Policy / legal factors

- Commonwealth direction / policies / funding
- Queensland Health direction / policies / funding
- relevant legislation
- licensing organisations
- professional groups
- Industrial groups / issues
- education imperatives

Economic factors

- international / national economy
- public / private interface
- private health care providers
- future capital works planned.

Social factors

Analysing your service area's prevalence of disease and population trends will provide useful insights into the required categories and levels of outpatient and ambulatory health services. Calculating the percentage of potential and known populations at risk will assist in workforce planning and management of nursing and midwifery workloads. Other questions to ask include:

- Is the population young or aging?
- What is the growth rate?
- How diverse is the population?
  - Example: a large non-English speaking population will require the use of interpreter services. Organising and using these services consumes resources, thereby increasing overall nursing or midwifery resources.
- Are the health needs of the community matched with the national and state priorities for health outcomes?
- Community and consumer expectations
  - What does the local community / consumer expect from its health services?
  - Are these expectations realistic and/or deliverable?
  - What is their level of awareness of the health services they require and that are provided?
  - What involvement does the community have in local health service planning?
- Workforce issues
  - Are there enough nurses and midwives with the skills required for your health service?
  - What other workforce recruitment and retention issues are there?

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- Technological factors
  - What is the impact of technology availability on the service?
- Research and Evidenced Based Practice
- What research developments are impacting, or have the potential to impact on services?
- Are you required to participate in State or National data collection? Does this impact upon workloads?

SWOT analysis

A SWOT analysis is a structured planning method used to evaluate the strengths, weaknesses, opportunities and threats involved in delivering a service in consultation with staff in the service / unit.

It involves identifying the internal and external factors that are favourable and unfavourable to the service area and can assist in identifying when and where additional resources may be required or better allocated to achieve greater effectiveness.

A SWOT analysis can assist in moving from a 'business as usual' position to a stronger focus on true work priorities.

- **Strengths**

These are internal characteristics of your services area that give it an advantage over others.

- **Weaknesses**

There are internal characteristics that place your service area at a disadvantage relative to others.

- **Opportunities**

These are external elements that your service area could exploit to its advantage.

- **Threats**

These are external elements that could cause challenges or difficulties for your service area.

A common practice for documenting a SWOT analysis is tabular as shown below. You may wish to follow this method in the service profile.

	Helpful	Harmful	
Internal (and largely controllable)	**Strengths** • characteristic • characteristic • characteristic	**Weaknesses** • characteristic • characteristic • characteristic	Typically happening now
External (and largely uncontrollable)	**Opportunities** • characteristic • characteristic • characteristic	**Threats** • characteristic • characteristic • characteristic	Typically happen in future
	Increase	Reduce	

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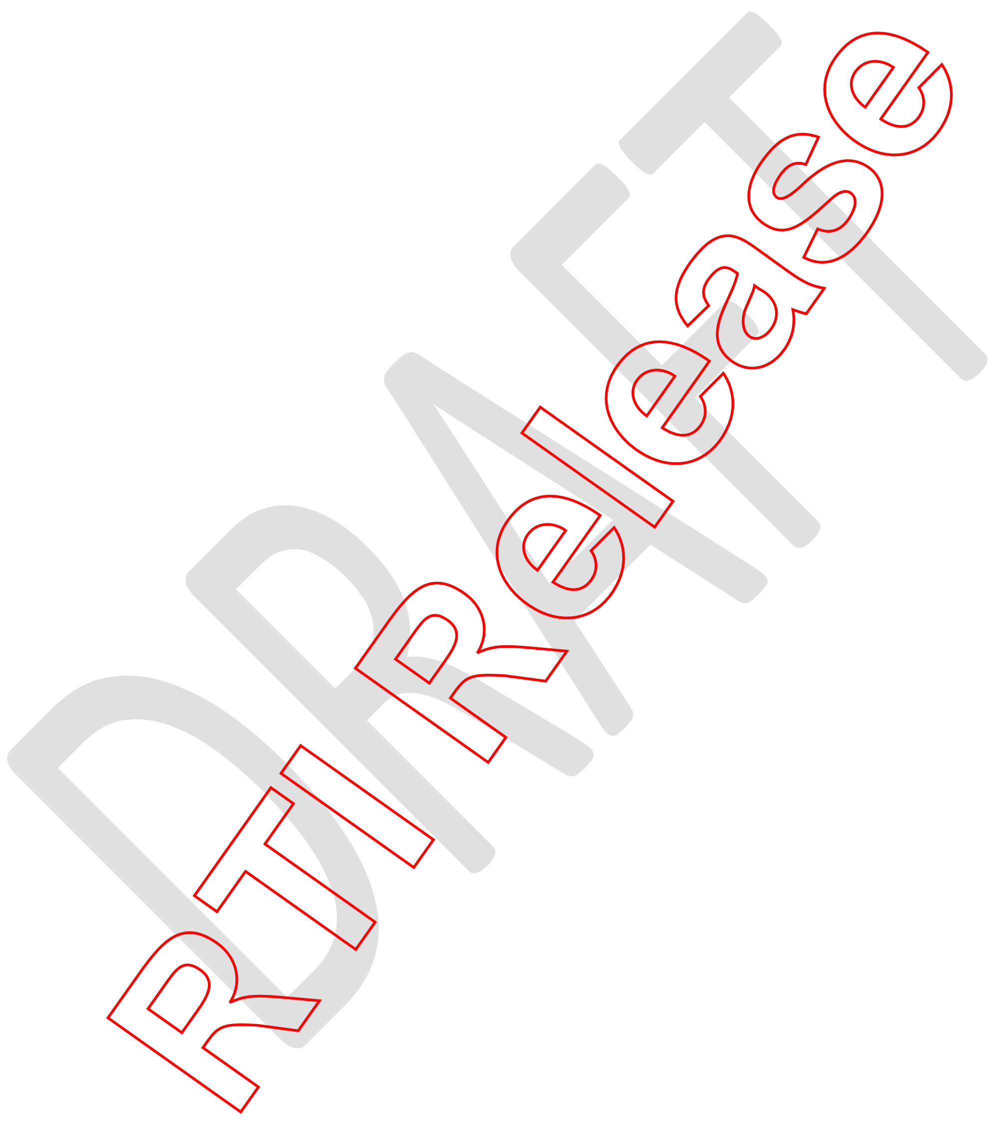
Significant achievements in the past 12 months

Consider the significant achievements that have occurred throughout the past twelve months. Reflect upon these and refer to the information collated within the internal, external and SWOT analysis as part of this framework to assist in the identification and projection of priority areas for service improvement for the oncoming financial year.



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Comparative analysis

ACTUALS

Patient / Client activity

- Identify and discuss patient client activity, consider in context to previous financial year activity and impact upon nursing and midwifery workloads
- Major DRGS / OOS
- Patient/client complexity and acuity
- Patient/client activity: Identify and report upon key activity data relevant to the service. Activity to consider are have a direct relation to nursing and midwifery workloads, **NB: Not all activity metrics are relevant to all services.**

(Listed below are examples/suggestions for reporting of YTD activity demand, consider what activity/activities of demand best represent the type of services provided and add or delete where appropriate)
Patient / Client activity

▪

▪ Number of separations	▪ Number of day surgery cases
▪ Weighted Activity Units	▪ Home visits occasions of service
▪ Total occupied bed days (fractional)	▪ Number of births
▪ Average occupancy	▪ Retrievals
▪ Occasions of service	▪ Back-transfers
▪ Emergency department presentations vs admissions	▪ Number of births: vaginal / caesarean
▪ Numbers per triage category	▪ Number of group sessions, numbers of attendees at group sessions
▪ Number of operating theatre sessions / complexity	▪ Number of units of activity in Central Sterilising Departments
▪ Operating minutes	

Table xx: Activity factors

Top Ten DRG					
No.	**DRG**	**Description**	**ALOS**	**Peer Group Ave**	**Variance**
1					
2					
3					
4					
5					
6					

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7					
8					
9					
10					

Fractional Bed Days		
Month	Total	Ave.
Oct		
Nov		
Dec		
Jan		
Feb		
Mar		
Apr		
May		
Jun		
Jul		
Aug		
Sep		
Total		

Emergency Department Presentations							
Month	Cat 1.	Cat 2.	Cat 3.	Cat 4.	Cat 5.	Total	Weekly Ave.
Oct							
Nov							
Dec							
Jan							
Feb							
Mar							
Apr							
May							
Jun							
Jul							
Aug							
Sep							
Total							

Occasions of Service								
Month	OOS 1	OOS 2	OOS 3	OOS 4	OOS 5	OOS 6	Total	Weekly Ave.
Oct								
Nov								
Dec								
Jan								
Feb								
Mar								
Apr								
May								
Jun								
Jul								
Aug								
Sep								
Total								

Ward Occupancy (Nurse Dependency System)

Insert your Nurse Dependency trends and highlight any particular issues.

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Performance

Financial performance

Financial performance against budget allocation, report the information in the table below and provide a brief description on the influencing factors of the budget variance. These factors need to be considered in the determination of nursing resources.

Cost centre	*YTD Actual*	*YTD Budget*	*YTD Budget Variance*
Labour			
Non labour			
Total Performance			

Identify and discuss nursing and midwifery labour performance indicators and influencing factors associated with negative trending outcomes for the financial YTD.

Trends may be occur on a daily, weekly, monthly, annual, seasonal or other regular basis.

Factors in trends to be considered include:

- why they exist
- how they occurred
- the degree of change
- the relationship among the changes.

Trends can indicate:

- increasing or decreasing activity at a steady rate
- fluctuations due to seasonal factors areas that require further investigation and action, for example, increasing sick leave.

Activity factors need to be monitored and reviewed as activity is one of the measures of organisational performance. While the listed measures are the major ones to be considered on a whole of organisation basis, within individual services, there may be other types of activity that need to be reviewed.

Therefore, each unit should develop a minimum data set which is a listing of the factors considered to be important indicators of workload for that particular service. For example, the information collected in the operating room will be different from a surgical ward or a community health service.

Workforce data from Queensland Health Decision Support System (DSS) is considered an important source of information and is used to support decision making in developing BPF service profiles. However DSS data does not delineate productive hours into direct and indirect clinical hours.

Availability of comparative data will support n/m leaders to make informed decisions related to adjusting nursing and midwifery workloads, staffing levels and skill mix.

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Reliable, standardised, accurate and timely operational management information is crucial given current efficiency measures. Robust workload data facilitates n/m leaders to effectively plan, deliver, monitor and evaluate the services provided. Duffield RBWH

Nursing / Midwifery Labour Performance Indicators				
YTD Sick Leave	YTD Casual	YTD Overtime	YTD Agency	YTD Vacancy
(%)	(% of productive hrs)	(% of productive hrs)	(% of productive hrs)	FTE

re

Identify and discuss nursing and midwifery labour YTD FTE and skill mix demands for external escorts and patient specialling where relevant to the service.

Patient specialling

Are there procedures that indicate a patient will need specialling post operatively or an assumption that a percentage of patients have a cognitive impairment and may require 1:1 care? What grade of nurse on average does your behavioural versus clinical specialling? Professional judgement should be used and skill mix dependant on acuity. Ad hoc basis maybe difficult to allocate budget, historical data may inform whether or not it should be recruited to.

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
TOTAL												

Patient escorts and retrievals

Is there a percentage of the patients in your service that will need escort/retrieval? What grade of nurse on average does your behavioural versus clinical? Professional judgement to be used and skill mix dependant on acuity. Ad hoc basis maybe difficult to allocate budget, historical data may inform whether or not it should be recruited to.

	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
TOTAL												

Nurse sensitive indicators

Consider what Nurse Sensitive Indicators are applicable to your service. Report in the table below the incident rates, these may be dependent on the setting of the service. At the system level, incident rates are adjusted to the Service Level Agreement financial penalties.

It is imperative that the nursing and midwifery resources determined for clinical service delivery are considered in the context of local reported clinical incident types given the variances across clinical environments.

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Clinical incidents

Incident type	SAC1	SAC2	SAC3	Total No.	OBD	Rate
Falls						
Medication incidents						
Pressure injuries						
Blood transfusion						
Infection rate						

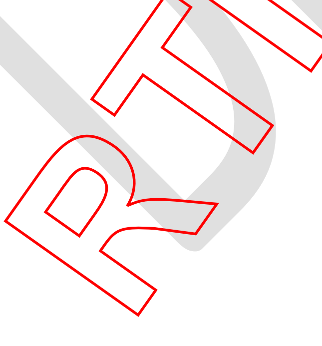
Resource Allocation

Reviewing the current health workforce allocations will allow some longitudinal benchmarking. For the forthcoming financial year, depending on whether activity targets are a growth, reduction or maintenance of current service levels. This current state analysis allows for a workforce reassessment that aligns with the forecasted activity for the service, and assists the service in determining if more, less or the same resources are required.

Nursing resource allocation

Priorities for next 12 months

Annual activity targets set by Queensland Health (outlined in the service agreement) need to be factored into forecasting. Once the data has been analysed, activity levels can be estimated for the following year. It is important to record assumptions made during the forecasting.



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FORECAST (PLANNED/PROJECTIONS)

- Baseline (previous year)

Actuals - Budgeted = Variance

- Estimated Future Activity - Targets

Forecast Activity or Estimated Future (Health Service) Activity (EFA) Methodology

http://qheps.health.qld.gov.au/ppb/docs/hsram/efa_methodolgy20152016_v1.pdf

A key component of healthcare purchasing negotiations is to set activity targets for each Hospital and Health Service (HHS). Estimated future (health service) activity (**previously referred to as "assessment of health service need"**) has played an informing role in the development of service agreements for both 2012–13 and 2013–14.

For the 2014–15 service agreements, priorities in terms of investment were identified based on a comparison of levels of activity purchased in 2013–14 against the estimated future activity for 2016–17. It is expected that a similar approach will be adopted for the 2015-16 service agreements.

The starting point for establishing activity targets is the assessment of estimated future activity. For the 2015-16 three year Service Agreements, 2016–17 estimated future activity is being used as a "target end point" to inform the allocation of resources. As such estimated future activity is not being provided for the interim years. In most cases, the Service Agreement activity targets relate to HHSs as a whole; therefore, estimated future activity has not been assessed for individual facilities.

Estimated future activity has been assessed by:

- service stream:
- – Acute Inpatient;
- – Interventions and Procedures;
- – Outpatients;
- – Emergency Care;
- – Sub and Non-Acute;
- – Mental Health, and

Other Activities.

- Hospital and Health Services of treatment, plus Mater Health Services (public only, Mater Children's Hospital will be allocated to Children's Health Queensland);
- Hospital and Health Services of residence (where possible);
- both adults and children (where possible);
- with a relevant level of service type detail for each stream (e.g. SRG for Inpatients, Tier 2 Clinic for Outpatients, Triage Category for Emergency)

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FORECAST

Nursing Resource Determination

Defining activity in specialty areas

In some specialty areas where nursing activity is not measured using the Nursing Hours Per Patient Day (NHPPD) model, additional consideration may have to be given to the definition or measurement of activity. The principles of the BPF can be applied in a clinical area using an agreed unit of activity. Some units of activity that may apply, other than NHPPD include

- number of separations (discharges, transfers, deaths)
- weighted separations
- total occupied beds
- average occupancy
- occasions of service
- emergency department presentations
- numbers per triage category
- number of theatre sessions
- day surgery cases
- outpatient occasions of service
- number of births
- retrievals
- home visits
- client separations
- number of group sessions
- number of clients attending group sessions
- operating minutes

Nursing Resource Determination
<INSERT YEAR>

Step 1: Calculate Average Productive NHPPD or NHPOS or NHPUA

Average Nursing Hours per Patient Day =	Total Annual Productive Hours / Total Activity (FBD's/OOS/UA)

Average NHPPD/NHPOS/NHPUA=	5.89 (example)

Step 2: Determine the Weekly Nursing Hours

Weekly Nursing Hours =	**Total Annual Productive Nursing hours/52 weeks**

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Weekly Nursing Hours =	52 992/52 weeks (example)
Weekly Nursing Hours Total =	1019 hrs

Step 3: Develop Master Staffing Roster Profile

Proposed Master Staffing Roster Profile is developed within **WorkMAPP** workforce planning system. Roster Profiles include direct and indirect hours as allocated to position ID. Once finalised attach a copy of the Roster Custom Report to this document. NB: (Proposed Service Profiles) The weekly hours determined in step three must equal the weekly hours total in the WorkMAPP Roster. (Agreed Service Profiles) The WorkMAPP Roster Total FTE must equal the Rostered FTE in the BPF excel spreadsheet.

Step 4: Confirm Direct Care Shift Profile

(Example)

Direct Care Shift Profile						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
8.0 : 7.0 :3.0	8.0 : 7.0 :3.0	8.0 : 7.0 : 3.0	8.0 : 7.0 : 3.0	8.0 : 7.0 : 3.0	7.0 : 7.0 : 3.0	7.0 : 7.0 : 3.0

Step 5: Confirm Notional Nurse Patient Ratio

(Example)

Notional Nurse Patient Ratio – Direct Care Hours				
Shift	**Resourced Beds**	**Nursing Hours**	**Nursing Headcount**	**Nominal Ratio**
Day	24	64	8	1:3
Evening	24	56	7	1 : 3.4
Night Shift	24	24	3	1:8

Summary

In finalisation of the Service Profile document consider the significant achievements that have occurred throughout the last twelve months. Reflect upon these and consider the information collated within the Internal, External and S.W.O.T analysis to assist in the identification and projection of priority areas for service improvement for the oncoming financial year.

Significant Achievements in the last Twelve Months

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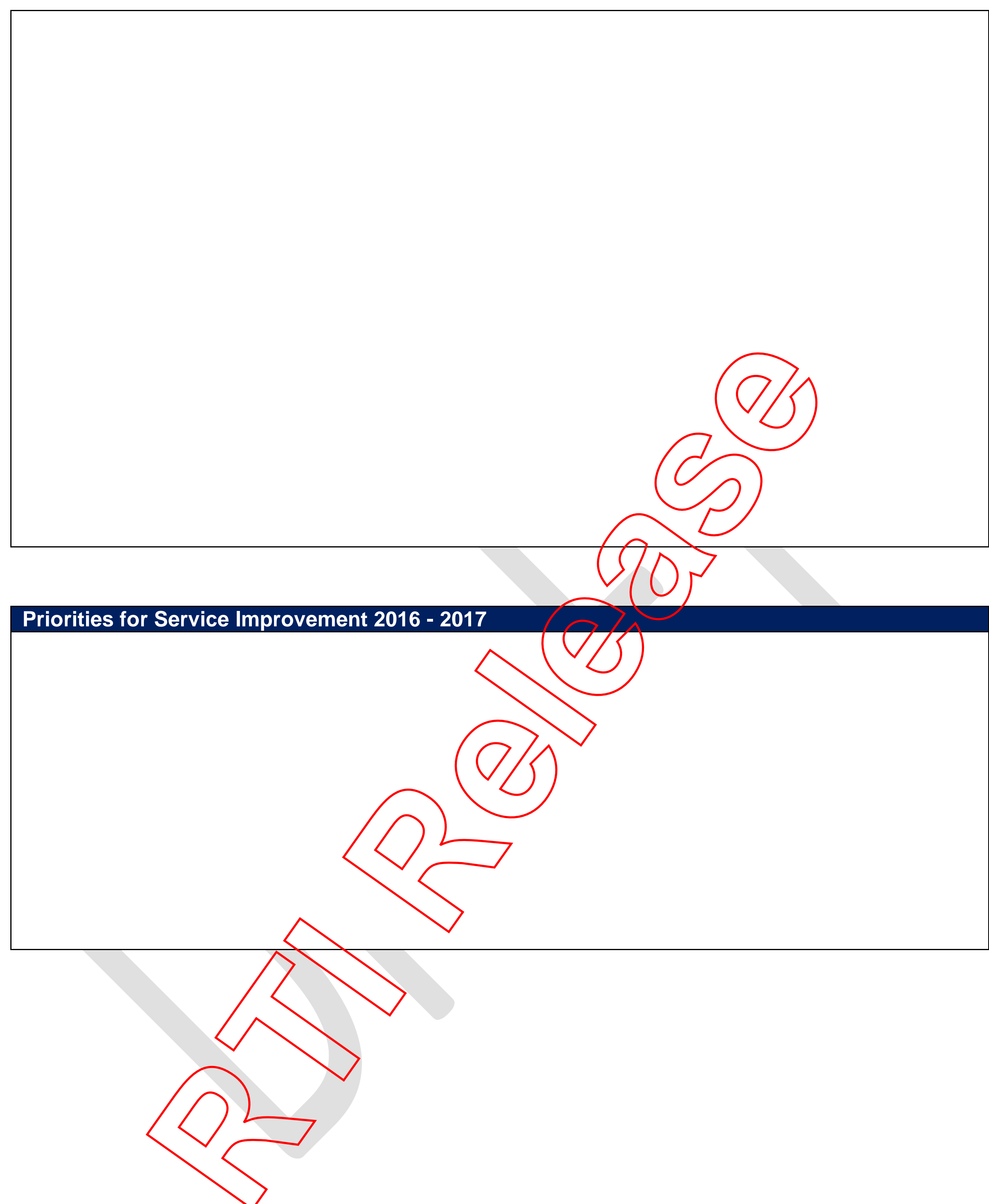

Priorities for Service Improvement 2016 - 2017

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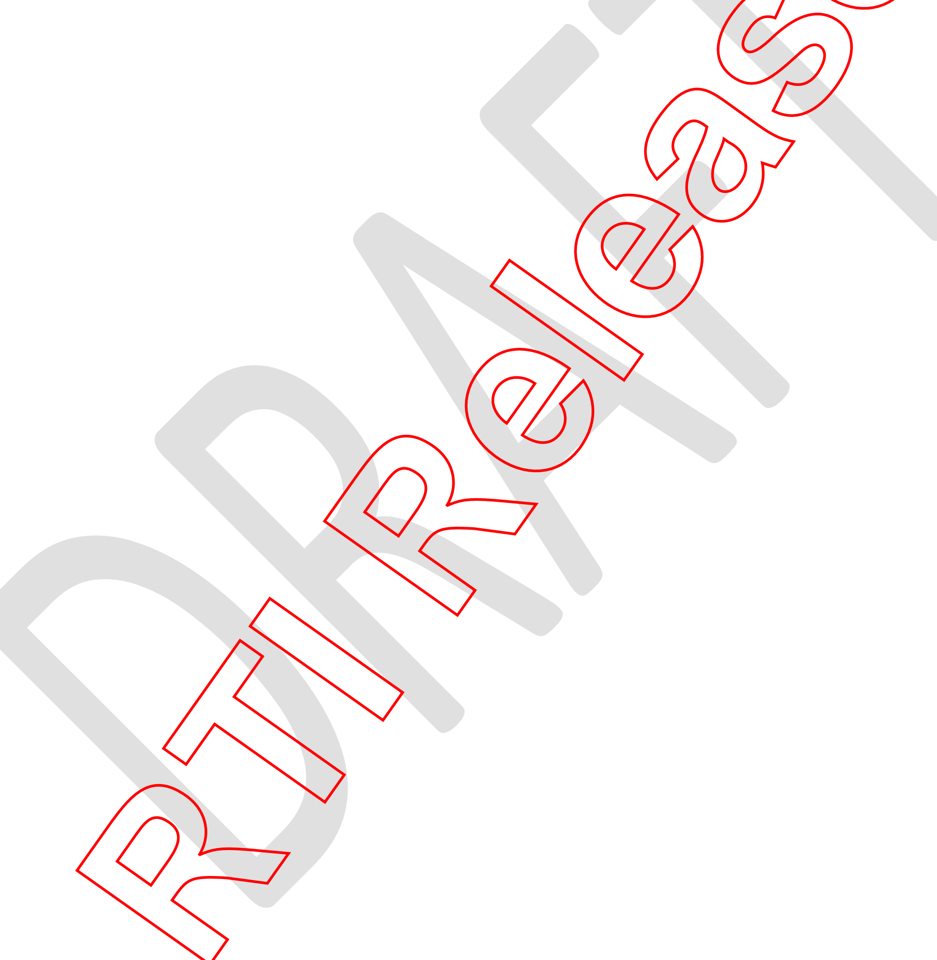
Approval

Once your template has been completed and finalised, use it for discussions and negotiations with your relevant supervisors and senior managers. Once you have consensus, have them sign off the document, as outlined in the BPF Introduction.

Service Improvement Business Case

A service improvement business case is required to be submitted for 2016-17 to support service delivery changes: See the template at Appendix 2 for an example, however each HHS may have a different template, and templates may differ depending on the amount of additional funding required.



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Chapter 2: Calculations of Nursing and Midwifery resources

Action!

- Complete calculations under the Guide

In a nutshell:

This second Chapter of business planning focuses on estimating the nursing and midwifery resources required to meet activity based on the service profile (Chapter 1). The estimation process is simplified by tools and information that help convert the identified demand requirements into actual dollars. Methods for allocating resources in response to demand are explained and response strategies are provided where the allocation of funds does not balance with identified service requirements.

Defining

Remember: Always refer to the service profile when calculating the resource allocation, taking into account any negotiations that have occurred at a local level and the unique environmental characteristics of your service area.

- Establish the total nursing and midwifery resources allocation required:

(i) Calculate total annual productive nursing/midwifery hours required to deliver service.

(ii) Determine skill mix / category of nursing / midwifery hours.

(iii) Convert productive nursing/midwifery hours into full-time equivalents.

Finance will determine the operating budget and complete the following, but it is important for nursing and midwifery line managers to understand how the following calculations:

Calculate non-productive nursing/midwifery hours according with nursing and midwifery award entitlements.

(iv) Convert non-productive nursing/midwifery hours into full-time equivalents.

(v) Add productive and non-productive full-time equivalents together and convert into financial resources

(vi) Allocate nursing/midwifery hours to service requirements.

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Guide to calculations

Estimating the nursing and midwifery resources required will provide a framework for allocating and controlling nursing resources. Determining the nursing and midwifery resource estimates can occur once the following activities have been undertaken:

- analysis of nursing hours per unit of activity used in the past
- analysis of trends in patient acuity data
- identification of levels of forecasted activity
- comparative analysis with similar services
- consultation with staff providing the services – the staff who deliver the services have the professional judgement, knowledge and experience to advise on the level of resources required to deliver care.

The annual resource allocation for nursing or midwifery includes all labour expenditure (i.e. salaries and wages) for nursing or midwifery staff, including productive costs (and non-productive costs (such as annual and sick leave) explained in detail in the following section.

Calculating the Total Nursing and Midwifery resource allocation required

A summary of the multipliers are located on each BPF staffing profile and are used to calculate the total workforce required to meet clinical activity.

The BPF multipliers are calculated using a standardised methodology and are based on the Nurses and Midwives Award 2012 (Queensland Health, 2012 – hyperlink to new award once available).

BPF Staffing Profile - Multiplier Methodology	
BPF Multiplier	**Calculation**
Productive Direct FTE	NHPPD x Bed Capacity x Occupancy x days of service
Productive Indirect FTE	NHPPD x Days per week x weeks per annum/1976
Mandatory Training FTE	Minimum 5 days per headcount plus an additional 6 days for all new starters per headcount
Professional Development FTE (paid)	Award entitlement for all permanent employees grade 3 and above working > 16 hours per fortnight. Full time employees entitled to 24 hours per annum (pro rata for part time employees).
Training and Conference Leave (including travel time) (paid) Optional	Based on average of training and conference leave accessed over the last three years (please note includes average travel time accessed)
Sick Leave (paid)	Based on average of sick leave accessed over last three years
Sick Leave (unpaid) ***Include?***	Based on the average of unpaid sick leave accessed over the last three years
Family Leave (paid) ***Check correct title***	Based on average of family leave accessed over the last three years
Maternity Leave (paid)	Based on average of maternity leave accessed over the late three years

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Other Leave paid	Based on average of other leave accessed over the last three years
Unpaid Leave (FTE)	Based on average of unpaid leave accessed over the last three years. This calculation is included to measure flexible resources required to meet the BPF needs of each Service Line.
Recreational Leave FTE	Based on award entitlement, 6 weeks per FTE for three shift rotating workers, 5 weeks per FTE for non-shift work employees
Long Service Leave	Based on average of long service leave accessed over the last three years

Queensland Health has developed electronic tools to assist with the process of developing the total nursing and midwifery resource allocation required to meet project activity. However it is important to understand the principles and the methodology behind these calculations so that estimations and allocations are applied consistently across service areas.

A total nursing and midwifery resource estimates incorporate both productive and non-productive components, which are defined as follows:

- **Productive hours** - contribute to patient care and include both *direct clinical* and *indirect clinical hours*.
  Direct clinical hours - activities directly related to care provided to the patient / client such as planning and assessment of care, and documentation.

  Indirect clinical hours - activities undertaken which benefit the patient / client while not in direct contact with them, including education and training on the clinical unit, mandatory competence attainment, quality improvement activities, portfolio activities, performance appraisal and unit orientation time.

  Total productive hours = direct clinical hours + indirect clinical hours

- **Non-productive nursing hours** - are employment entitlements which do not involve patient / client care, such as annual and sick leave. They are often referred to as 'on-costs'.

Converting total hours into full-time equivalent (FTE) staffing resources

There are six steps in establishing the total annual resource estimates for nursing and midwifery to meet planned activity and inform the annual operating budget. The nursing hours calculated are considered in terms of averages for a specific period. The steps are:

1. Calculate total productive nursing and midwifery hours
2. Calculate total annual productive nursing and midwifery hours required to deliver services
3. Determine skill mix categories of the required hours
4. Convert productive hours into full-time equivalent (FTE)
5. Calculate non-productive hours
6. Convert FTE into dollars

Professional judgement is recognised that is a valid criterion for deeming a definitive staffing level of nurses and midwives as being safe. The total nursing and midwifery resources required to meet the approved service requirements must be able to be determined and validated by completing:

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(a) service analysis and profile

(b) analysis of historical nursing/midwifery hours per unit of activity and sufficiency in meeting service demand

(c) analysis of trends in activity data

(d) forecast level of activity

(e) comparative analysis with similar services

(f) consultation with staff delivering services.

Step Approach for Determining Required Nursing FTE

Calculate Productive Hours

- Need to calculate HPPD / HPOS.
- Need to calculate nursing hours worked.

How to calculate HPPD / HPOS:

Method 1
This method is easiest if you have a stable consistent acuity level of patients within unit, or similar OPD clinic session times.

Identify number of nursing hours worked for past financial year (data from Trend or Necto). Do not forget to include casual, overtime, special and escort hours within your calculation of house worked. Plus, identify occupied bed days or occasions of service.

Calculation

$$\frac{\text{Nursing hours worked}}{\text{Total occupied bed days of occasions of service}} = \text{HPPD / HPOS}$$

Method 2
This method is used if you have a unit with diverse acuity: So HPPD will alter with DRG.

Example:

DRG	Average no of nursing hours	No of occupied bed days	Total no of hours
D1gZ	3	500	1500
Dg2Z	4	250	1000
D9k1	5	100	500
TOTAL		**850**	**3000**

Calculation

$$\frac{3000}{850} = 3.5 \text{ HPPD}$$

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(Examples for residential aged care, peri operative community child health, emergency, mental health will be provided at end of document).

Calculate Productive Hours

Productive hours = Direct plus indirect hours

Direct hours relate to nursing activities that contribute to patient care including documentation.

Indirect Hours include activities required for patient but does not require direct contact with patient (i.e. education/training on ward, quality activities and unit orientation).

Calculation NHPPD
x
Total occupied bed days = productive hours (Direct + Indirect Hours).

Calculation 3.5
x
850 = 2975 productive nursing hours
(Note productive hours can also be obtained from TrendCare or NECTO).

Determine Skill Mix

Break annual productive hours into a weekly figure.

Calculation 2975
52 = 57 hours per week
Note: this example is utilising small numbers to explain a concept, and generally numbers in reality will be greater.

Determine skill mix within the 57 hours:

- Grade 6 16hrs per week
- Grade 5 24 per week
- Grade 3 17 per week

Note: if you have minimal safe staffing; this is where you would state that you have minimum of 2 staff per 8hr shift = 16x3 - 48hr x7= 336 hrs per week (provide rationale for minimal safe staffing).

- CN 168hrs
- RN 168hrs
- EN 0hrs

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Only the positions (e.g. grade 7 or clinical facilitators) may not be included in the calculations if they are additional to productive hours, unless they provide a direct care or run a clinic.

Convert Productive Hours to FTE

Total productive nursing hours per week/38 = FTE equivalent

Example 1 7hr per week / 38 = 0.18FTE

Example 2 336 hrs per week / 38 = 8.8 FTE
Note: if you are calculating a part time FTE equivalent that works .3 shifts per week = 24hrs / 38 = 0.63 FTE.

Calculate Non-Productive FTE

Majority of these costs are automatically calculated with semi-automated tool. This is for information purposes.

Determine annual leave requirements:

- Is annual leave to be built into resource allocation
- If your annual leave percentage is less than 1 FTE, you need to manage your leave with placing casual staff on temporary contracts, or increasing part time contracts to cover annual leave (agency staff are not encouraged to backfill annual leave).

Determine sick leave:

- This should be based on last year's state average.

Determine Mandatory training;

- Currently there is an agreed 11 days for new staff and 5 days for existing staff (However, health services may negotiate a standard based on previous year usage and/or other determined factors. This is currently under negotiation within XXHHS and until told otherwise please utilise the standard 5/11 day ratio.

Professional development leave:

- 3 days per headcount > 16 hours per fortnight

On costs:

- Penalty allowances etc are determined by a percentage
- A nurse works 52 weeks x 38 hours = 1976

  To calculate 1 day (7.6 hour as percentage):
  (7.6 / 1976 = 0.0038)
  Multiply x 100 = 0.38 % N.B: only works at FTE percentage level, not at headcount level

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Add Productive FTE with Non-Productive FTE to Determine Resource Estimates required to meet activity

This step is calculated automatically within the semi-automated tool

Example:

	Required hrs per week	Weekly FTE	Required hours per year/1 FTE	Yearly FTE
Grade 7	38	1	1786	1.11
Grade 6	168	4.42	1748	5.00
Grade 5	365	9.6	1748	10.86
Grade 4	112	2.95	1748	3.26
Grade 3	112	2.95	1748	3.26
TOTAL	**795**	**17.92 FTE**	**8778 Hours**	**23.49 FTE**

Determine Seasonal Demand

Month

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	TOTAL
OBD	100	200	200	400	400	500	500	400	300	200	200	200	**3700**
%	2.7	5.4	5.4	10.8	?	?	?	?	?	?	?	?	**100%**
Req NHPPD	4	4	4	5									
Total hrs req	**400**	**800**	**800**	**2000**									

Week

Surgical Ward (agreed example HPPD 4)

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Pt days	20	30	28	25	25	15	10
Hrs req per day	80	120	112	100	100	60	40

Calculation Pt days
x
HPPD = hr required per day.

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Additional Examples for Determining HPPD/HPOS within Specialty Areas

Residential Aged Care (Utilise residential classification scale)

Data to be obtained from QHERS or NECTO.

RCS Categories	1	2	3	4	5	6	7	8	TOTAL
Ward 1	3	5	6	2	0	1	1	0	**18**
Ward 2	6	10	4	5	1	2	0	0	**28**
Total no of residents	9	15	10	7	1	3	1	0	**46**
Her per cat calc	3.86	3.3	2.79	1.86	1.29	1.28	1.28	1.28	
Total res x hrs per cat	34.74	49.5	27.9	13.02	1.26	5.4	1.28	1.28	**134.42**

Indicated nursing hours per day = 134.42 / = 2.9 hours per resident day.

No of residents = 46

Short Stay

- Base on top 5 DRG utilise method 2 of HPPD calculation
- Or Fixed staffing model:

*** All patients who episode of care is deemed appropriate for admission to short stay / obs ward must have their admission data captured in both EDIS and HBCIS at the time of short stay admission*

Please Select Staffing Model → Fixed — NB: Select N/A if no designated Short Stay unit available

Occupancy = — NB: Occupancy should be adjusted to reflect actual Short Stay usage

Total Available Beds = 8 — NB: Maximum number of beds / spaces available (not funded beds)

Using Fixed Staffing Model

Position	Hrs / Wk	Wks / Year	FTE
CN			0.00
RN	336	52	8.84
EN			0.00
AIN			0.00
			0.00
			0.00
			0.00

Total productive FTE: **8.84**

* Caution Required as staffing Short Stay Units may be absorbed or extracted from Core Business Staffing numbers depending on activity levels and may be a source of over budgeted FTE

Total Hrs Required (Year) = 17472

Therefore....

NHPPD x Beds x Occ% should equal (=) 47.868493

Therefore....

NHPPD = 5.9836

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Community / Mental Health / Child Health

- Data to be obtained from QHERS for occasions of service.
- Productive hours from Trend and NECTO.

Calculation Nursing hours worked divided by occasions of service:

$$\frac{20000}{4000} = 5 \text{ HPOS}$$

Hospital In The Home (HITH)

- Data to be obtained from QHERS for occasions of service.
- Productive hours from Trend and NECTO.

Top 5 DRG (Method 2)

Day Surgery

- 5 day Service
- Operating hours 7-5

NHPPD: Total productive hours / obd

CSSD

- Average Nursing hours per CSSD Tray 2.87hrs
- Average nursing hours per CSSD loan tray 1.2;

Calculate number of CSSD Loads and multiply by above denominators.
Add together to provide with required nursing hours.

Compare this with historical productive nursing hours to determine if nursing hours meet demand.

Theatre

- Minimum staffing as per acorn standards;

Determine productive hours as per recovery calculation determining theatre session lengths in time multiplied by number of theatre.

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- Number of theatres: 2
- Operating minutes plus down time for cleaning and preparation of cases
- Number of working days per year: 242
- No of nursing staff per operating room: 3.5
- Annual meal relief required: if sessions do not stop for lunch: 30min per staff; 91.5

Annual productive hours: No x operating rooms x no x operating hours x no of working days x no of staff annual meal relief = 2x 9x242x 3.5 + 91.5 = 15337.5 productive hours

-

Divide annual productive hours by 52 to determine weekly productive hours = 295hrs

295 divided by 38 = 7.76 Productive FTE

Recovery

- Data to be obtained from ORMIS, NECTO, TrendCare and QHERS

Number x hours opened per day 0800-2000- 12hrs (if your recovery does not run at 100% occupancy) you can calculate no of hours required for service per week and divide x 5 or 7 (5day service or 7 day service0 to determine an average daily number)

If your Recovery works on 2 x 4 hour sessions per day for three days per week and 1 3 hour session on 2 days per week; your calculated hours would be based on 8x 3 + 2x 3= 30 hours per week divided by 5 days = average hrs per day = 6hrs
No of working days per year (242) closed for 14 days at xmas
No of staff (1 per operating room (plus 1 runner) (Note this is for staffing recovery only.
(Note if you only have one operating room running at one time then staffing would be 2.

Total productive hours:
Average daily session hours x working days per year (Subtract any compulsory closure days from 365 to establish working days and subtract weekends if not a 7 day service. X by number of staff required = Productive hours)

6 x 242 x 3= 4356productive hours

Divide annual productive hrs to hrs per week- 4356/ 50 (52- 2 weeks for compulsory xmas closure) = 87.12 hours
Divide weekly hours x 38 to determine FTE- 187.12/38-=2.29FTE

Mental Health

- Data to be obtained from CIMHA, QHERS and NECTO

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-

Inpatient unit: Top 5 drg model (Method 2)
Outpatient dept: utilise total nursing hours divided by total occasions of service= HPPD

Emergency Department

- Data to be obtained from EDIS, QHERS, TrendCare and NECTO

http://qheps.health.qld.gov.au/nmoq/workforce/documents/BPF_ED_calc_tool_.xls

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Rostering

Nursing and midwifery rostering

Nursing and midwifery rostering practices support provision of high quality health care that meets the patient's needs whilst also meeting the requirements of the organisation and employees. Effective rostering juggles work / life balance issues, understanding the skill set required, professional nursing and midwifery judgment, compliance with Industrial awards, legislation and policy, prevention of fatigue in employees, cultural and generational considerations and legal implications within a framework that promotes fairness and equity.

The Service recognises the need to consider accrued leave when employing new staff members; with the aim to negotiate that excess leave be taken prior to employment. Additionally, when staff are seconded to the Service, leave accrued during the secondment is rostered to be taken prior to completion of the contract.

Rostering practices for nurses and midwives employed in the Service should conform with 'The Principles of Best Practice Rostering: Queensland Health Guidelines' (2012). This document can be located http://qheps.health.qld.gov.au/schsd/docs/edu/tmd/20064.pdf

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Chapter 3 - Reaching a balance

In a nutshell:

This third stage of business planning focuses on analysing the differences between the demand for resources and the actual resources allocated. It allows service area managers, staff and senior management to identify gaps and agree on a resolution. That solution is likely to be one of three potential outcomes:

- *change the demand for resources*
- *change the investment of resources*
- *alter the mix of resources to achieve agreed outcomes.*
- *An agreement by the nursing / midwifery leader and staff is required in order to meet demand by varying staffing levels if demand changes. When there is an excess of staff, predesignated list of activities that are enabled or disabled depending on the workload management status.*

Exercising professional judgement

- Advocating for the provision of safe, quality care is one of the most important activities that you as a nurse or midwife can undertake to protect yourself and your patients, clients or residents.
- Professional nursing judgement is a process that requires decision making based on critical reflection, evaluation and clinical expertise in order to resolve issues, problems and dilemmas. When you exercise your professional judgement on what constitutes safe workloads you are advocating for your patients and keeping yourself and them safe.
- It is essential you, as a nurse or midwife, are confident in asserting your professional judgement as this is the tool of accountability for your interventions and care. In Queensland Health, nurses' and midwives' professional judgement is accepted as a valid method for determining safe workloads.
- Professional judgement in health involves practitioners in finding not the right answer (which probably does not exist in the absolute sense), but in deciding what is best in the situation they find themselves. When exercising professional judgment the nurse / midwife must take into account all the aspects, even though some of them seem to be unimportant.
- The background of professional judgment is formed of the specialist's knowledge, technical skills, competence, experience and abilities. Besides these essential characteristics, documentation is very important and must be able to defend the opinion. See http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/scope-of-practice.aspx for the 'A national framework for the development of decision-making tools for nursing and midwifery practice'. *http://www.nursingmidwiferyboard.gov.au/search.aspx?q=decision%20making%20framework*

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Data Analysis

The analysis of workforce data alongside other information such as activity and clinical outcomes can assist greatly in identifying and allocating resources because it enables assessment of the effectiveness of those allocated resources. For example, monitoring the use of nursing and midwifery hours / occasion of service and expenditure will help to explain variances.

Duffield et al (2006) reaffirms the importance of determining a measure for nursing and midwifery workload in a standardised manner and establishing a relationship to retention and patient and staff safety, which are of state and national concern.

Strategies to evaluate and address an imbalance of supply and demand

Data Analysis

The analysis of workforce data alongside other information such as activity and clinical outcomes can assist greatly in identifying and allocating resources because it enables assessment of the effectiveness of those allocated resources. For example, monitoring the use of nursing and midwifery hours / occasion of service and expenditure will help to explain variances.

Duffield et al (2006) reaffirms the importance of determining a measure for nursing and midwifery workload in a standardised manner and establishing a relationship to retention and patient and staff safety, which are of state and national concern.

Strategies to evaluate and address an imbalance of supply and demand

A systematic approach to planning the nursing and midwifery operating resource estimates allows the service area manager to identify, clarify and document the many issues impacting on the allocation. The ultimate aim of the BPF process is to achieve a balance between supply and demand, but it also helps to quickly identify imbalances when:

- service demand is greater than the supply of resources, or
- supply of resources is greater than service demand.

When differences occur, a balance can only be achieved by adjusting either supply or demand, or both.

Managing variances

- *Unfavourable variances* ***(demand exceeds supply)***

Reasons for unfavourable variances may include increased activity or costs that were overlooked during the service planning, or unforeseen due to unpredictable changes to the working environment. It is important to determine whether the resource t allocation is sufficient to meet the demand so that this can be remediated in future. Unfavourable variances may be addressed by any of the strategies listed in the previous section, '*Strategies to address an imbalance of supply and demand*'.

- *Favourable variances* ***(supply exceeds demand)***

Favourable variances could bring unwanted repercussions which is why it is important to investigate their cause. Obvious reasons may be that activity is less than predicted or efficiencies have been made. However, savings may also have been made by under-staffing, which could lead to a decrease in the quality of service.

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Strategies for managing emergent situations

Emergent situations will arise such as:

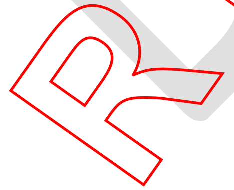
- unexpected sick leave of staff members who are unable to be replaced
- unplanned activity e.g. increased number of inpatients, higher acuity.

Using the flow sheet in Chapter 4, nurses and midwives within clinical work units can, in consultation with their supervisor, identify strategies for managing workloads in the short-term to address roster deficits or inefficiencies related to patient care, acuity, staffing, skills mix and safety needs. It is essential in these situations that safety for patients and staff is the priority.

Strategies for managing temporary vacancies

Traditionally, casual pool staff and agency staff have been employed on temporary contracts to backfill temporary vacancies created (but not limited to) by industrial instrument leave entitlements such as long service leave, maternity and parental leave, parental work agreements, approved leave without pay, long-term sick leave and staff secondments. These vacancies can have a significant impact in a team and may result in:

- instability of staffing in work units
- variable skills mix
- increased workloads
- increased need for preceptor support and training of temporary staff
- decreased staff morale
- increased sick leave
- increased costs.



Ultimately this can impact on the effective management of nursing and midwifery workloads. Existing practices of backfilling by temporary contracts of external / casual pool staff, or managing the unfilled shifts on a daily basis with agency staff, additional part-time shifts or overtime, can be inefficient when looking at the long-term impact on the service.

Each HHS will individually need to investigate and establish a strategy to managing temporary / permanent vacancies with consideration of complexity of the service.

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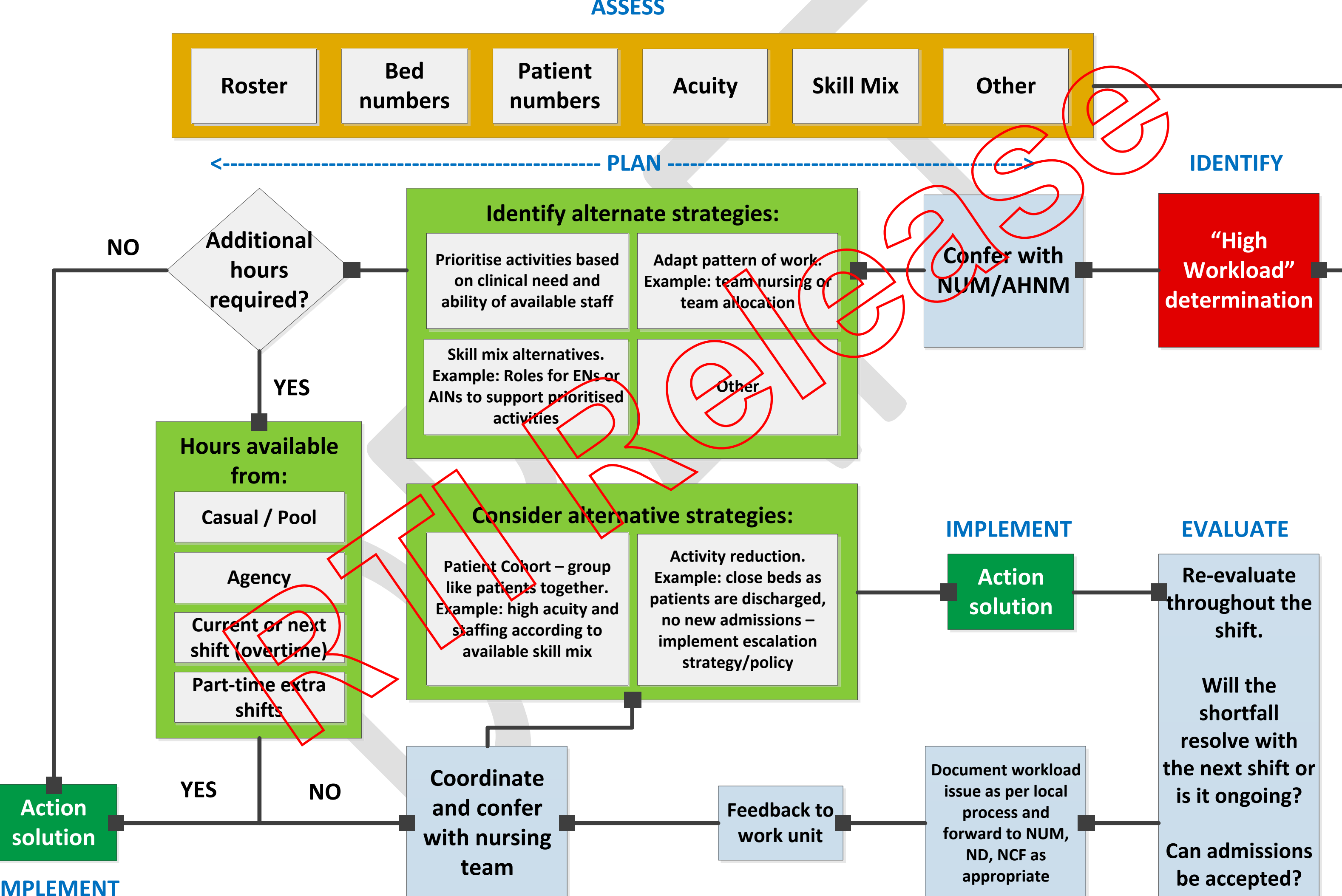
BUSINESS PLANNING FRAMEWORK

Management of Emergent Situations



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<table>
<tr><th colspan="2">Suggested strategies</th></tr>
<tr><td>When service demand is greater than the supply of resources

Hospital and Health Boards (Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015 will mandate ratios of 1:4, 1:4, 1:7 commencing 1 July 2016. The ratios will be implemented in a phased approach, with only prescribed acute wards and facilities in the public health sector having to comply with ratios.</td><td>When the supply of resources is greater than service demand</td></tr>
<tr><td>The environmental analysis identifies factors impacting on service demand. While changes to any of these may reduce demand, the following strategies should be considered:
• nursing / midwifery team to clearly identify capabilities with the available staff
• replacing nursing / midwifery staff with like for like skill mix as a first priority
• changing patient mix
• exploring improved support services
• improving bed utilisation / bed reductions
• exploring alternate funding sources
• prioritising clinical / work unit activity
• exploring opportunities for efficiencies
• reviewing indicators - patient / client, staff, quality.</td><td>When an over-supply of resources has been identified, the following strategies should be considered:
• reduce nursing / midwifery hours
• approve leave
• review flexibility of core roster
• review nursing / midwifery practices
• re-direct allocated nursing / midwifery hours
• increase services
• agreed activity list (eg: audits; training; review documents)</td></tr>
</table>

Finalising the service profile

Once the initial service profile is completed, it will be used during discussions and negotiations for financial year budget allocation. Once the agreed budget and the level of service is finalised and agreed, the 'proposed service profile' should be reviewed and amended accordingly to ensure the profile reflects the available resources and service priorities. The final document is recognised as the 'Agreed service profile' and should be signed off by senior nursing / midwifery management and the Chief Finance Officer. See Flowchart on next page.

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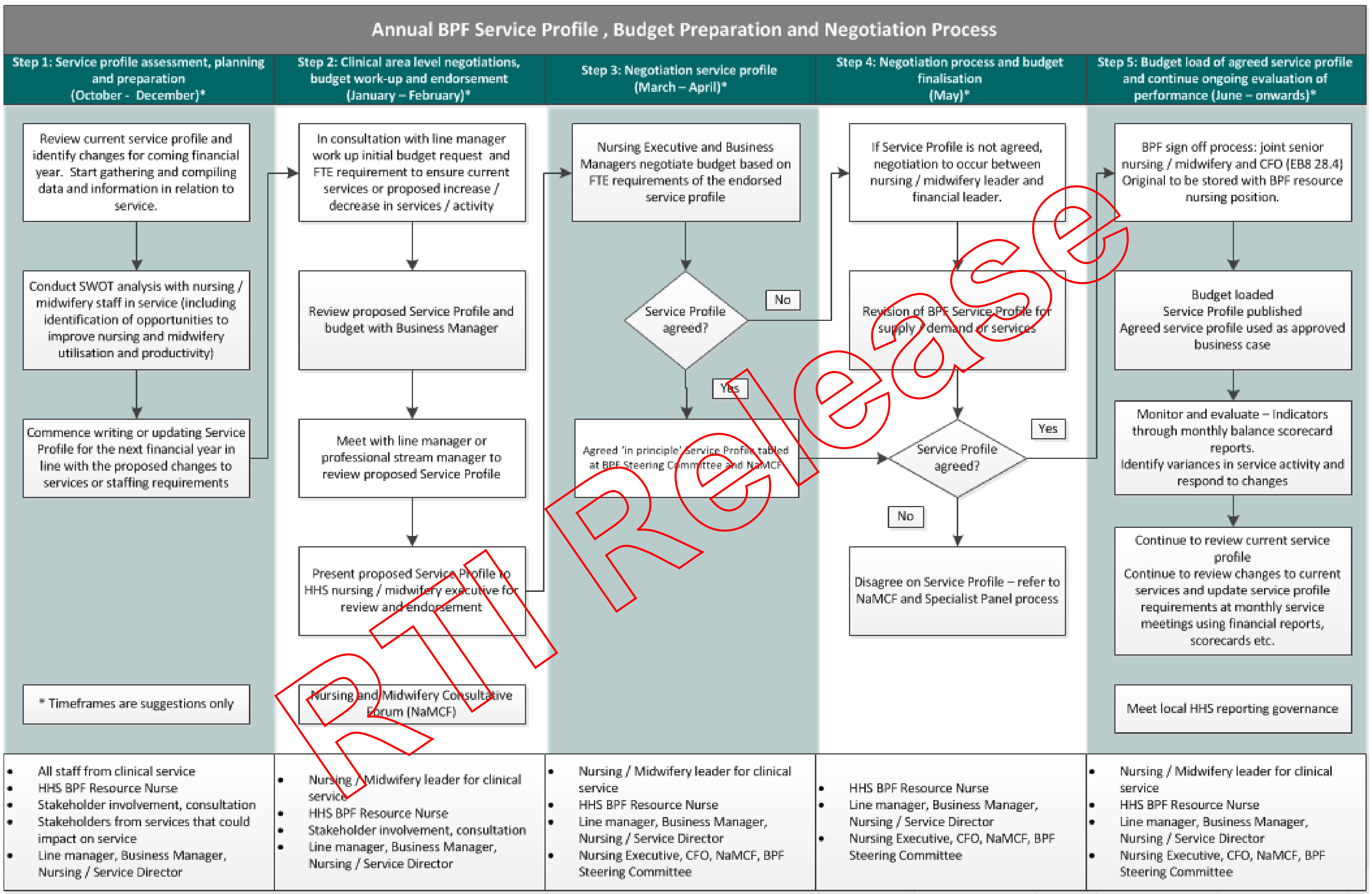

- Queensland Industrial Relations Commission, 2012, Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012, viewed 1 June 2015, http://www.qirc.qld.gov.au/resources/certified_agreement/cert_agreement/2012/ca105_2012.pdf
- Queensland Industrial Relations Commission, 2012, Queensland Health Nurses and Midwives Award – State 2012, view 1 June 2015, http://www.qirc.qld.gov.au/resources/pdf/awards/q/q0090_swc13.pdf
- Queensland Health, 2008, HR Policy B5: Nursing Workload Management, Queensland Health, Brisbane, viewed 1 June 2015, http://www.health.qld.gov.au/qhpolicy/docs/pol/qh-pol-180.pdf

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Chapter 4 – Escalation

Action!

- See Nursing and Midwifery Workload Management Process (FUTURE STATE)
- See Nursing and Midwifery Workload Management Specialist Panel Referral Process

In a nutshell:

This fourth Chapter of the BPF Manual looks at the importance of a mandated escalation pathway when the differences between the demand for resources and the actual resources allocated cannot be resolved. It allows nursing / midwifery managers, staff and senior management to agree on a resolution.

Workload management issue escalation process (for nursing and midwifery award 2015)

The process of escalation for identified workload management issue must be:

Step 1
The workload issue is identified by nurse/midwife and raised immediately at the service level.
The line manager or after-hours nurse/midwife manager immediately investigates workload issue identified and implements actions (including implementing service agreed low priority strategies) to resolve the identified issue or mitigate risk to patient safety and prevent reoccurrence.

Step 2
If the workload issue cannot be resolved at the service level at Step 1, it is to be escalated to the Nursing/Midwifery Executive team. The Nursing/Midwifery Executive team will review the identified issue and implement further actions to resolve or mitigate risk to patient safety and prevent re-occurrence, within 7 days of the workload issue being identified. A detailed summary of all resolved issues will be tabled at the Nursing and Midwifery Consultative Forum (NaMCF).

Step 3
If the workload issue cannot be resolved at Step 2, the NaMCF will review the identified issue and recommend actions to resolve or prevent re-occurrence of the identified issue.

If there is a workload management issue identified as critical to patient safety, an extraordinary NaMCF can be requested.

A report outlining identified issues and outcomes from each monthly NaMCF must be provided to the Chief Executive and the patient quality and safety committee.

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Step 4

If the workload issue cannot be resolved at Step 3, a specialist panel must be convened by the Hospital and Health Service within 7 days of the NaMCF meeting, to review the identified workload issue and recommend actions to resolve or mitigate risk to patient safety and prevent re-occurrence of the identified issue.

The recommendations of the specialist panel meeting must be published within 3 days. The recommendations of the specialist panel meeting will be implemented by the relevant Hospital and Health Service within the timeframes set by the specialist panel.

Step 5

If the workload issue cannot be resolved and recommendations not agreed to at Step 4, the matter is to be referred within 7 days from the specialist panel meeting to the Queensland Industrial Relations Commission for assistance and if necessary arbitration.

Communication and Reporting

The line manager provides communication to staff affected by the identified workload issue on the actions taken.

The Nursing/Midwifery Executive team will communicate to all affected staff on the actions taken and to be taken to address identified workload issue within three days of convening Specialist Panel meeting.

The Nursing/Midwifery Executive team must provide a thematic summary of identified workload issues and actions to the Hospital and Health Services Patient Quality and Safety Committee and Executive Committee to endorse recommendations if required.

Compliance measures

All performance reporting frameworks must be evidence based, align with national clinical and safety standards for health services and be documented within local service agreements.

The report on workload issues deemed to impact patient safety, including matters that fail to comply with the escalation timeframes, are tabled at Hospital and Health Service Nursing and Midwifery consultative forums at least monthly.

Reports that monitor the correlation between the identified workload issue and the key performance indicators, including patient safety measures and quality of services are to be tabled at Hospital and Health Service Nursing and Midwifery Consultative Forums at least quarterly and made available to the Chief Executive (Queensland Health) for the purposes of public reporting.

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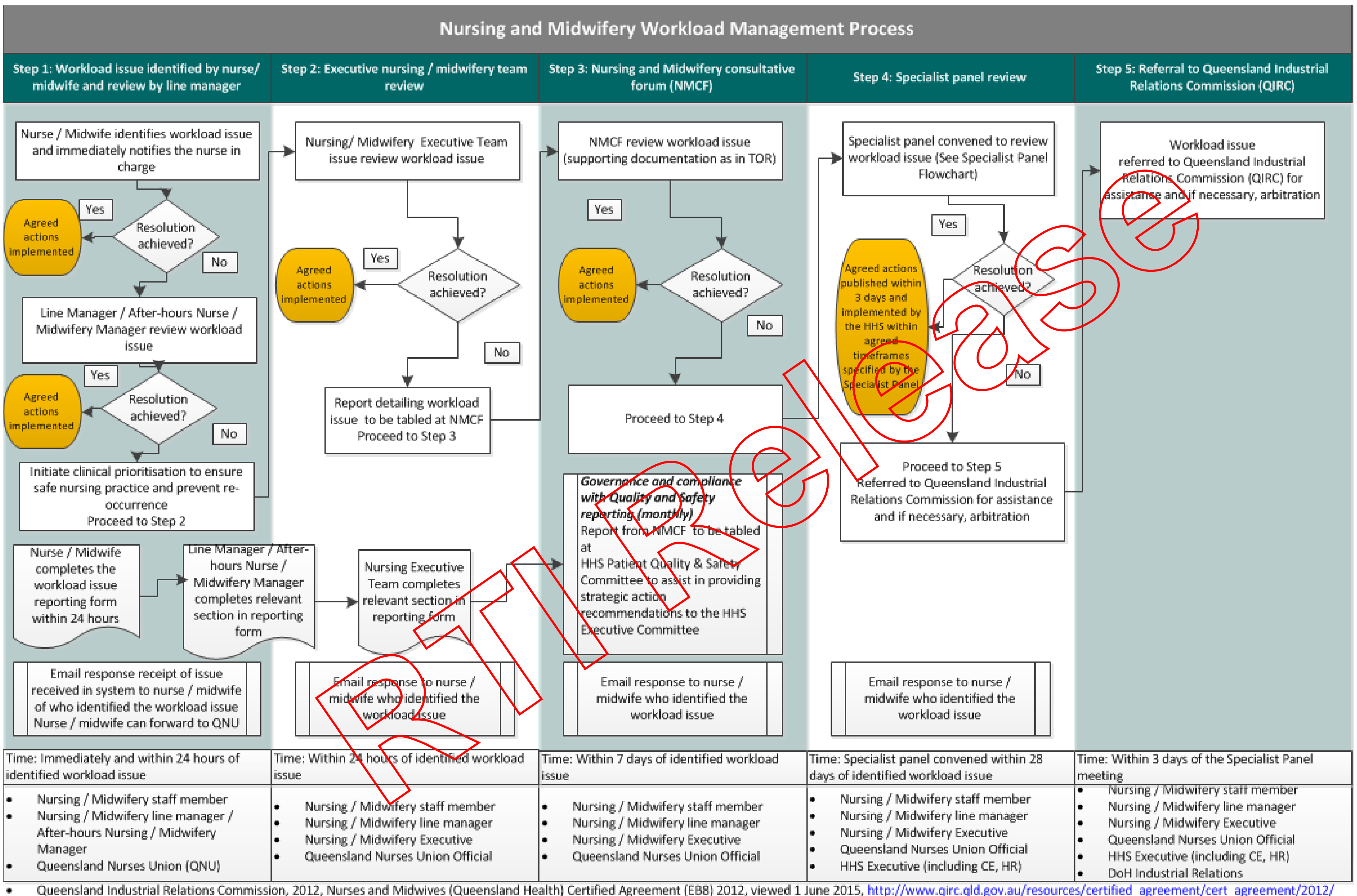

- Queensland Industrial Relations Commission, 2012, Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012, viewed 1 June 2015, http://www.qirc.qld.gov.au/resources/certified_agreement/cert_agreement/2012/ca105_2012.pdf
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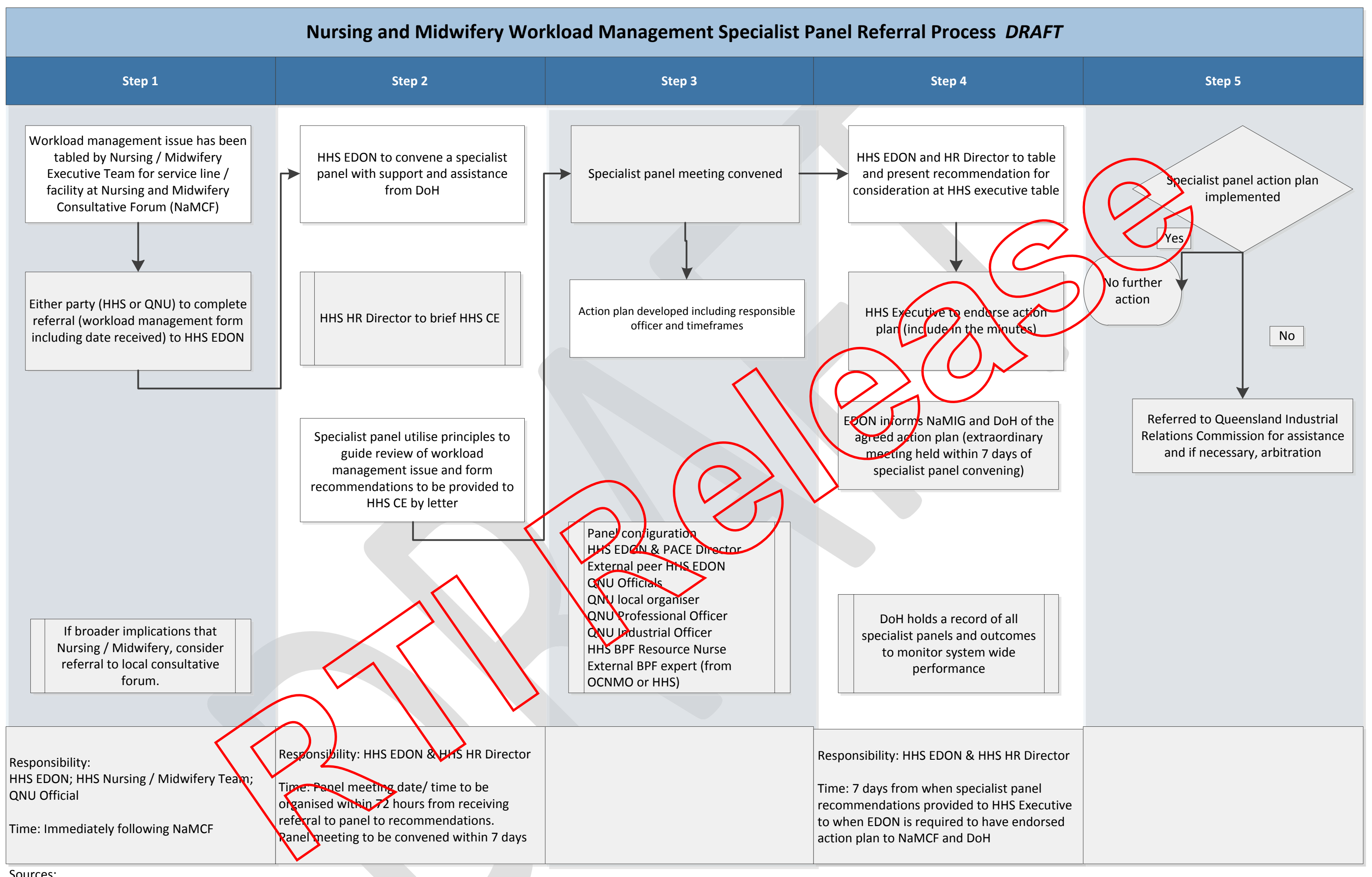

Sources:

- Queensland Industrial Relations Commission, 2012, Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012, viewed 1 June 2015, http://www.qirc.qld.gov.au/resources/certified_agreement/cert_agreement/2012/ca105_2012.pdf
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Chapter 5 – Performance Metrics

Action!
Refer to: Office of the Chief Nursing and Midwifery Officer website for updates and links on metrics and anayltics

In a nutshell:
This fifth Chapter of the BPF Manual looks at the importance of monitoring the unit, service, facility and HHS performance. The language in the area of performance metrics can often be confusing as the words monitor, evaluate, performance, evidence-base, benchmarking and best practice are often used simultaneously or interchangeably. This chapter also defines these terms and attempts to provide a broader overview of how the balance of supply and demand may affect the safety and quality of patient care indicators. Changes in these indicators may reflect suboptimal outcomes, poor resourcing decisions and provide evidence that may be able to be used to advocate the appropriate levels of nursing resources.

The primary objective of the Australian health care system over the last few decades has been the improvement of population health resulting from the use of efficient and cost-effective health care interventions. Evaluation is a central function for improving the health system's performance and is based on immediate objectives such as improving safety, efficacy, and appropriateness and on long term outcomes such as life expectancy.

Activities, disciplines and methods that are available to identify, implement and monitor the available evidence in health care are called 'best practice', and health care has been and is still working towards this continuous improvement for quality. The four disciplines: clinical research, clinical epidemiology, health economics and health service research develop an evidence base to inform best practice. The different disciplines are related to each other in three 'domains': (a) input (b) dissemination / implementation and (c) monitoring / outcome. These provide evidence on (a) the (potential) effects of health care interventions and policies (b) on ways to implement them; and (c) on ways to monitor their actual outcome.

Best practice, synonymous with **benchmarking**, is referred to as a process-oriented concept to achieve improvements within individuals, agencies or settings over time, and therefore related to quality (Perleth, M et al). Best practice is the best way to identify, collect, evaluate, disseminate and implement information as well as **monitor the outcomes** of health care interventions for patients / population groups and defined indications or conditions. Information is required on the best available evidence on **safety, efficacy, effectiveness, cost-effectiveness, appropriateness,** social and ethics values and quality of health care interventions and the process of obtaining this information has become a discipline known as **evaluation.**

There are many different types of evaluation (design, impact, process, outcome, formative to name several), however measurement is centric to all types and includes the **robust collection and analysis of qualitative and quantitative data to answer specific questions and undertake comparison.** Simplistically, if you are going to measure efficacy of yoga as exercise to lower blood pressure, a baseline of the subject's blood pressure using

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a sphygmomanometer before and then after they perform yoga over a number of weeks is a method of **monitoring**. Monitoring generally means to be aware of the state of a system, to observe a situation for any changes which may occur over time, using an appropriate measuring device. There are many measuring devices to take a range of metrics, including instruments such as validated questionnaires that are tools to measure more nebulous concepts such as patient satisfaction or consumer engagement.

The term '**metrics'** is often applied to these **measurements** and in the future as health care information is collected into integrated computerised systems, data linkage will enable the emerging field of **analytics and metadata** to provide the discovery and communication of meaningful patterns in data. Health care is rich with recorded information and electronic systems capable of collecting and collating this data are emerging in Queensland, as analytics relies on the simultaneous application of statistics, computer programming and operations research to quantify performance.

Effectiveness - the degree to which something is successful in producing a desired result; success. When talking in terms of efficacy versus effectiveness, effectiveness relates to how well a treatment works in the practice of health care, as opposed to efficacy, which measures how well treatment works in clinical trials.

Efficacy is the capacity for beneficial change (or therapeutic effect) of a given intervention (for example a drug, medical device, surgical procedure, or a public health intervention). If efficacy is established, an intervention is likely to be at least as good as other available interventions, to which it will have been compared. Comparisons of this type are typically made in 'explanatory' randomized controlled trials, whereas 'pragmatic' trials are used to establish the effectiveness of an intervention.

A Key Performance Indicator **(**KPI**) is a measurable value that demonstrates how** effectively a company is achieving key business objectives. **Organisations use** KPIs **to evaluate their success at reaching targets.**

The Performance Management Reference Guide (http://www.premiers.qld.gov.au/publications/categories/guides/perf-manage-framework.aspx) provides examples of developing performance indicators for the difference measures of activity, process, input, quality or access/equity that may be relevant to and retained for your agency's internal monitoring. http://www.safetyandquality.gov.au/our-work/national-standards-and-accreditation/

The Hospital and Health Service Performance Management Framework (https://publications.qld.gov.au/dataset/e1c2648f-eb8e-4e7f-a0d7-42604cd9212f/resource/94ce3c3b-59dd-44d4-8d3c-ada71f6379bc/download/sd2hhspmf1415.pdf) explains key performance indicators, targets and tolerances.

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Why performance management matters

> ***Performance management*** *is considered to be the system, which integrates organisational strategic management, performance information, evaluation, performance monitoring, assessment and performance reporting.*
>
> (OECD, Working Definitions, 2002)

The Queensland Government Performance Management Framework (PMF) is designed to improve the analysis and application of performance information to support accountability, inform policy development and implementation and create value for customers, stakeholders and the community. The PMF enables a clear line of sight between planning, measuring and monitoring results and public reporting.

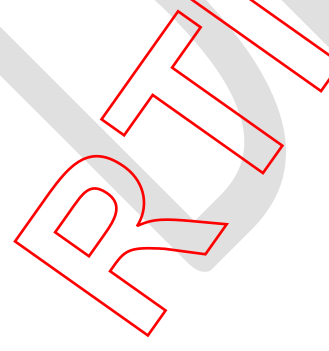
The updated Queensland public sector guide reflects the continuous improvement of the Queensland public sector agencies in performance management.

Opportunities exist for agencies to continuously improve organisational performance to better meet the government's broad objectives for the community. This guide establishes the minimum requirements for agencies in relation to performance management.

Measuring performance is the means of reviewing the overall effectiveness, efficiency and appropriateness of the **inputs, outputs and outcomes of the allocation of resources**. It involves the evaluation of **both financial and non-financial results.**

In evaluating performance, actual results may be compared with:

- **planned indicators, measures and activity targets**
- **previous results**
- **the performance of other services, either internal or external to the organisation.**



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Principles of Nursing Metrics

It is essential that performance metrics are important, scientifically sound, useable and feasible. Useability relates to the extent to which intended audiences can understand results and are likely to find them useful in decision making, while feasibility relates to the ability to obtain quality data in a timely manner with a demand on resources that is proportionate to the benefits. Griffiths et al (2008) determined that good nursing-specific metrics should be:

TABLE12: Determinants of a good nursing indicator

Measurable using existing data and at a reasonable cost	**Evidence based and linked to important outcomes**
Able to inform remedial action	**Sensitive to nursing – the sensitivity should be evidenced and there should be substantial variability associated with nursing practice**
Recognised as important to nurses, managers and the public	**Risk-adjusted to compare performance in different settings**
Recognised as being the responsibility of nursing staff	**One that minimises the risk of a 'perverse incentive' (where improving performance on the indicator detracts from overall performance)**

The biggest challenge lies in striking the right balance between the data collection burden and the need to ensure that performance metrics represents broad achievement of the goals of nursing processes that deliver these goals. The more metrics that are collected the greater the data collection burden, however the danger on focusing on a few narrowly defined metrics lies in the creation of perverse incentives where maximising performance on metrics detracts from overall performance.

Patient Experience

Part of the challenge in developing meaningful nursing metrics is how to incorporate patient feedback and views into the system. Nursing is essentially a patient centred activity with a significant qualitative component. The use of interactive and intuitive patient experience questionaries could provide a straightforward metric to be incorporated into the current Nursing Performance Scorecard.

This feedback provides an understanding of the needs and expectations of patients, and a reliable measure for the hospital's performance in delivering patient-centred care. The program is embedded in all areas of the hospital and fully supported by the leadership team. It educates staff on the issues that matter most to patients. Key features include a Consumer and Community Engagement Committee with staff from each hospital service working in partnership with consumers to develop a sustainable framework. Hospital departments have taken the program a step further, developing their own engagement activities specific to

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individual service needs with the goal of improving patient safety, experience and outcomes. The RBWH framework empowers and encourages staff and consumers to work together to contribute, develop, learn, be innovative and creative in the delivery of patient-centred care.

The below metrics should be considered as a means of capturing patient experience with the Queensland Health environment:

- % of complements received as a proportion of total feedback received
- % of complaints about nursing care as a proportion of total complaints received.

Satisfaction with nursing is among the most widely used nursing outcome measures and is a major determinant of overall satisfaction scores. There are a plethora of instruments for patient-reported outcome measures available, including PROMS and provide patients opportunities to assess their treatment outcome, they warrant consideration for evaluation of specific nursing interventions or narrowly focused nursing services.

Nurse Sensitive Indicator Tool and Reports

The State-wide Nurse Sensitive Indicator (NSI) reporting tool delivers a series of useful and relevant reports to help Queensland Health (QH) adult facilities to analyse, trend, monitor, compare and/or benchmark the care delivered by nurses.

These reports can be used to develop quality improvement initiatives which support the delivery of patient safety and care.

The NSI tool features 63 NSIs under 9 in-hospital sub categories including:

- reported falls clinical incidents
- reported pressure injuries clinical incidents
- reported medication administration clinical incidents
- reported blood transfusion clinical incidents
- health care associated staphylococcus aureus bacteraemia
- hand hygiene compliance
- nursing agency
- nursing skill mix
- nursing sick leave

The reports are generated from corporate QH systems and include Decision Support System, Prime CI, Queensland Health Statistic Centre and the Centre for Health care Related Infection Surveillance and Prevention.

For further information about the NSI tool and reports, please view the frequently asked questions or contact the Project Team.
http://qheps.health.qld.gov.au/nmoq/profession/nsi_about.html

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Nursing Performance Scorecard

The Nursing and Midwifery Office, Queensland (NMOQ) has developed a nursing performance scorecard to assist with reporting and monitoring trends across public nursing and midwifery services. The scorecard is interactive and enables a review of multiple interrelated measures across skill mix, sustainability, productivity and quality *(Queensland Health, 2014).* A snapshot of the scorecard is presented below:

Nursing Performance Scorecard – KPI attributes

Skill Mix	Sustainability	Productivity and efficiency	Quality
Workforce Profile - Total Workforce (Headcount) Workforce Profile – Clinical Workforce (Headcount) Nursing Skill Mix (FTE) Registered Nurse Skill Mix (FTE) Internal-External Skill Mix	Age Profile Age Profile by Skill Mix Fractional FTE Rate by Age Average Age Graduate Employment Graduate FTE Rate Leave Profile Leave Over Limit FTE Leave Over Limit of Total Nursing Percentage Leave Over Limit Value Banked RDO FTE Banked RDO Percentage Banked RDO Value Workcover rates Turnover rates	Agency Rate Casual Rate Overtime Rate EB8 Efficiency Nursing Cost per WAU WAU Profile	Reported Blood Transfusion Incidents Reported Medical Administration Incidents / 1,000 per patient day/s Reported Hospital Acquired Falls Reported Hospital Acquired Pressure Injuries

(Queensland Health, 2014).

The above scorecard metrics should be used as Key Performance Indicators and considered from the three principles of business planning (patient, staff and organisation). An updated version of the scorecard will be provided to each HHS every six months. Keep in mind that the Nursing Performance Scorecard is an indicative tool only and input from nursing and midwifery executive at a service level is required to fully interrogate data to make meaningful analysis.

In 2014, the Office of the Chief Nursing and Midwifery Officer performed analysis to provide a clear illustration of the inter-relationship between workforce metrics and nurse sensitive clinical safety and quality metrics and the impact these factors have on perceived nursing efficiency. Data analysed suggested that the reduction of clinical incidents associated with falls and medication administration incidents; and optimal resourcing of Grades 1-2 and 3-4 staff (i.e. appropriate skill mix) are where the greatest efficiency gains are likely to be achieved.

Further challenges exist to develop metrics that inform decision making systems that are dynamic with congruence between available nurse skill and patient demand using skill matching of both permanent and agency staff.. Such metrics and systems have the potential to prevent clinical compromise to patients and at the same time promote fiscal responsibility.

The below section details specific metrics that should be considered for inclusion in the current NMOQ Performance Scorecard. The outlined metrics have been included due to

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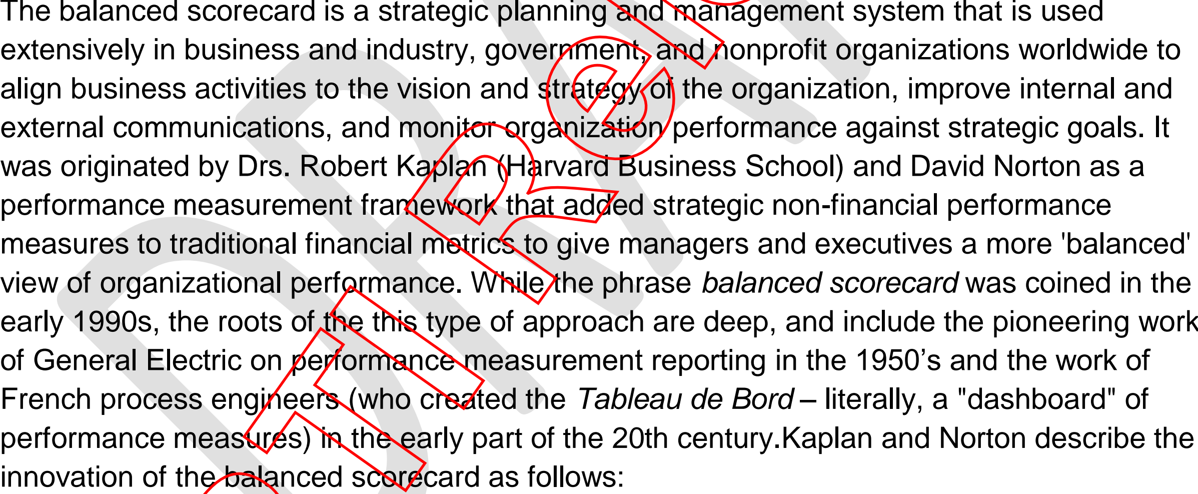
their compliance with the above determinants outlined in Table 12. While metrics cannot provide a complete picture or a complete solution, they can provide a powerful mechanism to incentivise quality by making the contribution of nursing more visible within the healthcare system.

There are a variety of reporting methods:

- Balanced Scorecard / Dashboard
- Strategic Plan KPI progress reports
- Cost Centre Management reporting (suites of reports are provided to cost centre managers to support effective and timely evaluation of performance at the operational level):
- DSS Necto finance and variance reports
- full-time equivalent (FTE) Reports
- overtime reports
- absenteeism reports
- payroll reports
- KPI reports, financial and non-financial
- workforce efficiency report
- agency and locum usage report.
- number of clinical incidents



The balanced scorecard is a strategic planning and management system that is used extensively in business and industry, government, and nonprofit organizations worldwide to align business activities to the vision and strategy of the organization, improve internal and external communications, and monitor organization performance against strategic goals. It was originated by Drs. Robert Kaplan (Harvard Business School) and David Norton as a performance measurement framework that added strategic non-financial performance measures to traditional financial metrics to give managers and executives a more 'balanced' view of organizational performance. While the phrase *balanced scorecard* was coined in the early 1990s, the roots of the this type of approach are deep, and include the pioneering work of General Electric on performance measurement reporting in the 1950's and the work of French process engineers (who created the *Tableau de Bord* – literally, a "dashboard" of performance measures) in the early part of the 20th century.Kaplan and Norton describe the innovation of the balanced scorecard as follows:

The balanced scorecard retains traditional financial measures that tell the story of past events, an adequate story for industrial age companies for which investments in long-term capabilities and customer relationships were not critical for success. These financial measures are inadequate, however, for guiding and evaluating the journey that information age companies must make to create future value through investment in customers, suppliers, employees, processes, technology, and innovation. Kaplan & Norton:1996

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The balanced scorecard comprises four perspectives, and metrics should be developed to collect and analyse data relative to each of these four perspectives:

- Learning and Growth
- Business Process
- Customer
- Financial.

Balanced scorecards and dashboards provide a succinct summary capturing the information most relevant to effectively monitor a facility or health service's performance against strategic goals and established performance measures. Balanced scorecards and dashboards include a range of indicators to manage and measure both financial and non-financial data that is compared to a target value within a single concise report.

A dashboard is where all data and metrics are collated and presented as useful information for the organisation. A dashboard is created by using metrics and Key Performance Indicators (KPIs). In essence, a dashboard is a multilayered performance management tool that enables organisations to measure, monitor and manage business activity by using both financial and non-financial measures. The dashboard provides analysis into the progress of the organisation toward achieving each defined objective. A dashboard comprises a toolset of visual displays that provide timely, relevant information in an easy to understand format, utilising multiple sources of existing data, and displays information in real time required to inform daily decisions that help drive process improvement (VisionEdge Marketing, 2007). See http://qheps.health.qld.gov.au/hsu/dashboards/dbhome.htm and click on the various collections to see dashboards as described above.

Setting tolerances and targets

Consideration should be given to establishing tolerances and targets for relevant metrics contained in the current Nursing Performance Scorecard. Establishing and incorporating tolerances and targets in combination with a traffic light system (similar to what is contained in the current QLD Health DSS dashboard) within the scorecard would allow HHS and/or facilities to see what is acceptable, what needs action, and how urgently action is needed.

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Benchmarking

Benchmarking is the process of comparing the cost, cycle time, productivity, or quality of a specific process or method to another that is widely considered to be an industry standard or best practice. Essentially, benchmarking provides a snapshot of business performance and assists in understanding actual performance in relation to a particular standard. This often results in a business case for making changes in order to improve services. Benchmarking is used most often to measure performance using a specific indicator (cost per unit of measure, e.g. WAU) resulting in a metric of performance that is then compared to others.

"Best practice benchmarking" or "process benchmarking", is a process in which organisations evaluate various aspects of their processes in relation to best practice, usually within a peer group defined for the purposes of comparison. This then supports organisations to develop plans on how to make improvements or adopt best practice, usually with the aim of increasing some aspect of performance. Benchmarking may be a once only event but is often treated as a continuous process in which organisations continually seek to challenge their practices. **BPF communities of practice** (CoP) between HHS share successes and learn from each other's lessons learnt, evidence and stories.

Types of benchmarking

Process benchmarking	The organisation focuses its observation and investigation of business processes with a goal of identifying and observing the best practices from one or more benchmarks from other organisations. Activity analysis will be required where the objective is to benchmark cost and efficiency.
Financial benchmarking	Performing a financial analysis and comparing the results in an effort to assess an organisation's overall competitiveness.
Performance benchmarking	Allows an assessment of competitive position by comparing products and services with those of target facilities.
Product benchmarking	The process of designing new products or upgrades to current ones. This process can sometimes involve reverse engineering which involves deconstructing products to find strengths and weaknesses.
Strategic benchmarking	Involves observing how others compete. This type of benchmarking is usually not industry specific, meaning it is preferable to observe other industries.
Functional benchmarking	A facility will focus its benchmarking on a single function in order to improve the operation of that particular function.

Benchmarking can be undertaken internally within the organisation or externally with other organisations. When benchmarking, it is best to select other units / facilities / organisations with similar characteristics of:

- role delineation / Clinical Services Capability (Framework)
- casemix
- activity.

In analysing the use of nursing and midwifery resources, it is important that where there are differences in the benchmark results, the analysis of the differences be carefully considered.

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The analysis should particularly focus on:

- skill mix / category of nurses and midwives
- support services
- team structure / numbers (other than nursing).

Conclusions

An emphasis on the quality of nursing care and keeping quality high on the agenda of Hospital and Health Service management is vital for the improvement of nursing. In this respect nursing metrics may be both important and effective. Metrics could allow nurses to regain control of nursing quality. It seems likely that to achieve this goal, measurement and analysis of nursing care outcomes will become more important. For this to be meaningful, the outcomes measured need to be consistent and sensitive, and have the ability to be measured without detracting from the core role of nursing, that is, providing high quality care to patient

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TEMPLATE

Business Planning Framework

Service Profile

Document Approval

Name:

____

Nurse Unit Manager

Date:

Name:

____

Service Director / Nursing Director / Director of Nursing

Date:

Name:

____

XXHHS Nurse Manager, Business Planning Framework

Date:

Name:

____

XXHHS Executive Director of Nursing and Midwifery

Date:

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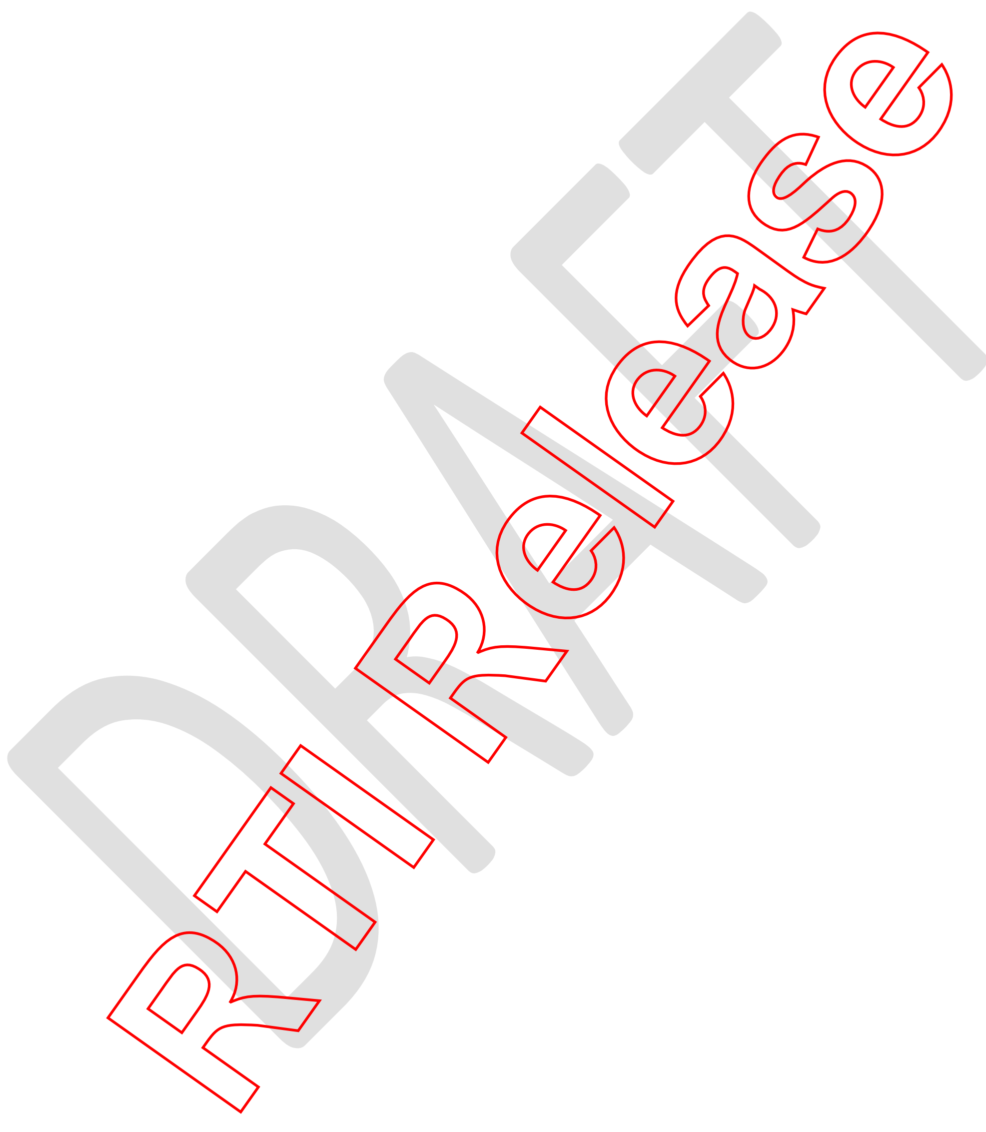
Service Profile Document Control

Version	Date	Prepared by	Comments

**Drafts should use format vX.1 (eg. start at v0.1). Final versions should use format vX.0 (eg. v1.0).*



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Service Overview

Service Name

Aim

Objectives

The key objectives of our Service are:

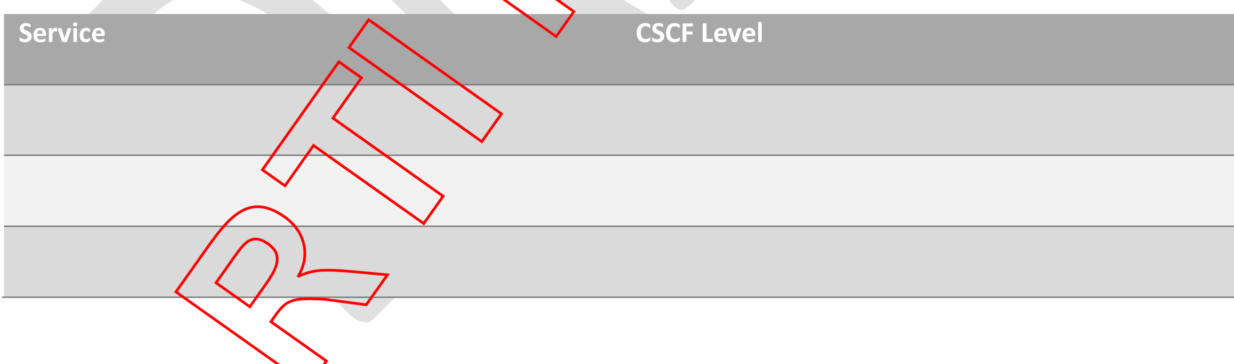
Describe the Present Service

Internal Environmental Analysis

Location and Size

Services within the Facility

The Service capability is assessed against the Queensland Department of Health Clinical Services Capability Framework for Public and Licensed Private Health Facilities (v3.1) and is documented in the XXHHS Service Agreement xxxxxxxxxxxxx.



Service	CSCF Level

Service Structure

The service and unit structures provide transparent lines of accountability and responsibility.

Leadership and Management

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Staffing Structure

Nursing / Midwifery Structure:

(Copy and paste Excel Table – table below is an example or copy and paste WorkMAPP Cost Centre Structure)

Nursing Officer Grade	Position Name	Position ID	Cost Centre	Productive FTE	% of Workforce = Skillmix	Temp (T) or Perm (P)	Roles & Responsibilities	Proposed FTE
Nurse Grade 10	Director of Nursing							
Nurse Grade 9	Nursing Director Assistant Director of Nursing							
Nurse Grade 8	Nurse Practitioner							
Nurse Grade 7	Clinical Nurse Consultant Nurse Unit Manager Nurse Manager Nurse Educator Nurse Researcher Public Health Nurse, and Midwifery equivalents							
Nurse Grade 6-7A	Associate/Advanced Practice role							
Nurse Grade 6	Clinical Nurse							
Nurse Grade 6	Clinical Midwife							
Nurse Grade 5	Registered Nurse							
Nurse	Registered Nurse							

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Grade 5	Midwife (only)							
Nurse Grade 5	Registered Nurse (Graduate)							
Nurse Grade 4	Enrolled Nurse Advanced Practice							
Nurse Grade 3	Enrolled Nurses							
Nurse Grade 2	Undergraduate Student Nurses / Midwives							
Nurse Grade 1	Assistant in Nursing							
	Total			**0.00**				

Non-Nursing Support positions Support Staff

- Staff who are not employed by the service, and not rostered exclusively to the service. Eg physiotherapist / occupational therapists, CNC specialist roles.

Position level	Position Name	Position ID	Cost Centre	Productive FTE	% of Workforce = Skillmix	Temp (T) or Perm (P)	Roles & Responsibilities	Proposed FTE
	Total			**0.00**				

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Current Model of Care

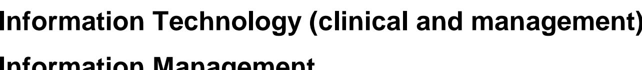
Human Resource Management

Core staff working in the service

Teaching and training/development commitments/needs

Clinical Support Base activities

Information Technology / management:



Information Technology (clinical and management)

Information Management

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External Environmental Analysis

Policy/Legal Factors	
Economic Factors	
Social Factors	
Technology Factors	
Research and Evidenced Based Practice	

S.W.O.T Analysis

Strengths to build on • **Strength is a distinctive competence of the service**	
Weaknesses to address • **A weakness is a deficiency that limits the performance of the service**	
Opportunities to take advantage of • **An opportunity is a factor external to the service that presents an area of potential for the service**	
Threats to neutralize • **A threat is an unfavourable factor in the external environment**	

Comparative Analysis

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ACTUALS

Patient / Client activity

Top Ten DRG					
No.	DRG	Description	ALOS	Peer Group Ave	Variance
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Fractional Bed Days		
Month	Total	Ave.
Oct		
Nov		
Dec		
Jan		
Feb		
Mar		
Apr		
May		
Jun		
Jul		
Aug		
Sep		
Total		

Emergency Department Presentations							
Month	Cat 1.	Cat 2.	Cat 3.	Cat 4.	Cat 5.	Total	Weekly Ave.
Oct							
Nov							
Dec							
Jan							
Feb							
Mar							
Apr							
May							
Jun							
Jul							
Aug							
Sep							
Total							

Occasions of Service								
Month	OOS 1	OOS 2	OOS 3	OOS 4	OOS 5	OOS 6	Total	Weekly Ave.
Oct								
Nov								
Dec								
Jan								
Feb								
Mar								
Apr								
May								
Jun								

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Jul								
Aug								
Sep								
Total								

Performance

Financial Performance Calender Year (to date)			
Cost centre	Actual	Budget	Budget Variance
Total Performance			

Nursing Labour Performance Indicators Calender Year (to date)				
Sick Leave (%)	Casual (%)	Overtime (%)	Agency (%)	Vacancy (FTE)

Patient Specialling													
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Hours													

Patient Escorts													
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Hours													

Nurse Sensitive Indicators

Clinical Incidents				
Incident Type	SAC 1	SAC 2	SAC 3	Total No.
Falls				
Medication Incidents				
Pressure Injuries				
Blood Transfusion				
(insert other relevant)				

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Forecast

Nursing Resource Determination 2016-2017

Nursing Resource Determination 2016-2017

Step 1: Calculate Average Productive NHPPD or NHPOS or NHPUA

Average Nursing Hours per Patient Day =	Total Annual Productive Hours / Total Activity (FBD's/OOS/UA)
Average NHPPD/NHPOS/NHPUA=	

Step 2: Determine the Weekly Nursing Hours

Weekly Nursing Hours =	**Total Annual Productive Nursing hours/52 weeks**
Weekly Nursing Hours =	
Weekly Nursing Hours Total =	

Step 3: Develop Master Staffing Roster Profile

Insert master roster profile

Step 4: Confirm Direct Care Shift Profile

(Example)

Direct Care Shift Profile						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
8.0 : 7.0 :3.0	8.0 : 7.0 :3.0	8.0 : 7.0 : 3.0	8.0 : 7.0 : 3.0	8.0 : 7.0 : 3.0	7.0 : 7.0 : 3.0	7.0 : 7.0 : 3.0

Step 5: Confirm Notional Nurse Patient Ratio

(Example)

Notional Nurse Patient Ratio – Direct Care Hours				
Shift	**Resourced Beds**	**Nursing Hours**	**Nursing Headcount**	**Nominal Ratio**
Day	24	64	8	1:3
Evening	24	56	7	1 : 3.4

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Night Shift	24	24	3	1:8

Summary

Significant Achievements in the last Twelve Months

Priorities for Service Improvement 2016 - 2017

Attachments

- **Proposed Service Profile**

References

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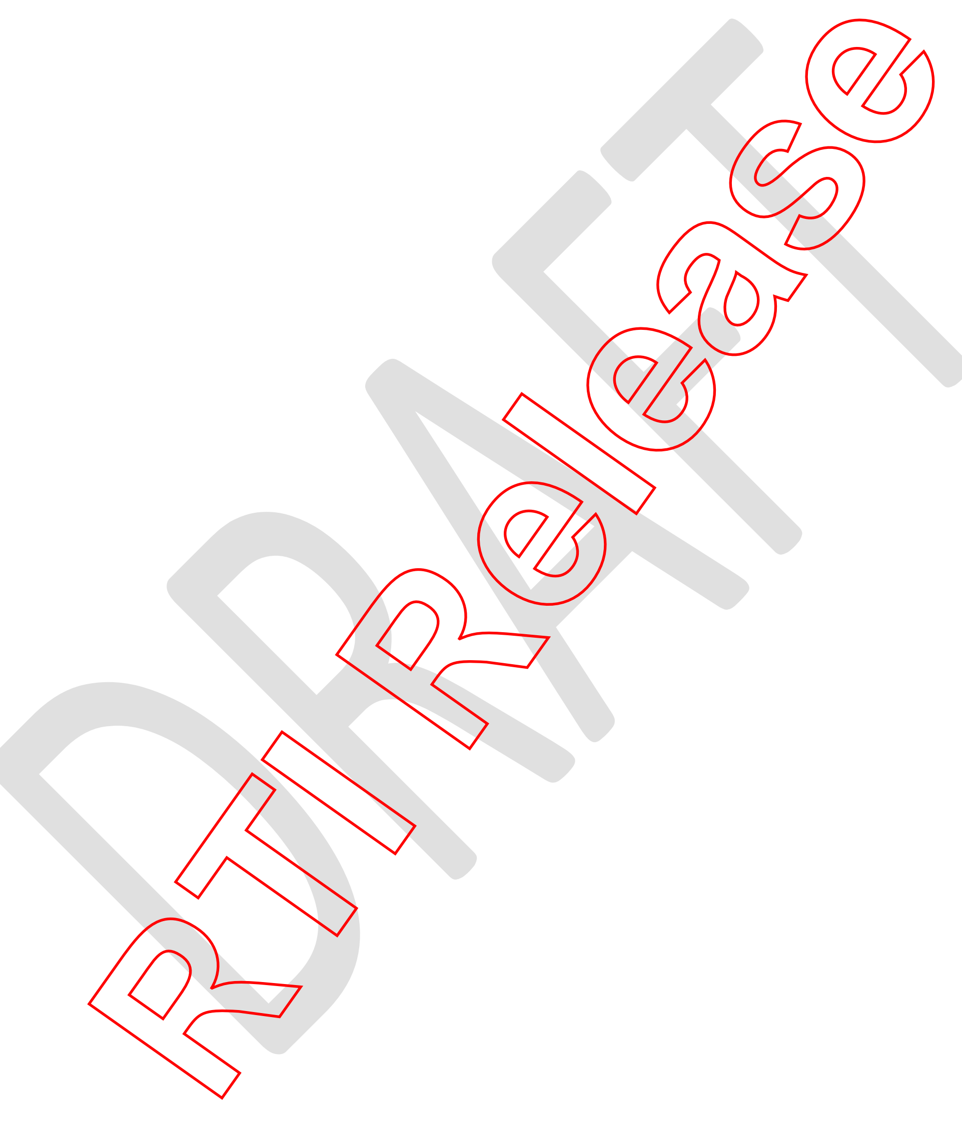
- **Service Improvement Business Case**

A service improvement business case is required to be submitted for year - year to support service delivery changes:

☐ Yes

☐ No



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TEMPLATE
Service Profile & Budget Negotiation Formal Agreement (optional)

- Sign off needs to occur by the designated nursing / midwifery leaders and Chief Finance Officer. This signed document needs to be tabled at the local governance meeting.
-

Ward / Unit Name: ____________________

Hospital & Health Service: ____________________

Service Group: ____________________

Financial Year Period: ____________________

Agreed

NHPPD		:	______	Beds	@	______	% Occupancy
NHPOS		:	______	Daily OOS	@	100	% Occupancy
NHPUA		:	______	Daily UoA	@	100	% Occupancy

	Proposed FTE	Budgeted FTE	Agreed FTE*	% of total agreed FTE	Agreed FTE inclusions					Total budget $
					Base	A/L	S/L	MDT	PDL	
NUM					100%					
CNC					100%					
CN					100%					
RN					100%					
GRAD					100%					
SIN					100%					
AIN					100%					
Total										

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*Agreed FTE is the total FTE allowable to be recruited to without formal application to increase FTE with the relevant Nursing & Service Group Directors. This number would match and be reportable using Panorama DSS

Note: comments / details of discussions may be documented on the reverse of this page as necessary

Approval

This is to certify that negotiations have occurred as per the Business Planning Framework and agreement has been reached in regards to the nursing resource requirements outlined above.

Service Director	Nursing Director	Business Service Manager	Nurse Unit Manager
Date:	Date:	Date:	Date:

☐ Budget provided to NUM / Line Manager

☐ Service Profile provided to Nursing BPF Resources for publishing

Discussion Details / Notes

It is expected that this document is completed and signed by all relevant stakeholders

by 30 June each year

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Annexure 1: BACKGROUND - Understanding the funding environment

COAG agreed, out-of-session in August 2011, to the National Health Reform Agreement, which aim to deliver major reforms to the organisation, funding and delivery of health and aged care. The Agreement sets out the shared intention of the Commonwealth, State and Territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health care system.

The reforms aim to achieve better access to services, improved local accountability and transparency, greater responsiveness to local communities and provide a stronger financial basis for our health system into the future through increased Commonwealth funding. This new agreement gives effect to the commitment made by COAG on 13 February 2011, and in doing so, supersedes the National Health and Hospitals Network Agreement and the Heads of Agreement on National Health Reform.

Figure 2: Funding flows under the National Health Reform Agreement

Under the National Health Reform Agreement, the Commonwealth is providing an extra $16.4 billion, through to 2019-20, for public hospitals. Under the Agreement, a component of the National Health Reform funding is identified as public health funding, to be paid by the Commonwealth into the National Health Funding Pool, and from there to state or territory health departments:

Aligning the Business Planning Framework with the funding system

When developing and then negotiating budgets based on your Business Planning Framework's service profile, it is beneficial to understand the wider financial framework

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your service area operates. In Queensland, service agreements are negotiated between the Queensland Health System Manager (Department of Health) and each of the Hospital and Health Services (HHSs). The service agreement determines the type and number of services provided by HHSs and the funding that the Department of Health provides for the provision of these services.

- Activity Based Funding (ABF) for larger public hospitals – where funding flows to local Hospital and Health Services according to the type and number of services they provide, based on a Queensland base price (http://www.ihpa.gov.au/internet/ihpa/publishing.nsf) for each type of service.

Independent Hospital Pricing Authority

The Independent Hospital Pricing Authority (IHPA) is an independent agency established under Commonwealth legislation as part of the National Health Reform Agreement (NHRA) signed by the Council of Australian Governments (COAG) in August 2011.

The IHPA:

- sets the National Efficient Price (NEP), the National Efficient Cost (NEC), and the price weights based on national data provided by the state and territory governments
- determines the Activity Based Funding model
- uses the National Hospital Patient Costing Standards http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/costing-standards-lp

The National Hospital Patient Costing Standards aims to provide direction for hospital patient costing through the development of standards for specific elements of the costing process and reporting requirements. It provides the framework and guidelines to regulators, funders, providers and researchers that submit data to the National Hospital Cost Data Collection (NHCDC).

It is important that costing data conforms to the costing standards outlined in the document to meet the Council of Australian Governments (COAG) requirement for national consistency. This will also allow any relevant cost studies to consistently and reliably reflect the changes in hospital output prices and clinical practice in public and private sectors.

IHPA works in partnership with the National Health Performance Authority and Australian Commission on Safety and Quality in Health Care to ensure that pricing, quality and performance measures for public hospitals are complementary and facilitate a strong national framework for the delivery of public hospital services.

Two key measures developed from this work are the NEP and the NEC.

The NEP, the NEC and the National Weighted Activity Unit (NWAU) are determined annually by the IHPA. The NWAU is the unit of measure of the ABF system. Each year, IHPA publishes a draft Pricing Framework for Australian Public Hospital Service – a key policy which helps guide the NEP and NEC.

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IHPA receives activity data from each jurisdiction on a quarterly basis. This data includes inpatient admissions, emergency department presentations and outpatient appointments as well as a range of mental health and rehabilitation services.

- For more information visit:
  - National Health Performance Authority - measures performance http://www.nhpa.gov.au/internet/nhpa/publishing.nsf/Content/home-1
  - National Health Funding Body – provides the funds from the Commonwealth http://www.nhfb.gov.au/

Efficient price determination

(NEP) = $4993

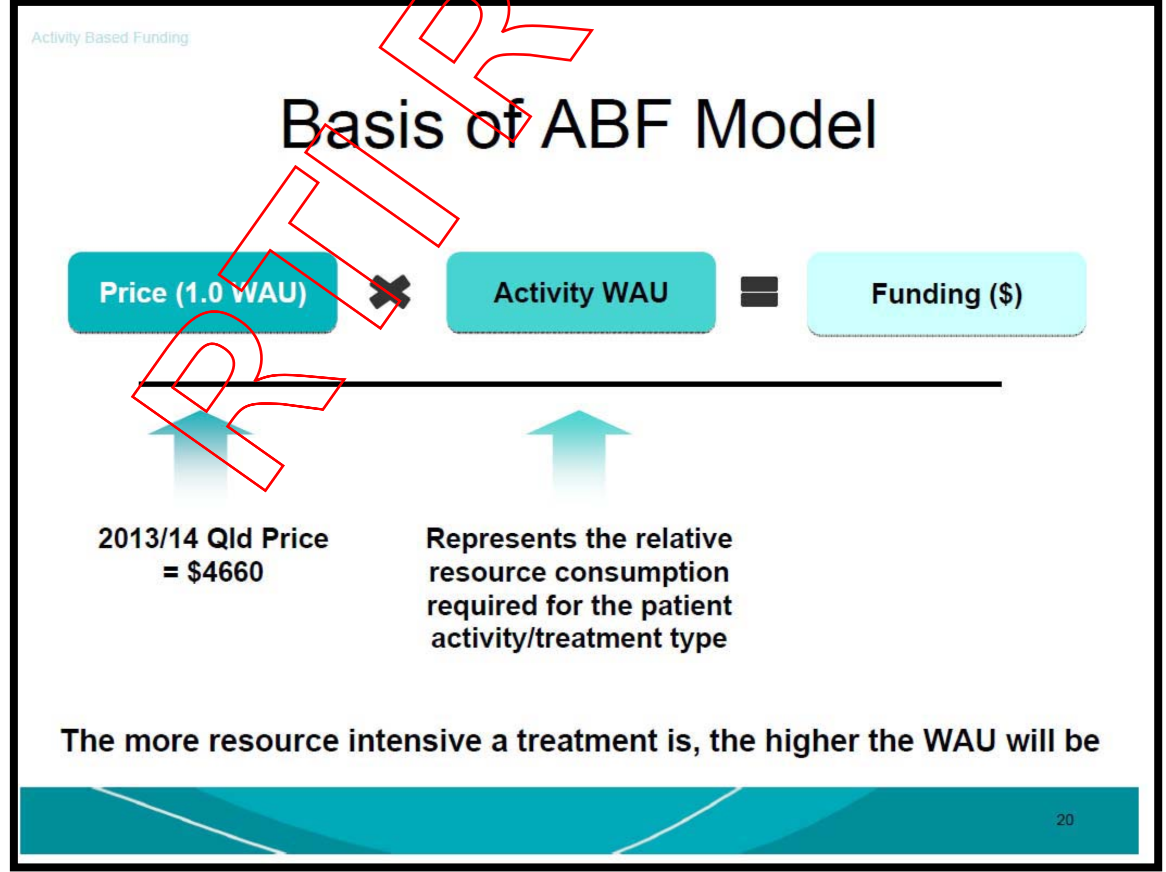
(QEP) =$4660

Reason for difference is:

- Corporate overheads
- Site specific grants
- Clinical education and research.
  - For more information visit: http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/national-efficient-price-determination-lp

Cost weights and trim points

Weighted Activity Units, or cost weights, are used to measure patient care. They are a standardised ratio of the average resource requirements for treating a patient and represent the complexity of a care type and how much it costs to deliver it



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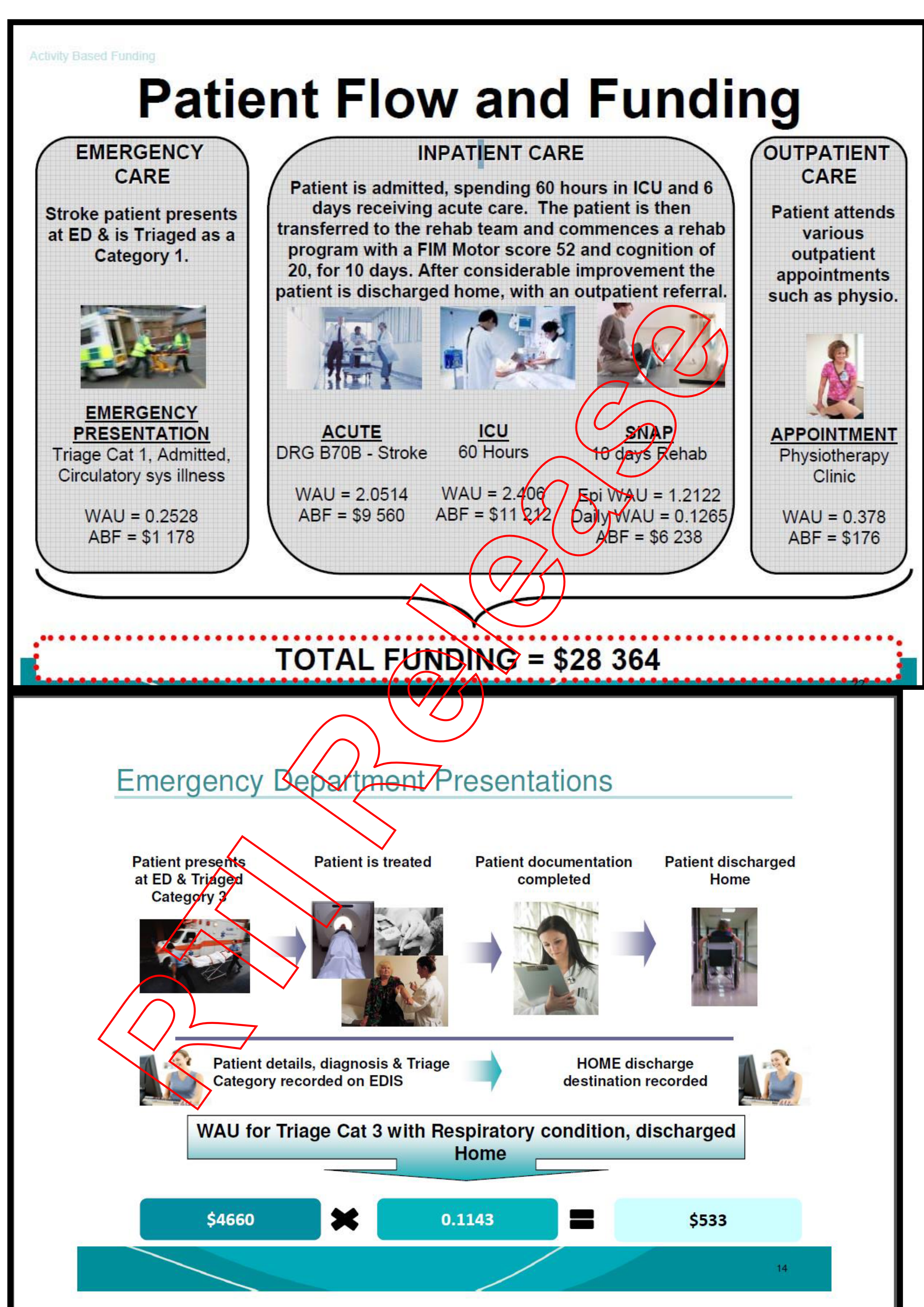

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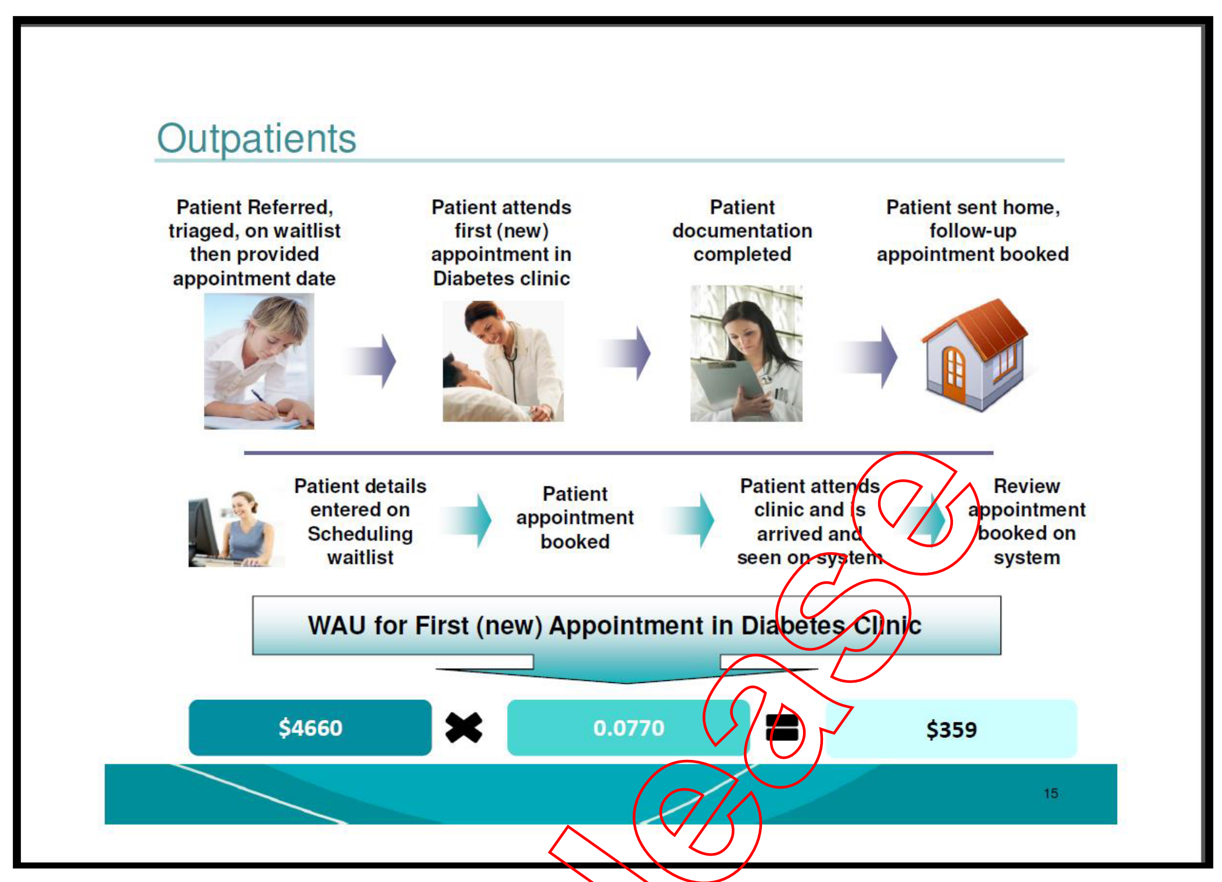

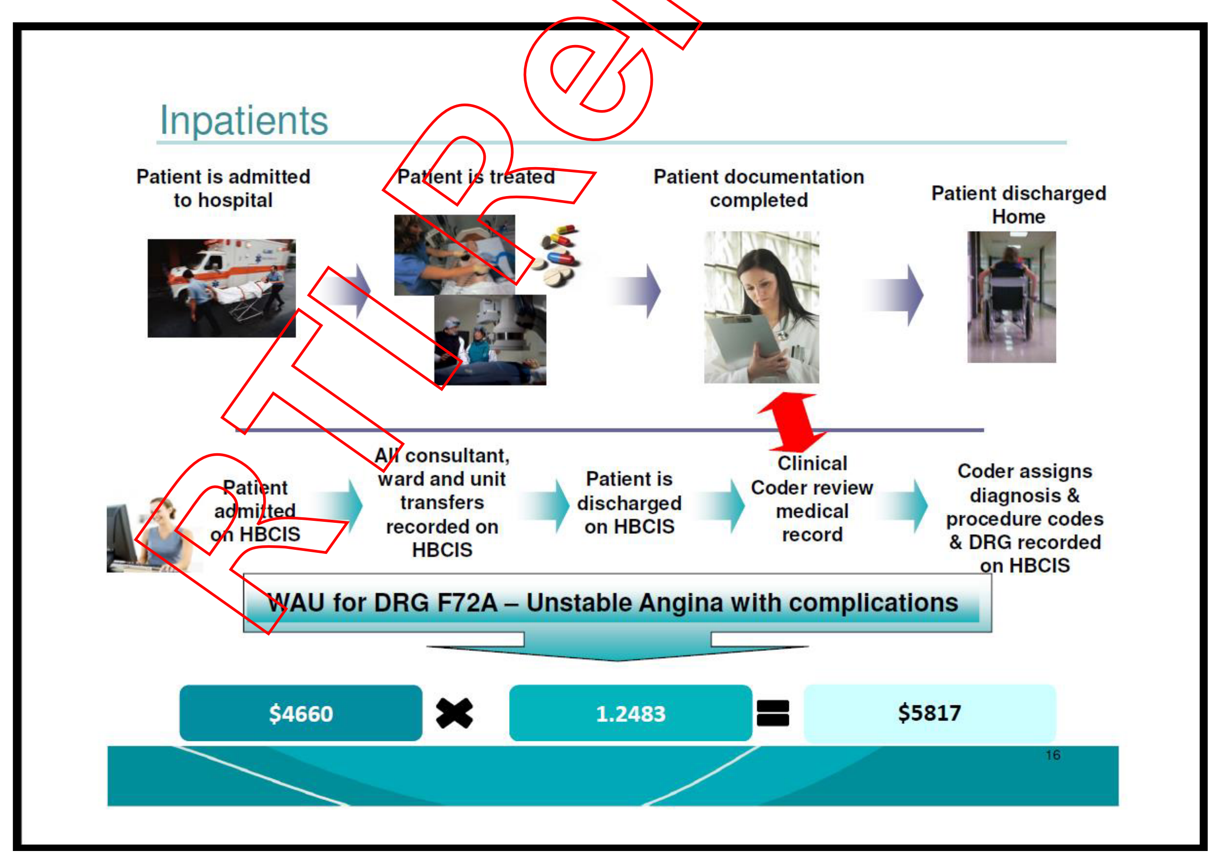

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- For more information visit:

  http://qheps.health.qld.gov.au/abf/home.htm
  http://qheps.health.qld.gov.au/nmoq/workforce/documents/ABF_Overview.pdf

- A block funding approach for small and regional hospital services – where funding is provided by historic block funding, based on the hospital's intention to treat patients (availability).
  http://www.publichospitalfunding.gov.au/national-health-reform/funding-what

Cross-border activity based funding

When a resident of one state receives hospital treatment in another state, the 'resident state' compensates the treating or 'provider state' for the cost of that care via a 'cross-border' payment.

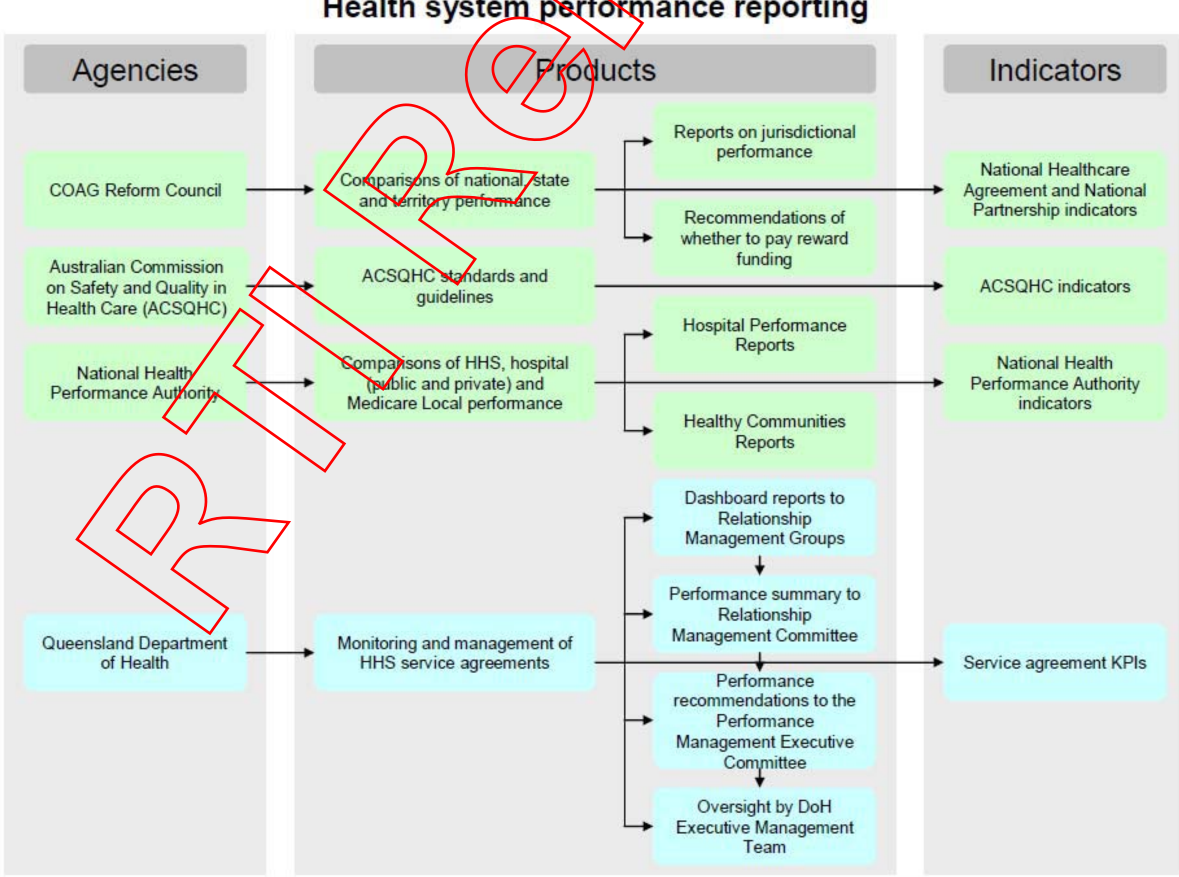
- For more information visit:

  http://www.publichospitalfunding.gov.au/national-health-reform/funding-what

- Nationally consistent classifications and data collection for hospitals.
  - For more information visit:

http://qheps.health.qld.gov.au/abf/html/002-how-fund-calc.htm

Figure A: Health System Performance Reporting



- Nationally consistent classifications and data collection for hospitals.
  - For more information visit:

http://qheps.health.qld.gov.au/abf/html/002-how-fund-calc.htm

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Funding models - Different payment systems from the Australian and International Health Care systems

Type	Description	Advantages	Disadvantages
Block Funding (still used for small and regional Australian public hospitals)	Traditional approach by government often based on historical levels of funding.	• simple to develop • simple to administer • budget and expenditure are predictable • can supplement other funding - target specific areas	• limited accountability • lack of transparency • no incentive to promote efficiency • does not promote equity
Population based funding	Payment for anticipated activity based on population. Based on measures of expected health need.	• aims to distribute funding equitably based on population need • can be simple to implement and understand • budget allocation and expenditure are predictable • service providers must understand their community and can promote them providing health promotion and prevention programs to remain financially viable	• selecting and measuring the right population measure may be difficult • may not result in equitable access due to service configuration and efficiency • health services with good reputations may attract patients from outside their area and be financially disadvantaged • not suitable for funding specialist and statewide services
Fee for service (primary health care and private specialists in Australia funded by Medicare and co-payment by consumer)	Funding provided on a per service basis. Common price per service.	• transparent and easy to measure output • funding level closely related to cost • removes incentives to reduce service delivery (e.g. no pressure to discharge patients early)	• may not result in equitable access to services • may provide incentives to over service • may provide incentives to select 'profitable' patients • may discourage innovation and efficiency gains
Casemix (ABF) Public hospitals in Australia	Health services are reimbursed for provision of patient care based on the type and mix of the patients treated. A set amount is paid to the provider based on the relative cost of the group to which the patient is classified.	• funding is transparent based on measurable outputs • promotes accountability • promotes technical efficiency • promotes innovation • financial risk is shared between the purchaser and the service provider	• requires significant infrastructure to establish i.e. classification, reporting, governance • funding does not necessarily equal cost • may provide incentives to select 'profitable' patients • may provide incentives to provide fewer services than what is clinically appropriate
Bundled payments Used by HMOs in the US and Primary Care Trusts in the UK	Episode based payment with reimbursement for provider bundled into a single, comprehensive payment that covers all of the services involved in a patients care. Focuses on specific conditions, such as those with defined time frames, defined services or based in specific care settings.	• goal is to improve population health, boost the patient experience and reduce costs • promotes control cost, integrates the care and restructure of the delivery of care • shares financial risk between funder and provider	• difficult to set prices – and if inappropriate price funding allocation will be inefficient • may promote providers selecting 'profitable' patients and providing fewer services than what is clinically appropriate

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Glossary

Terms	Proposed definition / description	Evidence reference / link
Acuity	The term acuity is used interchangeably with the complexity and intensity to identify service demand within outpatient and ambulatory health care services. Also known as client acuity	
ADO	Accrued Day Off (ADO) means a day accrued as a result of the method of working ordinary hours where employees are rostered off on various days of the week during a particular work cycle.	http://www.qirc.qld.gov.au/resources/pdf/awards/q/q0090_swc13.pdf
Benchmarking	Benchmarking is a way of measuring performance against a similar-sized service to identify how to improve.	http://www.business.qld.gov.au/business/starting/market-customer-research/benchmarking-business
Business plan	Referring to the HHS Strategic / operational plans.	http://www.health.qld.gov.au/services/default.asp
Casemix	Casemix is a generic term for a method of classifying the activities that health services deliver. It is a description of the mix and type of patients treated in a hospital. Casemix may be defined as an information tool involving the use of scientific methods to build and make use of classifications of patient care episodes. The term may be taken to refer to both: • the number and types of patients treated • the mix of bundles of treatments, procedures and so on provided to patients.	What is Casemix Funding
Client acuity	Within the BPF, the term client acuity is used interchangeably with complexity and intensity to identify service demand within health care services.	
Client complexity	A measure used to assist nurses and midwives in identifying and planning the resources required to meet the care demands of consumers.	
Clinical costing system	In brief, the clinical costing system does the following: • takes financial and patient information from feeder systems (e.g. DSS, Payroll, HBCIS) • organises financial information and patient utilisation into departments • costs products at department level • assigns products and costs to patients.	http://casemix.health.qld.gov.au/CC/costing.html
Clinical Service Capability Framework (CSCF)	The Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3.1 (CSCF v3.1) has been developed as a result of a review of version 3.0 which was released in 2011. The responsibility for implementing, monitoring, complying with and notifying changes in service levels in public health facilities will rest with Hospital and Health Service Chief Executive Officers. It is a classification of the capability a facility has to provide a service. For example, if a hospital has no orthopaedic surgeon then it does not have the capability of providing orthopaedic surgery.	http://www.health.qld.gov.au/cscf/
Cost Centre	A cost centre is an area where the costs for all services for a particular unit or setting are allocated.	http://qheps.health.qld.gov.au/financenetwork/financial_policy/docs/FMPM/fmpm_appendices.pdf
Diagnosis-related groups (DRGs)	A patient classification system used in Australia that groups similar diagnosis and procedure types together. This information is used to provide a meaningful and consistent way to clinically assess the types of treatment received and to inform activity costing processes for the purposes of activity based funding models, patient costing and benchmarking.	http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf http://qheps.health.qld.gov.au/abf/home.htm
Direct nursing / midwifery hours	The nursing / midwifery hours used to support direct care to patients / clients.	

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Terms	Proposed definition / description	Evidence reference / link
Episode of care	The period of admitted patient care between a formal statistical admission and a formal or statistical separation, characterised by only one care type. An admission may be 'statistical' in that the patient changed from one type of admitted patient to another (between any two of acute, rehabilitation, palliation, or non-acute) without being separated from the hospital.	LINK 1: http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf LINK 2: DSS casemix glossary
External environmental factors	Factors that are generally outside of the control of the business. This may include political decisions, technological changes, market demographics and competitor behaviour.	http://www.business.qld.gov.au/business/starting/market-customer-research/swot-analysis/example-swot-analysis
Fixed costs	Costs which do not change as volume changes.	Nil available
Forecast	A prediction of some future value e.g. activity levels, acuity levels, nursing and midwifery hours required.	Nil available
Fractional bed day	Actual hours a bed is occupied.	
Full-time equivalent (FTE)	The number of employee hours (paid, unpaid or contracted hours) divided by the Award standard hours per fortnight.	http://qheps.health.qld.gov.au/financenetwork/financial_policy/docs/FMPM/fmpm_appendices.pdf
Appointed FTE	Number of FTE that are appointed / used against established positions.	http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/procedures/fte_budfte_paper.pdf
Approved FTE	Number of FTE that are approved, and have been established within the payroll system. A position, for example, may be generic to five staff who are all setup against one position as represented in a position occupancy report.	
Budgeted FTE	Positions that are captured when developing the annual budget for the respective business unit. Budgeted FTE are the funded positions that are likely to be filled during the financial year. Budgeted FTE includes overtime and external FTE.	http://qheps.health.qld.gov.au/financenetwork/bud_fore_data_ana/docs/bus_ana/procedures/dis_bfte_upl_ins.pdf
Hospital and Health Service (HHS)	A HHS is a statuary body with a Hospital and Health Board, accountable to the local community and the Queensland Parliament.	http://www.health.qld.gov.au/health-reform/
Indirect nursing / midwifery hours	Indirect clinical hours - activities undertaken which benefit the patient / client while not in direct contact with them, including education and training on the clinical unit, mandatory competence attainment, quality improvement activities, portfolio activities, performance appraisal and unit orientation time.	
Internal environmental factors	Factors that are generally internal to the business and therefore can be influenced by the business. This may include: funding that is available, resources / staff and current processes.	http://www.business.qld.gov.au/business/starting/market-customer-research/swot-analysis/example-swot-analysis
MOHRI Occupied FTE	MOHRI stands for – Minimum Obligatory Human Resource Information. It is a Whole of Government (WoG) methodology for producing an Occupied FTE value sourced from the QHealth payroll system data for reporting and monitoring. The data reported is based on the cost centre that the position is assigned to in payroll. MOHRI FTE is calculated by dividing the contracted employee hours into the award standard hours that the employee should work.	http://dss.health.qld.gov.au/dss/docs/MOHRI_Occupied_FTE_and_Headcount_explanation.pdf
MOHRI Occupied FTE (Diagram)	Refer to diagram in link	http://dss.health.qld.gov.au/dss/docs/explanation_diagram_mohri_vs_qh_fte.pdf
Non-productive nursing and midwifery hours	Paid, non-worked hours where the employee is not physically contributing to patient care. This can also be measured through a non- productive FTE and includes annual leave, sick leave, paid parental leave, work cover leave.	
Nurse Sensitive Indicator (NSI)	Nurse Sensitive Indicators (NSI) capture nursing contributions to health care outcomes through collecting process, structure and outcome measures such as workforce and patient outcome indicators.	http://qheps.health.qld.gov.au/nmoq/profession/nsi_about.htm

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Terms	Proposed definition / description	Evidence reference / link
Nursing and midwifery hours per patient day	The average nursing and / or midwifery hours per unit of activity for hospital inpatients.	
Nursing and midwifery hours per occasions of service	The average nursing hours per unit of activity for ambulatory patients (e.g. Emergency Department, outpatients).	
Occasions of services	Any examination, consultation, treatment or other service provided to a non-admitted patient in a functional unit or a health service facility.	
Occupied bed day (OBD)	The occupancy of a hospital bed by an inpatient for up to 24 hours.	http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf
Operating expenses	The costs associated with the operations of the service. This includes all overhead, fixed and non fixed costs.	
Patient Dependency System (PDS)	A system that classifies patients according to the intensity of nursing / midwifery care needs and therefore indicates the amount of nursing hours required.	http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf
Productive nursing and midwifery hours	Productive hours are the hours that an employee is paid for which directly contribute to patient care. When measured through FTE, this includes base salary and wages, overtime and recall. In the Business Planning Framework, the definition of productive hours also includes study and training leave. It is important to note that from a financial perspective study and training leave are measured as non-productive FTE.	Only reference is in BPF documents
QH FTE	Internal QH mechanism for measuring FTE. It is reported based on the cost centre the employee is paid from in payroll and may NOT be the same as the cost centre assigned to the position worked in. QH FTE is calculated by dividing the actual hours worked into the award standard hours that the employee should work.	http://qheps.health.qld.gov.au/financenetwork/financial_policy/docs/FMPM/fmpm_appendices.pdf
Scorecards	Scorecards are a collection of management reporting tools used to measure the performance or a respective business area or unit against the objectives outlined within the operational plan or service level agreement.	http://dss.health.qld.gov.au/dss/docs/scorecard_intro.pdf
Service agreements	An agreement between Queensland Health and each HHS. It explains how funding is allocated and provides details about HHS performance and includes a protocol for managing concerns about performance when they arise.	http://www.health.qld.gov.au/hhsserviceagreement/default.asp
Service profile	Describes the role and function of a service.	http://www.health.qld.gov.au/services/default.asp
Skill mix	Skill mix refers to the diversity of the skill sets and training required to meet patient needs.	
Staffing plan	A document which identifies the numbers and categories of staff members required for patient / client care	
Standard FTE	Standard FTE is the performance reporting FTE for Queensland Health (QH) and is a key performance indicator in the Queensland Health Scorecard. Standard FTE includes all paid hours, including overtime, sick leave, special leave and maternity leave with pay. It excludes unpaid, long service and recreation leave. Penalties and back pays do not result in the production of an FTE figure and therefore are not included in any FTE calculations.	-
Strategic plan	Strategic Plan for Department of Health, HHS & individual hospitals, streams, divisions, units	http://www.health.qld.gov.au/about_qhealth/strat_plan/12-16/
SWOT analysis	A SWOT analysis is a tool for documenting internal strengths (S) and weaknesses (W) in your business, as well as external opportunities (O) and threats (T). You can use this information in your business planning to help achieve your goals. To work out if something is an internal or external factor, ask yourself if it would exist even if your business didn't. If it would, then it's an external factor (e.g. new technology).	http://www.business.qld.gov.au/business/starting/market-customer-research/swot-analysis

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Terms	Proposed definition / description	Evidence reference / link
Variance	A variance is defined as any difference to the proposed	
Variance analysis	Investigation into the reasons for any differences between the actual results and the expected / forecast results. • For example, variance analysis is conducted to explain differences between the planned nursing hours and the actual nursing hours used within the rostered period or the actual expenditure against the forecast expenditure for the month.	
Weighted Activity Units (WAU)	Value applied to the activity of hospitals that denotes the amount of resources used. The greater the WAU, the higher the resource usage.	http://qheps.health.qld.gov.au/ppb/docs/qms/data/gdl206_data_guide.pdf
Year-to-date	A measure of the position from the start of financial year to the current date. Used to inform financial reporting for example to give an indication of the performance to date.	

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Natalia Rosenblatt

From: s73 Irrelevant Information @qnu.org.au>
Sent: Wednesday, 21 October 2015 2:11 PM
To: CNO_ESO
Subject: Career and Classification Working Group final report - NaMIG
Attachments: 111219 - Draft Classification and Career Structure Final Report.doc

Hi Di,

Given the upcoming two day workshop via NaMIG to progress the career and classification structure body of work, we're currently re-acquainting ourselves with what was undertaken during EB7 re same. To that end, I wanted to enquire whether a final report was ever published for the project and, if so, whether you could send me over a copy? All I'm able to locate is the attached final draft published in late 2011.

Regards and thanks,

s73 Irrelevant Information
s73 Irrelevant Information
Secretary to Professional Officers
Queensland Nurses' Union
Phone: 07 3840 1409
Email: s73 Irrelevant Information @qnu.org.au
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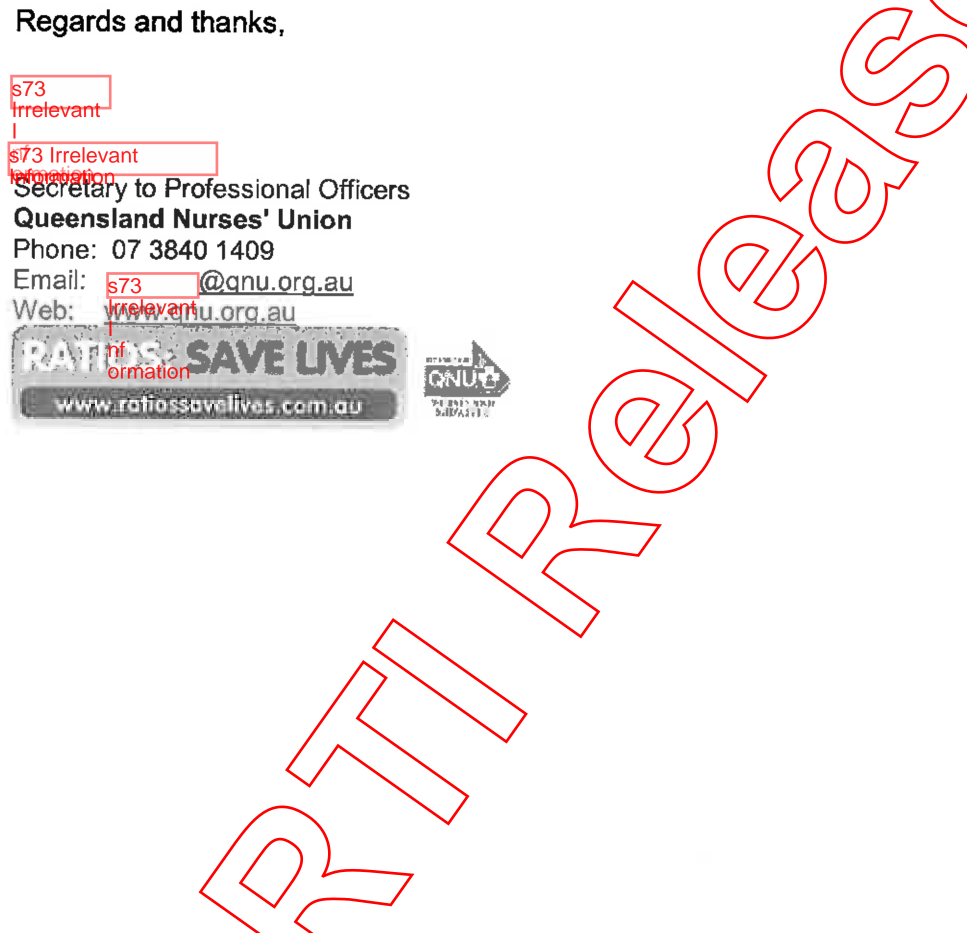

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Nurses and Midwives Implementation Group

Classification and Career Structure

Refinement and Enhancement

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PROJECT REPORT

Collaborative Project – Queensland Nurses' Union/Queensland Health Nurses and Midwives Implementation Group (NAMIG)

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Review date:	August 2014
Endorsed by:	Nursing and Midwifery Office, Queensland and the Enterprise Bargaining 7 Nursing and Midwifery Implementation Group
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This Project was been executed by Queensland Health under the collaborative sponsorship of the Human Resources Coordination, Nursing and Midwifery Office, Queensland and the Queensland Nurses Union.

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	Salt Design

Associated Projects

This project collaborated closely with the following projects:

- Business Planning Framework Refinement and Enhancement
- Working Arrangements; and
- Models of Nursing and Midwifery

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Close collaboration with Phase II of the Role of the Nurse Unit Manager and Role of the Nurse Educator Projects were integral to the success of this project.

Thanks is also given to the nurses and midwives working within Queensland Health for 1) contributing to this project and 2) their focus on delivering excellent standards of evidence based patient care each day to the people of Queensland.

Disclaimer

This report has been prepared from the EB7 project scope by the *Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009*, Nursing and Midwifery Workforce Planning Strategy, Project Scope Management Plan.

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1. Executive Summary

This report has been prepared from the EB7 Project Scope Management Plan developed as a result of the *Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009*. The 12 grade nursing and midwifery classification structure was introduced following the previous round of enterprise bargaining. The classification structure and Generic Level Statements were developed in recognition of the expanded roles of nurses and midwives within Queensland Health. The purpose of this review was to refine and enhance the current nursing and midwifery classification structure.

The *Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009 ('the Agreement'): 25.6.4 Classification and Career Structure - a review of the existing classification and career structure focusing on the Generic Level Statements and definitions to support contemporary models of nursing and midwifery. There will be a focus on optimizing the utilization of roles within the structure with a particular emphasis on key roles such as enrolled nurses, midwives, nurse practitioners and nurse unit managers. The work undertaken in these areas will inform the career structure review.*

The aim was to enhance the current Generic Level Statements and definitions to reflect contemporary nursing and midwifery roles. It was agreed that any new structure should provide opportunities for career progression and also embrace innovation to improve the status of the profession as it meets technological and population demands.

The project has been conducted over an 18 month period, which included a Discovery Phase that consulted with over 600 Queensland Health nurses and midwives consulted through over 70 focus groups. This consultation provided nurses and midwives the opportunity to reflect on their roles and validate the currency of the Generic Level Statements, which overall, demonstrated they remain a reliable tool from a general, broad, non-specific description of skills, knowledge and behaviour required to perform at each classification level.

The feedback from the Discovery Phase used to refine and enhance the former Generic Level Statements in the *Nurse (Queensland Health) Section 170MX Award 2003,* the Nursing and Midwifery Classification Structure - Human Resources B7 policy and most recently the *Queensland Health Nurses and Midwives Interim Award – State 2011* ('the Award'*)*; has resulted in Revised Generic Level Statements, with Explanatory Notes. The National Competency Standards for Enrolled Nurses, Registered Nurses, Midwives and Nurse Practitioners was cross-referenced, wherever possible.

The project also provided an opportunity for nurses and midwives to identify their anomalies and issues around the classification and career structure, and state their views on what is often not explicitly articulated in the work context of nursing and midwifery. Many requested their issues be explicitly expressed in industrial frameworks, as is the case for other health professions within Queensland Health. This and other related feedback resulted in the drafting of Explanatory Notes to accompany the Revised Generic Level Statements, as a mechanism to address many of the identified anomalies and issues, as described in this report.

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1.2 Project Context

The *Nurses (Queensland Public Hospitals) Award 1991* was varied by consent order of the Australian Industrial Relations Commission on 27 November 1992 (order effective from June 1992) to provide the first nursing career structure. It consisted of five grades, from Registered Nurse (level 1) through to Director of Nursing (level 5). Various iterations followed with varying impacts and name changes.

As part of the *Nurses (Queensland Health) Certified Agreement (EB6) 2006*, Queensland Health and the Queensland Nurses' Union developed and implemented the new grade classification structure for nurses and midwives being grades 1 to 12 (prescribed at Schedule 6 of the Agreement). The 12 grade classification structure recognised the expanded roles of nurses and midwives in Queensland Health and aimed to improve cohesion of the nursing and midwifery workforce.

Comment [AG1]: ? Sched 6

The introduction of Queensland Health policy IRM 4.8-2 Nursing and Midwifery Classification Structure in September 2007, and later B7 Policy, incorporated the new 12 grade classification structure and defined in the process for the evaluation / re-evaluation of positions based on the developed generic level statements. The generic level statements are to be read in conjunction with Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009 and Schedule 4 of the Agreement (*Nurses (Queensland Health) - Section 170MX Award 2003*).

The Nursing and Midwifery Classification Structure - Human Resources Policy B7 (*'B7 Policy'*) published in May 2008, describes in detail the process for evaluation and re-evaluation of nursing and midwifery positions under the 12 grade structure. The Generic Level Statements are to be read in conjunction with Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009 and Schedule 1 of the *Queensland Health Nurses and Midwives Interim Award – State 2011.*

When the re-classification or development of new roles has been undertaken over the last two years, this has been performed at a district level, and if no agreement was reached, matters were referred to Human Resources Coordination. Fifteen cases have been reported to corporate office during this time, which indicates overall a high acceptance of the classifications in this time period.

As one of the four projects to be addressed during the life of the EB7 Agreement, the *Nursing Classification and Career Structure Refinement and Enhance Project* scope was to focus on the refinement of descriptors and Generic Level Statements to be addressed during the life of the EB7 Agreement, the *Nursing Classification and Career Structure Project* was to focus on the refinement of descriptors and generic level statements that reflect and define contemporary nursing and midwifery roles. Preliminary semi-structured interviews with members from the Nurses' and Midwives' Implementation Group (NAMIG) identified a number of anomalies and ambiguities.

This project was identified as a priority area of work to form an important part of a sustainable nursing and midwifery workforce planning strategy for Queensland Health. The needs of clients remain the central concern of the project and provide the basis for a clinical culture that will demonstrate effectiveness and efficiency within Queensland Health together with an improved professional culture through a well trained, flexible health workforce. This means one that can respond to changing models

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of care, developing evidence-based practice and able to provide high standards of nursing care together with a multitude of other factors affecting future health service delivery in Queensland.

1.3 Project Overview

At the commencement of this project, there was common understanding between Queensland Health and its stakeholders that a nursing career can span at least four streams during a nurse's lifelong learning and development: clinical practice (general, advanced or specialised), management, education and research. These career streams intersect with the 12 grade classification structure but are currently not considered to be clearly articulated as a career pathway within the existing salary spine. This articulation could provide a matrix rather than linear approach to more visible career pathways.

It was originally considered that work level statements should reflect the context and functions of each contemporary and emerging nursing role within the classification structure across all settings. However, while the Generic Level Statements are sometimes vaguely defined around scope, accountability and level of skills and knowledge, they are by nature generic. Generic, as defined by the Oxford Dictionary, used as an adjective, means characteristic of or relating to a class or group of things; not specific.. At the March 2011 NaMIG meeting it was agreed that there would only be Generic Level Statements, not Work Level Statements. Work Level Statements are more behaviourally specific to the context.

Advanced practice is context-specific and cannot be adequately described in Generic Level Statements as the skills, knowledge and behaviour for advanced practiced in one setting may differ substantially to advanced practice in another setting. Advanced practice is currently being more carefully defined in the national context. To date there has been no explanatory notes in the Awards around the Generic Level Statements, or how they should be applied. While there is B7 Policy, it discusses recruitment and evaluation of positions and has not to date addressed the specific anomalies raised throughout the Discovery Phase of the project

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1.4 Project Implementation

This project performed both an impact and outcome evaluation of the previous Classification and Career Structure with the aim to obtain the following:

- the scope and nature of current work performed by various nursing and midwifery roles (specifically grades 4-8, and 9-10) across various clinical settings and geographical contexts
- a comprehensive understanding of role functions within clinical practice, current and emerging models of care
- revised Generic Level Statements for each of the 12 classification levels
- points of differentiation for advanced levels of clinical practice and career streams.

There was consultation with all parties, including the QNU through the Project Reference Group (detailed in Addendum 1) and the Directors of Nursing and Midwifery Advisory Committee (DONMAC) on how best to perform the consultation and capture the data. A range of methods was proposed such as surveys, interviews with key experts, focus groups and a continuous review of the literature and evidence base (Addendum 9) to support the nursing classification and career structure.

The methodology and project implementation are documented in Addenda 4 – 6. Addendum 7 describes the Issues and Anomalies identified by the Queensland Health nursing and midwifery workforce,.

Regular updates were provided to the Project Reference Group, Nurses and Midwives Implementation Group, Directors of Nursing and Midwifery Advisory Committee, Chief Nursing and Midwifery Officer and the Workplace Relations Unit through reports and presentations at meetings. There was considerable dialogue between the parties about the Classification and Career Structure's refinements and enhancements, and a range of views on the plethora of anomalies and issues proposed through the Discovery Phase. There was agreement through this dialogue that a number of these anomalies and issues require further consideration in enterprise bargaining negotiations and are proposed in Additional Matters.

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2.0 Additional Matters

The following anomalies, issues or potential solutions have been discussed by the parties throughout the life of the project at Project Reference Group and Nurses and Midwives Implementation Group meetings and deemed noteworthy for further consideration.

It was agreed during the development of the Project Scope that anomalies and issues raised during the Discovery Phase of the project were all of value despite some as out-of-project scope. All anomalies and issues have been included in the information provided to all stakeholders, to inform organisational priorities and future enterprise bargaining agreements.

~~Agreed Outcomes~~Matters generally agreed to by the Project Group for reference to NaMIG / EB Forum:

- ~~1.~~ Work Value Assessment - Refer Addendum 6, page 37 and Addendum 14, page 82
  - ~~a.~~ A proposed centralised governance process for work value assessment of Grades 7 – 12 and the stewardship of the Generic Level Statements, based on two principles of self-governance for nursing and midwifery and equity, agreed by members. (~~See~~ Refer Flowchart Page 138~~, Addendum 12, Revised Generic Level Statements with Explanatory Notes~~).
- ~~2.~~ Compression of Grades – Refer Addendum 6, page 33
  - ~~a.~~ No compression of grades 11 and 12 or grades 9 and 10.
- ~~3.~~ Nurse Grade 7 – Refer Addendum 6, page 34
  - ~~a.~~ Public Health nurses and Nurse Practitioner Candidate, grade 7, to be removed as specific classifications.
- ~~4.~~ Enrolled Nurse-Advanced Practice – Refer Addendum 11, page 49
  - ~~a.~~ The Enrolled Nurse-Advanced Practice role requires guidelines through a statewide HR policy to inform and educate nursing and midwifery managers and executives about the process for embedding this role in their units, services or divisions.
- ~~5.~~ Midwifery nomenclature – Refer Addendum 6, page 36
  - ~~a.~~ Midwifery nomenclature incorporated where possible to include the midwifery setting. This does not include the grade 8 level where a midwife must be a Nurse Practitioner and a Midwife.
- ~~6.~~ Scope of practice
  - ~~a.~~ Nurses and midwives working to their full professional capacity.
- ~~7.~~ Inclusion of desirable qualifications in role descriptions
  - ~~a.~~ Queensland Health role descriptions to include the following desirable qualifications:
    - ~~i.~~ Assistant in Nursing – Certificate III (Refer Addendum 10, page 48); and
    - ~~ii.~~ Enrolled Nurse–Advanced Practice – Advanced Diploma.

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2.1 Further Matters in-project scope proposals for EB8 negotiations For further discussion at NaMIG / EB Forum

In-scope

- Generic Level Statements – Refer Addendum 12, page 52
  - The revised Generic Level Statements with explanatory notes, including the four stream classification structure i.e. clinical, management, research and education.
- Work value assessment – Refer Addendum 14, page 82
  - A revision of the B7 Policy Attachment 3 *Grades 9 - 12 Evaluation Guide* is required. There has been no agreement on a robust instrument for considering the complexity of the role and its environment for Grades 7 – 12.
- Advanced practice roles – Refer Addendum 6, page 37
  - Possible expansion of Grade 8 roles to include Sole Practitioners and incorporate into the career structure and Generic Level Statements.
- Nurse/Midwife Unit Manager – Refer Addendum 6, page 32
  - Workload of the Nurse/Midwife Unit Manager needs to be considered compared to other Grade 7 roles, as addressed in the *Nurse Unit Manager Project Report*, and specifically principles 5 and 6.

Out-of-scope

2.2 Further Matters out-of-project scope proposals for EB8 negotiations

- Fatigue management – Refer Addendum 6, page 33
  - On call arrangements for Directors of Nursing, Grade 10 remains a workload and fatigue management issue and requires a review. It was agreed that the Director of Nursing title remain an incentive for those rural and remote positions. This includes consideration of whether the Sole Practitioner is appropriately graded and remunerated.
- Clinical preceptor-ship
  - Recognition of the additional workload and burden placed upon many nursing and midwifery staff working in direct care by student placements and new graduate mentorship while maintaining usual workloads
- Regional, rural and remote – Refer Addendum 6, page 39
  - Better clinical education pathways for most settings and facilities.
  - More Clinical Nurse or Midwifery Educators/Clinical Facilitators for new graduates.
  - Reconsideration of rural and remote incentives. The Remote Area Nursing Incentive Package (RANIP) has not increased since 1995.
- Nurse Practitioners – Refer Addendum 8, page 45

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- Right to private practice arrangements and the opportunity to review employment arrangements under this model.
- Succession planning, leave relief and lack of flexibility in work arrangements for Nurse Practitioner to improve work life balance – across Local Health and Hospital Networks locum arrangements.
- Professional development allowance for Nurse Practitioners requires alignment with the national registration requirements.

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Proposed centralised governance process for work value assessment of Grades 7 – 12: Refer Work Value Assessment page 11

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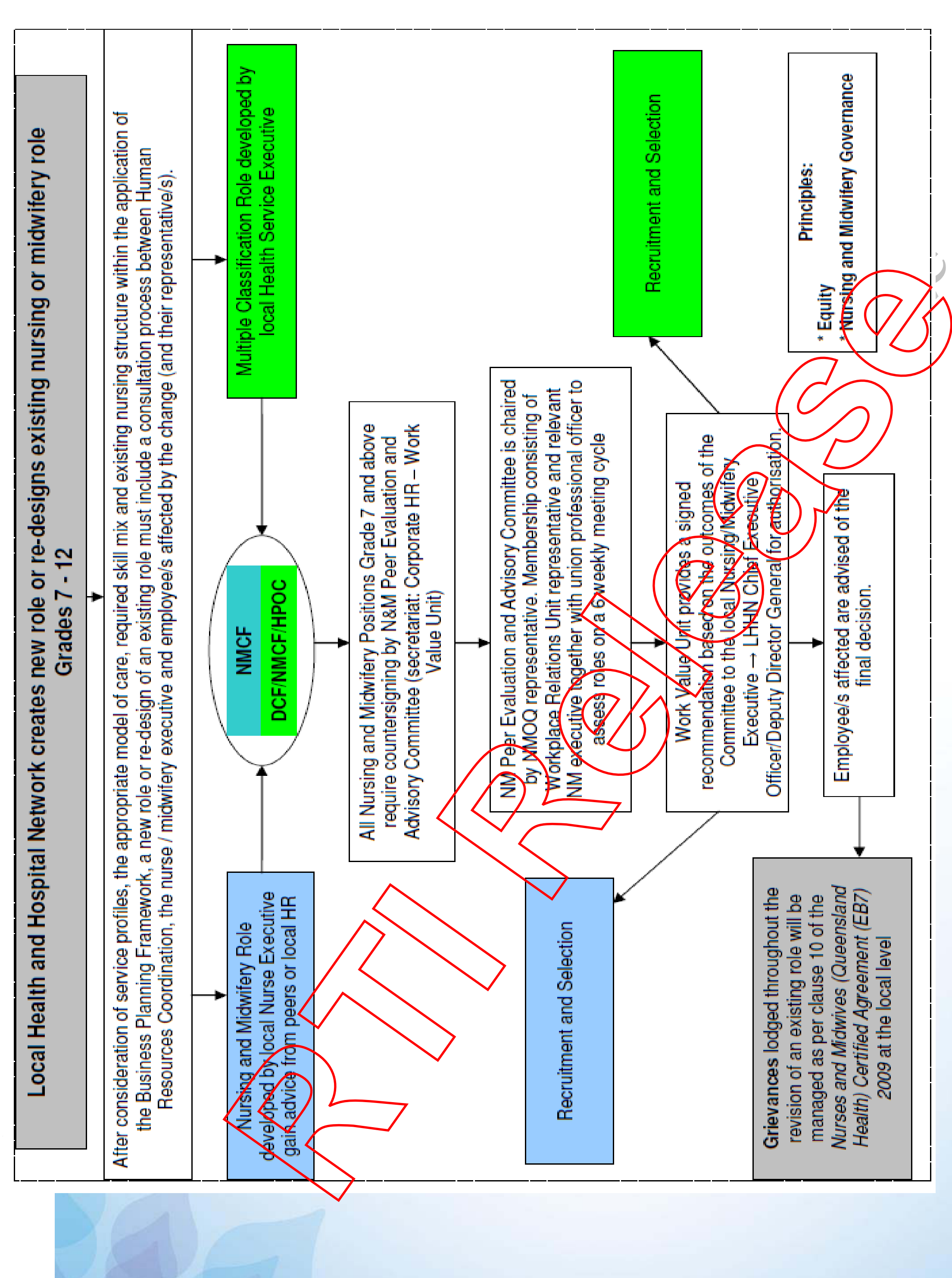

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~~2.3~~2.2 CONCLUSIONS

The rapidly changing and increasingly pressured health service delivery environment has impacted upon the nursing and midwifery profession. This has been concurrent with over two decades of university educated registered nurses and midwives entering the Queensland workforce and an increasingly professional profile of nursing and midwifery as career choices. The scope of each nursing and midwifery role is becomingly increasingly complex, both within the profession and with other professions within the clinical workforce.

The overall purpose of the project refine and enhance the existing Classification and Career Structure is to support the recruitment and retention of Queensland's nurses and midwives in their delivery of safe, high quality health care. The clearer articulation of the career pathways within the existing salary spine will ensure that across the four stream of clinical, management, education and research roles continue to develop and mentor our nurses and midwives to meet the demand of service delivery.

National health reform and national regulation may provide the perfect environment in which nursing and midwifery roles are further standardized according to Duffield et al. Additionally it may provide fertile ground for sharing the plethora of models of care that are evolving, and will continue to evolve in an attempt to meet the increasing demand for health care.

~~2.4~~2.3 THE WAY FORWARD

This has been a difficult piece of work for a multitude of reasons: the complexity of trying to align role with functions and the project's narrow scope of refinement and enhancement and, with no inclusion of a job evaluation methodology (work level determination). There needs to be a non-partisan objective assessment of how nursing and midwifery can move forward using the evidence base of other Australian jurisdictions who have implemented an objective tool to align their nursing and midwifery roles.

A clear, concise Nursing and Midwifery Career Structure will assist the workforce across all settings to clarify roles and responsibilities in a changing environment.

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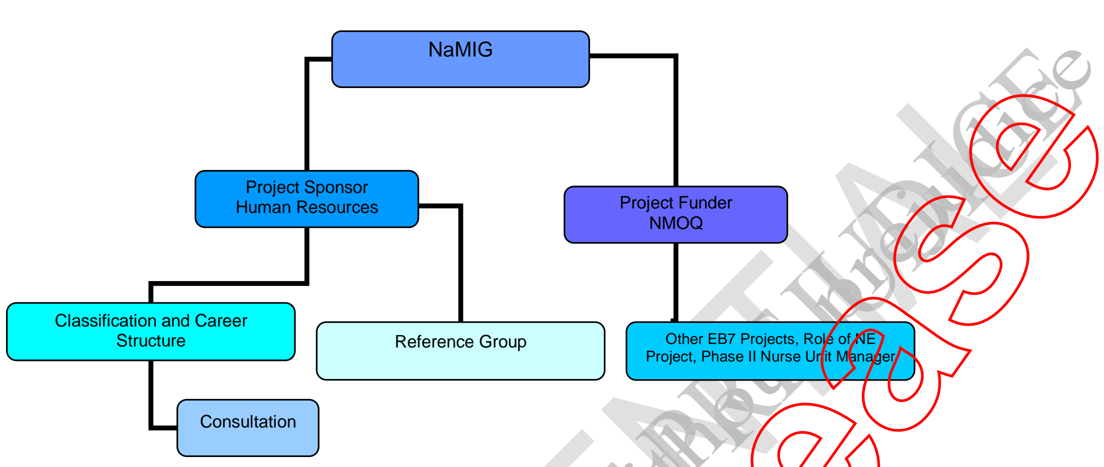
ADDENDUM 1: PROJECT GOVERNANCE



A Classification and Career Structure Project Strategic Reference Group was established to provide consensus on strategic oversight and leadership. Terms of Reference were developed collaboratively and endorsed by the Reference Group members, listed below on 22 October 2010:

Chair: Helen Ceron, Deputy Executive Director, HR Coordination / Nicholas Ede, Director, Capacity Development / Work Value, HR Coordination

Members: Diana Schmalkuche, Director of Nursing, Nursing and Midwifery Office Queensland

Michael Reeves / Kylie Badke, Program Manager, Workplace Relations Unit

Don Hamilton, Program Manager, Work Value Unit

Veronica Casey, Executive Director of Nursing (EDON), Metro South Health Service District (HSD) – Project Champion

Lesley Fleming, EDONM, Royal Brisbane & Women's Hospital – Project Champion

Shirley Godfrey, District Director of Nursing (DDON), Central West HSD / Michelle Garner, District Director of Nursing, Mt Isa HSD

Nursing Director – Education and Training, ClinEdQ

Kym Barry, Professional Officer, Queensland Nurses' Union

Juliana Virine / Mark Dougherty, Industrial Officers, Queensland Nurses' Union

The Project Reference Group aimed to meet every second month, or monthly when required. There were a range of views on the plethora of issues arising from the Project's Scope, and these were recorded through the Minutes.

The other party to the Agreement, the Australian Workers' Union (AWU) was consulted and informed

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through regular updates by the Project Manager to the AWU Implementation Group.

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ADDENDUM 2: METHODOLOGY

The Project Implementation Strategy was endorsed by the Project Reference Group on 22 November 2010.

2.1 Methodology Design

The following is a summary of the project methodology. It was important that the design of the project methodology was capable of generating reliable information about the current duties and responsibilities undertaken by nurses and midwives assigned to each of the 12 classification grades.

In addition to the project scope, project methodological considerations were influenced by the scale of work and affected employees, the clinical setting in which nursing and midwifery work is performed, the characteristics of the work and the sources of data. Details of the current headcount distribution of nurses and midwives across the respective classification levels are detailed in 5.2 Findings.

This posed challenges for the level and nature of employee inclusiveness in data and information collection. However design advice provided by Queensland Health's Measurement, Redesign and Analysis Team from the Patient Safety and Quality Improvement Service made the following recommendations on sample sizes. The use of third party contributions (supervisors, professional peers and subject matter experts) were also incorporated.

2.2 Sample size representative of the Population

Consulting a representative sample of Queensland Health's 2011 32,431.53 nurses and midwives (Source: HR Informatics 2011) was essential to achieving an evidence base for this project, in order to make reliable and valid findings. The sample size of at least 200 people demonstrated enough reliable data upon which the project team could draw conclusions.

Lower level grades where the differential between the grades was based on qualifications or training was assessed as less necessary to sample from unless there were conditions which would create them working beyond their scope of practice. Hence a Desktop Review of Grades 1-4 was agreed, and the following Recommendations were included in the Executive Summary.

A sample of around 25-30 from each of the Grades (4 upwards) was sufficient to establish if an anomaly was present or absent. The reasoning for what may be considered a 'small' sample size is based on the assumption that the anomaly was either present or it was not present.

2.3 Clinical Setting

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The clinical setting is influenced by:

- service types – aged care, acute, mental health, maternity, community, public health, emergency critical care;
- location – metropolitan, regional, rural and remote;
- clinical services capability framework (CSCF) – levels 1-6

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ADDENDUM 3: PROJECT PLAN DELIVERY

3.1 Project Purpose

The purpose of this Project was to refine the Generic Level Statements and descriptors of the current nursing and midwifery classification structure in the *Nurses (Queensland Health) Section 170MX Award 2003*.

As a result of this project, the following outcomes were sought:

1. Descriptors and Generic Level Statements, which better reflect contemporary and new nursing and midwifery roles for each of the classifications that are sensitive to the contextual settings Queensland Health nurses are employed in;
2. clearer role delineation and increased recognition of available career paths to assist in the attraction, retention and professional development of nurses and midwives;
3. information and data identified or collected through the consultation and review process but was extraneous to the scope of this project has been collated as reference material for the parties' future consideration; and
4. recommendations from the project were to be made and may be referred to NaMIG.

To be able to refine and enhance the current role descriptors and for these roles to develop clearer role delineation and career paths, it was an imperative that the project team have the opportunity to consult with homogenous focus groups, understand the core scope of practice for each classification level and validate the current descriptors, identify anomalies/issues and where appropriate, propose alternatives.

The Project's briefing and scoping was all developed on the *Nurses (Queensland Health) Section 170MX Award 2003*. The *Queensland Nurses and Midwives State Award 2011* was not released by the Australian Industrial Commission until mid 2011. The Project Team was made aware by the Workplace Relations Unit Program Manager in April 2011 that the new Award would be imminent but was not available until July – August 2011. This Project used the Generic Level Statements in the former document, *Nurse (Queensland Health) Section 170MX Award 2003*, as the Generic Level Statements for the purposes of the Discovery Phase (January-April 2011), outlined further in the Project Methodology section of this report. However, a merged and compared document with *Queensland Nurses and Midwives State Award 2011* Schedule 1 and the Revised Generic Level Statements with Explanatory Notes is available for perusal from Workplace Relations Unit.

The Workplace Relations Unit Program Manager in April 2011 advised the Project Team that the Generic Level Statements proposed by this Project would supersede the new Award, and this message was discussed at the July Project Reference Group meeting with all members. This was also part of the presentation this Project made at the August 2011 NaMIG workshop, and there was apparent agreement around the table that this was to be one of the major deliverables of this Project. This was also reported through to the Chief Nursing and Midwifery Officer.

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3.2 Objectives

The objective of this project was to refine and enhance the classification and career structure for nurses and midwives and the current Generic Level Statements and definitions. The project focused on key roles such as:

- midwives
- enrolled nurses
- nurse managers and other grade 7 descriptors
- nurse practitioners

Performance indicators for these objectives were to be:

- work level statements and definitions that align to actual job requirements, including core functions
- match between competencies, duties and classification; and
- improved status of the profession.

Post-project performance measurement:

- As guided by stakeholder and employee feedback – local employee measures for opportunities and job satisfaction – completion of staff survey.

3.3 Critical Success Factors

- Communication between key stakeholders involved in this project
- Production of sensitive descriptors and Generic Level Statements to reflect contemporary models of care
- All critical time frames and deliverables are met.

3.4 Project scope

The Project was designed to focus on optimizing the utilisation of roles within the existing structure using definitions that capture and are sensitive to the variety of settings and complexities in which Queensland Health nurses and midwives are employed.

i. Out of scope

- Rights to private practice arrangements and the opportunity to review employment arrangements under this model
- Succession planning, leave relief and lack of flexibility in work arrangements for NP to improve work life balance – across statutory bodies arrangements
- Professional practice requires Nurse Practitioners to undertake education and research activities within their existing workload and roster (equivalent wording to the Health Practitioner Award)
- Professional development allowance for NP is inadequate given the additional national registration requirements for an additional 10 points related to endorsement

ii. Inclusions

- Revised descriptors and Generic Level Statements

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- Understanding and considering role ambiguities, where they exist
- Aligning roles and functions with skills and responsibilities through accurate Generic Level Statements across streams
- Advanced and specialised clinical practice, and subsequent equivalency across management, research and education streams

iii. Assumptions

- The revised descriptors and level statements will be ready for inclusion in EB8 in 2012.
- Cost implications of any proposed changes will be considered in a separate government process and may form part of future enterprise bargaining agreements; and
- A career structure is a complementary but separate function of this project; however the revised descriptors and level statements should support clearer career pathways for nurses and midwives.

iv. Constraints

- As proposed national health reforms are being implemented during the course of this project, as much synergy as possible with the changing systems and models of care will be encapsulated.
- The move to national registration (from the Queensland Nursing Council to the Australian Health Practitioner Regulation Agency/Australian Nursing & Midwifery Council) occurred from 1 July 2010. Consistent nomenclature between jurisdictions would be a logical consequence of this reform.

v. Exclusions

- The remuneration of each grade, band and pay point along the classification structure was not addressed by this project
- Industrial issues arising from the consultation and refinement of the existing structure that need to be negotiated as part of the next enterprise bargaining negotiations
- Job evaluation methodology instrument; and
- Outcome evaluation of the impact of refinements and enhancement.

vi. Pre-requisites

This project was agreed through negotiations within the Nurses' and Midwives' Implementation Group (NaMIG). Two champions were volunteered:

- Veronica Casey, Executive Director of Nursing, Metro South Health Service District
- Lesley Fleming, Executive Director of Nursing; Royal Brisbane Women's Hospital

The original NaMIG scoping documents stated that "Queensland Health will conduct the review from 1 November 2009 to November 2011 and will involve a range of key stakeholders. The aim is to enhance the current Generic Level Statements and definitions to reflect contemporary and new nursing and midwifery roles.

Any new structure should provide opportunities for career development and also embrace innovation to

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improve the status of the profession as it meets technological and population demands."

vii. Dependencies

Many closely related and interdependent issues were evolving concurrently with this project.

- Related initiatives included the move to national registration and accreditation for health professionals through the Australian Health Practitioner Regulation Agency. There is no other 12 grade classification system in other Australian jurisdictions, or in the US or UK.
- Queensland is the only jurisdiction to include Assistants in Nursing and Students in Nursing in their classification and career structure. Enrolled Nurses' inclusion varies between other jurisdictions.
- There were dedicated projects to review intersecting topics such as:
- Business Planning Framework, Models of Care, Working Arrangements - the other three EB7 projects
- Succession Management and Mentoring (ClinEdQ) completed March 2011.
- Two projects that informed major issues within this Project were the:
- Mapping the role of nurse educators, concurrently implemented by ClinEdQ, completed by July 2011.
- Nurse Unit Manager Role - Phase II, concurrently implemented by Nursing and Midwifery Office Queensland, completed August 2011.

The third piece of work that may provide some useful references is the *Clinical Nurse and Clinical Nurse Consultant role*, completing 2011, performed by the Queensland Children's' Hospital

Integration with the Role of the Nurse Educators project recommendations were achieved although challenging due to the need to be inclusive of the clinical, management and research streams at the grade 4, 6, 7 and possibly grade 8 levels. The proposal to band grade 9 by the ClinEdQ project was not a joint recommendation from this Project.

The Phase II Nurse Unit Manager project ('the NUM project') had a broader scope than this Project, however there was collaboration on the consultation phase of the project, and mutually agreed recommendations as an outcome.

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ADDENDUM 4: PROJECT PHASES

The project was to report on the following outcomes throughout the four phases described in Section 6 below, as they relate to the 12 nursing and midwifery Generic Level Statements:

4.1 Approach

The approach and processes to achieve these outcomes included the following timeline:

Phase	Description	Techniques	Dates
6.1 Discovery	Identification of work performed against assigned classification grades/levels having regard for homogenous services, clinical models of care and contexts where possible	Sampling Focus Groups Role Observation Survey	December 2010 to July 2011
6.2 Issues Analysis	Analysis of possible changes in work level statements and definitions for each existing classification level– including pre-testing with focus group participants and open for consideration by nursing workforce	Work level mapping and existing work alignment	April 2011 to July / August 2011
6.3 Proposed Recommendations	Recommended changes to work level statements and definitions for each existing classification level for consideration by Reference Group and NaMIG on what elements to progress for the purpose of informing EB8	Interim Report for NaMIG's consideration	September 2011 to October 2011
6.4 Potential Implementation of Recommendations	Identification of issues outside the project scope for consideration of the Classification and Career Structure Refinement and Enhancement Project Reference Group for further consideration	Issues papers	November 2011
	Endorsed recommended changes in the Generic Level Statements and definitions of the existing classification and career structure and concept design for the implementation of any recommendations.	Final project report	December 2012

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4.2 Discovery Phase

Triangulation of method or "mixed method" research methodology is the act of combining several research methods to study one thing. This has the effect of balancing each method out and giving a richer and ideally truer account. Triangulation of method was attempted for gathering information as outlined in the sample selection table below. In terms of the sample size of 200, the project exceeded this target by more than 300%.

Sample Selection

Grade	Other Info	Desktop Review	Focus Group (Total Population)	Observation if indicated (1hr Review)	Possible Survey	Time frame
Grade 1		Yes	N/A	N/A		
Grade 2		Yes	N/A	N/A		Nov-Dec 2010
Grade 3	(Low)	Yes	N/A	N/A		
Grade 3	(High)	Yes	25-30	10		Jan – April 2011
Grade 4		Yes				
Grade 5 Grade 6			25-30	10		
Grade 7	Clinical Nurse Consultant		25-30	10		Jan – June 2011
Grade 7	Nurse Unit Manager		25-30	10		
Grade 7	Manager / Public Health Nurse…		25-30	10		
Grade 8	Nurse Practitioner		N/A	10		Jan – June 2011
Grade 9	Group A		25-30	10		Jan – July 2011
Grade 9	Group B			10		
Grade 10	Group A		25-30	10		
Grade 10	Group B			10		
Grade 11				N/A		
Grade 12				N/A		
	* Group A – Clustering using homogenous contexts and settings		2-4 focus groups between 6-15 people			
	* Group B – Clustering using homogenous contexts and settings					

The methodological design relied on obtaining predominantly qualitative data through focus groups and semi-structured interviews, using a sample size that is representative of Queensland Health's nursing

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and midwifery workforce across settings and contexts. (As stated under 4.1.2, the sample size of 200, was considered statistically significant, that is, the findings are unlikely to have occurred by chance). A survey did not need to be used to obtain both quantitative and qualitative data as there were no conflicting results from the first two methods.

Conducting these activities in the Discovery Phase (in collaboration with the NUM Project, when appropriate) ensured that the project team had a comprehensive understanding of each role and classification level. The consultation provided an opportunity to validate the current Generic Level Statements (*Nurse (Queensland Health) - Section 170MX Award 2003*) and provide proposed changes based on the lived experience of nurses and midwives in a range of Queensland Health settings.

From the project team's preliminary investigation, there are several grades with anomalies or ambiguity within the nursing and midwifery structure. The discovery phase of the project methodology provided the potential to identify and clarify the work performed and related matters. Issues distilled from project activities, including those possibly 'out of scope', were progressively referred to the Classification and Career Structure Refinement and Enhance Project Reference Group for consideration and advice.

Existing professional and other project specific networks were utilised wherever possible. The project team worked closely with these networks and District Directors of Nursing to establish the requisite focus groups.

4.2.1 Grades 1 - 4

Desktop Review

Grades 1-4 was a desktop review of work already performed by various Health Service Districts and Statewide services. Potential recommendations are included in the Executive Summary and described in detail through the Issues Identification and Discussion section of this Report. The findings were presented to the Project Reference Group in April and May 2011.

4.2.2 Experienced Grade 3 and Grades 4-12

Focus Groups

Focus groups were homogenous clusters whenever possible with a representative sample of localities, service types and CSCF levels - a cross selection of staff from all classifications, specialties and representations to confirm the current generic level statement and identify any anomalies or issues.

4.3 Exceptions

Nurse Practitioner candidates, Grade 7 and Nurse Practitioner, Grade 8 were consulted separately through the Queensland Chapter of the Australian College of Nurse Practitioners. Their Executive submitted a set of recommendations included in Addendum 8. Their population is too small to justify focus groups. The Nurse Educators, Grade 7, were not listed in the sampling suggestions due to the concurrent consultation through the Role of the Nurse Educator Project, however there were often Nurse Educators present in many of the focus groups conducted.

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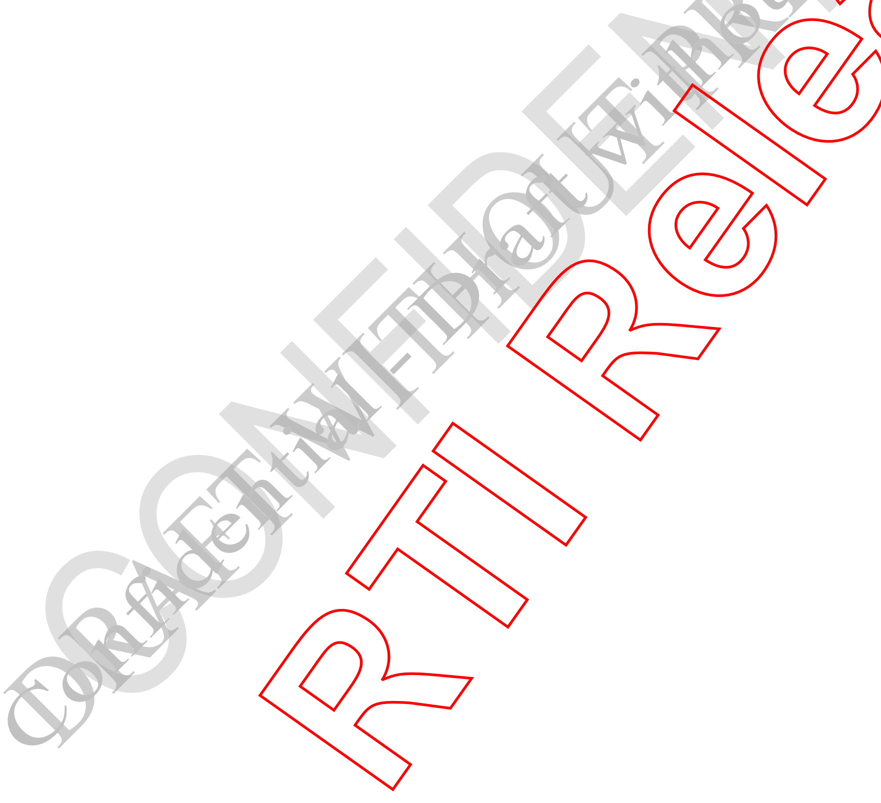
4.4 Data collection tools

The approach used to gather the data from the focus groups was consistent but flexible, depending on the size of each group. With the large groups, sub-groups were asked to consider their role, the skills required, and the differences between their grade and their previous grade as a brainstorming exercise and document their thoughts onto butcher's paper for presentation to the group. This provided a rich thematic landscape from which information was identified and analysed with the Project Reference Group, and led to the proposed re-drafting of the Generic Level Statements where appropriate and the accompanying explanatory notes.

Each focus group was transcribed and recorded using de-identified data, and the recurrent themes captured in Addendum 6, Issues / Anomaly and Potential Solutions. The following table shows a breakdown of the approximately 671 nurse and midwives consulted for the purposes of this Project. The timetable for the focus groups was forwarded to key members of the Project Reference Group in Queensland Health and QNU to inform and promote the Project's timetable.



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ADDENDUM 5: DISCOVERY PHASE RESULTS

Over 76 focus groups were conducted throughout Queensland Health facilities, across the state between January and April 2011.

5.1 Focus Group Attendance

Locality	EN	ENAPs	RN	RM	CN	CM	CNC	CMC	NE	ME	NUM	MUM	NM	NPC	NR	ND/AD	DON	DDON	EDON
PAH	14	4	3		8		2		2		4		9			4	3		
TPCH			3		10		3		2		2		2			6	1	1	1
SC HSD	5	8	4	1	18	3	3		5	1	5	1	1		2	8	3	1	
FC HSD			3		11		5		5		18	1	3			7	6	1	
RBWH			1		3	4	2	2	1	2		3	2			5			
Moreton Bay AC			2		4				1		7		1						
Met Nth CH																7	1		
Met Sth CH					15		4		2		6			1		1			
Cape Yk HSD																	9		
Townsville		8	9		3		5		3		5		2		2	9			
RCH			1		2		3		1		6				1	7			
DD HSD							2				2					2			
Kingaroy	10	1	6	1	13	1					6	1					1		
Ipswich	4	2	14		15	6		1	1	2	10	2	1			3	1		
Mackay		8		4	5		7				7		3			5	1	2	
Logan			1		3		2				2								
QEII																			
Redlands			4		2		1				4		2						
Mt Isa HSD							5		4		5	2	1		2	1	7	1	
CQ HSD			1		2		3		1		6					5	8	1	
SW HSD	1				8						3						8	1	
Cairns HSD											1								
DONMAC																		13	4
REBPSC																11			
OHS RSQ CHO	1				1		1				4		2						
NMOQ																11			
Serv Planners	4x A08																		
PSQ	8x A07; 2 x A08; 2 ND																		
SUB TOTAL from 76 sessions	35	30	50	6	87	16	48	2	28	5	103	10	29	1	7	99	49	21	5

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TOTALS: 624 nurses and midwives	EN	ENAP	RN	RM	CN	CM	CNC	CMC	NE	ME	NUM	MUM	NM	NPC	NR	ND/AD	DON	DDON	EDON

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Caveats on the focus group data

- Please note any Administration (AO) stream included in the focus groups for emerging roles were registered nurses, expressing the desire to be employed in the nursing stream.
- Midwives were only recorded where they had indicated their specific midwifery positions, these figures do not reflect the number of registered nurses that are midwives, or who maybe doing a dual role in a rural area

5.2 Findings

Each focus group participant was provided with a copy of their role's Generic Level Statement for perusal over several minutes. Depending on the size of the group, the Project Team responded with an appropriate method of consultation. Some groups consisted of very small numbers, often the grades that were providing direct patient care were unable to attend and semi-structured interviews were conducted with their representative participants. The larger groups, such as the nurses and midwives working at a grade 6 or 7 levels, were divided into sub-groups to consider the skills, knowledge and behaviours required for their specific role and the differences between their classification level and the one under their level.

Overall, the Generic Level Statements were accepted by the nurses and midwives as a reliable, generic description of their roles and still held currency, albeit with some minor amendments. Notably the Grade 7 classification is comprised of a diverse range of roles; however there was consensus between the groups that a large number of those qualities were generic to the level, and not specific to one role within that grade. This included feedback from the 33 nursing and midwifery educators who attended the groups and resulted in the Revised Generic Level Statements. These revisions were developed through the merging of the recommended Generic Level Statements for the grades 6, 7, 9 and potentially grade 8 roles, where appropriate, from ClinEdQ's Role of the Nurse Educator Project.

Further outlined in Addendum 6 Issues / Anomaly and Potential Solutions of this Report, the focus groups also provided an opportunity for nurses and midwives to comment on their perceptions of their current classification and career structure.

The Specialisation Framework (included in Addendum 12, Revised Generic Level Statements, describes the current environments of the twelvetwelve12 grade classification system, which spans across the broad range of streams, settings and contexts in which Queensland Health nurses and midwives are employed. The diagram included in the Explanatory Notes does include some settings that have not had skill mix in their workforce to date. However, this has been a joint finding of all the EB7 projects.

The data in the tables on the following pages has been provided by Queensland Health Human Resources Informatics Branch (with the caveat that the data may not be current). The data quality is dependant on regularly updating by the Health Service Districts. It shows the distribution by health service districts and growth in the numbers of each nursing and midwifery classification between the end of June 2005 and the end of June 2011.

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MOHRI FTE – Nurses & Midwives **Source:** QH HR Informatics Workforce Profiles	Cairns & Hinterland		Cape York		Central QLD		Central West		Childrens		Darling Downs		Gold Coast		Mackay	
	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011
AIN - USINM - EN - ENAP (Grade 1- Grade 4)	212.17	298.74	5.23	14.13	271.66	341.23	43.10	42.52	37.86	44.42	499.88	625.89	173.68	301.65	109.00	142.37
Registered Nurses (Grade 5 - Grade 12)	862.46	1,281.57	85.75	124.28	635.33	813.56	75.20	82.78	462.46	643.35	1,727.23	2,324.89	962.10	1,839.77	402.24	582.22
Nurses in Admin positions	2.42	1.00	0.00	0.00	2.74	1.91	0.53	0.00	0.00	0.50	3.00	2.00	4.50	2.00	0.84	0.00
Other Nurses	6.12	2.00	0.00	0.00	5.14	1.50	0.00	0.00	0.63	0.00	14.77	1.00	0.75	1.80	4.00	1.00
TOTAL	1,083.17	1,583.31	90.98	138.41	914.87	1,158.20	118.83	125.30	500.95	688.27	2,244.88	2,953.78	1,141.03	2,145.22	516.08	725.59

MOHRI FTE – Nurses & Midwives **Source:** QH HR Informatics Workforce Profiles	Metro North		Metro South		Mount Isa		Sunshine Coast		South West		Torres Strait		Townsville		Wide Bay	
	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011
AIN - USINM - EN - ENAP (Grade 1- Grade 4)	738.33	982.91	496.40	762.49	29.69	36.73	287.50	265.35	92.60	110.57	15.38	14.63	305.05	404.43	-	278.47
Registered Nurses (Grade 5 - Grade 12)	3,174.78	4,845.39	2,507.32	3,857.79	137.15	226.96	1,407.41	1,253.18	135.08	185.54	58.92	97.13	1,041.18	1,615.27	-	870.36
Nurses in Admin positions	11.10	8.42	5.63	2.93	0.00	0.00	4.05	1.26	0.00	0.00	1.00	1.00	4.00	2.00	-	0.00
Other Nurses	8.70	1.00	15.01	3.63	0.00	1.00	9.40	1.00	2.84	1.00	0.00	0.00	4.42	2.00	-	0.00
TOTAL	3,932.91	5,837.72	3,024.36	4,626.84	166.84	264.69	1,708.36	1,520.79	230.52	297.11	75.30	112.76	1,354.65	2,023.70	-	1,148.83

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MOHRI FTE – Nurses & Midwives Source: QH HR Informatics Workforce Profiles	Cairns & Hinterland		Cape York		Central QLD		Central West		Childrens		Darling Downs		Gold Coast		Mackay	
	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011
AIN - USINM - EN - ENAP (Grade 1- Grade 4)	212.17	298.74	5.23	14.13	271.66	341.23	43.10	42.52	37.86	44.42	499.88	625.89	173.68	301.65	109.00	142.37
Registered Nurses / Midwife - Grade 5	462.22	693.41	17.78	25.02	312.21	378.72	42.36	20.73	244.82	351.69	945.81	1,241.20	546.23	1,028.50	213.72	305.98
Clinical Nurse / Midwife - Grade 6	256.22	386.13	35.97	52.76	207.66	282.39	15.34	23.99	141.79	177.26	527.85	711.41	287.36	535.43	124.98	174.14
Clinical Nurse Consultant, Manager, Educator - Grade 7	119.60	169.61	22.00	31.50	91.62	121.24	3.00	12.06	65.81	103.40	207.26	307.56	117.51	238.27	50.54	84.10
Nurse Practitioner - Grade 8	0.00	2.00	0.00	1.00	0.00	4.84	0.00	0.00	0.00	2.00	0.00	10.59	0.00	11.57	0.00	3.00
Nurse Director, Assistant Director of Nursing - Grade 9	5.00	10.00	0.00	0.00	4.00	6.97	1.00	0.00	9.04	7.00	20.47	19.13	11.00	25.00	4.00	6.00
Director of Nursing - Grade 10	19.42	18.42	10.00	13.00	18.84	18.40	13.50	24.00	0.00	0.00	25.84	32.00	0.00	0.00	9.00	8.00
District Director of Nursing - Grade 11	0.00	2.00	0.00	1.00	1.00	1.00	0.00	2.00	1.00	2.00	0.00	2.00	0.00	0.00	0.00	1.00
Executive Director of Nursing - Grade 12	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	1.00	0.00	0.00
Nurses in Admin positions	2.42	1.00	0.00	0.00	2.74	1.91	0.53	0.00	0.00	0.50	3.00	2.00	4.50	2.00	0.84	0.00
Other Nurses	6.12	2.00	0.00	0.00	5.14	1.50	0.00	0.00	0.63	0.00	14.77	1.00	0.75	1.80	4.00	1.00
TOTAL	1,083.17	1,583.31	90.98	138.41	914.87	1,158.20	118.83	125.30	500.95	688.27	2,244.88	2,953.78	1,141.03	2,145.22	516.08	725.59

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MOHRI FTE – Nurses & Midwives Source: QH HR Informatics Workforce Profiles	Metro North		Metro South		Mount Isa		Sunshine Coast		South West		Torres Strait		Townsville		Wide Bay	
	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011	2005	2011
AIN - USINM - EN - ENAP (Grade 1- Grade 4)	738.33	982.91	496.40	762.49	29.69	36.73	287.50	265.35	92.60	110.57	15.38	14.63	305.05	404.43	-	278.47
Registered Nurses / Midwife - Grade 5	1,976.83	2,888.85	1,474.70	2,200.05	62.94	105.44	742.55	649.34	70.21	88.34	14.42	19.10	576.01	875.90	-	465.78
Clinical Nurse / Midwife - Grade 6	774.54	1,284.02	731.54	1,123.36	41.58	56.01	446.67	413.05	33.61	50.08	16.50	22.03	300.99	472.28	-	270.04
Clinical Nurse Consultant, Manager, Educator - Grade 7	370.41	579.92	260.84	459.70	19.63	48.51	188.69	168.49	13.42	22.51	26.00	51.00	139.21	220.75	-	105.51
Nurse Practitioner - Grade 8	1.00	16.92	1.00	21.84	0.00	2.00	0.00	4.60	0.00	0.00	0.00	1.00	0.63	9.84	-	4.00
Nurse Director, Assistant Director of Nursing - Grade 9	42.00	63.68	31.34	44.84	0.00	1.00	12.00	10.70	1.00	3.00	1.00	3.00	12.00	21.00	-	13.00
Director of Nursing - Grade 10	7.00	7.00	6.40	7.00	11.00	13.00	14.50	5.00	16.84	20.61	1.00	1.00	12.34	13.50	-	10.03
District Director of Nursing - Grade 11	1.00	2.00	1.00	0.00	2.00	1.00	3.00	2.00	0.00	1.00	0.00	0.00	0.00	0.00	-	2.00
Executive Director of Nursing - Grade 12	2.00	3.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.00	-	0.00
Nurses in Admin positions	11.10	8.42	5.63	2.93	0.00	0.00	4.05	1.26	0.00	0.00	1.00	1.00	4.00	2.00	-	0.00
Other Nurses	8.70	1.00	15.01	3.63	0.00	1.00	9.40	1.00	2.84	1.00	0.00	0.00	4.42	2.00	-	0.00
TOTAL	3,932.91	5,837.72	3,024.36	4,626.84	166.84	264.69	1,708.36	1,520.79	230.52	297.11	75.30	112.76	1,354.65	2,023.70	-	1,148.83

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MOHRI FTE – Nurses & Midwives Source: QH HR Informatics Workforce Profiles	Cairns & Hinterland	Cape York	Central QLD	Central West	Childrens	Darling Downs	Gold Coast	
	Variance 2005-2011	Variance 2005-2011	Variance 2005-2011	Variance 2005-2011	Variance 2005-2011	Variance 2005-2011	Variance 2005-2011	Va
AIN - USINM - EN - ENAP (Grade 1- Grade 4)	86.57	8.90	69.57	-0.58	6.56	126.01	127.97	33.37
Registered Nurses / Midwife - Grade 5	231.19	7.24	66.51	-21.63	106.87	295.39	482.27	92.26
Clinical Nurse / Midwife - Grade 6	129.91	16.79	74.73	8.65	35.47	183.56	248.07	49.16
Clinical Nurse Consultant, Manager, Educator - Grade 7	50.01	9.50	29.62	9.06	37.59	100.30	120.76	33.56
Nurse Practitioner - Grade 8	2.00	1.00	4.84	0.00	2.00	10.59	11.57	3.00
Nurse Director, Assistant Director of Nursing - Grade 9	5.00	0.00	2.97	-1.00	-2.04	-1.34	14.00	2.00
Director of Nursing - Grade 10	-1.00	3.00	-0.44	10.50	0.00	6.16	0.00	-1.00
District Director of Nursing - Grade 11	2.00	1.00	0.00	2.00	1.00	2.00	0.00	1.00
Executive Director of Nursing - Grade 12	0.00	0.00	0.00	0.00	0.00	1.00	1.00	0.00
Nurses in Admin positions	-1.42	0.00	-0.83	-0.53	0.56	-1.00	-2.50	-0.84
Other Nurses	-4.12	0.00	-3.64	0.00	-0.63	-13.77	1.05	-3.00
TOTAL	500.14	47.43	243.33	6.47	187.32	708.90	1,004.19	

MOHRI FTE – Nurses & Midwives Source: QH HR Informatics Workforce Profiles	Metro North	Metro South	Mount Isa	Sunshine Coast	South West	Torres Strait	Townsville	
	Variance 2005-2011	Variance 2005-2011	Variance 2005-2011	Variance 2005-2011 (split into Wide Bay)	Variance 2005-2011	Variance 2005-2011	Variance 2005-2011	New Distr
AIN - USINM - EN - ENAP (Grade 1- Grade 4)	244.58	266.09	7.04	-22.15	17.97	-0.75	99.38	278.47
Registered Nurses / Midwife - Grade 5	912.02	725.35	42.50	-93.21	18.13	4.68	299.89	465.78
Clinical Nurse / Midwife - Grade 6	509.48	391.82	14.43	-33.62	16.47	5.53	171.29	270.04
Clinical Nurse Consultant, Manager, Educator - Grade 7	209.51	198.86	28.88	-20.20	9.09	25.00	81.54	105.51
Nurse Practitioner - Grade 8	15.92	20.84	2.00	4.60	0.00	1.00	9.21	4.00
Nurse Director, Assistant Director of Nursing - Grade 9	21.68	13.00	1.00	-1.30	2.00	2.00	9.00	13.00
Director of Nursing - Grade 10	0.00	0.60	2.00	-9.50	3.77	0.00	1.16	10.03
District Director of Nursing - Grade 11	1.00	-1.00	-1.00	-1.00	1.00	0.00	0.00	2.00
Executive Director of Nursing - Grade 12	1.00	1.00	0.00	0.00	0.00	0.00	2.00	0.00
Nurses in Admin positions	-2.68	-2.70	0.00	-2.79	0.00	0.00	-2.00	0.00
Other Nurses	-7.70	-11.38	1.00	-8.40	-1.84	0.00	-2.42	0.00
TOTAL	1,904.81	1,602.48	97.85	-187.57	66.59	37.46	669.05	

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ADDENDUM 6: ISSUES/ANOMALY IDENTIFICATION AND POTENTIAL SOLUTIONS

Concurrent to the development of the Desktop Review Recommendations was the analysis of the Discovery Phase. The Project Team developed an Issues Paper around the broad themes drawn from the analysis of the focus groups and semi-structured interviews. There were areas that required further clarification and discussion between QNU and Queensland Health. At a meeting held in May 2011 of the Project Reference Group members, a variety of issues pertaining to Grades 1-12 were discussed and documented.

It was agreed at Project Reference Group meetings that a cultural shift is required to promote models of care with an appropriate skill mix, after a predominantly graduate workforce has been promoted over the last few decades. This was reinforced by findings of the Nursing and Midwifery Models Project, Working Arrangements and Business Planning Framework Refinement and Enhancement Projects. Duffield et al has received an Australian Research Council grant and is investigating the impact of AINs on the quality of nursing care.

A number of other interdependent issues have been raised in these discussions and were organised into major themes, both in and out of project scope, for further exploration and examination. **Please note the following issues were raised by nurses and midwives, and do not necessarily reflect the views of the Classification and Career Structure Project Team, Project Reference Group members nor NaMIG members.**

The implementation of the project was initially informed by a number of key classification issues identified by opinion leaders and previous industrial forums and processes. Based on semi-structured interviews with key opinion leaders, nurses and midwives providing services and documentation from Human Resources Coordination, there are consistent anomalies in the current structure.

Role Ambiguity

Issue/anomaly:

- Between the grade 3 and 4 Enrolled Nurse (EN) and the grade 5 Registered Nurse (RN)– the commonly held perception that scope of practice has become more and more blurred as role creep has occurred within the Enrolled Nurse, grades 3 and 4. The basic difference between the EN and RN is the ability to assess and plan care, with practice under the supervision of a Registered Nurse.

Potential solution:

- Promote and reinforce both the Enrolled Nurse and Registered Nurse National Competency Standards and the Generic Level Statements to Registered Nurses.

Issue/anomaly:

- Clarity between Clinical Nurse, Grade 6 and Clinical Nurse Consultant and Nurse Educator, Grade 7 roles are required

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Solution:

- To some degree the ClinEdQ "Role of the Nurse Educator" project provided clarity between Clinical Nurse, Grade 6 and Clinical Nurse Consultant and Nurse Educator, Grade 7 roles. Their recommendations within the education stream were incorporated into the Revised Generic Level Statements wherever possible.
- Further investigation of the Clinical Nurse, Grade 6 and Clinical Nurse Consultant, Grade 7 has been performed by Queensland University of Technology and Logan Hospital. The Queensland Children's Hospital commissioned an examination of the Clinical Nurse, Grade 6 and Clinical Nurse Consultant, Grade 7 role, and will seek permission to disseminate their final report to NaMIG.

Workload and remuneration

Issue/anomaly:

- The multiple classification system for positions in mental, community and acute health care settings is causing conflict due to the inequity and disparity with remuneration with the Health Practitioner (HP) stream, for equal work value. This has led to an Integrated Model in Mental Health, where the Team Leader role became an HP 5 role and nurses have been required to abdicate their nursing professional status (Nurse Unit Manager, Grade 7) and enter the HP stream.

Solution:

- Out of project scope. Refer to enterprise bargaining negotiations

Issue/anomaly:

- There is great variance between facilities and districts for the Grade 7 role in support structures and resources managed.
- The Nurse (Midwifery) Unit Manager (NUM), Grade 7 role remains a critical issue in the nursing and midwifery workforce compared with other job roles within the same grade. This may be attributed in part to the compression of the NO3 (Clinical Nurse Consultant and Educators) and the NO4 (Nurse Manager) levels in 2006.
- The NUM role is extremely challenging and pressured compared to the other Grade 7 roles, due to the human resource management / budget delegations, and the lack of administrative support (many of administrative tasks are clerical duties, which take the NUM away from the floor and their clinical governance responsibilities, i.e. to ensure their staff maintain standards of care, etc). There is still ambiguity about who is responsible for clinical leadership/excellence (clinical nurse consultant or NUM or Nurse Practitioner, where applicable – or combined).
- The role of Clinical Nurse Consultant, Grade 7 remains anomalous between facilities and districts, meaning different responsibilities, sometimes synonymous with the Nurse Unit Manager, Grade 7. In most rural and remote areas there is a hybrid role that exists.

Solution:

- The Nursing and Midwifery Office Queensland has completed Phase II of the Role of the Nurse Unit Manager, with mutually agreed principles.
- The Nurse Unit Manager, Clinical Nurse Consultant or Clinical Nurse Educator, Grades 7 could be banded according to breadth and depth of their role within the grade 7, and where there is

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significant human resource and budget delegations, a Nurse Unit Manager, Grade 8 role could be introduced.

Issue/anomaly:

- The penalty rates from shift work for the Registered Nurse, Grade 5 role acts as a disincentive for a Monday to Friday Clinical Nurse, Grade 6 role, and a Clinical Nurse, Grade 6 role with penalty rates is a disincentive to act in the Nurse Unit Manager, Grade 7 role.

Solution:

- Out of scope.

Issue:

- The Clinical Nurse, Grade 6 and Clinical Nurse Consultant, Grade 7 in rural and remote areas also earn more than the Director of Nursing/Facility Manager, Nurse Grade 10 (1 – 3) role due to paid overtime versus the 24/7 on call for the Directors of Nursing, Grade 10.

Solution:

- Out of project scope. Refer to enterprise bargaining negotiations
- On call arrangements for Directors of Nursing, Grade 10 remains a workload and fatigue management issue. It was agreed that the Director of Nursing title remain an incentive for those rural and remote positions. This includes consideration of whether the Sole Practitioner is appropriately graded and remunerated.

Issue/anomaly:

- Paypoint progressions provide no incentive for Nursing Directors / Assistant Directors of Nursing, Grade 9s to want to backfill or become Directors of Nursing, Grade 10s – some paypoints are less or equivalent to each other, e.g. Director of Nursing Grade 10(4) paid same as Nursing Directors / Assistant Directors of Nursing 9(3) yet vastly different levels of responsibility

Solution:

- Compress Grades 9 and 10, clearly showing the work relativity between facilities versus service line/division (this solution was rejected by NaMIG).
- The original intent of the Grades 9 and 10 differentiations was to demonstrate relative job value between Nursing Directors-, ADONS - service line/division based versus Directors of Nursing (facility based management positions). This has been implicit to date and not expressed in any documentation. Members agreed that marketing a clearer guide around the requirements of these roles could resolve these issues, which can be included in the Generic Level Statements and updated Evaluation Guide.
- [or increase remuneration as the classification increases within the nurse executive]

Issue/anomaly:

- Qualifications allowance for Grades 9-12 - expectation by organisation to have post-graduate qualifications (generally at least Master level) but not remunerated

Solution:

- Out of project scope. Refer to enterprise bargaining negotiations

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Business practices

Issue/anomaly:

- The Nurse Practitioner Candidate, Grade 7 role remains challenging due to the recruitment process required for progression to the Nurse Practitioner, Grade 8 role on completion of their studies. This recruitment process must be a merit based open selection process. This is a disincentive for Health Service Districts to pursue the position of the Nurse Practitioner, Grade 7 when there is no guarantee the candidate will become their selected Nurse Practitioner upon the completion of their studies. It is also not a productive or efficient use of time for nursing, midwifery and administrative personnel and creates unnecessary red tape.

Solution:

- A Clinical Nurse Consultant would be the most appropriate Grade 7 title and role for the nurse or midwife undertaking the Master of Nurse Practitioner, if they were being financially supported by their business unit. A Nurse Practitioner Candidate (NPC) is a title used for academic purposes and is not necessary in Queensland Health.

Resolution:

- Delete NPC role from *Queensland Health Nurses and Midwives Interim Award – State 2011* Schedule, 1 Classifications.

Issue/anomaly:

- The title Public Health Nurse at only a Grade 7 classification level limits the career structure and subsequent skill mix / roles for that setting. It also highlights one speciality over another.

Solution:

- At a number of meetings, the Project Reference Group and NaMIG agreed that the Generic Level Statement for Public Health Nurse, Grade 7 could be removed.

Issue/anomaly:

- The nursing and midwifery classification and career structure rewards nurses and midwives who move away from direct clinical practice (with the exception of the nurse practitioner role). Unlike other health professions, nursing and midwifery reward a career move away from direct patient care rather than the maintenance of clinical skills through a balance of clinical care and the other streams/activities their role entails through their career / classification mobility. Within the nursing stream of Queensland Health, clinical skills are not recognised or rewarded by status or remuneration unless you are a Nurse Practitioner. Nurse Practitioners would also like the opportunity to perform management or executive roles but maintain a clinical load within this role.

Solution:

- Articulate in the industrial framework the option to maintain a clinical load when undertaking a management position.

Issue/anomaly:

- The notion of advanced clinical practice is complementary with CliniEdQ's lifelong learning framework. All grades should bridge the four streams (clinical, management, education and research) of nursing and midwifery and be inclusive of emerging roles such as patient safety and quality, informatics, service planning, project management and policy development roles. This would provide an opportunity for adequate mentoring, transitioning and succession planning.

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- Statewide roles need better definition from the deliverables of this project.
- Unique, innovative or emerging roles, including informatics or statewide services such as the Nursing and Midwifery Office Queensland, Patient Safety and Quality Management; Retrieval Services Queensland, Public Health, Offender Health, DonateLife Qld Organ and Tissue Service and service planning expressed the concern that the current Generic Level Statements are not inclusive of their settings.

Solution:

- These environments are succinctly captured through the Specialisation Framework, included in the Explanatory Notes of the Revised Generic Level Statements. The Framework describes the current range of clinical and non-clinical environments, which is comprised of a multitude of practice strands, specialties and common skill domains. The Specialisation Framework is consistent with the nationally developed framework for categorising nursing and midwifery specialization and if included in the Explanatory Notes with the Generic Level Statements, assists to promote and include the broad spectrum of nursing and midwifery careers.

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Issue/anomaly:

- Nurses and midwives are leading models of care across the continuum of population health - prevention, screening, early detection and intervention, primary and secondary care through to treatment, follow up, chronic disease management and end of life care. Emerging roles are likely to arise during the life of each enterprise bargaining agreement, and how can these be recognised by the Nursing and Midwifery Classification and Career Structure?

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Solution:

- The Nursing and Midwifery Office Queensland, or equivalent corporate structure, has the authority to formally approve these emerging roles and Generic Level Statements if and when they evolve throughout the life of this Award or the next enterprise bargaining agreement.

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Issue/anomaly:

- Lack of awareness about business practices by nursing and midwifery staff and district Human Resources Coordination staff. The development of service profiles and the subsequent relationship of workforce planning and models of care to establish the appropriate nursing and midwifery structure within a service line or division or business unit is not always fully conceptualised, and can lead to conflict and misunderstanding in the implementation of emerging roles.

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Solution:

- It will remain the Local Health and Hospital Network's discretion to design organisational structure and link to service, business planning and models of care frameworks. These business practices together with the promotion of human resource policies, establish emerging roles for nurses and midwives. When a business unit creates a position, careful consideration should be given to what skills, knowledge and behaviour are required to designate the role within the nursing and midwifery stream. This may seem to the reader to be stating the obvious, but is a recurrent theme in the anomalies or inadequacies of the current Generic Level Statements, Classification or Career Structure for nurses and midwives.

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This is specifically evident with the ENAP role, and emerging roles in settings such as Patient Safety and Quality and the Skills Development Centre. Linking these concepts and reinforcing service and workforce design messages within industrial frameworks is an important capacity building tool.

Issue/anomaly:

- Many nurses and midwives expressed the desire to link their roles and performance development to their business unit's key performance indicators.

Solution:

- Further implementation of the business planning framework can ensure these linkages can be included in the performance appraisal and professional development of nurses and midwives.

Naming conventions

Issue/anomaly:

- Invisibility of midwifery in the current classification and career structure.

Solution:

- Incorporate midwifery nomenclature where possible to incorporate into the midwifery setting, apart from the grade 8 level where a midwife must be a Nurse Practitioner and a Midwife.

Issue/anomaly:

- Inconsistent naming conventions e.g. a Nurse Unit Manager role called a Clinical Nurse Consultant role.

Solution:

- Consistent naming conventions are an important tool in identifying and measuring our workforce and understanding roles, and should be applied whenever possible. Titles proved to be important to nurses and midwives in the focus groups, and midwifery nomenclature has been included wherever possible. While there is some variation in titles such as Clinical Nurse Facilitator, there should be clear documentation of its classification as a Clinical Nurse (Education), Grade 6 for workforce data purposes, with the descriptor added, if desired for client and staff recognition.

Issue/anomaly:

- The Directors of Nursing and Midwifery Advisory Committee (DONMAC) suggested and agreed in April 2011 that compression of Grades 11 and 12 occur to prepare for future reforms, to ensure they achieved recognition by other health service executives as the leaders of the nursing and midwifery workforce in their LHHNs.

Solution:

- Further to discussion from the NAMIG workshop in August 2011, the Project Reference Group agreed that the title Executive Director of Nursing and Midwifery could be enabled as a more apt title going forward into health reform, but that compression of these grades is not a favoured approach at this time.

Midwifery models of care

Issue/anomaly:

- Midwives have increasing autonomy through emerging models of care.

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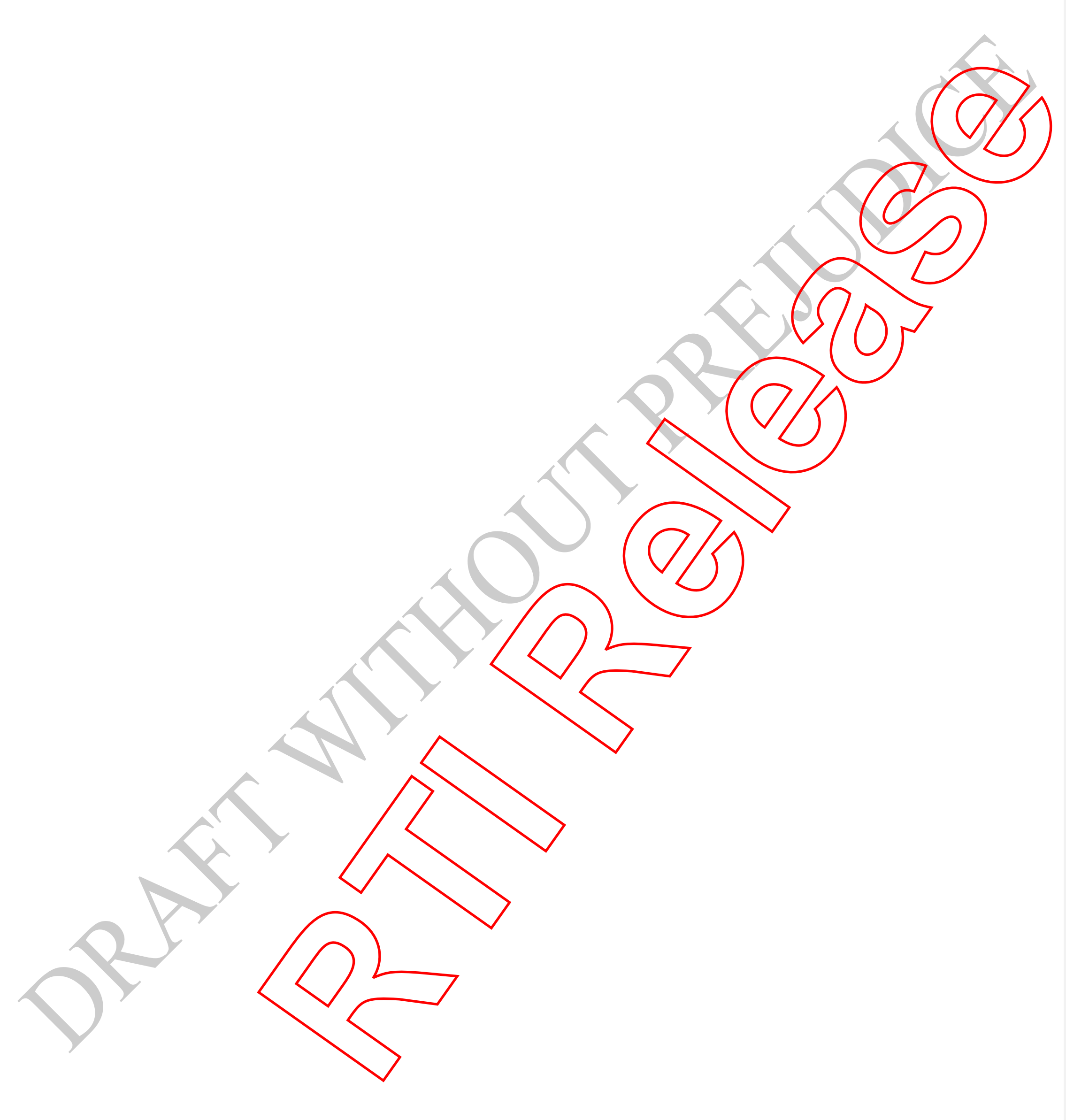

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Solution:

- Further exploration of an independent midwifery classification as the profession evolves independently from nursing, and models of care are embedded.

Work level determination

Issue/anomaly:

Attachment 3, B7 Policy – Grades 9-12 Evaluation Guide requires updating:

- The most resounding theme from the consultation with Nurse Executives, based on a shift in human resource management trends (within Queensland Health and outside) was the counting of FTE IS NOT a reflection of a complexity of a role or a definitive quantitative factor.
- Organisational structure within the variety of Queensland Health settings has become extremely complex, particularly where multidisciplinary teams are in operation and reporting structures reflect this complexity. Organisational charting has become difficult to perform or to read.
- The reporting structures are often extremely complex for the Nursing Directors/Assistant Directors of Nursing, Grade 9 across a range of settings and nomenclature is out dated for Grades 10-12
- Nurse managers and executives recurrently reported that nursing and midwifery work level determination methods are not able to rigorously measure role complexity versus complexity of the environment.
- Links to the Clinical Services Capability Framework should be considered from the perspective that a level 6 facility has more support structures and services for a role and does not reflect work value. The current use of the CSCF favours metropolitan facilities

(See Refer Addendum 9, Draft Work Level Data Gathering Descriptor Matrix)

Solution:

- The introduction of activity based funding through the Health Reform Agenda will enable more rigour in the counting of nursing hours per patient per day, but has not yet been implemented for enough time to include in an updated version as maybe a more informative and accurate indicator of role and environment complexity.
- The development and adoption of a more objective assessment through a centralised self-governance process (Addendum 12, Explanatory Notes) to ensure a more consistent and transparent approach to governing classification and career paths.
- The potential development of a more robust methodology to determine a relative value of a role's complexity, impact, sphere of influence, independence, environment, diversity and integration, judgement, problem solving, resources managed, resource provided and integration with other clinical and service areas to capture nuances across all settings, including non-hospital settings for rural and remote; community, public, offender health and aged care; regional and metropolitan hospitals. This rating would consider service profiles, and the full range of demographic indicators to provide an objective view of the complex environment the nurse or midwife executive is operating within.

Advanced practice roles

Issue/anomaly:

- Some Registered Nurses, Grade 5 and Clinical Nurses, Grade 6 have reported a desire for reward and recognition of advanced clinical practice for nurses remaining "at the bedside".

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Solution:

- The Clinical Nurse Specialist role (Mackay Health Service District) has already established this role at the Grade 6 level.
- The Australian Health Practitioners Regulation Agency is performing work to clarify advanced practice.

Issue/anomaly:

- The Rural and Remote District Director of Nursing Network met with the Project Team throughout the life of this Project to discuss specific rural and remote issues for the nursing and midwifery workforce. The Sole Practitioner role was identified as extremely fatiguing and difficult, with no nursing or midwifery staff to assist with workload or relief arrangements.

Solution:

- The Sole Practitioner role could be more appropriately classified as an advance practice grade 8 roles (not necessarily a Nurse Practitioner role) with terms and conditions that meet the demands of fatigue and safety more adequately.

Issue/anomaly:

- There is a gap between nursing and midwifery roles in the current Classification and Career Structure with only the Nurse Practitioner, Grade 8 role in between Grades 7 and 9.

Solution:

- Further examination of the significant growth of the Grade 9 (1) in some districts within Queensland Health may inform us further about the aforementioned challenges of the Grade 7 classification for advanced practice roles with significant strategic influence and resources managed.
- There is potential for the grade 8 classification to be developed across the four streams to include other advanced practice roles, not only the Nurse Practitioner. This would provide further career progression and a more logical and sequential pathway for nurses and midwives within Queensland Health. This would also provide equity with other streams and improve the critical success factors in the clinical setting such as recruitment, retention, professional development, succession planning, transition and management, for the nursing and midwifery workforce.

Career pathway development

Issue/anomaly:

- At the commencement of the project, it was agreed by the parties that the existing Nursing and Midwifery Career Structure should be more clearly articulated across the four streams of clinical, management, research and education.

Solution:

- The Nursing and Midwifery Career Model at Addendum 12, Explanatory Notes, visualises career pathways for Queensland Health nurses and midwives that promote both vertical and horizontal career mobility.

  The development of streamed Clinical Nurse, Grade 6 positions was a mutual recommendation from the Phase II Role of the Nurse Unit Manager (NUM) Project, for example, a Clinical Nurse (Management) role could focus on professional development and mentoring for transition and succession planning to the NUM role.

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Issue/anomaly:

- The upper echelon of the Career Structure is not streamed and the clinical role "glass ceiling" is at Nurse Practitioner, Grade 8

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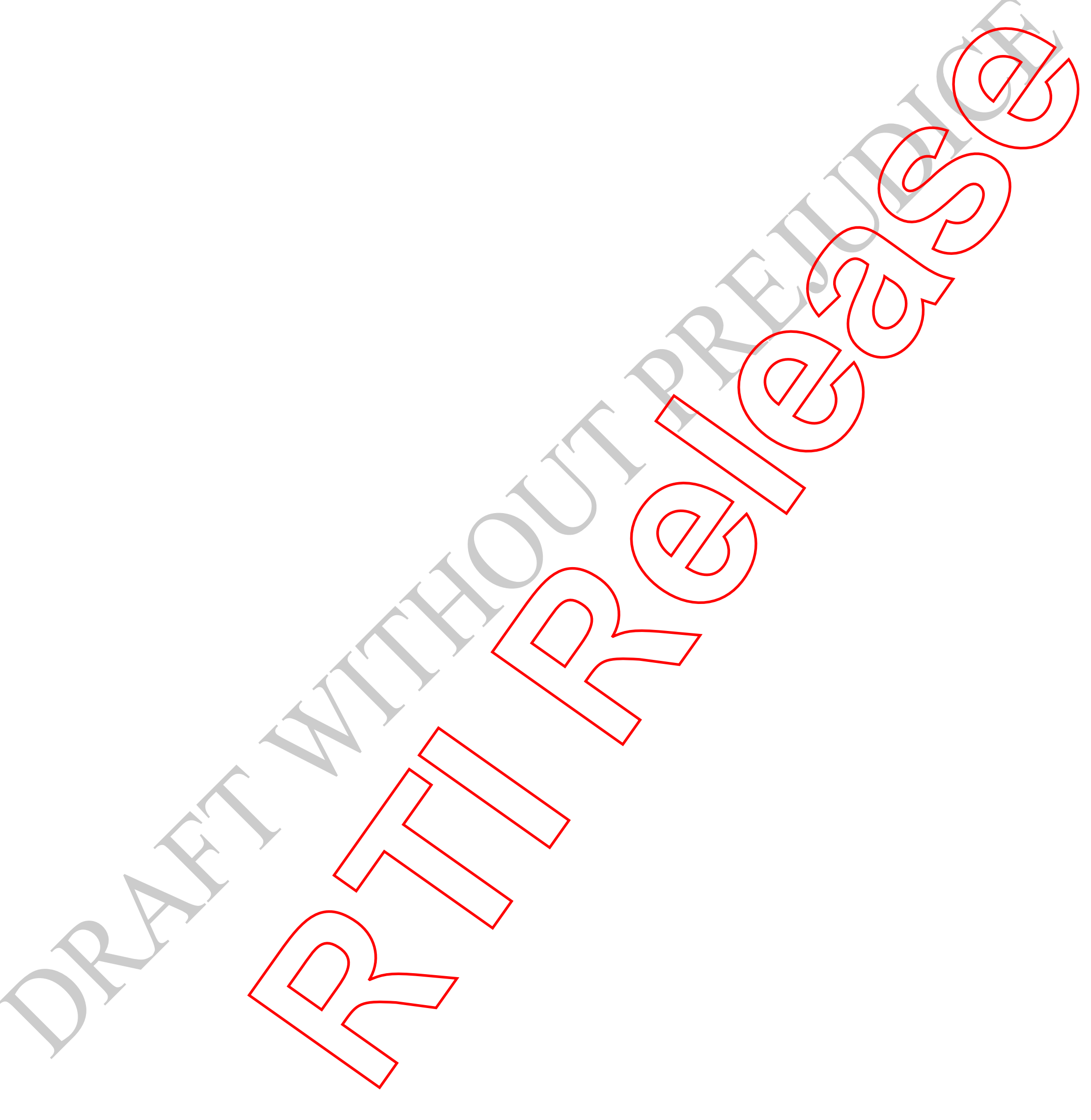

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Solution:

- The development of a Nurse Consultant Grade 10 or 11 role that would be positioned within a clinical speciality such as Critical Care and aligned with a University

Delegation

Issue/anomaly:

- Professional and operational reporting have become highly ambiguous, often developed within complex and confusing organisational structures. This is largely due to the development of multidisciplinary teams. The Evaluation Guide for Grades 9-12, Attachment Three to B7 Policy reporting delegations are not contemporary.

Solution:

- The Evaluation Guide for Grades 9-12, Attachment Three to B7 Policy, should omit grade 9 reporting delegations and update Grades 10-12 to avoid contradictory reporting requirements in a rapidly changing environment.
- The Executive Director of Nursing and Midwifery services has a professional relationship with the Chief Nursing and Midwifery Officer of Queensland but is accountable to the Chief Executive Officer of the Local Health and Hospital Network (LHHN).

Issue/anomaly:

- In an increasingly multidisciplinary environment, professional supervision needs to continue for nurses and midwives, regardless of the qualifications of the operational supervisor.

Solution:

- Every nurse / midwife must have a professional reporting line to a registered nurse / midwife who has delegation to oversee their work.

Issue/anomaly:

- Traditional hierarchical reporting structures are not contemporary, a nurse or midwife is operationally communicating to a lower grade in many settings. This was most frequently reported by the Nurse Practitioner.

Solution:

- It is possible that a nurse or midwife may operationally communicate to a lower grade if that is the logical organisational structure and most commonly occurs with the Nurse Practitioner role providing their operational matters to a Nurse Unit Manager. Professional supervision by a higher classification is mandatory.

Rural and Remote Issues

The following issues were most commonly raised by the Grade 10 Nurse Executives due to their predominantly rural and remote roles pertaining to their own classification, but many of the issues raised were related to the whole of the nursing and midwifery workforce. These issues are terms and conditions, a subject out of project scope but may be referred to enterprise bargaining negotiations.

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Comment [T3]: Needs evidence and issue clarification

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- Rural and remote setting request consideration given to using the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system. The purpose of the structure is to classify data from census Collection Districts into broad geographical categories, called Remoteness Areas (RAs) – RA1 Major Cities of Australia, RA2 Inner Regional Australia, RA3 Outer Regional Australia, RA4 Remote Australia, and RA5 Very Remote Australia. The Australian Government uses this index when placing doctors. Remote Area Nurse Incentive Package (RANIP) is out of date and has not been increased since 1995
- Salary sacrificed benefits such as flights end up being more expensive and cumbersome. There is a large gap between medical and nursing and midwifery staff's incentives and rewards for rural service
- Rewarding rural and remote service with a sabbatical (amount of time linked to length of service) could be an incentive and reward for this group
- Rural or remote nurses and midwives do not get bonuses like free housing and utilities for working in rural and remote like the medical stream
- Other government departments get benefits for being "so far" from Brisbane (e.g. free flights home) such as Qld Police or Centrelink staff in Roma
- Queensland maybe able to influence Commonwealth to promote the Higher Education Scheme rebate for rural service by nurses and midwives.

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Solution:

- Out of project scope. Refer to enterprise bargaining negotiations.

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Industrial Frameworks

Issue/anomaly:
Some nurses and midwives expressed industrial frameworks are not inclusive of the following:

- the portability of nursing and midwifery status into administrative or management roles;
- the ability to have a role split between two streams, for example, a clinical role with dedicated research time of 0.4 FTE per fortnight; and
- the option to maintain a clinical load when undertaking a management position.

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Solution:

- Make inclusions as amendments to the Award.

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ADDENDUM 7: LITERATURE REVIEW

There is a paucity of literature around the topic of nursing and midwifery classification, and within the jurisdictions of Australia, each classification differs significantly from the Queensland model. However, there is a more substantial body of work written about the issues of skill mix, career mobility and nursing regulation.

The International Council of Nurses' Position Statement on Career Development in Nursing believes that career development is a major contributing factor in the advancement of health systems and the nursing profession worldwide, and is directly linked to the maintenance of high quality care delivery. Career development must therefore be supported and sustained by means of an articulated educational system, recognized career structures (including clinical ladders) flexible enough to provide career mobility, and access to nursing intra/entrepreneurship and or independent practice opportunities.

Carr-Hill et al (2003) carried out a scoping review of skills mix in 82 National Health Service (NHS) trusts in the United Kingdom in 2003, focusing on new emerging roles and positions at this time (specifically Nurse Consultants and Nurse Practitioners) and the development of the unlicensed assistant. This study provides evidence for the view that the nursing role is subject to redefinition at both the basic and advanced levels.

In 2005, Rosemary Bryant developed an Issues Paper published by the International Council of Nurses on regulation, roles and competency development. Bryant highlighted that initial and continued competence are particularly relevant today as there is pressure by the public for more transparency in health professional regulation and for greater consumer involvement….education of nurses, initial and continuing competence, employer responsibilities, role definition, overlap and skills mix all interact to reach the end point. "What is unambiguous in this rich interplay is the obligation and responsibility of professional nursing organizations to participate in all of these elements….Skills mix, new roles and role overlap all has implication for regulation and competency development…." Bryant's paper is an overview of the contemporary evidence and opinion of the workforce implications of regulation, competency development and role definition. "These three elements are inextricably linked to each other and are fundamental to the practice of nursing in today's environment. Delegation of nursing care and its relationship to regulation is particularly important in this context".

The International Council of Nurses' Position Statement on Career Development in Nursing highlights that to "*realize its full potential, career development of nursing personnel needs to evolve within the context of the health system as a whole and must allow for horizontal as well as vertical career mobility. Career mobility in nursing may be defined as the movement of nurses to more advanced levels, to different areas of nursing practice or to positions in which different functions predominate, including nurse entrepreneurship and independent, autonomous professional roles (e.g. advanced practice, consultant).*

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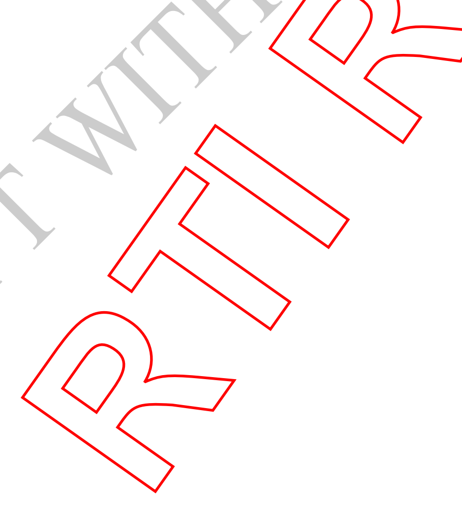
Career mobility is important to nurses in furthering their careers and to society in allowing nursing to adapt and respond to changing health needs. Career mobility enables nurses to achieve personal career goals and contributes to the nursing profession by raising the competency of its members. Career mobility allows nursing to respond to scientific, technological, social, political and economic changes by modifying or expanding the roles, composition and supply of nursing personnel to meet identified health needs.

Research nurses and members of the Research and Evidence-based Practice Steering Committee highlighted Peter McCallum Cancer Centre's ('Peter Mac') work on Advanced Practice Nursing, and the *Peter Mac Nursing Career Model (Appendix 1*), following page of this report. This Career Model was a very similar layout to the matrix developed by the Project Team. However, the major difference was the diversity of positions within each classification from Grades 3-7, approximately our equivalent to Grades 6 – 9. The matrix approach to visualize career pathways across the four streams rather than the traditionally linear table is also evidenced in the Northern Territory Public Sector Career Pathways for Nurses and Midwives included in the following page of this report.

The Australian Nursing and Midwifery (Accreditation) Council (ANMC) released in 2007 a national framework for the development of decision-making tools for nursing and midwifery practice identifies that:

The United Kingdom's Royal College of Nursing has developed an integrated core career and competence framework for registered nurses, which their Chief Nursing Officer states is a key feature to driving service and role redesign. The NHS also has a careers framework and job evaluation methodology which provides the opportunity to break down traditional occupational boundaries, enables greater movement and transferability of skills and provides better career opportunities for all staff. Key to these changes will be effective mentoring arrangements.



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Appendix 1: Peter Mac Nursing Career Model

Nursing Career Structure October 2010

Grade	Management Role	Clinical Role	Research Role	Education Role	Qualifications
Executive Contract	Exec. Director of Cancer Nursing				Masters/Doctorate
Grade 7			Professor Director Cancer Nursing Research		PhD
Grade 6	Nurse Directors* Infection Control Manager*	Apheresis Nurse Consultant* Nurse Practitioner*	Clinical Trials Nurse Director Deputy Director Cancer Nursing Research (PhD)*	Nurse Director Education* & Credentialing	Masters/Doctorate/ PhD
Grade 5	Associate DON*/PSM Clinical Product Coordinator	Clinical Nurse Consultant*, Clinical Nurse Co-ordinator – Advanced Practice (APN) Quality and Safety Coordinators	Senior Clinician Researcher Senior Clinical Trials Manager	Senior Lecturer Practitioner Senior Educator Coordinator*	Masters/Doctorate/ PhD
Nurse Manager	Nurse Unit Managers*				Grad. Dip/Masters
Grade 4	Project Roles ANUM PM@H* ESAS Manager No Lift Co-ordinator Clinical Product Advisor	Clinical Nurse Co-ordinator Transfusion Practice Nurse Smoking Cessation Nurse Practice Development Nurse - (APN Masters) ICU Liaison Nurse Pre Admission Nurse Cancer Support Nurse	Clinician Researcher Clinical Trial Manager	Lecturer Practitioner Clinical Nurse Educator Program Coordinators - Nursing Education	Graduate Dip/Masters
Grade 3	Associate Nurse Manager* Project Officer Operating Suite Equipment Nurse	Practice Development Nurse HiTH Liaison Nurse* Visiting and HITH Nurse*	Clinical Trial Nurse/Research Assistant	Graduate Support Nurse	Graduate Cert./Graduate Dip.
Clinical Nurse Specialist		Clinical Nurse Specialist* (Ward or Clinical Service) Clinical Trials Nurse	Clinical Trial Study Co-ordinator		Graduate Cert.
Grade 2		Registered Nurse*, Graduate Nurse*			Ba. Nursing
EN Adv Diploma		Enrolled Nurse* General Wards and Clinics			Adv. Diploma
EN Diploma					Diploma
EN Post Basic					Post Basic Module 6 Mths/Med. Admin
EN Cert.					Certificate IV

* Denotes EBA Imbedded Position

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DEPARTMENT OF HEALTH AND FAMILIES

NT Public Sector Nursing and Midwifery Career Pathways

Registered Nurse/Midwife (N3-N8)			Enrolled Nurse Specialist (N1)
Clinical	**Management and Policy**	**Education and Research**	**Clinical**
Clinical Nurse Specialist (Acute, Mental Health)	Clinical Nurse Manager (Acute, Community, Mental Health)	Clinical Instructor (specialty)	Renal
Clinical Nurse Specialist – Child and Family Health	Primary Health Care Manager	Clinical Nurse Educator (specialty)	Community Health
Clinical Nurse Specialist – Community and Primary Care	Nurse Resource Coordinator – Hospitals	Nurse Education Consultant (specialty)	Operating Theatres
Clinical Nurse Specialist – Discharge Planning	Nurse Program Coordinator – Hospitals	Nursing Education Adviser (specialty)	Paediatrics
Health Promoting School Nurse	Nurse Coordinator Remote	Nursing Director Education	Emergency Department
Primary Health Care Nurse	Coordinator Professional Practice Nurses	Professor Clinical Nursing (DHF/CDU partnership)	Intensive Care
Community Mental Health Nurse	Nursing Director (specialty)		Mental Health
Public Health Nurse (specialty)	Director of Nursing/ Executive Director of Nursing		
Professional Practice Nurse – Remote	Senior Nursing Adviser (specialty)		
Clinical Nurse Consultant (specialty)	Project Consultant Nursing (specialty)		
Nurse Practitioner (specialty)	Principal Nursing Adviser		

NOTE: Midwife can be substituted for Nurse where applicable.

i'm a territory nurse   www.nursing.nt.gov.au   i'm an outback midwife

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ADDENDUM 8: SUBMISSION FROM GRADE 8 NURSE PRACTITIONER EXECUTIVE COMMITTEE – FEBRUARY

- The (NP)role sits across all domains – clinical leadership, management, education and research
- Consideration of additional bands within NP - Level 1 and 2 as no recognition for depth of knowledge and expertise over time
- Consideration of an allowance for Masters qualification other than NP qualification
- Rights to private practice arrangements and the opportunity to review employment arrangements under this model
- Definition of the Nurse Practitioner Candidate (NPC) role and creation of positions in this stream
- Operational reporting structures for NP up the career structure and across services is often difficult (operational V professional)
- Succession planning, leave relief and lack of flexibility in work arrangements for NP to improve work life balance
- More flexibility to move across all nursing streams
- Professional development allowance for NP is inadequate given high level skills and knowledge required (money for the above should be increased at least by 33% - given the additional national registration requirements for an additional 10 points related to endorsement)
- NP / DON role in rural setting – clarification
- Some Nurse Practitioners wish to be integrated into the classification and career system as one of the choices for career progression but maintain their ability to progress to clinical, management, education or research streams, if desired.

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ADDENDUM 9: POTENTIAL ADDITION TO GRADE 8 GENERIC LEVEL STATEMENTS

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Is a Registered Nurse and or Registered Midwife who demonstrates a level of maturity in advanced practice, leadership, education and research skills, and highly developed capability in one or more of the four streams: clinical, management, education or research. The role is responsible for operational, effective coordination of resources aligned to standards of practice across a facility and/or a Division/Service Line within a facility/Local Hospital Network.

Generic

- Demonstrates leadership and management skills associated with problem solving complex situations
- Collaborates in the development of priorities and implements strategies
- Collaborates in advancing and sustaining a work based culture
- Demonstrates leadership in negotiation and communication to enhance working relationships
- Demonstrates effective human, material, financial and resource management related to service requirement
- Supports ethical decision making
- Demonstrates expert knowledge and application of contemporary nursing and midwifery practice
- Support application of quality improvement initiatives within a quality framework
- Engages with colleagues and partners to progress change and service provision

Clinical (Sole Practitioner)

is a Registered Nurse and/or Registered Midwife who is responsible and accountable as a sole practitioner for provision of direct clinical care in a remote setting and has no nursing staff reporting to the position. It is desirable they have completed the *Rural and Isolated Practice Health (Drugs and Poisons) Regulation 1996* - Registered Nurse Course or they are an endorsed Nurse Practitioner.

The Sole Practitioner is accountable for the non-nursing operational staff and managing the facility (Level 1-2 Clinical Services Capability Framework).

Management (Policy / project / program planning / implementation / monitoring)

Is a Registered Nurse and or Registered Midwife who demonstrates advanced policy development, program and/or project implementation skills. The role is responsible for managing the process of planning, implementing and monitoring of all aspects of policy, program and/or project management cycles in a local or network wide setting. It may also include embedding best practice into integrated clinical practice and service delivery through change management processes.

Consultation, facilitation, negotiation and conflict resolution skills are required. Social marketing combined with strong interpersonal and written communication skills are essential.

Education

Is a Registered Nurse and or Registered Midwife who demonstrates advanced leadership and highly developed capability in education. The role is responsible for operational activities and effective coordination of educational resources and programs of learning aligned to standards of practice across a facility and/or a Division/ Service Line across multiple sites/ or Network wide focus.

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The role also:

- Demonstrates expertise in the application of contemporary educational theory to evidence based nursing practice
- Demonstrates educational expertise and leadership in the application of organisational and professional practice needs related to specific workplace learning requirements
- Displays innovation in the development of nursing education initiatives related to resources and programs of learning requirements
- Coordinates education resources and programs to achieve Key Performance Indicators or service related outcomes
- Demonstrates effective negotiation and communication skills in developing constructive working relationships.

Alternative to this: Lecturer Practitioner

Senior nurse who can utilise these skills in clinical practice and develop junior nurses. A potential pathway for nurse educators and CNCs, combined advanced clinical skills with education skills and through attainment of a higher degree and affiliation to an accredited higher educational provider.

Research (Policy / project / program design, development, evaluation)

Is a Registered Nurse or Registered Midwife who demonstrates advanced research skills and experience in the nursing or midwifery profession, and has contributed to the development of an evidence base in a specialty. This role has an overt imperative to generate new knowledge and establish best practice evidence available within a specified clinical environment through the design, development or evaluation of a policy, project or program across multiple sites or Network wide focus.

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ADDENDUM 10: DESK TOP REVIEW RECOMMENDATIONS

The Desktop Review was presented to the Project Reference Group in February 2011, with the following set of Recommendations agreed upon at the May 2011 meeting:

i. Queensland Health needs to consider consistent statewide policy through Health Service Districts for:

ii. the benefits of Assistants in Nursing receiving professional recognition and regulation through registration with the Australian Health Practitioners Registration Authority; and

iii. Minimum qualifications for AINs such as Certificate III

iv. Consistent statewide policy on the scope of practice and expected competencies of second and third year undergraduate students in nursing needs to be mandated (such as the Townsville HSD model), combined with statewide marketing of the benefits of recognizing AINs engaged in undergraduate studies as USINs

v. USIN Generic Level Statement to be updated and included in the development of revised Generic Level Statements post-consultation phase of this project

vi. Possible pay progression points for third year USINs from AIN may increase the motivation for AINs to gain this recognition from their employer

vii. A more descriptive generic level statement is required for the Grade 3 Enrolled Nurse to be updated and included in the development of revised Generic Level Statements post-consultation phase of this project. Work completed by the Sunshine Coast Health Service District's Professional Practice Model Generic Enrolled Nurse Staff Development Plan will form the basis for this revision.

viii. The Enrolled Nurse in Advance Practice (ENAP), Grade 4, has had varied utilisation from Health Service Districts due to the lack of clarity around what is defined as advanced practice and the role descriptors within the generic level statement of what this means for an Enrolled Nurse. It is dependant on the business practices of each business unit to identify need and establish these positions. Addendum 11 is a draft statewide policy pending EB8 negotiations.

ix. Future work on the ENAP role may include dissemination statewide of what constitutes advanced practice for each context or setting, with many facilities already establishing these parameters.

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ADDENDUM 11: DRAFT – ENROLLED NURSES - ADVANCED PRACTIVE (ENAP) DIRECTIVE – HUMAN RESOURCES COORDINATION

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Identifying ENAP positions – What to Consider?:

The ENAP position is established by a Health Service District based on an identified need. The positions designated by the Health Service District, which require EN Advanced Practice, must add value to the services provided by the facility.

It is recommended Districts consider the following when identifying ENAP positions:

- how do the specific responsibilities of the ENAP in this unit/area add value to the Health Service
- how does the position of ENAP in this unit/area differ from the (regular) Enrolled nurse position in this unit/area – units/areas should provide a clear description of how the two roles differ in that unit
- does the ENAP role in this unit/area meet the delegation, supervision and accountability criteria expected by the Health Service
- is the ENAP the most appropriate level nurse to undertake the intended role in terms of cost, quality, responsibility and scope of practice
- does implementation of the ENAP role in this unit/area meet the principles outlined in the Business Planning Framework: Nursing Resources (step 3 - Determining skill mix/category)
- will implementation of this role impact on other roles in the area? If so have strategies been developed to address issues
- is the specific role (and associated competencies) for this unit/area consistent with the generic position description and selection criteria (see below)
- is there an appropriate education program in place (or being developed) to support both the incumbent in the role, and succession planning for Enrolled nurses.

Background

The introduction of the *Nurses (Queensland Health) - Section 170MX Nurses Award 2003* provided for the implementation of the Enrolled Nurse (Advanced Practice) role. The MX Award states the ENAP is an employee who is appointed to that classification and practices at an advanced level beyond that of an Enrolled Nurse.

The advanced practice is context specific within each of the following 4 domains: Care Delivery/ Clinical Responsibilities; Learning and Inquiry; Leadership Responsibilities; Networks Partnerships and Teamwork Responsibilities.

The purpose of this summary document is to attempt to provide preliminary guidelines in relation to identifying, establishing and appointing to ENAP positions, as requested by the Australian Workers Union (AWU).

ENAP role requirements

The concept of 'advanced practice' is context specific. This refers to the environment in which nursing is practising in and includes the type of service provided, the resources available, the physical setting and the complexity of services required by the people.

It is recognised that not all enrolled nurses are practising, or would practise, at an advanced level. Enrolled nurses in ENAP positions will practise at an advanced level as identified in the position description.

Most areas requiring an ENAP position will require the incumbent of this position to have their Endorsement to Administer Medications, however it should be noted that this endorsement alone does not demonstrate Advanced Practice.

The requirement for an ENAP position is based on the complexity of services required and the availability of resources, both human and material, necessary to provide those services.

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Establishing and filling ENAP positions

When an ENAP position is identified, the process for establishing the position will depend on the availability of suitably skilled and experienced ENs in the work unit. If the employer can identify a need for an ENAP in a certain work unit, and an existing EN in the unit possesses the skills and experience to allow them to practice and function in a broader scope than an EN, reclassification of an existing EN position can be sought in accordance with HR Policy B7 Nursing and Midwifery Classification Structure. Alternatively, new positions can be created at the ENAP (Grade 4) level.

An enrolled nurse can be directly appointed to an ENAP position if they meet the eligibility criteria for direct appointment as outlined in HR Policy B1 Recruitment and Selection, and demonstrate advanced practice within each of the stipulated four domains as outlined in the Generic Level Statement (below).

If there are more existing ENs in the work unit that meet these eligibility requirements than there are ENAP roles to fill, approval to use a specified vacancy advertising (previously known as limited applicant pool or closed merit) process can be considered in accordance with HR Policy B1. If no existing EN meets the direct appointment eligibility criteria and advanced practice requirements, the ENAP position would have to be advertised and appointed to through an open merit process.

ENAP Generic Level Statement

Applications for the ENAP role focus on demonstrated advanced practice in each of the Four Domains of Practice (these domains from the Nurses 170MX Award 2004 have been incorporated into the Nursing and Midwifery Classification Structure - HR Policy B7):

1. Care Delivery/Clinical Responsibilities
   The ENAP will demonstrate a greater depth of knowledge and experience, and more effective integration of theory to practice. The ENAP provides care at an advanced level under supervision of a Registered Nurse and in accordance with the Queensland Nursing Council's Scope of Nursing Practice Decision Making Framework. This would include ability to practise more autonomously with supervision by the Registered Nurse being more often indirect rather than direct. The ENAP would also collaborate with the Registered Nurse in the development of nursing care plans and the provision of nursing care in order to complement the Registered Nurse role.

2. Learning and Inquiry
   The ENAP will demonstrate performance that enhances self professional development and professional development of others. This will include initiation of an ongoing professional development program for self, involvement in peer review and participation in activities related to the enhancement of context specific practice. The ENAP will also contribute to clinical research at a unit level and contribute to and support the implementation of evidence based practice.

3. Leadership Responsibilities
   In the demonstration of leadership responsibilities, the ENAP will act as a role model within the health care team. This would include contributing to the development, implementation and review of ward/service business plans. The ENAP will also provide support and direction, within their level of competence, to other Enrolled nurses and Assistants in Nursing. The ENAP may also take responsibility for unit activities other than direct patient care e.g. workplace health and safety officer, manual handling coordinator.

4. Networks, Partnerships and Teamwork Responsibilities
   The role requires the ENAP to demonstrate sound and effective communication skills with members of the health team, patients, families, visitors and staff from other agencies. This would include initiating, maintaining and using team networks in a mature, confident and assertive manner to achieve positive patient outcomes. The ENAP also participates in local and District projects, activities and committees as appropriate.

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Generic key responsibilities/criterion (suggested as a template)

1 Ability to contribute at an advanced level to the nursing assessment and care of individuals and groups by practising within their Scope of Practice as an Enrolled Nurse (Advanced Practice), demonstrated by:

i. proficiency in the clinical competencies required for <specific area of practice>; and
ii. an advanced level of integration of theory and practice; and
iii. an ability to practice more autonomously under mostly indirect supervision of the registered nurse; and
iv. an ability to respond appropriately in emergency situations until a registered nurse or medical officer is available; and
v. contributing to evidence based practice through participation/support of quality improvement activities and research as applicable.

2 Ability to provide leadership within context of practice as an enrolled nurse, and to contribute to professional practice within the unit.

3 Actively participating in own professional development and contributing where applicable to the development of others.

4 Ability to practice collaboratively with the health care team to promote the safety, security and personal integrity of individuals and groups, including demonstrated effectiveness in communication and interpersonal skills.

5 Knowledge of, or an ability to acquire knowledge of, procedures, policies, regulations and standards which impact upon the position, in particular Public Sector Guidelines, and a knowledge of contemporary human resource management issues such as workplace health and safety, equal employment opportunity, and anti-discrimination.

ENAP classification

Once appointed as an ENAP, an enrolled nurse will be remunerated in accordance with the wage rates stipulated for a Nurse Grade 4 in the *Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009*.

If an ENAP is required to relieve in another work unit in the capacity of an enrolled nurse (Grade 3), they will still be paid at the ENAP level (Grade 4).

If an ENAP requests a transfer at level in accordance with HR Policy B41 Transfers in Queensland Health, and an ENAP position is available in the other unit, the ENAP must be able to demonstrate they could meet the advanced practice requirements in that unit.

References/For more information see:

Southern Queensland Renal Clinical Network's Enrolled Nurse Advanced Practice Renal Implementation Guide, available at http://www.health.qld.gov.au/cpic/documents/renal_enap_v3.pdf

Townsville Health Service District's District Procedure: Career and Education Pathway for Enrolled Nurses, available at http://qheps.health.qld.gov.au/tville/policies/thsdsup/thsdsup100465.pdf

Nurses (Queensland Health) - Section 170MX Award 2003
Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009
Queensland Health Nurses and Midwives State Award 2011

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ADDENDUM 12: REVISED GENERIC LEVEL STATEMENTS

Introduction

Introduction

The Generic Level Statements are a refinement and enhancement of the former Generic Level Statements in the *Nurse (Queensland Health) Section 170MX Award 2003* and the *Queensland Health Nurses and Midwives Interim Award – State Award 2011* to capture the essence of the work level performed for each role in each grade. There is a strong relationship with business planning and models of care frameworks.

Nurses and midwives want the option to maintain clinical skills when performing management and executive roles, and to work across streams, depending on the model of care and subsequent role design. This document provides generic level statements Generic Level Statements for all Queensland Health nurses and midwives, outlining the broad duties, skills and responsibilities of each nursing and midwifery grade (from 1 to 12) within this classification system. The Generic Level Statements provide for hybrid roles as most nursing and midwifery roles have varying emphasis from each of the four streams: clinical, management, education and research.

The Classification and Career model on page 7 outlines the variety of roles for Queensland Health nurses and midwives, articulating career mobility, both horizontal and vertical. It will remain the Local Health and Hospital Network's discretion to design organisational structure and link to service, business planning and models of care frameworks.

Although the Generic Level Statements provide a generic description of nursing and midwifery roles at each of the given nursing levels, they are not a role description and are not designed to be used as such. The definition of a Generic Level Statement is a broad, concise statement of the duties, skills and responsibilities. By nature they are generic and can be expanded upon for the purposes of developing a role description. Generic level statements Level Statements enable the creation of new and emerging roles and identify from this the appropriate grade in which the position should be remunerated.

Context and settings underpinning the Generic Level Statements

Context and settings underpinning the Generic Level Statements

Queensland Health's nurses and midwives are employed in a wide range of contexts and settings, with many employed in an advanced practice role. These are captured through the Specialisation Framework on page X5, which describes the current clinical environment, comprised of a multitude of practice strands, specialties and common skill domains. The Specialisation Framework is consistent with the nationally developed framework for categorising nurses and midwives.

The Generic Level Statements should be used as a flexible tool, applicable to any context or setting, inclusive of unique, innovative or emerging roles including informatics or statewide services such as

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the Nursing and Midwifery Office Queensland, Patient Safety and Quality Management;;, Retrieval Services Queensland, Public Health, Offender Health, DonateLife Qld Organ and Tissue Service and service planning. Nurses and midwives are leading models of care across the continuum of population health - prevention, screening, early detection and intervention, primary and secondary care through to treatment, follow up, chronic disease management and end of life care. The Nursing and Midwifery Office Queensland has the authority to formally approve these emerging roles and Generic Level Statements if and when they evolve throughout the life of this Agreement / Award.

As part of the *Nurses (Queensland Health) Certified Agreement (EB6) 2006* (the Agreement) Queensland Health and the Queensland Nurses' Union developed and implemented the twelvetwelve12 grade classification structure for nurses and midwives, in recognition of the expanding roles of nurses and midwives in Queensland Health. These roles have been one of the major changes in health service delivery globally, with the emergence of various specialist and advanced practice nursing and midwifery roles over a number of decades. Advanced practice roles continue to be defined in the Australian context, and are expected to be clarified by the national regulation authority in due course.

Advanced nursing practice is an umbrella term describing an advanced level of clinical nursing/midwifery practice that maximises the use of graduate educational preparation, in depth nursing or midwifery knowledge and expertise in meeting the health needs of individuals, families, groups, communities and populations. It involves analysing and synthesising knowledge, understanding, interpreting and applying nursing theory and research and developing and advancing nursing knowledge and the profession as a whole. Nurses and midwives employed in the roles classified at Grades 4, 6 – 8 are working within the advanced practice levels identified by Queensland Health's career structure.

Nurses and midwives practicing at an advanced level may be educationally prepared at post-graduate level and may work in a specialist or generalist capacity. However, the basis for recognition of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse/midwife-patient/client/woman relationship to achieve optimal outcomes, through critical analysis, problem solving and accurate decision making. Tenure or years of practice does not automatically equate to an advanced practice role.

Nursing and Midwifery Role Design

After consideration of the population's' needs and subsequent service requirements, the appropriate models of care and the existing organisational structure within the application of the Business Planning Framework, a new role or re-design of an existing role must include a consultation process between Human Resources Coordination, the nurse / midwifery executive and employee/s affected by the change (and their representative/s).

Application of the Generic Level Statements

Application of the Generic Level Statements

The health reform agenda is orienting health services back to more patient centric models, based on community and population health needs. Models of care and business planning are based on the

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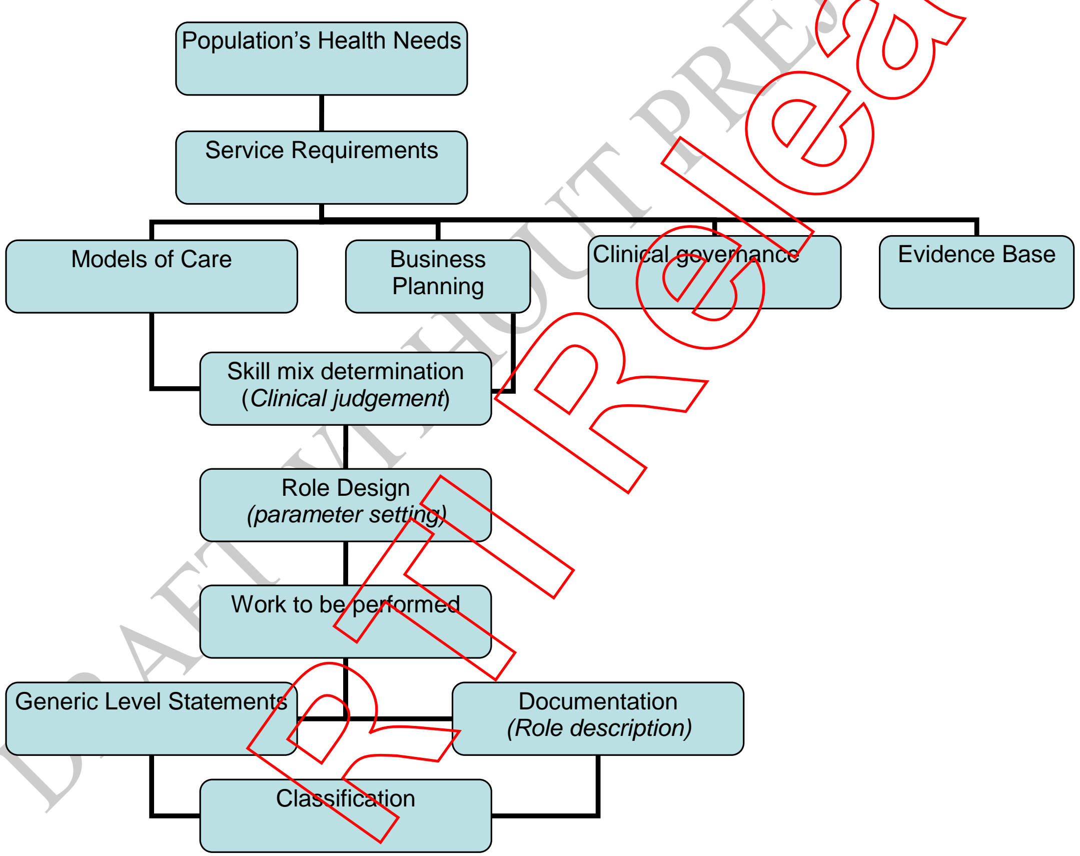
population's needs and their subsequent service requirements. The development of service profiles is critical to identifying these service needs. Clinical governance and the evidence based for clinical practice also need to be foremost principles in the development of new or re-oriented nursing and midwifery roles. Role design and its parameters are part of the workforce planning process, in tandem with skill mix determination using professional judgment about the work that needs to be performed. The next step in the role design process is its documentation through the development of a role description. The Generic Level Statements are an instrument to cross-reference the role description and to assist in determining work level and the appropriate classification of the role. The benchmarking of positions and the central repository for standardised role descriptions for each position enables the nurse manager and executive to access the right information in a timely way, at the same time promoting consistency and equity across the Local Health and Hospital Networks.

Newly established or re-designed roles will be allocated to a level based on an evaluation of all aspects of their role. This includes appropriate consideration of the responsibilities across the four streams of the career structure: clinical, research, education and management.



Role Evaluation

Queensland Health has introduced initiatives aimed at facilitating greater equity by adopting a more consistent and transparent approach to governing classification and career paths. An integral step to this is the establishment of the Nursing and Midwifery Peer Evaluation and Advisory Panel, (NMPEAP) a centralised governance process for evaluation of senior nursing and midwifery roles.

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Queensland Health is continuing its commitment to facilitate greater equity and consistency across the health care workforce.

The NMPEAP meets regularly to evaluate roles from grades Grades 7 -12. The Panel consists of representatives from the parties, including the Workplace Relations and Work Value Units, Nursing and Midwifery Office Queensland, professional and industrial officers from the relevant unions. This will be articulated in policy agreed to by the parties.

Job Titles / Naming Conventions

A nationally consistent approach to job titles and classifications in the future will assist with data collection and workforce planning. Consistent naming conventions are an important tool in identifying and measuring our workforce and understanding roles, and should be applied whenever possible:

- Nursing and midwifery titles should contain the word Nurse / Midwife, a descriptor may be applied post title eg Clinical Nurse Consultant (Haematology/Oncology); Nurse Researcher (Clinical Trials), Midwife Unit Manager (Birthing Centre);
- Whenever possible titles should be consistent with the career streams in the new Nursing and Midwifery Classification Structure;
- The title should reflect the job so that a non-health professional can read and understand what the person's job is;
- The title should fit on a name badge and be legible;
- Whatever nursing/midwifery title is selected, it should be followed by the management and executive in the naming of positions and this nomenclature should be consistently documented in other policy, legal and industrial documents to describe the various roles and titles to avoid confusion and ambiguity; and
- In the event that a title cannot be found for a nursing or midwifery position or a title is in need of change or development, the manager is required to consult with the Work Value Unit. The Unit will instigate the same governance process that the re-classification of a new or existing position triggers for advice and direction, prior to any application of the new title for the nursing or midwifery position.

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Recognition of qualifications recognised for entry into the Nursing and Midwifery Classification

Requisite qualifications are required to be an Enrolled Nurse, Registered Nurse, Registered Midwife, and Nurse Practitioner.

All grade five Grades 5-12 roles must be performed by Registered Nurses / Midwives nurses and midwives registered with the Australian Health Practitioner Regulation Agency (AHPRA).

Relevant qualifications are highly desirable in non-base grade positions.

Grades 5 -7 and 10 (1) are eligible for the Continuing Education Accelerated Advanced Entitlement (Clause 27 *Nurse (Queensland Health) Section 170MX Award 2003* Clause 27) / *Queensland Health Nurse and Midwives Award – State 2011*, Clause 5.7.2

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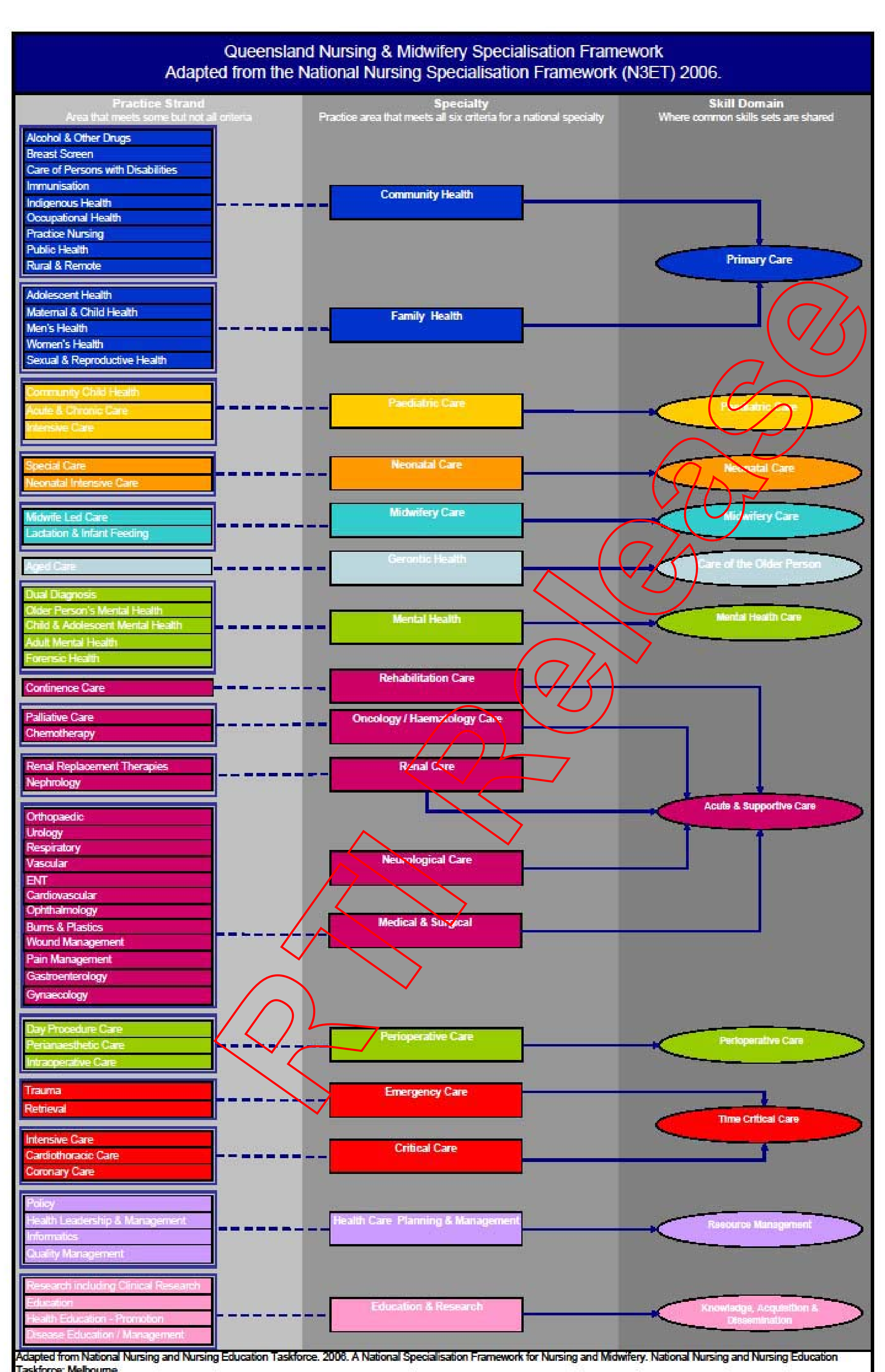

Adapted from National Nursing and Nursing Education Taskforce. 2006. A National Specialisation Framework for Nursing and Midwifery. National Nursing and Nursing Education Taskforce: Melbourne.

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Professional and Operational Reporting

Every nurse / midwife must have a professional reporting line to a registered nurse / midwife who has delegation to oversee their work.

Operational Management

Operational management (or line management) is the formal management of a team, unit or department. Duties include:

- attendance, work allocation, performance appraisal activities and workplace issues
- a single point of accountability (direct supervisor) and the primary and formal reporting line for employees
- supervision of a multidisciplinary team
- responsibility for recruitment and selection
- accountability for service activity and outcomes
- financial management
- quality assurance
- strategic planning and service improvement within organisational goals.

It is possible that a nurse or midwife may administratively inform and liaise with a lower grade if that is the logical organisational structure. This most commonly occurs with the Nurse Practitioner role operationally reporting to a Nurse Unit Manager.

Professional Supervision

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Professional supervision is an essential element of clinical governance and requires high frequency supervision within a clinical environment.

Multi or inter disciplinary teams

When the operational manager and the professional supervisor are not the same position performing professional and operation supervision, both positions are required to communicate regularly. Duties include:

- involvement and allocation of daily duties
- supervising caseloads
- developing technical skills and knowledge base
- providing feedback to the operational manager on performance appraisal activities and workplace issues
- informal supervision on a day to day basis

An example of operational management and professional supervision would be in a multidisciplinary team if the there is an HP Team Leader, and a professional report to the Nursing Director (if the service profiles indicate this is an appropriate model of care).

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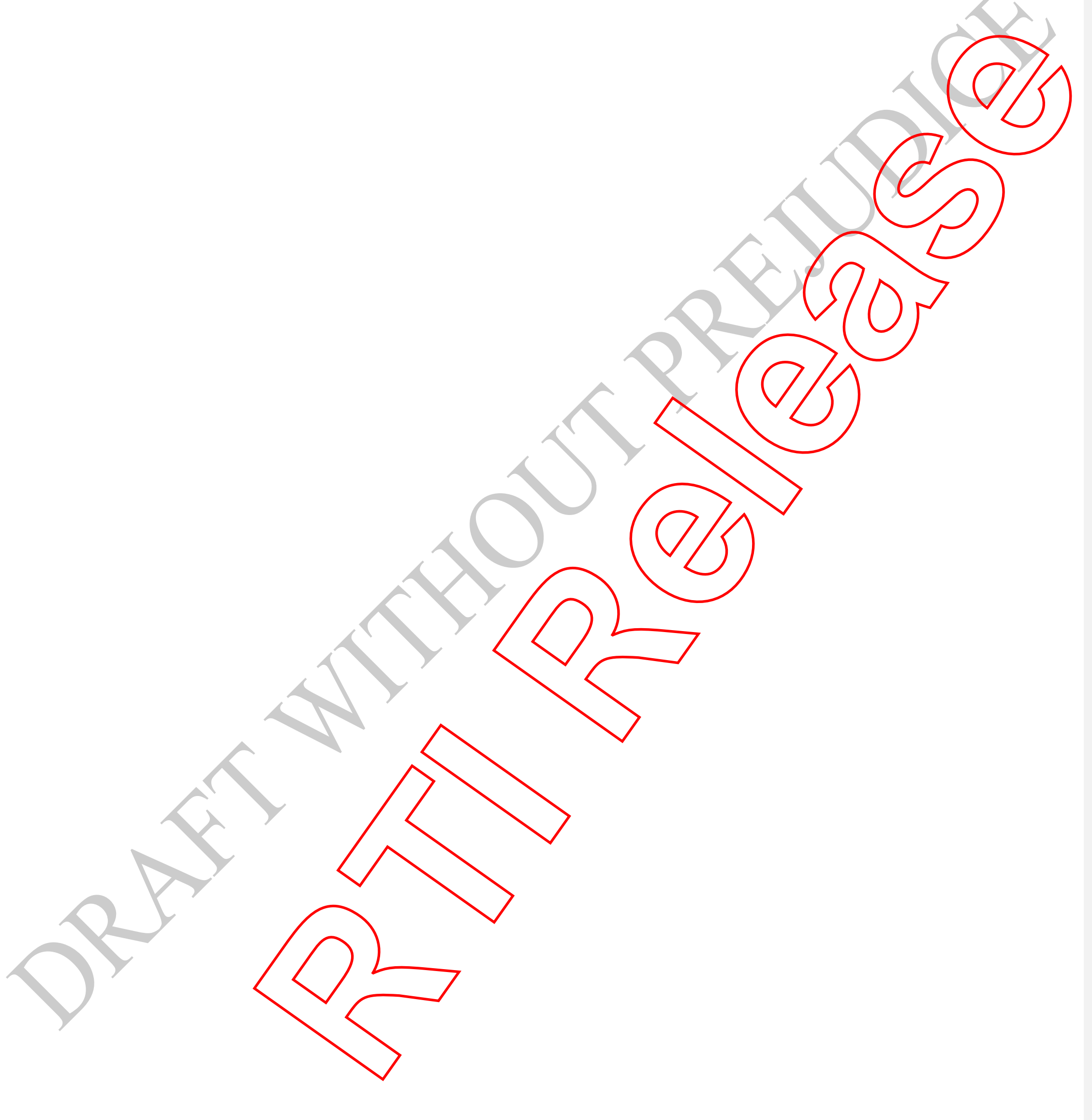
Another example is the Nurse Practitioner who may administratively inform or liaise with the Nurse Unit Manager of a service line, but professionally report to a Nursing Director/Director of Nursing of the Division / Facility.



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Nursing & Midwifery Career Structure

Clinical	Management	Education	Research
Executive Director of Nursing and Midwifery			
	Director of Nursing and Midwifery/ Facility Manager		
	Nursing/Midwifery Director (Management)	Nursing/Midwifery Director (Education)	Nursing/Midwifery Director (Research)
Nurse Practitioner* *(Masters)*	Nurse Practitioner* *(Masters)*	Nurse Practitioner* *(Masters)*	Nurse Practitioner* *(Masters)*
Nurse/Midwife Unit Manager	Nurse/Midwife Unit Manager	Nurse/Midwife Educator	Nurse/Midwife Researcher
Clinical Nurse/Midwife Consultant	Nurse/Midwife Manager		
Clinical Nurse/Midwife	Clinical Nurse/Midwife (Management)	Clinical Nurse/Midwife (Education)	Clinical Nurse/Midwife (Research)
Registered Nurse/Midwife*	Registered Nurse/Midwife*	Registered Nurse/Midwife*	Registered Nurse/Midwife*
Enrolled Nurse Advanced Practice *(Diploma)*	Enrolled Nurse Advanced Practice *(Diploma)*	Enrolled Nurse Advanced Practice *(Diploma)*	Enrolled Nurse Advanced Practice *(Diploma)*
Enrolled Nurse* *(Diploma)*	Enrolled Nurse* *(Diploma)*	Enrolled Nurse* *(Diploma)*	Enrolled Nurse* *(Diploma)*
Undergraduate Student in Nursing/Midwifery *(undertaking year 2–3 Bachelor of Nursing/Midwifery)*			
Assistant in Nursing	Assistant in Nursing	Assistant in Nursing	Assistant in Nursing

Informatics, Patient Safety and Quality, Service Planning, and Statewide Nursing and Midwifery Office Queensland roles can be integrated into the management or research stream.

* *Please note these titles are protected through national legislation*

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Nursing & Midwifery Classification Structure					
Nursing					**Midwifery**
Title	**Grade**	**Band**	**Pay Point**	**Mandatory Qualification**	**Title**
Assistant in Nursing	**Grade 1**		1 2 3 4 5 6		**Assistant in Midwifery / Maternity Support Worker**
Undergraduate Student Nurses	**Grade 2**		2nd Year Student 3rd Year Student	**Undertaking Year 2-3 Bachelor of Nursing / Bachelor of Midwifery**	**Undergraduate Student Midwives**
Enrolled Nurses	**Grade 3**		1 2 3 4 5	**Diploma**	
Enrolled Nurse Advanced Practice	**Grade 4**		1 2	**Diploma**	
Registered Nurse	**Grade 5**		Re-entry 1 2 3 4 5 6 7	**Bachelor of Nursing / Bachelor of Midwifery**	**Midwife (only)**
Clinical Nurse / Clinical Nurse (Clinical Management) / Clinical Nurse (Education) / Clinical Nurse (Research)	**Grade 6**		1 2 3 4	**Bachelor of Nursing / Bachelor of Midwifery**	**Clinical Midwife**
Clinical Nurse Consultant, Nurse Manager, Nurse Unit Manager, Nurse Educator, Nurse Researcher	**Grade 7**		1 2 3	**Bachelor of Nursing / Bachelor of Midwifery**	**Clinical Midwifery Consultant / Midwifery Unit Manager**
Nurse Practitioner	**Grade 8**		1 2	**Bachelor of Nursing / Bachelor of Midwifery & Masters Degree**	
Assistant Director of Nursing / Nursing Director	**Grade 9**	1 2 3	1 2 1 1	**Bachelor of Nursing / Bachelor of Midwifery**	**Assistant Director of Midwifery**

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Director of Nursing and Midwifery	Grade 10	1	1	Bachelor of Nursing / Bachelor of Midwifery	
			2		
			3		
		2	1		
			2		
		3	1		
		4	1		
			2		
Executive Director of Nursing and Midwifery	Grades 11 and 12		1	Bachelor of Nursing / Bachelor of Midwifery	

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GENERIC LEVEL STATEMENTS

Assistant in Nursing, Grade 1

An Assistant in Nursing (AIN) is an unlicensed health care worker appointed to the Grade 1 classification and is required to assist in the performance of nursing duties. The work of an AIN is under the direction and supervision of a Registered Nurse/Midwife.

An Assistant in Nursing works under the direction and supervision of a Registered Nurse/Midwife by assisting with the care of residents/patients as delegated by the Registered Nurse/Midwife. The Assistant in Nursing;

- performs a range of duties which require basic skills, training or experience;
- works within a multidisciplinary team and demonstrates an understanding of the mission and values of the organisation;
- demonstrates a commitment to personal and professional development and ensures that skills and knowledge relating to work remain current; and
- contributes to the residents'/patients' care needs by:
  - gathering information about resident/patients care needs by observing the resident/patient and reporting to the Registered Nurse/Midwife to assist the Registered Nurse/Midwife (and above) to assess, plan and evaluate care;
  - performing and reporting procedures as delegated by the Registered Nurse/Midwife (and above);
  - assisting with the resident's/patient's personal hygiene and appearance;
  - contributing to and maintaining the residents'/patients' care environment; and
  - contributing to the maintenance of a safe and secure environment for residents/patients and staff.

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Pay Point Progression

Progression within the AIN classification will occur upon completion of 12 months at the previous pay point (or the part time/casual incremental advancement requirements of the parent Award), however;

- AINs must have a relevant Certificate III qualification before progressing to pay point 3 with the exceptions mentioned in the grandparenting arrangements Nurses (Queensland Health) Certified Agreement (EB6) 2006 (Schedule Five).
- AINs can only progress past Grade 1(2) upon completion of 12 months (or part time/casual incremental advancement requirements) at that rate and have a Certificate III qualification. Where an AIN has 12 months or more at Grade 1(2) and obtains a Certificate III they will progress to Grade 1(3) as from the date of approval of the qualification.
- The targeted training allowance for AINs is to be paid when an AIN has been at AIN Grade 1 (6) for more than 12 months.

Twelve 12 Month Trained Assistant in Nursing – Central Sterilising Supply Department (CSSD)

A 12 months trained Assistant in Nursing is an employee who has undertaken a course of 12 months duration in CSSD, and where the satisfactory completion of such training is, in the opinion of the employer, relevant in the performance of duties; and does not lead to registration maintained by the Australian Health Practitioner Regulation Agency (AHPRA)..

The following shall apply in relation to pay point progression:

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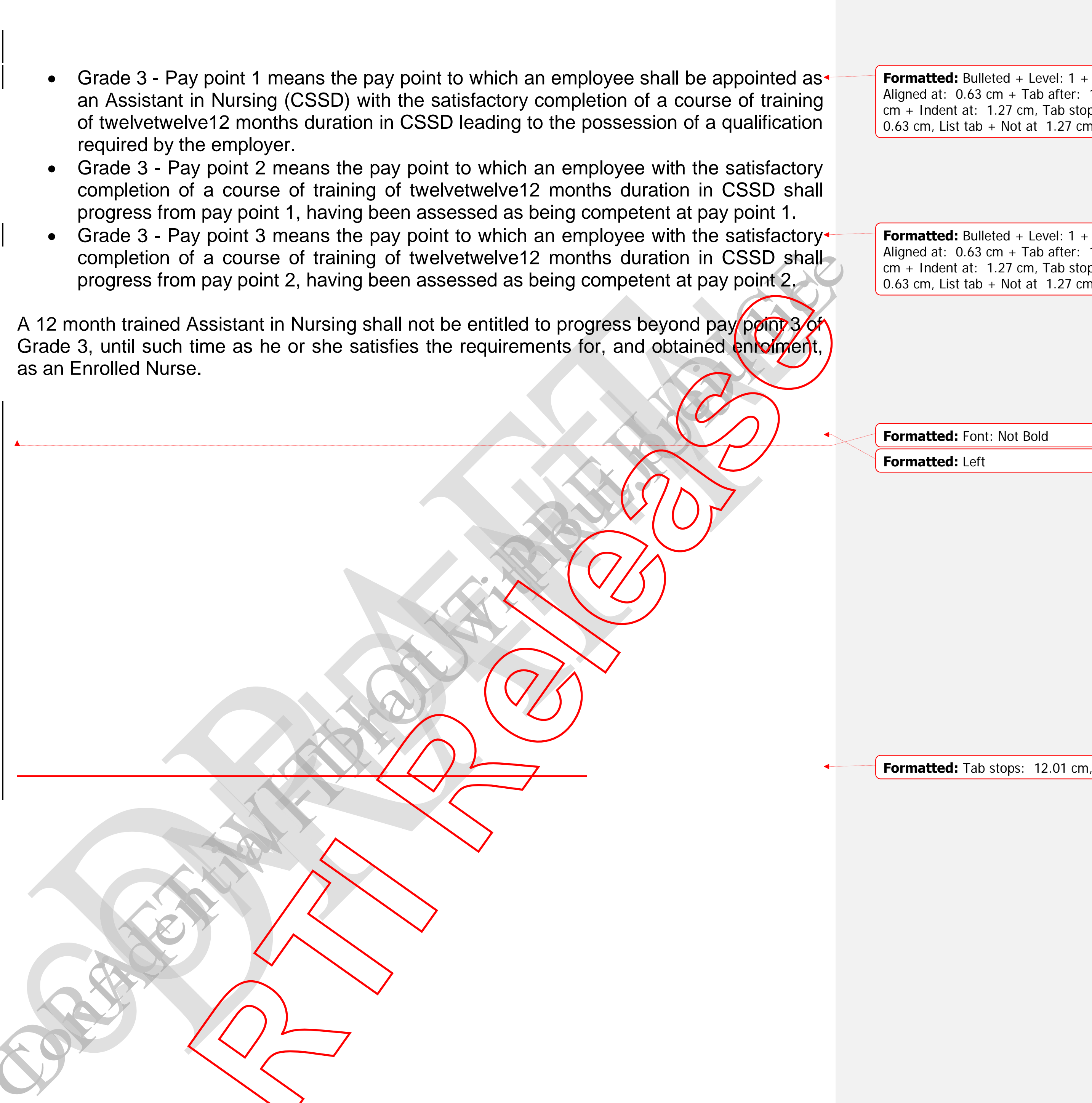
- Grade 3 - Pay point 1 means the pay point to which an employee shall be appointed as an Assistant in Nursing (CSSD) with the satisfactory completion of a course of training of twelvetwelve12 months duration in CSSD leading to the possession of a qualification required by the employer.
- Grade 3 - Pay point 2 means the pay point to which an employee with the satisfactory completion of a course of training of twelvetwelve12 months duration in CSSD shall progress from pay point 1, having been assessed as being competent at pay point 1.
- Grade 3 - Pay point 3 means the pay point to which an employee with the satisfactory completion of a course of training of twelvetwelve12 months duration in CSSD shall progress from pay point 2, having been assessed as being competent at pay point 2.

A 12 month trained Assistant in Nursing shall not be entitled to progress beyond pay point 3 of Grade 3, until such time as he or she satisfies the requirements for, and obtained enrolment, as an Enrolled Nurse.



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Undergraduate Student in Nursing / Midwifery, Grade 2

The Student in Nursing/Midwifery is a student of nursing / midwifery undertaking study and is in the second semester of second year or the final year of their university pre-registration nursing or midwifery qualification.

The Student in Nursing/Midwifery works under the direct or indirect supervision of a Registered Nurse/Midwife by assisting with the care of residents/patients as delegated by the Registered Nurse/Midwife. The Student in Nursing/Midwifery;

- performs a range of duties commensurate with the level of training and assessed competencies;
- works within a team and demonstrates an understanding of the mission and values of the organisation;
- contributes to the residents'/patients' care needs; and
- is registered with the Australian Health Practitioner Regulation Agency (AHPRA).

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Enrolled Nurse, Grade 3

An Enrolled Nurse is responsible for the provision of quality patient care, under the supervision of the Registered Nurse, as delegated by the Australian Health Practitioner Regulation Agency (AHPRA).and who holds a current annual licence with AHPRA.

The Enrolled Nurse performs within the core national competency standards mandated by AHPRA to assist nurses in delivering safe and competent care. These competency standards are broken in to the following domains:

DOMAIN: Professional and Ethical Practice

- Functions in accordance with legislation, policies and procedures affecting enrolled nursing practice.
- Conducts nursing practice in a way that can be ethically justified.
- Conducts nursing practice in a way that respects the rights of individuals and groups.
- Accepts accountability and responsibility for own actions within enrolled nursing practice.

DOMAIN: Critical Thinking and Analysis

- Demonstrates critical thinking in the conduct of enrolled nursing practice.

DOMAIN: Management of Care

- Contributes to the formulation of care plans in collaboration with the registered nurse, individuals and groups.
- Manages nursing care of individuals and groups within the scope of enrolled nursing practice.

DOMAIN: Enabling

- Contributes to the promotion of safety, security and personal integrity of individuals and groups within the scope of enrolled nursing practice.
- Provides support and care to individuals and groups within the scope of enrolled nursing practice.
- Collaborates with members of the health care team to achieve effective health care outcomes.

Refer to the AHPRA website for more information on the National Competency standards for the Enrolled Nurse: http://www.ahpra.gov.au/

Pay Point 1 [Re-entry]
Means the pay point to which an Enrolled Nurse who has been absent from nursing for a period of five years or more and who is no longer registered with AHPRA. An Enrolled Nurse undertaking a re-entry course accredited by the Australian Nursing and Midwifery Accreditation Council, will commence on Grade 3(1) rate during the period of training until the employee grains the appropriate competencies based on the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Enrolled Nurse. Once an employee is deemed competent all service including the period of training will be recognised for previous service.

Pay Point 2
Means the pay point to which an Enrolled Nurse with satisfactory completion of a Diploma in Nursing leading to enrolment as an Enrolled Nurse.

Progression beyond pay point 2 will occur upon completion of 12 months at the previous pay point (or the part time/casual incremental advancement requirements of the parent Award).

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Enrolled Nurse Advanced Practice (ENAP), Grade 4

An Enrolled Nurse (EN) - Advanced Practice is an Enrolled Nurse who is registered with the Australian Health Practitioner Regulation Agency (AHPRA), and practises at an advanced level within the context or setting in which they are employed.

The Enrolled Nurse - Advanced Practice role is service delivery based and will be created depending on organisational need. There is not an automatic progression or promotion to the Enrolled Nurse - Advanced Practice classification from the Enrolled Nurse classification level. [subject to EB 8 negotiation]

The Enrolled Nurse - Advanced Practice role is characterised by the following:

- Specialisation in an area or field of practice
- A higher level of clinical knowledge and skills informed by further education and context-specific competencies
- A greater level of responsibility in the management of client care, which may include clinical and non-clinical roles
- Acting as a resource to other staff; and
- More indirect level of supervision.

Requirements for the advanced enrolled nurse were refined and enhanced in Queensland Health within the four domains of the national competency standards for the Enrolled Nurse:

DOMAIN: Professional and Ethical Practice

The Enrolled Nurse - Advanced Practice will demonstrate performance that enhances self professional development and professional development of others. This will include initiation of an ongoing professional development program for self, involvement in peer review and participation in activities related to the enhancement of context specific practice. The Enrolled Nurse - Advanced Practice will also contribute to clinical research at a unit level and contribute to and support the implementation of evidence based practice.

DOMAIN: Management of Care

The Enrolled Nurse - Advanced Practice will demonstrate a greater depth of knowledge and experience, and more effective integration of theory to practice. The Enrolled Nurse - Advanced Practice provides care at an advanced level within the context of practice and can practise more autonomously with supervision by the Registered Nurse being more often indirect rather than direct. The Enrolled Nurse - Advanced Practice would also collaborate with the Registered Nurse in the development of nursing care plans and the provision of nursing care in order to complement the Registered Nurse role.

DOMAIN: Critical Thinking and Analysis

In the demonstration of leadership responsibilities, the Enrolled Nurse - Advanced Practice

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will act as a role model within the health care team. This would include contributing to the development, implementation and review of ward/service business plans. The Enrolled Nurse - Advanced Practice will also provide support and direction, within their level of competence, to other Enrolled Nurses and Assistants in Nursing. The Enrolled Nurse - Advanced Practice may also take responsibility for unit activities other than direct patient care e.g. workplace health and safety officer, manual handling coordinator.

DOMAIN: Enabling

The role requires the Enrolled Nurse - Advanced Practice to demonstrate sound and effective communication skills with members of the health team, patients, families, visitors and staff from other agencies. This would include initiating, maintaining and using team networks in a mature, confident and assertive manner to achieve positive patient outcomes. The Enrolled Nurse - Advanced Practice also participates in local and Local Health and Hospital Network projects, activities and committees as appropriate.

Refer to the AHPRA website for more information on the National Competency standards for the Enrolled Nurse: http://www.ahpra.gov.au/

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Registered Nurse, Grade 5

A Registered Nurse is a nurse licensed to practise nursing without supervision and who assumes accountability and responsibility for own actions and acts to rectify unsafe nursing practice and/or unprofessional conduct. It is essential that the nurse is registered by the Australian Health Practitioner Regulation Agency and holds a current practising licence. The Registered Nurse performs within the national competency standards to assist nurses deliver safe and competent care.

The nurse may be a beginning to an experienced practitioner or a Registered Nurse returning to the field after a period of absence.

The nurse will follow the Code of Ethics for Nurses in Australia and the following Value Statements:

- Nurses value quality nursing care for all people.
- Nurses value respect and kindness for self and others.
- Nurses value the diversity of people.
- Nurses value access to quality nursing and health care for all people.
- Nurses value informed decision making.
- Nurses value a culture of safety in nursing and health care.
- Nurses value ethical management of information.
- Nurses value a socially, economically and ecologically sustainable environment promoting health and wellbeing.

Responsibilities

The Registered Nurse provides nursing care based on the national competency standards to a group of patient/clients in collaboration with other health service providers.

These National Competency standards competencies are grouped into 4 domains:

Professional Practice

A Registered Nurse demonstrates a satisfactory knowledge base, accountability for practice, functioning in accordance with legislation affecting nursing, and the protection of patients'/clients' rights.

Critical Thinking and Analysis

A Registered Nurse undertakes self-appraisal, professional development and values evidence and research for practice. Reflecting on practice, feelings and beliefs and the consequences of these for patients/clients, is considered an important professional benchmark.

Provision and Coordination of Care

A Registered Nurse is required to assess patients/clients, as well as plan, implement and evaluate their care.

Collaborative and Therapeutic Practice

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Competencies are essential for establishing and sustaining the nurse/patient relationship. It integrates the maintenance of safety, skills in interpersonal and therapeutic relationships, and communication as well as organisational skills to ensure the provision of care. It also includes the ability to interact with other members of the health care team.

[Re-entry]
Means the pay point to which a Registered Nurse who has been absent from nursing for a period of five years or more and who is no longer registered with the Australian Health Practitioner Regulation Agency (AHPRA).. Those Registered Nurses undertaking a re-entry course (or restoration pathway) will commence on Grade 5 (re-entry) rate during the period of training until the employee gains the appropriate competencies based on the national competency standards for the Registered Nurse.

Once the employee is deemed competent all service including the period of training will be recognised for previous service.

Pay Point 1
Means the pay point to which a Registered Nurse who has attained an undergraduate degree in nursing.

Progression beyond pay point 1 will occur upon completion of 12 months at the previous pay point (or the part time/casual incremental advancement requirements of the parent Award).

Registered Midwife (Only), Grade 5

A Midwife (Only) is a midwife who has attained a sole undergraduate degree in midwifery and is licensed by the Australian Health Practitioner Regulation Agency to practise midwifery without supervision and who assumes accountability and responsibility for own actions and acts to rectify unsafe midwifery practice and/or unprofessional conduct.

The Midwife (Only) will follow the Code of Ethics for Midwives in Australia and the following Value Statements:

- Midwives value quality midwifery care for each woman and her infant (s).
- Midwives value respect and kindness for self and others.
- Midwives value the diversity of people.
- Midwives value access to quality midwifery care for each woman and her infant (s).
- Midwives value informed decision making.
- Midwives value a culture of safety in midwifery and health care.
- Midwives value ethical management of information.
- Midwives value a socially, economically and ecologically sustainable environment promoting health and wellbeing.

Responsibilities

A Midwife provides care based on the national competency standards to a group of clients in collaboration with other health service providers.

The national competency standards are grouped into four domains:

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Legal and Professional Practice

This domain contains the competencies that relate to legal and professional responsibilities including accountability, functioning in accordance with legislation affecting midwifery and demonstration of leadership.

Midwifery knowledge and practice

This domain contains the competencies that relate to the performance of midwifery practice including assessment, planning, implementation and evaluation. Partnership with the women is included in this domain.

Midwifery as primary health care

This domain contains the competencies that relate to midwifery as a public health strategy. Included are the notions of self determination and the protection of individual and group rights.

Reflective and ethical practice

This domain contains the competencies relating to self appraisal, professional development and the value of research. The competencies, elements and cues are outlined in the following pages.

Re-entry Midwives (including nurse who are also midwives)
Means the pay point to which a midwife who is authorised to practice midwifery has been absent from midwifery for a period of five years or more and who is no longer registered with the Australian Health Practitioner Regulation Agency (AHPRA). Those midwives undertaking an accredited re-entry course by the Australian Nursing and Midwifery Accreditation Council will commence on Grade 5 (re-entry) rate during the period of training until the employee gains the appropriate competencies based on the national competency standards for the Midwife.

Once the employee is deemed competent all service, including the period of training, will be recognised for previous service.

Pay Point 1
Means the pay point to which a midwife who has attained an undergraduate degree in midwifery or successfully completed a post-registration accredited midwifery qualification or an accredited midwifery / nursing double degree.

Progression beyond pay point 1 will occur upon completion of 12 months at the previous pay point (or the part time/casual incremental advancement requirements of the parent Award).

Refer to the AHPRA website for more information on the Code of Ethics: http://www.ahpra.gov.au/

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Clinical Nurse/Midwife, Grade 6

A Clinical Nurse/Midwife means a Registered Nurse or Midwife by the Australian Health Practitioners Regulation Agency, who is appointed to a role with responsibilities that may include, but are not limited to the following:

The Clinical Nurse/Midwife role requires a broad developing knowledge in professional midwifery issues and an advanced specific knowledge-base in relation to a field of practice. The Clinical Nurse/Midwife assumes accountability and responsibility for their own actions and acts to rectify unsafe midwifery practice and/or unprofessional conduct.

A Clinical Nurse/Midwife is responsible for a specific client population, and is able to function in more complex situations while providing support and direction to a Registered Nurse/Midwife, students and other non-registered midwifery personnel.

The Clinical Nurse/Midwife identifies, selects, implements and evaluates nursing and midwifery interventions that have less predictable outcomes.

The Clinical Nurse/Midwife may specialise in the Clinical Management, Education or Research streams or work across all of these specialties.

The Clinical Nurse/Midwife is able to demonstrate the following:
- advanced level clinical skills and problem-solving skills;
- planning and coordination skills in the clinical management of patient care;
- ability to work within and/or without a multidisciplinary collegiate/team structure;
- awareness of and involvement with quality;
- advanced communication skills;
- ability to undertake independent clinical practice;
- ability to educate staff, patients and external clients in the area of expertise; and
- contribution to professional practice related to area of expertise.

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Responsibilities
- Provides advanced nursing and midwifery care to a group of patients/clients.
- Acts as a positive role model for Registered Nurses/Midwifes, junior staff and other non-licensed personnel in the provision of holistic patient/client care.
- Contributes to and facilitates professional development plans and portfolios for Registered Nurses/Midwives.
- Communicates effectively with clients, stakeholders and colleagues within a multidisciplinary environment.

Clinical Nurse/Midwife (Clinical Management)
The Clinical Nurse/Midwife (Clinical Management) provides support to the Nurse Unit Manager in the coordination of clinical practice in a specific patient/client area. The Clinical Nurse/Midwife (Clinical Management) demonstrates a strong team commitment and active participation in the development and achievement of unit/team goals.

Additional Responsibilities
- Participates in business planning activities including cost centre management, resource allocation, effective co-ordination of staff and roster preparation;
- Provides leadership and direction promoting a positive working environment, encouraging and supporting team work; and

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- Participates and assists with professional development and coaching activities within a multidisciplinary unit/team.

Caseload model midwives have grade 6 annualised salaries of 27.5% to include on-call/overtime. Should this be stated here?

Clinical Nurse/Midwife (Education)
The Clinical Nurse/Midwife (Education) is dedicated to the purpose of the continuing education and professional development of nursing/midwifery staff and has a portfolio of expertise related to the position. The Clinical Nurse/Midwife (Education) is able to demonstrate a sound knowledge of the principles of contemporary education; a sound knowledge of educational leadership and a commitment to learning and the learning process.

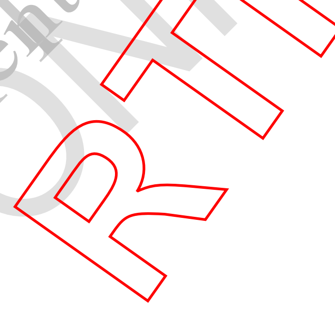
Additional Responsibilities

- Promotes and role models the principles of adult learning;
- Facilitates an optimal learning environment that promotes and supports both clinical and professional development of nurses and midwives;
- Participates in planning, assessing, implementing, evaluation of educational activity; and
- Supports the application of learning to practice within a clinical context.

Clinical Nurse/Midwife (Research)
The Clinical Nurse/Midwife (Research) is a registered nurse or midwife that has been appointed in a research capacity. The Clinical Nurse/Midwife (Research) is able to demonstrate an awareness of and involvement with evidence based practice and the research process.

Additional Responsibilities

- Undertakes research activities in line with good research practice and ethical principles.
- Applies evidence to improve nursing and midwifery practice.
- Provides leadership, support, direction and education to research participants and stakeholders in research projects.



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Registered Nurse / Midwife, Grade 7

A Registered Nurse or Midwife may be appointed to an advanced practice position as identified below. Specific leadership roles and responsibilities of each of these advanced practice positions may include, but are not limited to the following:

- integrates key objectives from the Strategic Plan (facility/division, clinical service) into service delivery for a clinical unit /departments;
- overall coordinates, formulates and directs policies relating to the provision of midwifery care or speciality services which includes integration of patient care across the continuum of care (inpatient and ambulatory care);
- operationalises the strategies (across a facility/division/clinical service) for a work based culture that promotes and supports education, learning, research and workforce development;
- implements education and applies research initiatives at the unit/division/clinical services/facility level;
- establishes a quality framework which integrates the strategic direction and priorities for quality improvement into a clinical service;
- demonstrates a knowledge of and the ability to apply relevant legislation, guidelines and standards;
- demonstrates knowledge of contemporary nursing and midwifery practice and theory;
- promotes evidence based clinical practice to facilitate positive patient outcomes;
- acts as a leader and mentor within a multidisciplinary environment;
- develops an awareness of and contributes to risk management processes within the unit/division; and
- builds relationships and networks to influence and manage change at a local level.

Clinical Nurse/Midwife Consultant

A Clinical Nurse/Midwife Consultant is a Registered Nurse or Midwife who is accountable at an advanced practice level for the coordination of clinical practice delivered in a clinical specialty and who (in addition to the above):

- applies specialised nursing and midwifery knowledge relevant to area of professional practice;
- participates directly or indirectly in the delivery of clinical care to individuals/groups;
- acts as a clinical resource for junior staff, colleagues and patients; and
- provides education and advice to internal and external health providers.

Nurse/Midwife Unit Manager

A Nurse/Midwife Unit Manager is a Registered Nurse or Midwife who is accountable at an advanced practice level for the coordination of clinical practice and the provision of human and material resources in a specific patient/client area and who (in addition to the above):

- has the ability to lead a multidisciplinary team in a service delivery environment utilising the principles of contemporary human, material and financial resource management;
- utilises business planning principles, aligning with organisational and strategic objectives;
- creates a culture of engagement amongst the team through strong clinical leadership and empowers staff to make sound clinical decisions;
- provides a working environment which promotes the retention of skilled staff and attracts new employees;

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- has the ability to promote the efficient utilisation of available resources to meet budgetary goals and enable consistent and safe service delivery; and
- participates directly or indirectly in the delivery of clinical care to individuals/groups.

Nurse/Midwife Manager

A Nurse Manager is a Registered Nurse or Midwife who is accountable at an advanced practice level for the provision of human and material resources either supporting a division or a specific patient/client area or systems or service and who (in addition to the above):

- provides midwifery expertise in a specialist area of midwifery management (i.e. Patient Flow, Informatics, After Hours Nurse Management);
- collaborates with and assists the Nurse/Midwife Unit Manager in all areas of clinical practise;
- organises interdisciplinary activities to reach common and patient focussed goals; and
- integrates the principles of contemporary human, material and financial resource management into service delivery.

Nurse/Midwife Educator

A Nurse Educator is a Registered Nurse or Midwife who is accountable at an advanced practice level for the development, implementation and evaluation of nursing/midwifery education activities. The Nurse Educator manages educational resources and provides nursing/midwifery expertise relating to educational issues within a service/division/facility/Health Service Local Health and Hospital Network and (in addition to the above):

- applies the principles of contemporary nursing/midwifery education;
- manages educational resources effectively and efficiently;
- builds and facilitates relationships with nurse leaders as well as internal and external stakeholders;
- advocates for nursing/midwifery education within multidisciplinary teams;
- provides educational expertise to support clinical organisational and professional practice needs; and
- collaborates with nursing/midwifery leaders, partners and networks to support educational initiatives.

Nurse/Midwife Researcher

A Nurse Researcher is a Registered Nurse or Midwife who is accountable at an advanced practice level for the development, coordination, implementation and evaluation of nursing/midwifery and/or non nursing/midwifery specific research projects/programs. The Nurse/Midwife Researcher ensures midwifery practice within the designated area is evidence based and (in addition to the above):

- participates in the development of research culture including the supervision of research projects;
- develops the capacity of nursing and midwifery staff to utilise research findings and provide care that is evidence based;
- collaborates with external providers and multidisciplinary colleagues to further midwifery strategic research priorities;
- collaborates with the Nurse/Midwife Educator to develop and facilitate research skills training; and

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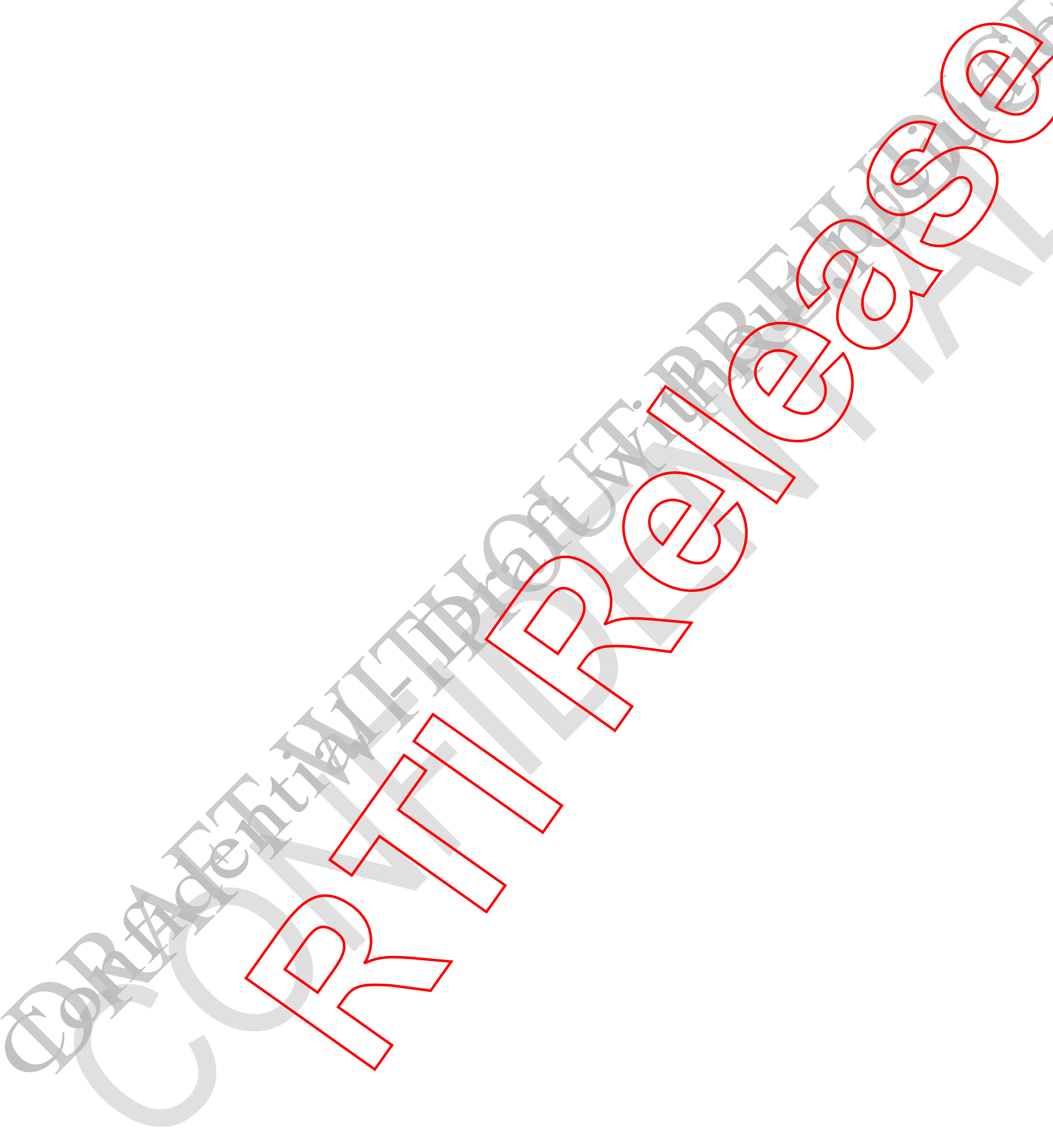
- demonstrates excellence in research leadership with a capacity to conduct and promote research and build a leading nursing/midwifery research program that attracts competitive research grants.

PUBLIC HEALTH NURSE HAS BEEN REMOVED

NURSE PRACTITIONER CANDIDATE HAS BEEN REMOVED



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Nurse Practitioner, Grade 8

A Nurse Practitioner is a Registered Nurse appointed to that position and who has been endorsed to practise as a Nurse Practitioner by the Australian Health Practitioner Regulation Agency. A Nurse Practitioner has a Masters degree and can function autonomously and collaboratively in an *advanced* and *extended* clinical role.

The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to:

- the direct referral of patients to other health care professionals;,
- prescribing medications; and
- ordering diagnostic investigations.

The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise.

Nurse Practitioner is a protected title and the national competency standards are an integral component of the regulatory framework. Refer to the AHPRA website for more information: http://www.ahpra.gov.au/

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Nurse Executives

Assistant Director of Nursing or Nursing Director, Grade 9

(To be titled Assistant Director of Nursing/Nursing Director/Relevant Section, Service Director or Divisional. i.e. Education, Research, Clinical Services, Community, Oncology, etc)

An Assistant Director of Nursing or Nursing Director is a Registered Nurse or Midwife who demonstrates clinical and management expertise within a multidisciplinary environment. The Assistant Director of Nursing or Nursing Director is responsible for the overall planning, coordination, formulation and direction of policies relating to the provision of clinical care, development of partnership models and strategies to support undergraduate and post-graduate education and research in the workplace. In addition, the Assistant Director of Nursing or Nursing Director is responsible for the provision of human and material resources for a clinical division, an assigned number of clinical units, Local Health and Hospital Network wide and/or Statewide and:

- Demonstrates expert and comprehensive knowledge of contemporary nursing practice.
- Designs, develops and implements innovative standards relating to improving facility/divisional performance.
- Demonstrates expertise in leadership. Specific leadership roles and responsibilities may include, but are not limited to the following:
  - participation in the development and integration of key objectives from the Local Health and Hospital Network strategic plan into service delivery for a Local Health and Hospital Network and/or facility and/or division;
  - participation in the development of strategies and policies on nursing/patient care and related service delivery issues across divisions and / or a division or within a community and/or aged care health service;
  - participation in the development of a strategy for a work based culture that promotes and supports education, learning, research and workforce development;
  - provision of strategic direction and priorities for quality improvement into a clinical service that establishes a quality framework which confirms/supports the direction a nursing service (Local Health and Hospital Network/facility) will take; and
  - management of change at a facility/divisional level.
- Demonstrates expertise in human, material, financial and resource management. Specific human, material, financial and resource management roles and responsibilities may include but are not limited to the following:
  - ~~2.~~ implementation of the Human Resource Framework across a facility and/or division and/or community and/or aged care health service and identifies opportunities to realise enhanced performance, recruitment and retention of nurses and career succession planning;
  - ~~3.~~ responsibility for functional planning for capital works and asset equipment at a division/program/service level;
  - ~~4.~~ coordination of the use of equipment and material resources across a facility and/or division and/or aged care facility and/or community health service; and

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5.- accountable or jointly accountable for the operational budget for a division and/or aged care facility and/or community health service.

- Statewide stewardship of policy development or program delivery and stakeholder management may be another category of Nursing Director roles. These roles focus on the development of system management frameworks, with the following functions:
  - 5.- sets direction for system design, governance and intersectoral coordination
  - 6.- conceptualisation of systems as well as its component parts
  - 3.0- articulates a vision and a strategic direction for that system
  - 4.0- develops priorities for action across the system that will take it in the appropriate direction
  - 5.0- monitors system performance: components and the whole
  - 6.0- uses intelligence and horizon scanning to explore opportunities and potential challenges, creating capacity to meet them
  - 7.0- builds human, capital, technological and knowledge capability

To determine the correct banding for this role as 9, please see the B7 Policy Attachment 3 Evaluation Guide.

Director of Nursing or Director of Nursing and Midwifery (Facility Manager), Grade 10

A Director of Nursing is a Registered Nurse or Midwife who demonstrates expertise in clinical practice and management within a multidisciplinary environment. The Director of Nursing is responsible for the activities of the nursing service in a facility and contributes to the development of facility policy.

The Director of Nursing is accountable for nursing practice within a facility, leadership of the nursing service, effective coordination of resources and the development of health strategies (in collaboration with others) and who:

- Demonstrates expert and comprehensive knowledge of contemporary nursing practice.
- Demonstrates expertise in strategic leadership. Specific leadership roles and responsibilities may include, but are not limited to the following:
  - development of a strategic approach to the integration and coordination of policy development and service delivery for a facility;
  - development of strategies and policies on nursing/patient care and related service delivery issues within a facility;
  - development of a vision strategy for a work-based culture that promotes and supports education, learning, research and workforce management;
  - development of effective liaison with external facilities/agencies to facilitate undergraduate and post graduate education and research;
  - provision of strategic direction and priorities for quality improvement that establishes a quality framework which supports the direction a nursing service will take; and
  - management of change.

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- Demonstrates expertise in human, material, financial and resource management. Specific human, material, financial and resource management roles and responsibilities may include but are not limited to the following:
  - implementation of the HR framework across a facility/community/aged care service and identification of opportunities to realise enhanced performance, recruitment and retention of nurses and career succession planning;
  - responsibility for functional planning for capital works and asset equipment at a facility level and/or coordination of the use of equipment and material resources across a facility and/or aged care facility and/or community health service; and
  - accountability or joint accountability for the operational budget for a facility and/or aged care facility and/or community health service.

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To determine the correct banding for this role as a Grade 10, please see the B7 Policy Attachment 3 Evaluation Guide.

Executive Director of Nursing and Midwifery (EDONM), Grades 11 and 12

An Executive Director of Nursing and Midwifery is a Registered Nurse or Midwife who is an equal and collaborative partner on the Local Health and Hospital Network Health Service Executive in the planning of health services and the associated budgetary accountabilities. This position may also have a Statewide responsibility to strategically develop the nursing / midwifery workforce/service to optimise patient and staff outcomes.

There is a professional relationship with the Chief Nursing and Midwifery Officer of Queensland with the role reporting directly to the Chief Executive Officer, Local Health and Hospital Network.

The Executive Director of Nursing and Midwifery:

- Demonstrates expert and comprehensive knowledge of all aspects of the nursing profession at a state, national and international level.
- Identifies, evaluates and incorporates emerging trends within the broader service and business industry which have the potential to enhance nursing and/or health services;
- has expertise at a higher level in policy, guidelines and standards development, design and implementation.
- Demonstrates expertise in strategic leadership. Specific leadership roles and responsibilities may include, but are not limited to the following:
  - Development of a strategic approach to the integration and coordination of policy development and service delivery for a Local Health and Hospital Network
  - Development of a vision (Local Health and Hospital Network and/or state wide) and strategy for a work based culture that promotes and supports education, learning, research and workforce development.
  - Establishment of a strategic direction and negotiation and communication with external education facilities/agencies to develop and support infrastructure for effective and sustainable undergraduate and postgraduate education and research.

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- Provision of strategic direction and priorities for quality improvement that establishes a quality framework which supports the direction a nursing service in a Local Health and Hospital Network will take.
- Management of change utilising a Strategic Development Framework.

- Demonstrates expertise in human, material, financial and resource management. Specific human, material, financial and resource management roles and responsibilities may include but are not limited to the following:
  - Responsibility for a strategic approach to developing and implementing contemporary human resource management policies and practices to optimise the organisations environment.
  - Strategic input into capital works and major asset/equipment management
  - Responsibility for Local Health and Hospital Network financial performance.
- Designs, develops and implements innovative standards relating to improving Local Health and Hospital Network and/or Statewide performance.
- Strategically coordinates the direction of nursing services from a Local Health and Hospital Network and/or Statewide perspective.
- Has the ability to strategically plan for the provision of clinical services within a multidisciplinary and dynamic environment.

To determine the correct banding for this role as a Grade 11 or 12, please see the B7 Policy Attachment 3 Evaluation Guide.

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Glossary of terms:

Glossary of Terms

AHPRA	Australian Health Practitioner's Regulation Agency

AHPRA	Australian Health Practitioner's Regulation Agency
ANM(A)C	Australian Nursing and Midwifery (Accreditation) Council
Appropriate	Matching the circumstances, meeting needs of the individual, groups or situation
Attributes	Characteristics, which underpin competent performance
Classification level	Comprises a number of paypoints in a particular stream through which Employees will be eligible to progress
Core Competency Standards	Essential competency standards for registration or licensure
Competence	The combination of skills, knowledge, attitudes, values and abilities that underpin effective performance in professional / occupational area
Competent	The person has competence across all the domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nursing being assessment
Competency Standards	Consistent of competency units and competency elements
Context	The setting / environment where competence can be demonstrated or applied
Generic level statement	A broad, concise statement of the duties, skills and responsibilities
Increment	All employees increase in salary from one paypoint to the next highest paypoint
LHHN	Local Health and Hospital Network
Multidisciplinary Team	In the health context it is a team comprised of diverse professional backgrounds such as nursing, medical and allied health practitioners. Sometimes call inter-

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professional teams

Paypoint	The specific rate of remuneration payable to Employees within a classification level
ANM(A)C:	Australian Nursing and Midwifery (Accreditation) Council
Appropriate:	Matching the circumstances, meeting needs of the individual, groups or situation
Attributes:	Characteristics, which underpin competent performance

Classification level - comprises a number of paypoints in a particular stream through which Employees will be eligible to progress.

Core Competency Standards:	Essential competency standards for registration or licensure
Competence: and professional /	The combination of skills, knowledge, attitudes, values abilities that underpin effective performance in occupational area
Competent: of at a standard that is nursing being	The person has competence across all the domains competencies applicable to the nurse, judged to be appropriate for the level of assessment
Competency Standards: elements	Consistent of competency units and competency
Context:	The setting / environment where competence can be demonstrated or applied

Generic level statement - means a broad, concise statement of the duties, skills and responsibilities

Increment- means for all Employees an increase in salary from one paypoint to the next highest paypoint.

LHHN	Local Health and Hospital Network

Multidisciplinary Team – in the health context it is a team comprised of diverse professional backgrounds such as nursing, medical and allied health practitioners. Sometimes call inter-professional teams.

Paypoint - means the specific rate of remuneration payable to Employees within a classification level.

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ADDENDUM 13: CURRENT NURSING AND MIDWIFERY CLASSIFICATION STRUCTURE (HR POLICY B7)

HR Policy B7 - Nursing and Midwifery Classification Structure

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ADDENDUM 14: WORK LEVEL DESCRIPTOR DATA GATHERING TOOL

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Complexity of Role	Complexity of Care Work Levels (CSCF) Descriptors	Level 1 Low complex ambulatory care services	Level 2 Low complex inpatient and ambulatory care services	Level 3 Low to moderate complex inpatient and ambulatory care services	Level 4 Moderate complex inpatient and ambulatory care services	Level 5 Moderate to high complex inpatient and ambulatory care services	Level 6 High complex inpatient and ambulatory care services	Network-wide	State-wide
	Setting	Acute / Aged Care / Community / Rural & Remote / Mental Health							
	ASGC - RA	RA1 - Major Cities of Australia RA2 - Inner Regional Australia RA3 - Outer Regional Australia RA4 - Remote Australia RA5 - Very Remote Australia							
	Work Span								
	Impact								
	Diversity & Complexity								
	Independence								
	Partnerships								
	Scope & Nature								
	Knowledge								
	Expertise								
	Budget Delegation								
	#of staff managed								

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Work Span

- Describes the environment and span of hours

Impact

Reflects the independence and influence of the position

- Resources managed
- Budget delegation
- Advice and advocacy provided
- Decisions made
- Responsibilities for which the position is accountable for

Diversity & Complexity

Describes the judgment capability of the position

- The extent of problem solving and reasoning to which the position is involved in to achieve clinical outcomes and objectives
- Whether the role is within a metro, rural, remote or regional facility (ASGC-RA classification)

Independence

Measures the positions level of autonomy, range of decision making and overall responsibility in the delivery of clinical services

- The level of human resource activities required to be performed by the role
- Decisions made
- Supervision of staff

Partnerships

Measures service integration

- Diversity of practice
- Integration with other clinical service areas, or external stakeholders such as other government agencies, the education sector, non-government agencies etc

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Scope & Nature
Typical responsibilities and activities of the role

Knowledge
Reflects the positions requirement for knowledge and skills
- Clinical knowledge
- Level of understanding of the work area's role within the organisation
- Knowledge of policies, procedures, practises and guidelines required to perform the role

Expertise
Describes the expertise level required for the position
- Including skill requirements in several areas; interpersonal, communication, clinical, work experience, specialty areas

Operational Management

Operational management (or line management) is the formal management of a team, unit or department. Duties include:
- attendance, work allocation, performance appraisal activities and workplace issues
- a single point of accountability (direct supervisor) and the primary and formal reporting line for employees
- supervision of a multidisciplinary team
- responsibility for recruitment and selection
- accountability for service activity and outcomes
- financial management
- quality assurance
- strategic planning and service improvement within organisational goals

Professional Supervision

Professional supervision is informal and includes the daily supervision within a clinical environment. The operational manager and the professional supervisor would communicate regularly. Duties include:
- involvement and allocation of daily duties
- supervising caseloads
- developing technical skills and knowledge base
- providing feedback to the operational manager on performance appraisal activities and workplace issues

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- informal supervision on a day to day basis

Work Level Descriptor Data Gathering Tool

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GLOSSARY OF TERMS

ADON	Assistant Director of Nursing
ANMAC	Australian Nursing and Midwifery (Accreditation) Council
AHPRA	Australian Health Practitioners Regulation Agency
AHW	Aboriginal Health Worker
AIN	Assistant in Nursing
ATODS	Alcohol, Tobacco and Other Drugs Services
ATSI	Aboriginal and Torres Strait Islander
BMI	Body Mass Index
CALD	Culturally and Linguistically Diverse
CHO	Chief Health Office
Classification	comprises a number of pay points in a particular stream through which Employees will be eligible to progress.
Competent	The person has competence across all the domains of competencies applicable to the nurse, at a standard that is judged to be appropriate for the level of nursing being assessed
Context	The setting / environment where competence can be demonstrated or applied
Core Competency Standards	Essential competency standards for registration or licensure
CM	Clinical Midwife
CMC	Clinical Midwife Consultant
CN	Clinical Nurse
CNC	Clinical Nurse Consultant
CSD	Central Sterilising Department
DON	Director of Nursing
DONMAC	Directors of Nursing and Midwifery Advisory Committee
DDON	District Director of Nursing
EDON/M	Executive Director of Nursing /and Midwifery
EB7	Enterprise Bargaining Agreement 7
EN	Enrolled Nurse
ENAP	Enrolled Nurse Advanced Practice
FTE	Full Time Equivalent
Generic level statement	means a broad, concise statement of the duties, skills and responsibilities
Increment	means for all Employees an increase in salary from one paypoint to the next highest paypoint
LHHN	Local Health and Hospital Network
ME	Midwifery Educator
MUM	Midwifery Unit Manager
Multidisciplinary team	in the health context it is a team comprised of diverse professional backgrounds such as nursing, medical and allied health practitioners.

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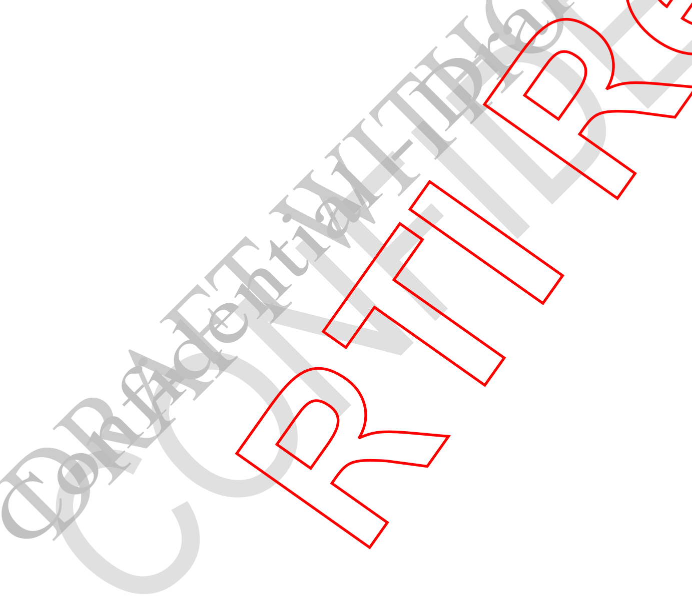
	Sometimes called inter-professional teams.
NAMIG	Nurses Interest Based Bargaining Implementation Group. The negotiating team made up of nursing representatives, Queensland Nursing Officials and Human resource branch who coordinate the implementation of EB7
NMOQ	Nursing and Midwifery Office Queensland
NE	Nurse Educator
NM	Nursing Manager
NP	Nurse Practitioner
NPC	Nurse Practitioner Candidate
NR	Nurse Researcher
NUM	Nurse Unit Manager
OCNO	Nursing and Midwifery Office Queensland, now NMOQ
OHS	Offender Health Services
PSQ	Patient Safety and Quality
QNC	Queensland Nursing Council
REBPSC	Research and Evidence-based Practice Steering Committee
RM	Registered Midwife
RN	Registered Nurse
RSQ	Retrieval Services Queensland
QH	Queensland Health
QNU	Queensland Nurses Union
Serv Planners	Service Planners, employed under Health Planning and Infrastructure Division
USIN	Undergraduate Student in Nursing



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Natalia Rosenblatt

From: s73 Irrelevant Information @qnu.org.au>
Sent: Monday, 2 November 2015 12:40 PM
To: Frances Hughes; Dave Waters; Sharon Durham
Cc: Kate Veach; s73 Irrelevant Information
Subject: FW: ADVANCED PRACTICE NURSING SURVEY REPORT
Attachments: ADVANCED PRACTICE NURSING SURVEY REPORT_WITHOUT APPENDICES.docx; ANSWER 4 NURSING_FINAL REPORT_20141110_MA.pdf; Final Report on NUM Study - 13 Jan 2012.pdf; 2011-12-13 NUM Project Phase II Final Report - v0.1 for NaMiG.doc; n_mum_project_report_EMAIL.pdf

Importance: High

Hi everyone,

As promised, here is the Glenn Gardiner/Christine Duffield report as discussed this morning. Please read the PDF (not the word document) as we have received the full document from Glenn but ANMF Federal Office had not. (I will remedy that now.)

On the way back to the office, I was thinking about other background materials to inform the discussion at the workshop, especially around NUMs. QH and QNU did significant work in this space, but it has not gone anywhere in the last three years. (I have attached three reports FYI – two commissioned by QH (and sorry I can't find on file the final PDF version of the NUM report) and the final QNU report.) Frances, are you able to locate the final PDF of the NUM report from your office and distribute it? The tracked changes version I have attached in word is a bit of a nightmare! (I do recall there weer issues with finalising the report, so maybe we do not have a final endorsed version?

NUMS are a pivotal ole in the system and a critical point of risk, so we will have to give close consideration to them as part of the career and classification work and EB 9.

Regards,

s73 Irrelevant Information

From: s73 Irrelevant Information @anmf.org.au]
Sent: Monday, 2 November 2015 9:32 AM
To: s73 Irrelevant Information @nswnma.asn.au); s73 Irrelevant Information @anmfvic.asn.au); s73 Irrelevant Information @anmftas.org.au); @anmfact.org.au; secretary@anmfnt.org.au; Elizabeth Dabars ; Mark Olson
Cc: Annie Butler
Subject: ADVANCED PRACTICE NURSING SURVEY REPORT

Dear Colleagues,

Please find attached Glenn Gardner's work on advance practice nursing. QNU are planning to use some of this work in their current public sector bargaining round.

Please note the report is minus attachments which I currently don't have but will get and send in a separate email. I have asked Glenn to come to November Federal Executive meeting to discuss.

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Regards

ACKNOWLEDGEMENT

As a national body, the Australian Nursing & Midwifery Federation (ANMF) Federal Office acknowledges the traditional owners and Elders past and present across Australia, with particular acknowledgment to the Greater Kulin Nation, the traditional owners of the lands where the Melbourne Office is located, and the Ngunnawal people, the traditional owners of the land where the Canberra Office is located.

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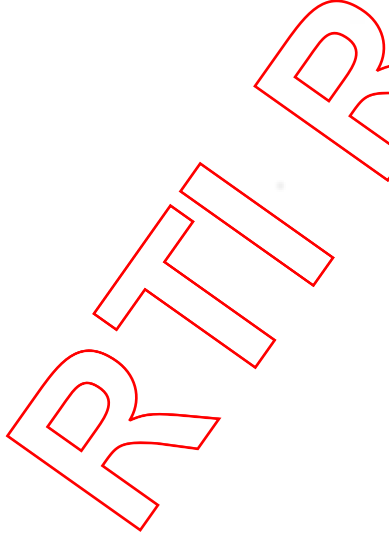

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SCOPING ADVANCED PRACTICE NURSING: A NATIONAL SURVEY

REPORT OF THE AUSTRALIAN NURSING/MIDWIFERY WORKFORCE SURVEY

Project Team

Investigators
Professor Glenn Gardner — Queensland University of Technology
Professor Christine Duffield — University of Technology, Sydney

Project Co-ordinator: Ms Margaret Adams

Statistical Support
Professor John Spicer
Ms Anna Doubrovsky

Project Sponsor: Australian Nursing and Midwifery Federation and State Branches.

Whilst this research was funded by the Australian Nursing and Midwifery Federation and State Branches no restrictions have been placed on the research approach or study findings.

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Executive Summary

This report provides the results of an investigation of the Australian nursing and midwifery workforce and was directed by two broad aims:

i) To map nursing titles across Australian jurisdictions according to patterns of clinical practice

ii) To establish an operational framework for differentiating and describing advanced practice nursing for the Australian health service context and future development of the nursing profession.

We conducted a national e-survey of nurses and midwives using the validated Advanced Practice Role Delineation (APRD) tool developed from the Strong Model of Advanced Practice. Participant recruitment was through wide and repeated information dissemination of the study through the ANMF and State and Territory Branches and other membership-defined nursing organisations. We recruited almost 7,000 participants.

Data analysis included descriptive statistics to describe the features of the sample and nursing and midwifery position titles listed by state/territory. One way ANOVAs were used to assist in identifying and delineating APN. Cluster analysis was used to map the state/territory-defined nursing position titles based on all five Domain mean scores of the APRD tool.

The results show a sample that is equivalent to the Australian nursing population on age and sex and that works across a range of geographical and service contexts. Nurses and midwives from all states and territories participated in the study. The main study findings are as follows:

1. Advanced practice nursing is characterised by the practice profile of the CNC position title.
2. The practice profile of the NP is delineated from the APN by significantly higher mean scores in the Direct Care Domain.
3. Other levels are delineated as having mean Domain scores at a determined metric below those of the APN.
4. The findings from this research provide an evidence base that Australian nursing workforce can be conceptualised as structured into three bands:
   - **Nurse practitioner,**
   - **Advanced Practice Nurse**
   - **Foundation Practice Nursing**

5. Mapping of titles across the eight Australian jurisdictions producing **seven cluster groups** each were identified as having a pattern of position titles from all states and territories. These groups and their patterns are:
   - **Cluster 1: Nurse Practitioner** (NP) cluster is uniform across all states and territories
   - **Cluster 2: Advanced Practice Nurse** cluster is primarily the clinical nurse consultant. Cluster 2 also incorporated five additional titles of practice at this level from ACT, SA, Vic, WA
   - **Cluster 3: Educator** titles in various forms were contained in position title lists from all jurisdictions. This is a homogenous group with high mean scores in the Education Domain.
   - **Cluster 4: Manager Type 1** cluster. This group includes clinical type managers across various titles. They are low in Direct Care but show moderately high levels in Education, Research and Professional Leadership Domains.

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- **Cluster 5: Manager Type 2** cluster. This is a smaller manager group similar the Type 1 but characterised by lower mean scores across all Domains. There is a very low nursing profile in this group
- **Cluster 6: Clinical Nurse** cluster. This is highly heterogeneous group made up of 12 different titles. The cluster is characterised by moderately high scores across the first three Domains but low in Research and Professional Leadership Domain scores.
- **Cluster 7: Registered Nurse** cluster represents all RN titles and shows a similar pattern of scores across Domains as the Clinical Nurse, except at a lower level.

Conclusion This research has revealed a large and significant body of new knowledge about the Australian Nursing Workforce. Two main findings relate to:

a) Delineation of nursing levels of practice above and below the APN practice profile providing an instrument to identify three primary bands of clinical nursing activity levels

b) Mapping of the diverse state and territory based nursing position titles into seven coherent groups. These seven clusters and their descriptions bring clarity and structure to the erstwhile confusing and disparate array of nursing position titles across Australia.

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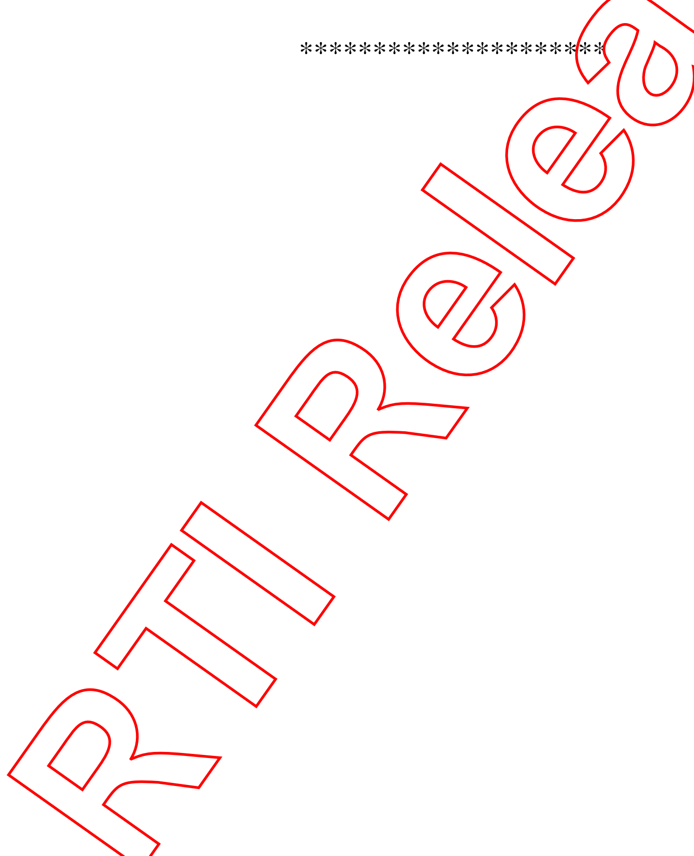

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CHAPTER ONE: INTRODUCTION

Over the past two decades advanced practice nursing roles have proliferated to fill gaps in the provision of health service across hospital, community and aged care settings. This has become important for health service improvement in a landscape that is increasingly complex with high cost drivers for change that include an aging population, a dramatic increase in chronic disease and pressure on the health budget. Researchers have reported[1] that the creation and growth of nursing roles has been effective in addressing short term problems of service delivery but the consequence has been uncoordinated development of nursing service with a confusing array of practice profiles, titles and roles. Further, this development has occurred in the absence of evidence-informed service planning.[2]

The area of advanced practice nursing (APN) is particularly exposed to *ad hoc* service planning at the local level by service managers and medical specialists and at the macro level by government bodies and health services experts.[3, 4] Furthermore, development of these new roles often progresses without formal and broad-based consultation with the profession[5]. In part this is a consequence of the confusion and lack of consensus related to the meaning of APN. The volume of peer reviewed international literature relating to APN is vast attesting to the quest to progress and refine knowledge about this evolving level of nursing service and the impact on patient outcomes.[6, 7] A consistent theme in the international literature is that APN is ambiguous, lacks universal understanding and is variously defined.[8-10]

In most countries APN is an umbrella term indicating nursing roles and levels above that of the foundation practice of the Registered Nurse (RN). In Australia APN covers a myriad of titles including clinical nurse specialist, clinical nurse consultant and nurse practitioner (NP).[1]
In the United States of America (USA) APN includes midwives, nurse anaesthetists, clinical nurse specialists and NPs[11] . Although the APN is applied as a generic descriptor for these diverse roles they do not share a common practice profile and they also differ in the legislative structure that governs practice activity.[11] Recent literature reports increasing calls for delineated and specific regulation and definition of NPs.[13,14]

Some efforts have been made to clarify APN across nations. Thoun[7] recently published a scholarly discussion paper that problematized the distinction between generic APN and the nurse specialist. She proposed that the difference was clearly related to depth, extent and complexity addressed at different level of education.[6] Furthermore, Thoun emphasises that the

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term advanced characterises *practice* and that nursing is the academic and practice discipline; giving semantic support and substance to the term advanced practice nursing in contrast to advanced nursing practice. Whilst Thoun's paper makes an important contribution to bringing clarity to the discussion on APN her dissertation does not address the problem of disparate practice profiles and levels that are covered by the term APN.

The UK position statement[15] and the Canadian Nurses Association Position Statement[16] on APN provide generic statements and "nationally agreed elements"[15] or 'characteristics[16] of advanced practice with no attention to the potential for difference in practice between the nurse practitioner and other non-defined advanced practice patterns. Similarly the International Council of Nurses definition of APN[17] is generic and applies to any senior clinical nursing role that may fall under the umbrella of advanced practice. The many definitions that are offered in these and other publications reflect what we recognise would be elements of advanced practice nursing. They speak to the values and practices easily recognised as central to the best of nursing practice. However, these definitions are not drawn from robust research that takes the question of what is advanced practice to examine the practice of nursing in context.

There are international consequences from the confusion related to APN. Research has shown that compared with standard care, APN achieves higher patient satisfaction, enhanced patient safety, reduced health service cost and improved quality of life.[6,18] However this research has limited application to inform policy and health service planning as there is no stability in the definition, parameters of practice or nomenclature to operationally define APN.

The research reported here is part of a health services research and development program developed over many years. Early research in the program[19] identified and isolated the Strong Model of Advanced Practice[20] from a range of published models and definitions as having potential to delineate the parameters of practice for the APN role in Australia. A survey tool from this model[21] was tested, amended and validated in the Queensland context[22-24] and provides a reliable instrument with strong psychometric properties. The Queensland study found significant differences in mean scores for total activities in all APN domains according to the grade and level of nurse. Regression analysis indicated that working in clinical APN roles with higher levels of education were strong predictors of APN activities overall.[24]

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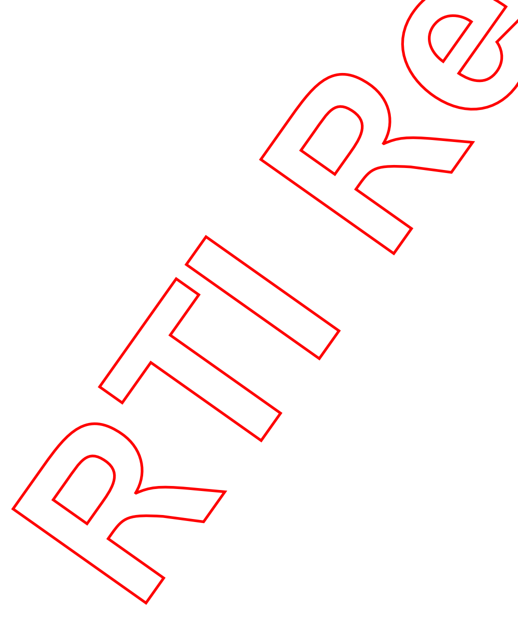
Australia is a Federation of States/Territories which adds an additional layer to the issue of stability in nomenclature of APN. Position classifications/titles are industrially determined and negotiated individually at the state/territory level. This has, over time, resulted in over 90 nursing/midwifery position titles across the eight jurisdictions with no standardised description of the practice profile of these position titles across state/territory borders. The exception to this is the title of nurse practitioner. This role is standardised across the country with national level regulation, title protection, practice standards and practice profile. It is time that other advanced nursing roles and titles that are regulated under the registered nurse scope of practice had the same level of clarity and definition. This will only be possible in the context of a broad based and robust examination and mapping of nursing titles and practice positions across all Australian states and territories.

Accordingly, the study reported here was conducted to achieve two broad goals:

iii) To map nursing titles across Australian jurisdictions according to patterns of clinical practice and

iv) To establish an operational framework for differentiating and describing APN for the Australian health service context and future development of the nursing profession.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This research conducted a national survey of registered nurses and registered midwives in Australia drawing upon previous APN work by the authors in Queensland.[22-24]. Data collection was conducted in the six-week period February/April 2014. The study aim was to describe the patterns of practice of Australian nurses according to position titles applying the Strong Advanced Practice Role Delineation (APRD) tool.

The study was guided by the following:

1. Research questions:

Q1. What is the pattern of advanced practice activity according to levels of practice as defined by nursing/midwifery position title?

Q2. To what extent do Australian registered nurses/midwives in different position titles carry out the activities of APN as itemised in the Modified Strong Advanced Practice Role Delineation tool?

2. Research objective:

To map titles of nurses and midwives across the eight Australian jurisdictions

Sample and Recruitment

A population sample of Australian registered nurses/midwives who were currently employed in a clinical service environment was eligible for inclusion in the study. At the time of the study there was an estimated population of 252,868 registered nurses, 29,915 registered nurse/midwives and 2,918 midwives working in Australia.[25]

Direct recruitment of survey participants from the population was not possible or financially feasible due to the size of the sample and lack of assured access to a central database of registered nurses and registered midwives. Therefore a multilevel and multimodal recruitment strategy was used. The basis of the recruitment approach was wide and targeted information dissemination and evidence-based strategies based on elements of Dillman's Tailored Design survey method approach.[26]

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The recruitment process was supported by the Australian Nursing and Midwifery Federation (ANMF) State and Territory Branches and other member organisations (details below) and was implemented in stages.

Stage 1: Initial study recruitment

Prior to the study commencement, the project coordinator made phone and email contact with each of the state and territory ANMF State Secretaries to discuss strategies for the sequential pre-notice announcements and distribution of a recruitment flyer to ANMF members. A promotional flyer describing the aims of the study and providing the e-survey hyperlink was developed in collaboration with the marketing team of the NSW Nurses and Midwives Association (See Appendix I for study recruitment material).

A report about the study and its aims was published in the ANMF National and Branch journals and on websites in the months prior to the e-survey 'go live' date and included:

Table 1 Recruitment dissemination sources

ANMF Publication	Publication Date
Australian Nursing and Midwifery Journal	December 2013
Nurse UNCUT blog	March 2014
The Lamp	February 2014
InTouch Bulletin	March 2014
Nursing Review	December 2013 and January 2014
The Collective Perspective	February 2014

A hyperlink to the e-survey was hosted by the ANMF national and state and territory websites and the Australian College of Nurse Practitioner (ACNP) website. To expand exposure of the target population to the study and its aims, additional recruitment outlets included nursing and midwifery professional colleges and associations. Information was disseminated by these organisations via weblinks, eNEWs and other specialty group publications (See Table 2 and Appendix I).

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Table 2 Professional organisations involved in e-survey recruitment

Professional organisation	Promotional Activity
Aged Care Network Brisbane	Item on agenda of quarterly meeting
Australian Nursing & Midwifery Accreditation Council	Recruitment letter emailed to all RNs & RMs on the organisation's 'Reviewer database'
Cardiac Nurses Group	Distribution of promotional flyer at national conference February 2014.
CareSearch Palliative Care Knowledge Network – Nurses Hub	Project information published in the March 2014 version of CareSearch Nurses[Hub]news via the www.caresearch.com.au
Coalition of National Nursing Organisations (CoNNO)	Email notice and project recruitment flyer distributed to membership of more than 50 national nursing organisations
CRANAplus	Published details of the study and flyer in newsletter
Nursing and Midwifery Office Queensland	Circulation of information about the study to networks
Renal Nurses Group	February 2014 Distribution of promotional flyer through the network
Royal Flying Doctor Service (RFDS)	General email to RN/RM staff
The Australian College of Nursing (ACN)	Recruitment Email to ACN membership Promotion in the College e-Newsletters
The Australian College of Nurse Practitioners (ACNP)	Hosted the promotional flyer and hyperlink to e-survey
The Australian Primary Health Care Nurses Association (APNA)	Publication in the December 2013 edition of *Primary Times* along with regular updates posted via eNews updates

Stage 2: Recruitment during data collection

During the six week data collection period, ANMF state and territory branches and other professional organisations continued to coordinate regular reminders to their members via email alerts, e-Bulletins, newsletter articles, industry publications and social media. The project team provided regular progress/status reports to ANMF state/territory secretaries to inform their support with participant recruitment.

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Instrument Development and Testing

The online survey was based on the APRD tool, used and adapted with permission from the authors[22] (See Appendix II).

The e-survey instrument was created in consultation with the High Performance Computing and Research Support team at Queensland University of Technology using *Key Survey* Software. The development of the e-survey instrument was a complex and lengthy process that occurred over a period of three months. This involved development and refinement of the questionnaire in the conversion of the APRD tool to *Key Survey* and testing the reliability and efficiency of the hyperlink. Finally, a pilot test of the e-survey instrument was conducted on a sample of 15 nurses and midwives in a major tertiary referral hospital for time burden, relevance of items and functionality of the hyperlink.

The Modified Strong Advanced Practice Role Delineation tool

The APRD tool identifies five domains which address the main areas of APN practice. The domain titles are Direct Comprehensive Care, Support of Systems, Research, Education and Publication and Professional Leadership. Within each domain are listed a number of activities undertaken by nurses practicing at an advanced level. The APRD questionnaire was previously modified to accommodate the professional and cultural content of Australian nursing and midwifery[23] practice and has undergone validity and reliability testing for use with an Australian nursing population[23-25] The instrument for this e-survey had three sections as follows:

Section A: Demographic data including aged and sex, state/territory currently working, title/position, current classification, number of years as RN/RM, number of years in current position, highest level of education, current practice setting, sector and region of work, and membership of professional organisations.

Section B: The APRD questionnaire comprises 41 items across five Domains of Practice namely: Direct Comprehensive Care (15 activities), Support of Systems (8 activities), Education (6 activities), Research (6 activities), Education and Professional Leadership (6 activities). In each Domain activity, respondents were asked to rate: in their current role, the extent to which they had undertaken the activity, on a 5 point Likert scale, where: 4 = to a very great extent; 3 = to a great extent; 2 = to some extent; 1 = to a little extent; 0=not at all

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Section C: of the tool asked respondents to indicate on the 5 point Likert scale the extent of time they spent working within each of the five domains.

Data Collection

This was a nation-wide electronic survey. Hyperlinks to the host website were provided in all electronic recruitment material, and the survey web address was provided in all print material. Through these media registered nurses and midwives were invited to log on and complete the questionnaire. On entering the website the potential participant was provided with the ethics committee approved study information and consent documents and advised that completion of the questionnaire was taken as consent to participate.

Data Analysis

SPSS (version 21 for Windows, SPSS, Inc., 2012)[27] was used for all analyses. Descriptive statistics were used to examine the characteristics of the sample. Data are presented in two ways. Categorical variables presented as counts and percentages and continuous variables presented either as means (standard deviation) or median (minimum and maximum) as appropriate to the distribution of the data.

Domain means for each participant were calculated from the survey responses which were recorded on a scale from 0 to 4. Evaluations of nursing position title at state/territory level were performed with the average of the domain means of all individuals within a position title.

Characteristics of state/territory nursing position titles that were grouped by cluster analysis (see following) were compared with one-way analysis of variance on state/territory nursing position title domain means. The alpha for all tests was set at 0.05. Significant effects were examined with Bonferroni *post hoc* comparisons to control for Type 1 error.

Cluster Analysis

Cluster analysis is an exploratory technique that was used in this study to reveal groups of state-defined nursing position titles that are similar to one another based on all five Domain mean scores (mapping). An agglomerative hierarchical approach was selected which uses a bottom up method where state nursing position titles are nested together as lower order clusters and give rise to increasingly larger higher order clusters. Proximity and dissimilarity measures are used to join titles or groups of titles into clusters based on best match in repeated cycles

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until all 66 state nursing position titles are in one highest order cluster. In this analysis squared Euclidean distances was used as the dissimilarity measure and Ward's method was used as the inter-group proximity measure. Cluster analysis has no goodness-of-fit indices, so the appropriate number of cluster solution was determined using a combination of dendrograms (visual representation of possible groupings) and expert judgment of the researchers. To conserve the separate clustering of the clinical nurse consultants and nurse practitioner groups, clustering was stopped at the point just before these two clustered joined giving rise to seven clusters.

Ethics Approval

The Queensland University of Technology Human Research Ethics Committee provided ethical approval for the study (See Appendix III).

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Profile of Study Participants

Almost 7000 nurses and midwives completed the survey. Data cleaning was conducted to remove ineligible responses, these included enrolled nurses and nurses not employed and those not working in Australia (n= 342). The remaining data set was split for analysis into nursing (n=5662), midwifery (n=502) and other titles not relevant to analysis (nursing directors, n=154). Some responses recorded positions not included in the relevant state/territory RN/Midwifery classification and career structure, these were removed (n=279).

Reporting of results in this document, with the exception of information in Tables 9 and 10, will focus on analysis of the nursing sample. Analysis of the midwifery sample data is reported in Appendix V

Distribution of Sample across States & Territories

Participants responded from all eight states and territories in Australia. A third of all participants came from Victoria. In NSW, SA and the NT the distribution of the survey participants was similar to the AHPRA published proportions of the Australian nursing population.[24] Response rates from both QLD and WA are lower, while response rates of VIC, TAS and the ACT were all higher than their national distribution of the nursing population. These results are displayed in Table 3.

Table 3: Sample distribution across State & Territory

	Number of Participants	Percentage	AHPRA distribution of nursing population
VIC	1901	33.5%	25.8%
NSW	1740	30.7%	29.4%
QLD	690	12.2%	19.7%
SA	487	8.8%	8.6%
WA	288	5.1%	11.1%
TAS	253	4.5%	2.5%
ACT	199	3.5%	1.7%
NT	101	1.9%	1.2%
TOTAL	5662	100%	100%

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Age and Sex of Participants

Survey respondents recorded their age in 10-year increments. Most respondents covered the 40-59 age groups as demonstrated in Table 4. This profile of age distribution is older than the AHPRA distribution of the nursing workforce employed in Australia. Participants in QLD, WA and the NT were younger than in other states.

Table 4. Age

	Number of Participants	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60-69 Years	70 Years and over
VIC	1901	11.3%	12.6%	24.9%	38.1%	12.6%	0.5%
NSW	1740	9.0%	13.1%	22.5%	41.2%	13.8%	0.5%
QLD	690	5.5%	14.9%	31.7%	39.4%	8.1%	0.3%
SA	487	3.8%	11.1%	25.5%	47.1%	12.1%	0.4%
WA	288	9.0%	16.7%	28.8%	36.5%	9.0%	0.0%
TAS	253	7.1%	13.0%	25.3%	42.7%	11.5%	0.4%
ACT	199	6.0%	15.1%	24.6%	41.2%	12.6%	0.5%
NT	101	7.5%	18.7%	20.6%	35.5%	17.8%	0.0%
Total	5662	8.7%	13.3%	25.2%	40.2%	12.3%	0.4%
AHPRA distribution of nursing population	257,236	16%	23%	25%	24%	11%	1%

Most participants were female, similar to the sex ratios found in the Australian nursing workforce. The ratio of male nurses was higher in the NT compared to the rest of the country. These are shown in Table 5.

Table 5: Sex

	Number of Participants	Female	Male
VIC	1901	92.1%	7.9%
NSW	1740	89.8%	10.2%
QLD	690	87.4%	12.6%
SA	487	87.5%	12.5%
WA	288	92.0%	8.0%
TAS	253	89.7%	10.3%
ACT	199	88.4%	11.6%
NT	101	83.0%	17.0%
TOTAL	5662	90.0%	10.0%
AHPRA distribution of nursing population	257236	88.2%	11.8%

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Distribution across Workplace Sector

Three quarters of all participants worked in the public sector. Overall almost 20% of the participants worked in the private sector with higher proportions in VIC, NSW, SA and TAS. Participants in the NT were more likely to be employed in non-government organisations compared with those in other states and in WA the proportion of sole traders were more than double the national average. These results are illustrated in Table 6.

Table 6. Workplace Sector

	Number of Participants	Public	Private	Non-Government Organisation (NGO)	Sole trader	Mixed	Unknown
VIC	1901	74.3%	20.6%	3.3%	0.5%	1.2%	0.2%
NSW	1740	74.3%	19.3%	5.1%	0.5%	0.6%	0.2%
QLD	690	80.6%	13.2%	4.1%	0.6%	1.4%	0.1%
SA	487	75.3%	18.3%	3.4%	0.4%	2.0%	0.6%
WA	288	74.7%	14.6%	7.3%	1.4%	1.7%	0.3%
TAS	253	75.1%	20.6%	3.2%	0.0%	0.8%	0.4%
ACT	199	81.4%	14.6%	1.0%	1.0%	1.0%	1.0%
NT	101	68.9%	10.4%	17.9%	0.9%	0.9%	0.9%
Total	5662	75.3%	18.4%	4.3%	0.6%	1.1%	0.3%

Distribution across Workplace Setting

Over half of all participants were employed in hospitals with a third working in the community. Six percent worked in aged care settings with another 4% working over multiple settings. These results are displayed in Figure 1.

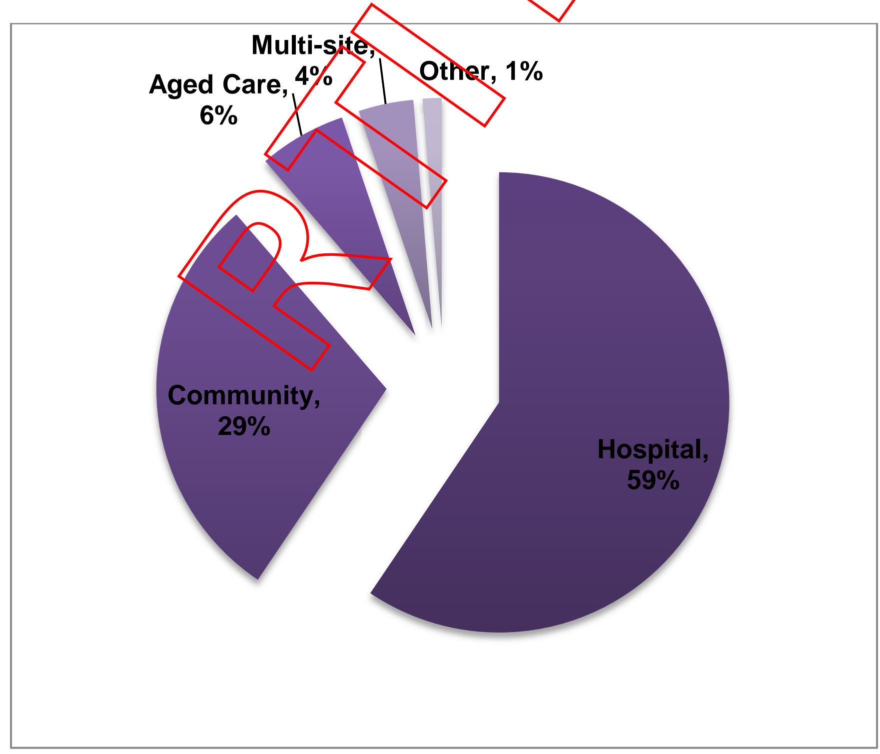

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Figure 1: Distribution across workplace settings.

Workplace Region

Most nurses worked in a regional or metropolitan location and almost a third of participants worked in a rural or remote area. The *mixed* category contained individuals who worked at the boundaries of rural and regional zones and those whose position was state-wide such as the Royal Flying Doctor Service or tele-health. These proportions reflected state population distributions (Table 7).

Table 7. Workplace Region

	Number of Participants	Metropolitan and Regional	Rural and Remote	Mixed
VIC	1901	63.4%	25.7%	10.9%
NSW	1740	47.5%	34.8%	17.7%
QLD	690	41.2%	43.6%	15.2%
SA	487	75.5%	11.9%	12.7%
WA	288	71.9%	15.6%	12.5%
TAS	253	47.0%	38.7%	14.2%
ACT	199	75.4%	24.6%	0.0%
NT	101	20.8%	13.2%	66.0%
Total	5662	56.2%	29.2%	14.6%

Highest Education Level of Participants

Table 8 shows the highest level of education in a nursing related field. The highest education of most participants was either a BN or postgraduate certificate or diploma. Almost 20% of participants had a Masters' degree, with a further 0.8% having a doctoral degree. Just over 10% had a hospital certificate as their highest level of education. Participants from QLD, SA, NT and WA were more likely to have postgraduate qualifications than the other states. Hospital certificate as the highest education varied from 16% in TAS to 4.5% in WA. Almost 10% of participants claimed their highest education was not in a nursing related field.

Table 8. Highest Education

	Number of Participants	PhD	Masters	Post Graduate Diploma	Post Graduate Certificate	BN or equivalent	Hospital Certificate	Other
VIC	1901	0.6%	13.9%	24.5%	16.5%	23.4%	11.0%	10.2%
NSW	1740	0.8%	19.3%	12.2%	22.2%	23.6%	12.6%	9.3%
QLD	690	1.2%	25.7%	10.9%	21.9%	22.6%	13.2%	4.6%
SA	487	0.8%	18.3%	22.1%	17.9%	22.1%	12.1%	6.6%
WA	288	1.0%	25.7%	17.4%	22.6%	19.4%	4.5%	9.4%
TAS	253	0.8%	11.9%	19.4%	17.0%	26.5%	16.6%	7.9%
ACT	199	0.5%	25.1%	15.6%	15.6%	23.1%	9.0%	11.1%
NT	101	0.0%	24.5%	26.4%	17.9%	19.8%	5.7%	5.7%

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Total	5662	0.8%	18.5%	18.0%	19.3%	23.1%	11.6%	8.7%

Years as a Registered Nurse

On average, participants had been registered as a nurse for 22.6 years with a range over 50 years. Most participants have been registered as a nurse for between 11-33 years (interquartile range) and nurses in WA and the NT were registered for shorter time than nurses in other states. These results are illustrated in Figure 2.

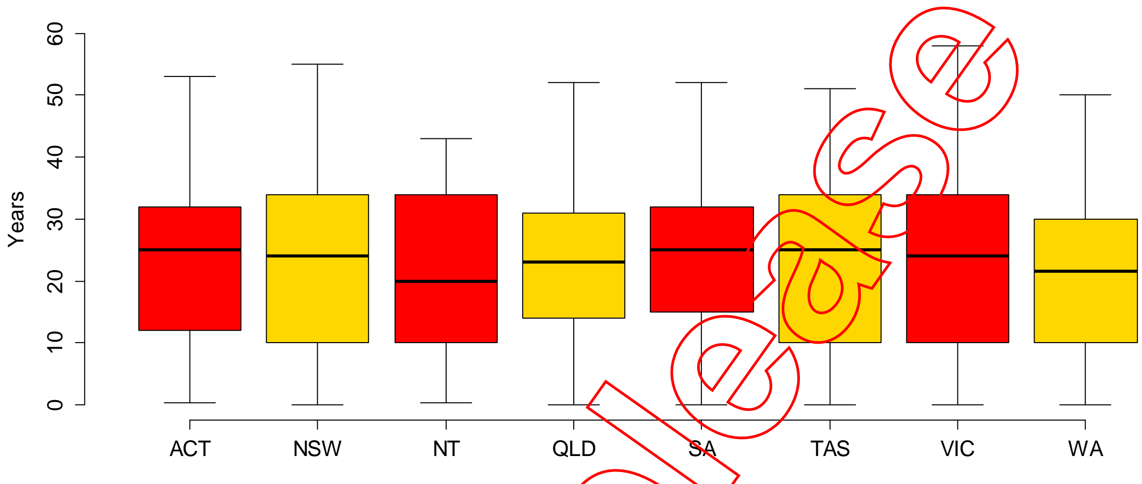

Figure 2: Distribution of years as a RN by State/Territory showing median and range.

Years in Current Position

Participants had spent on average 6.8 years (2-10 years interquartile range) in their current position. Nurses in the NT and WA had spent less time in their current position compared to those in the ACT, NSW, and VIC (see Figure 3).

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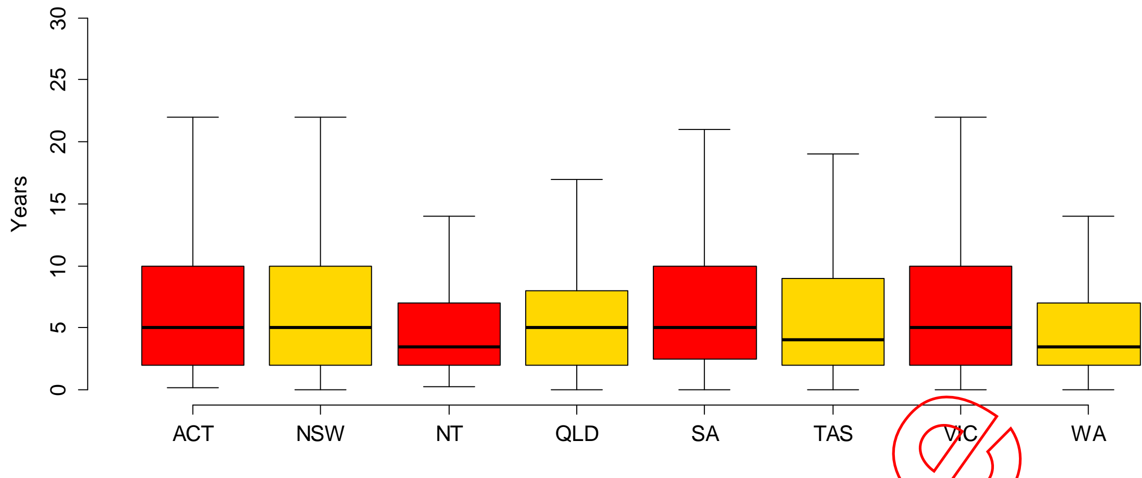

Figure 3: Distribution of years in current position by State/Territory showing median and range.

Membership of Professional Organisations

Most respondents held membership of a professional body. Table 9 lists the most common of these organisations. Table percentages are not cumulative since many participants were members of more than one group. Over 80% of respondents are members of the Australian Nursing and Midwifery Federation, the NSW Nurses and Midwives' Association or the Queensland Nurses Union.

Table 9: Professional Membership

Professional Organisation	Number	Percentage
Australian Nursing and Midwifery Federation (ANMF)	2706	47.7%
NSW Nurses and Midwives' Association	1436	25.3%
Australian College of Nursing (ACN)	824	14.5%
Queensland Nurses Union (QNU)	577	10.2%
Australian College of Nurse Practitioners (ACNP)	319	5.6%
Australian College of Mental Health Nurses (ACMHN)	218	3.8%
Australian Primary Healthcare Nurses Association (APNA)	212	3.7%
Australian College of Operating Room Nurses (ACORN)	172	3.0%
Australian Wound Management Association (AWMA)	171	3.0%
Australian College of Midwives (ACM)	128	2.3%
College of Remote Area Nurses Australia Inc (CRANAplus)	110	1.9%
Cancer Nurses Society of Australia (CNSA)	106	1.9%
Renal Society of Australasia	102	1.8%
Palliative Care Nurses Australia (PCNA)	81	1.4%
Australasian Sexual Health & HIV Nurses Association (ASHHNA)	78	1.4%
Australian College of Children and Young People's Nurses (ACCYPN)	64	1.1%
Australian College of Neonatal Nurses	37	0.7%
Royal District Nursing Service (RDNS)	31	0.5%
Australasian Hepatology Association	29	0.5%

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Thoracic Society of Australia and New Zealand (TSANZ)	22	0.4%
Australasian Cardiovascular Nursing College	19	0.3%
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)	8	0.1%

Nursing Position Titles across Australia

Table 10 shows all position titles recorded by survey participants by state and territory. Positions marked with an asterisk were not included in this analysis. This included midwifery positions that have been analysed as a group separate from nursing. Those participants who recorded a director title were also excluded before analysis as this role is well-defined, mostly non-clinical and has been clearly delineated from APN in previous work.[24] Positions recorded in the 'Other' option that were not listed as possible positions in the relevant state and territory nursing titles lists were also removed.

Table 10: Survey Participant Nursing and Midwifery Position Titles by State

Australian Capital Territory Position Titles	Number	Percentage
Advanced Practice Nurse	17	7.3%
Assistant Director of Nursing*	8	3.4%
Clinical Nurse	17	7.3%
Clinical Nurse Consultant	9	3.9%
Clinical Nurse Coordinator	14	6.0%
Director of Nursing*	4	1.7%
Midwife Consultant*	1	0.4%
Midwifery Educator*	1	0.4%
Nurse Coordinator	7	3.0%
Nurse Educator	7	3.0%
Nurse Manager	2	0.9%
Nurse Practitioner	11	4.7%
Other *	4	1.7%
Registered Midwife*	16	6.9%
Registered Nurse	115	49.4%

New South Wales Position Titles	Number	Percentage
Assistant Director of Nursing*	1	0.1%
Clinical Midwife Consultant*	9	0.5%
Clinical Midwife Educator*	5	0.3%
Clinical Midwife Specialist*	33	1.7%
Clinical Nurse Consultant	173	8.8%
Clinical Nurse Educator	55	2.8%
Clinical Nurse Specialist	254	12.9%
Deputy Director of Nursing*	2	0.1%
Director of Nursing*	10	0.5%
Midwife Educator*	1	0.1%
Midwife Manager*	1	0.1%
Midwife Practitioner*	3	0.2%

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Midwifery Unit Manager*	14	0.7%
Nurse Educator	34	1.7%
Nurse Manager	95	4.8%
Nurse Practitioner	65	3.3%
Nurse Unit Manager	94	4.8%
Other *	63	3.2%
Registered Midwife*	91	4.6%
Registered Nurse	970	49.2%

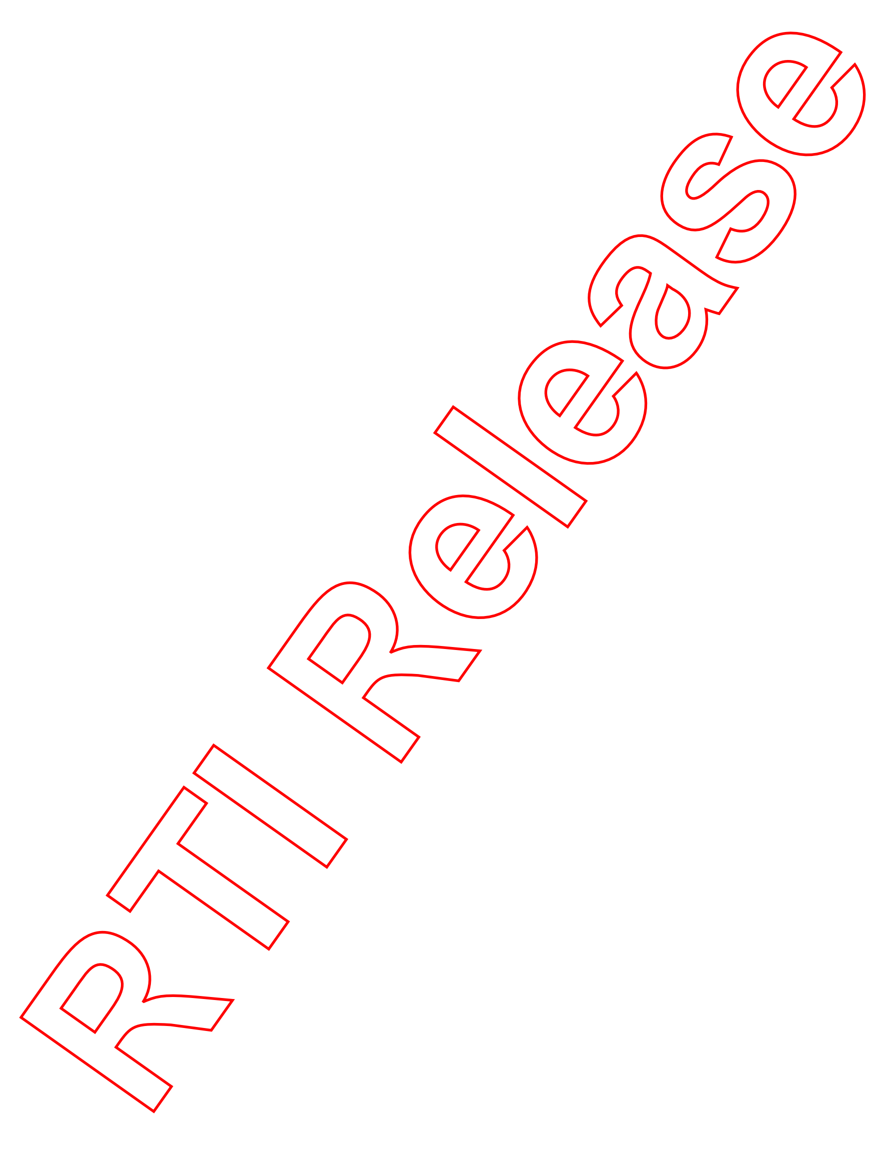
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Table 10 Continued: Survey Participant Nursing and Midwifery Position Titles by State

Northern Territory Position Titles	Number	Percentage
Nurse Educator	2	1.7%
Nurse Manager	3	2.5%
Nurse Practitioner	3	2.5%
Other *	19	12.5%
Registered Midwife*	4	3.3%
Registered Nurse	93	77.5%

Queensland Position Titles	Number	Percentage
Assistant Director of Nursing*	5	0.6%
Clinical Midwife*	6	0.8%
Clinical Nurse	213	26.8%
Clinical Nurse Consultant	97	12.2%
Director of Nursing*	15	1.9%
Executive Director of Nursing*	1	0.1%
Nurse Educator	48	6.0%
Nurse Manager	11	1.4%
Nurse Practitioner	44	5.5%
Nurse Researcher	8	1.0%
Nurse Unit Manager	54	6.8%
Nursing Director*	17	2.1%
Other *	24	3.0%
Registered Midwife*	37	4.7%
Registered Nurse	215	27.0%

South Australian Position Titles	Number	Percentage
Assistant Director of Nursing*	6	1.0%
Associate Clinical Service Coordinator	42	7.3%
Clinical Midwife*	6	1.0%
Clinical Nurse	110	19.1%
Director of Nursing/Midwifery*	8	1.4%
Nurse Manager	3	0.5%
Nurse Practitioner	31	5.4%
Nurse Clinical Practice Consultant	51	8.8%
Nurse Clinical Service Coordinator	35	6.4%
Nurse Education Facilitator	22	4.0%
Nurse Management Facilitator	17	2.9%
Nursing Director*	10	1.7%
Other *	29	5.0%
Registered Midwife*	25	4.3%
Registered Nurse	179	31.0%

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Table 10 Continued: Survey Participant Nursing and Midwifery Position Titles by State

Tasmanian Position Titles	Number	Percentage
Assistant Director of Nursing*	5	1.7%
Clinical Nurse Consultant	21	7.0%
Clinical Nurse Educator	11	3.7%
Director of Nursing*	6	2.0%
Nurse Manager	16	5.3%
Nurse Practitioner	9	3.0%
Other *	4	1.3%
Registered Midwife*	24	8.0%
Registered Nurse	188	62.5%
Specialist Nurse	8	2.7%

Victorian Position Titles	Number	Percentage
Assistant Director of Nursing*	9	0.4%
Associate Director of Nursing*	1	0.0%
Associate Midwife Unit Manager*	6	0.3%
Associate Nurse Unit Manager	60	2.6%
Clinical Consultant	114	5.0%
Clinical Midwife Consultant*	11	0.5%
Clinical Midwife Specialist*	58	2.6%
Clinical Nurse Specialist	251	11.1%
Clinical Support Nurse	19	0.8%
Community Health Nurse	45	2.0%
Deputy Director of Nursing*	10	0.4%
Director of Nursing*	21	0.9%
District Nurse	15	0.7%
Maternal & Child Health Nurse	212	9.4%
Midwife Unit Manager*	3	0.1%
Nurse Educator	76	3.4%
Nurse Manager	12	0.5%
Nurse Practitioner	47	2.1%
Nurse Researcher	8	0.4%
Nurse Unit Manager	86	3.8%
Nursing Director*	2	0.1%
Other*	118	5.2%
Registered Midwife*	127	5.6%
Registered Nurse	956	42.2%

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Table 10 Continued: Survey Participant Nursing and Midwifery Position Titles by State

Western Australian Position Titles	Number	Percentage
Area Manager	4	1.2%
Assistant Director Nursing*	1	0.3%
Clinical Midwife*	7	2.1%
Clinical Midwifery Consultant*	1	0.3%
Clinical Midwifery Manager*	1	0.3%
Clinical Nurse	67	19.7%
Clinical Nurse Consultant	21	6.2%
Clinical Nurse Manager	14	4.1%
Clinical Nurse Specialist	37	10.9%
Director of Nursing*	1	0.3%
Midwifery Manager*	1	0.3%
Nurse Manager	16	4.7%
Nurse Practitioner	46	13.5%
Nursing Director*	11	3.2%
Other *	22	6.5%
Registered Midwife*	7	2.1%
Registered Nurse	75	22.1%
Staff Development Educator	8	2.4%

*Midwifery and Director Position/Titles not included in further analysis in this report.

The Pattern of APN activities according to Nursing Title

Survey participants responded to each of the 41 items listing advanced practice nursing activities across the five Domains. These responses required the participant to record on a Likert scale the extent to which they carried out each of the activities. The scores were averaged within each of the five domains.

Five position titles were identified as common across all states and territories, these are: nurse practitioner, clinical nurse consultant, nurse educator, nurse manager and registered nurse. The means for each of the five domains for nurses with these titles are shown in Figure 4. Each of these positions shows a unique pattern of activities in the APRD tool.

Clinical nurse consultants score highly on all domains. They are similar to nurse practitioners who also score highly on all domains but with a prominent peak in Direct Care. Nurse educators score low in Research and noticeably in Direct Care but their practice activities peak in education and to a lesser extent in Support of Systems. Nurse managers also score poorly on Direct Care and less also on Education, Research and Professional Leadership but are differentiated by their Support of Systems response. Registered nurses score poorly on most domains except for Direct Care.

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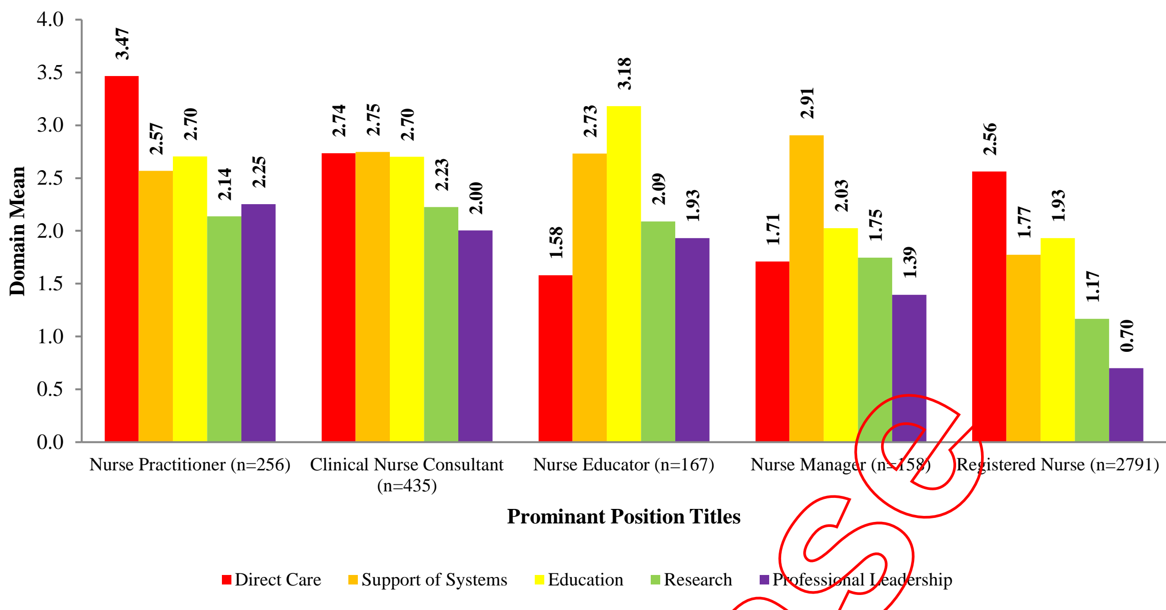

Figure 4: Domain means for five prominent positions across Australia.

Nurse Practitioners

Domain means for each of the eight state and territories nurse practitioner titles were calculated and are displayed in Figure 5. The pattern of advanced practice activities is similar across states and territories with all showing a distinguishing peak for Direct Care. Support of systems, Education and Research score highly and are uniform throughout the country. Professional Leadership does vary but is relatively higher than that of other positions.

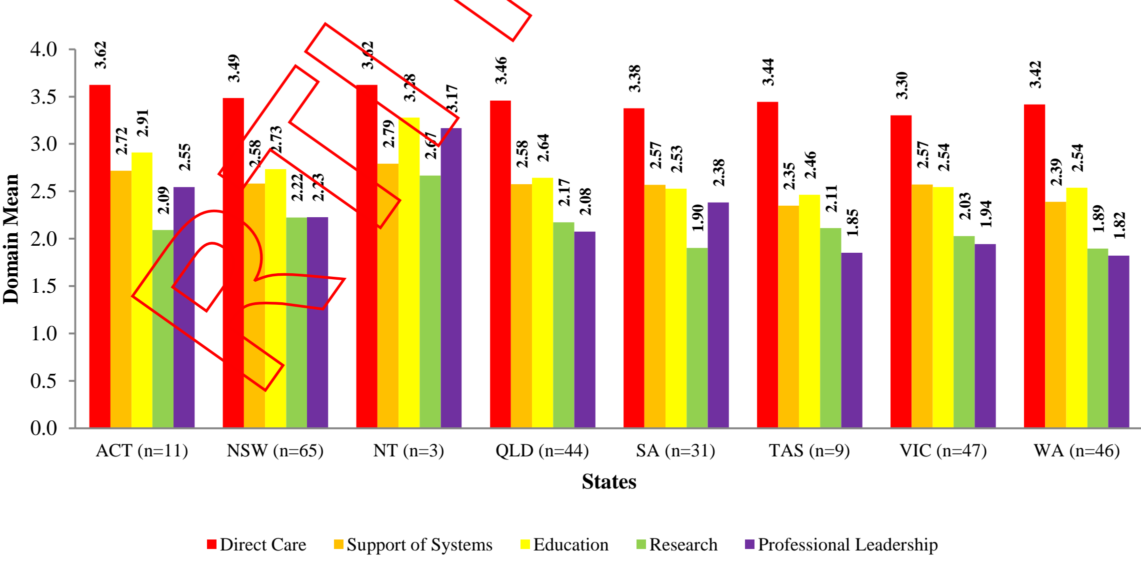

Figure 5: Domain means for nurse practitioner positions by State/Territory.

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Clinical Nurse Consultants

Clinical nurse consultant is a position title in six state and territories. Domain means for each of these positions are shown in Figure 6. Clinical nurse consultants are categorised by their high and even scores on all APN domains which show little variation between these positions across states and territories.

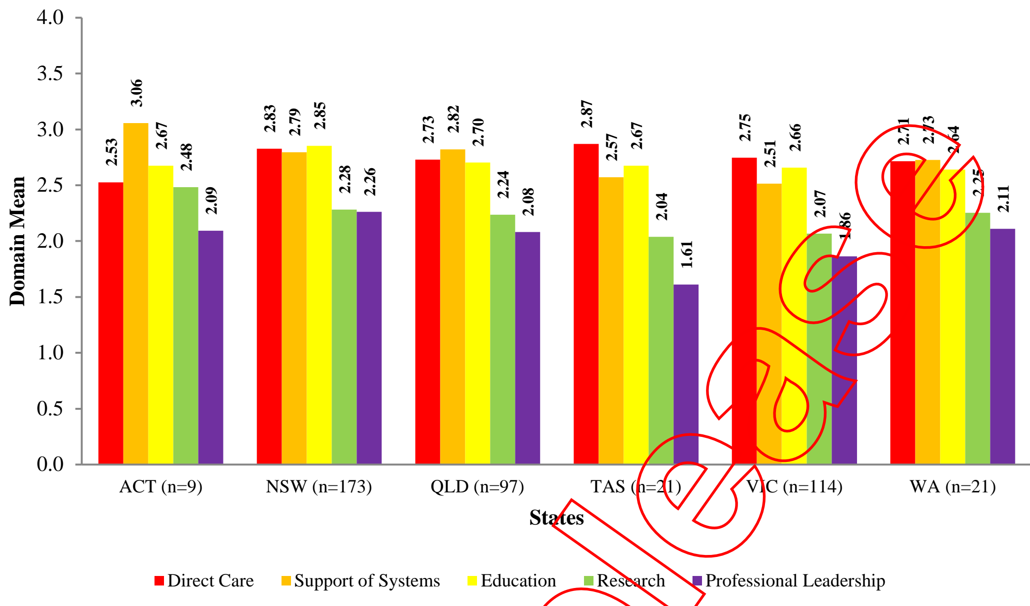

Figure 6: Domain means for clinical nurse consultant positions by State/Territory.

Nurse Educators

The position title nurse educator occurs in four jurisdictions – ACT, NSW, QLD and VIC. The Domain means for these positions are shown in Figure 7. These positions are characterised by low response to Direct Care activities and very high responses to both Support of Systems and Education. Research and Professional Leadership Domain means are reduced compared to Domain means for clinical nurse consultant.

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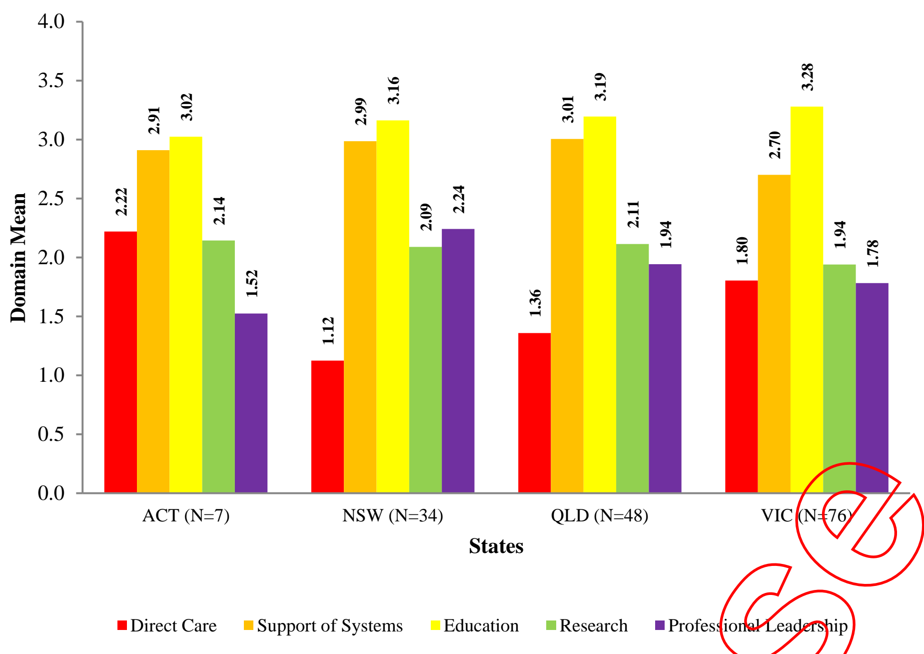

Figure 7: Domain means for nurse educator positions by State/Territory.

Nurse Managers

The position title of nurse manager was found in all states and territories except the NT. The domain means for these seven positions are shown in Figure 8. Similar to nurse educators, nurse managers scored low for Direct Care and high for Support of Systems. For nurse managers the three remaining domains, Education, Research and Professional Leadership were all below values for clinical nurse consultant positions.

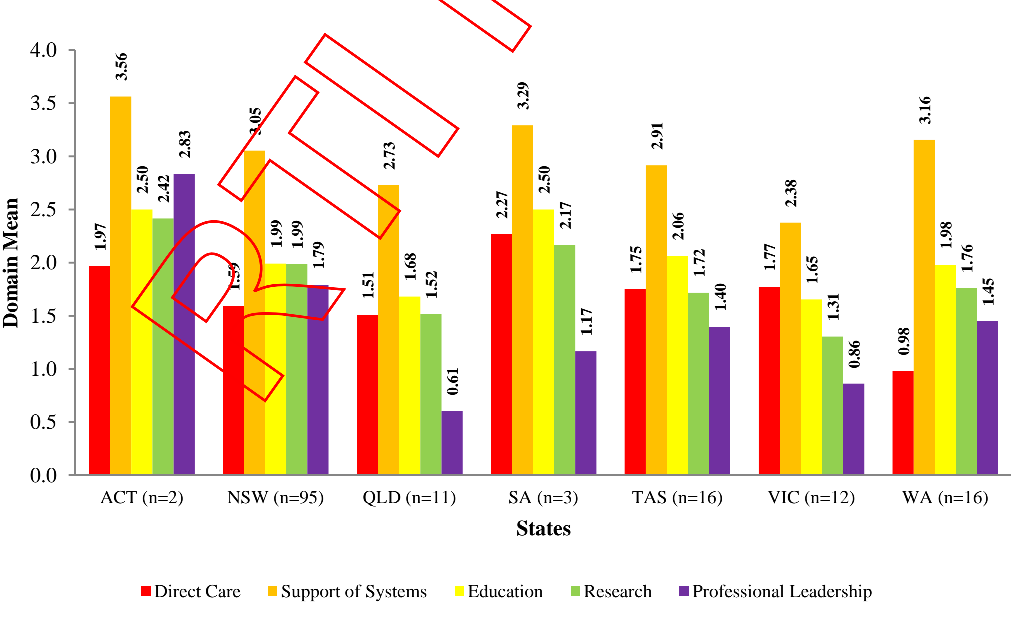

Figure 8: Domain means for nurse manager positions by State/Territory.

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Registered Nurses

All states and territories included the position title registered nurse. These positions scored high responses to Direct Care but low on all other domains. A comparison between the states is shown in Figure 9.

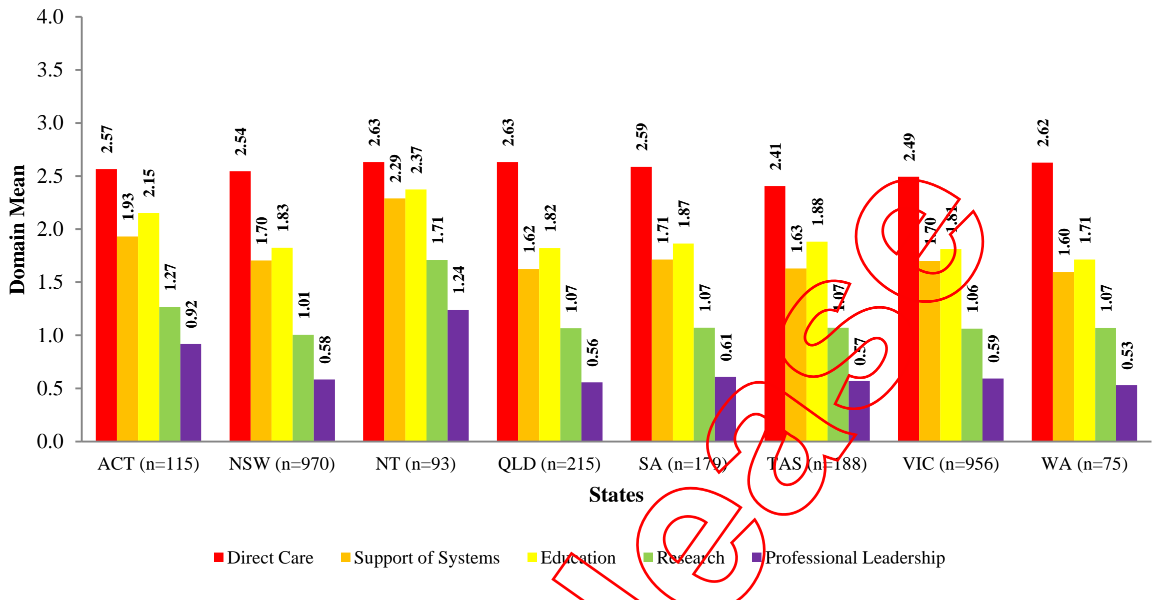

Figure 9: Domain means for registered nurse positions by State/Territory.

The extent to which different nursing titles carry out APN activities

The APRD is an advanced practice tool. That is, activities across all domains are carried out to a great extent by nurses who practice at an advanced level. This research question sought to determine if the tool would delineate advanced practice nurses from nurses practicing at other levels commensurate with titles.

Clinical Nurse Consultant

Analysis for research question 1 shows that advanced practice nursing is typified by the clinical nurse consultant position in all states and territories where the position occurs. Table 11 lists all six of these positions and their domain means. These are identified as APN domain means and their standard deviation and interquartile range of the 435 individuals in these positions are also listed in Table 11.

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Table 11. Calculation of the Advanced Practice Nurse Domain Means

Position	N	Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Clinical Nurse Consultant	9	2.53	3.06	2.67	2.48	2.09
NSW-Clinical Nurse Consultant	173	2.83	2.79	2.85	2.28	2.26
QLD-Clinical Nurse Consultant	97	2.73	2.82	2.70	2.24	2.08
TAS-Clinical Nurse Consultant	21	2.87	2.57	2.67	2.04	1.61
VIC-Clinical Consultant	114	2.75	2.51	2.66	2.07	1.86
WA-Clinical Nurse Consultant	21	2.71	2.73	2.64	2.25	2.11
Means of all CNC individuals APN Domain Means	435	2.77	2.72	2.75	2.21	2.08
Standard deviation		0.85	0.77	0.77	0.87	1.01
Interquartile Range		3.40 - 2.27	3.38 - 2.13	3.33 - 2.17	2.83 - 1.67	2.83 - 1.33

To determine which other positions were comparable to the clinical nurse consultant, a threshold was calculated at 0.5 of a unit below and above the APN domain means. For positions to be considered as equivalent to the advanced practice level of the clinical nurse consultant position, the means of *all* their domains must be within 0.5 of a unit of the APN domain means. These threshold values are listed in Table 12. Our results show that nine positions, including all eight nurse practitioner positions and the ACT nurse coordinator were above the upper APN threshold in the Direct Care domain. All these positions were also above the lower APN threshold. All domain means for these positions are tabled in Table 13.

Table 12. Calculation of the Advanced Practice and Nurse Practitioner Threshold

	Direct Care	Support of Systems	Education	Research	Professional Leadership
	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Upper APN Threshold 0.5 of a Unit above *any* of the domain means	3.27	3.22	3.25	2.71	2.58
APN Domain Means N=435	**2.77**	**2.72**	**2.75**	**2.21**	**2.08**
Lower APN Threshold 0.5 of a Unit below *any* of the domain means	2.27	2.22	2.25	1.71	1.58

Nine positions, including all six clinical nurse consultant positions as well as the ACT clinical nurse coordinator, the SA nurse clinical practise consultant and the WA clinical nurse specialist all had domain means below the upper APN threshold and above the lower APN threshold. The domain means for all these positions are listed in Table 14.

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Table 13. Nurse Practitioners: Positions above the Upper APN Threshold in *any* Domain and above the Lower APN Threshold in *all* Domains

		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Nurse Coordinator	7	3.41	3.02	2.7	2.5	2.26
ACT-Nurse Practitioner	11	3.62	2.72	2.91	2.09	2.55
NSW-Nurse Practitioner	65	3.49	2.58	2.73	2.22	2.23
NT-Nurse Practitioner	3	3.62	2.79	3.28	2.67	3.17
QLD-Nurse Practitioner	44	3.46	2.58	2.64	2.17	2.08
SA-Nurse Practitioner	31	3.38	2.57	2.53	1.90	2.38
TAS-Nurse Practitioner	9	3.44	2.35	2.46	2.11	1.85
VIC-Nurse Practitioner	47	3.30	2.57	2.54	2.03	1.94
WA-Nurse Practitioner	46	3.42	2.39	2.54	1.89	1.82

Table 14. Advance Practice Nurses: Positions within both the UPPER and LOWER Advanced Practice Domain thresholds for all domains

		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Clinical Nurse Consultant	9	2.53	3.06	2.67	2.48	2.09
ACT-Clinical Nurse Coordinator	14	2.60	2.95	2.62	2.19	1.92
NSW-Clinical Nurse Consultant	173	2.83	2.79	2.85	2.28	2.26
QLD-Clinical Nurse Consultant	97	2.73	2.82	2.70	2.24	2.08
SA-Nurse Clinical Practice Consultant	51	2.91	2.69	2.49	2.03	1.87
TAS-Clinical Nurse Consultant	21	2.87	2.57	2.67	2.04	1.61
VIC-Clinical Consultant	114	2.75	2.51	2.66	2.07	1.86
WA-Clinical Nurse Consultant	21	2.71	2.73	2.64	2.25	2.11
WA-Clinical Nurse Specialist	37	2.77	2.64	2.46	1.95	1.84

Registered Nurse

The registered nurse position title was in the nursing title structure for all eight states and territories. Table 15 lists all eight state/territory based registered nurse positions and their domain means.

Table 15. Registered Nurses

Position		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Registered Nurse	115	2.57	1.93	2.15	1.27	0.92
NSW-Registered Nurse	970	2.54	1.70	1.83	1.01	0.58
NT-Registered Nurse	93	2.63	2.29	2.37	1.71	1.24
QLD-Registered Nurse	215	2.63	1.62	1.82	1.07	0.56
SA-Registered Nurse	179	2.59	1.71	1.87	1.07	0.61
TAS-Registered Nurse	188	2.41	1.63	1.88	1.07	0.57
VIC-Registered Nurse	956	2.49	1.70	1.81	1.06	0.59
WA-Registered Nurse	75	2.62	1.60	1.71	1.07	0.53

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Other **Nurse Titles**

Forty eight nursing titles fell below the lower APN threshold but were, in domains relevant to their title, above the profile of the registered nurse. These include the nurse educator, manager and clinical nurse titles and are listed in Table 16 along with their domain means.

Table 16. Other Position/ Titles

		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Advanced Practice Nurse	17	3.01	2.41	2.47	1.78	1.27
ACT-Clinical Nurse	17	2.77	2.15	2.48	1.57	1.32
ACT-Nurse Educator	7	2.22	2.91	3.02	2.14	1.52
ACT-Nurse Manager	2	1.97	3.56	2.50	2.42	2.83
NSW-Clinical Nurse Educator	55	2.05	2.96	3.40	2.12	1.56
NSW-Clinical Nurse Specialist	254	2.79	2.18	2.44	1.42	0.99
NSW-Nurse Educator	34	1.12	2.99	3.16	2.09	2.24
NSW-Nurse Manager	95	1.59	3.05	1.99	1.99	1.79
NSW-Nurse Unit Manager	94	2.32	3.08	2.33	2.09	1.41
NT-Nurse Educator	2	1.40	2.06	3.25	2.17	2.17
NT-Nurse Manager	3	1.84	2.17	1.83	1.11	1.06
QLD-Clinical Nurse	213	2.82	2.13	2.39	1.46	0.92
QLD-Nurse Educator	48	1.36	3.01	3.19	2.11	1.94
QLD-Nurse Manager	11	1.51	2.73	1.68	1.52	0.61
QLD-Nurse Researcher	8	1.24	2.13	1.66	3.08	2.02
QLD-Nurse Unit Manager	54	1.96	3.22	2.25	2.35	1.76
SA-Assoc Clinical Service Nurse	42	2.78	2.22	2.32	1.44	1.06
SA-Clinical Nurse	110	2.77	2.20	2.44	1.50	1.13
SA-Nrs Clinical Service Coordinator	35	2.22	3.14	2.60	2.21	1.97
SA-Nurse Education Facilitator	22	1.37	2.97	3.11	2.04	1.96
SA-Nurse Management Facilitator	17	1.42	2.58	1.72	1.79	1.25
SA-Nurse Manager	3	2.27	3.29	2.50	2.17	1.17
TAS-Clinical Nurse Educator	11	1.61	2.68	3.06	2.29	1.79
TAS-Nurse Manager	16	1.75	2.91	2.06	1.72	1.40
TAS-Specialist Nurse	8	2.93	2.06	2.53	1.73	1.31
VIC-Associate Nurse Unit Manager	60	2.58	2.29	2.33	1.40	0.76
VIC-Clinical Nurse Specialist	251	2.69	2.07	2.37	1.36	0.81
VIC-Clinical Support Nurse	19	2.19	2.73	3.19	1.53	1.31
VIC-Community Health Nurse	45	2.79	1.81	1.96	1.35	1.05
VIC-District Nurse	15	2.81	1.88	1.89	1.16	0.94
VIC-Maternal & Child Health Nurse	212	2.79	2.20	2.18	1.61	1.25
VIC-Nurse Educator	76	1.80	2.70	3.28	1.94	1.78
VIC-Nurse Manager	12	1.77	2.38	1.65	1.31	0.86
VIC-Nurse Researcher	8	2.36	2.08	2.15	2.27	1.52
VIC-Nurse Unit Manager	86	2.50	3.05	2.65	2.05	1.53
WA-Area Manager	4	1.17	3.59	2.08	1.58	1.63
WA-Clinical Nurse	67	2.88	2.13	2.32	1.57	1.06
WA-Clinical Nurse Manager	14	2.10	2.90	2.15	2.00	1.62
WA-Nurse Manager	16	0.98	3.16	1.98	1.76	1.45
WA-Staff Development Educator	8	1.39	3.09	3.06	2.27	2.69

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Delineating Nursing Position Titles by Group

Delineation of Australian nursing position titles with thresholds created four classifications of nursing positions according to their level of advanced practice activities. This included the nurse practitioners, the advanced practice nurses (clinical nurse consultant and like positions), registered nurses and other positions/titles. An ANOVA with *post hoc* testing between all four groups for each of the domains was performed to analyse where the significant differences were to be found. Table 17 lists all domain means of the four position/title groupings and areas of significant difference are highlighted.

Table 17. Domain Means of Delineated Position Titles

		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Nurse Practitioners	263	3.46	2.62	2.70	2.18	2.25
Advanced Practice Nurses	537	2.74	2.75	2.64	2.17	1.96
Other Positions/Titles	2071	2.10	2.62	2.44	1.84	1.47
Registered Nurse	2791	2.56	1.77	1.93	1.17	0.70
ANOVA (F Sig)		21.04*	10.88*	5.86*	14.98*	20.67*

*p<0.001

Significant differences were highlighted by post hoc testing of these ANOVAs. For Direct Care, nurse practitioners perform at a level significantly higher than all of the other three groups and advance practice nurses perform at a level significantly higher than the other titles. In the Support of System, Education and Research Domains, registered nurses perform at a level significantly below all of the other three groups. In Professional Leadership, nurse practitioners and advanced practice nurses are similar and both are significantly different to both registered nurses and other titles.

Mapping of Australian Nursing Position Titles: Cluster Analysis

Mapping of state nursing position titles was based on the pattern of practice revealed by the five Domain mean scores for each state/territory position titles (n=66). This mapping was performed using cluster analysis statistics; details of this analytic approach are previously described, (see page 13). In order to conserve the separate clustering of the clinical nurse consultant and nurse practitioner groups, the cluster measure was stopped at the point just before these two clustered groups joined giving rise to seven clusters of state/territory nursing position titles which are considered to be equivalent. These clusters and their membership are listed in Table 18 and the dendrogram of the cluster formation is detailed in Appendix IV.

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The Domain means of these seven clusters are displayed in Figure 10 and further detailed in Table 19. The nurse practitioner cluster listed all nurse practitioner titles but also included the ACT nurse coordinator which is echoed in the nurse practitioner delineation threshold. The clinical nurse consultant cluster included all members of the advanced practice delineation thresholds including the SA Nurse Clinical Service Coordinator and the Victorian Nurse Researcher. The third cluster included all education titles characterised by their high responses to the Support of Systems and Education domains and low responses to Direct Care (see Figure 10). Management positions split into two clusters. The first larger grouping consisted of 10 titles that recorded a high response to the Support of Systems domain with low activity in Direct Care. All other domains were lower compared with nursing titles above the APN threshold. The second management cluster responded in a similar pattern to the first group, but at a lower magnitude.

The final two clusters were made up of positions with high clinical content. The first of these is a clinical nurse cluster listing 12 positions around the country which can be considered equivalent. Figure 10 shows that the clinical nurse cluster reported high levels of Direct Care and moderate levels of Support of Systems and Education but lower levels of Research and Professional Leadership. The last cluster was made up of mostly Registered Nurse and responded in a similar pattern to the clinical nurse cluster, but at lower levels.

The seven cluster solution identified and detailed above was further analysed through and ANOVA and post hoc testing to reveal where significant differences between the clusters lay. Details are shown in Table 19.

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Table 18. Cluster Membership for Mapping of State & Territory Nursing Position Titles						
Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5	Cluster 6	Cluster 7
Nurse Practitioner	Advanced Practice Nurse	Educator	Managers #1	Managers #2	Clinical Nurse	Registered Nurse
ACT-Nurse Coordinator	ACT-Clinical Nurse Consultant	ACT-Nurse Educator	WA-Area Manager	NT-Nurse Manager	WA-Clinical Nurse	ACT-Registered Nurse
ACT-Nurse Practitioner	ACT-Clinical Nurse Coordinator	NSW-Clinical Nurse Educator	WA-Clinical Nurse Manager	QLD-Nurse Manager	ACT-Advanced Practice Nurse	NSW-Registered Nurse
NSW-Nurse Practitioner	NSW-Clinical Nurse Consultant	TAS-Clinical Nurse Educator	WA-Nurse Manager	SA-Nurse Management Facilitator	ACT-Clinical Nurse	QLD-Registered Nurse
NT-Nurse Practitioner	QLD-Clinical Nurse Consultant	VIC-Clinical Support Nurse	NSW-Nurse Manager	VIC-Nurse Manager	NSW-Clinical Nurse Specialist	SA-Registered Nurse
QLD-Nurse Practitioner	SA-Nurse Clinical Practice Consultant	VIC-Nurse Educator	TAS-Nurse Manager		NT-Registered Nurse	TAS-Registered Nurse
SA-Nurse Practitioner	TAS-Clinical Nurse Consultant	NSW-Nurse Educator	NSW-Nurse Unit Manager		QLD-Clinical Nurse	VIC-Community Health Nurse
TAS-Nurse Practitioner	VIC-Clinical Consultant	QLD-Nurse Educator	QLD-Nurse Unit Manager		SA-Associate Clinical Service Nurse	VIC-District Nurse
VIC-Nurse Practitioner	WA-Clinical Nurse Consultant	SA-Nurse Education Facilitator	SA-Nurse Manager		SA-Clinical Nurse	VIC-Registered Nurse
WA-Nurse Practitioner	WA-Clinical Nurse Specialist	WA-Staff Development Educator	VIC-Nurse Unit Manager		TAS-Specialist Nurse	WA-Registered Nurse
	SA-Nurse Clinical Service Coordinator	NT-Nurse Educator	QLD-Nurse Researcher		VIC-Associate Nurse Unit Manager	
	VIC-Nurse Researcher	ACT-Nurse Manager			VIC-Clinical Nurse Specialist	
					VIC-Maternal & Child Health Nurse	

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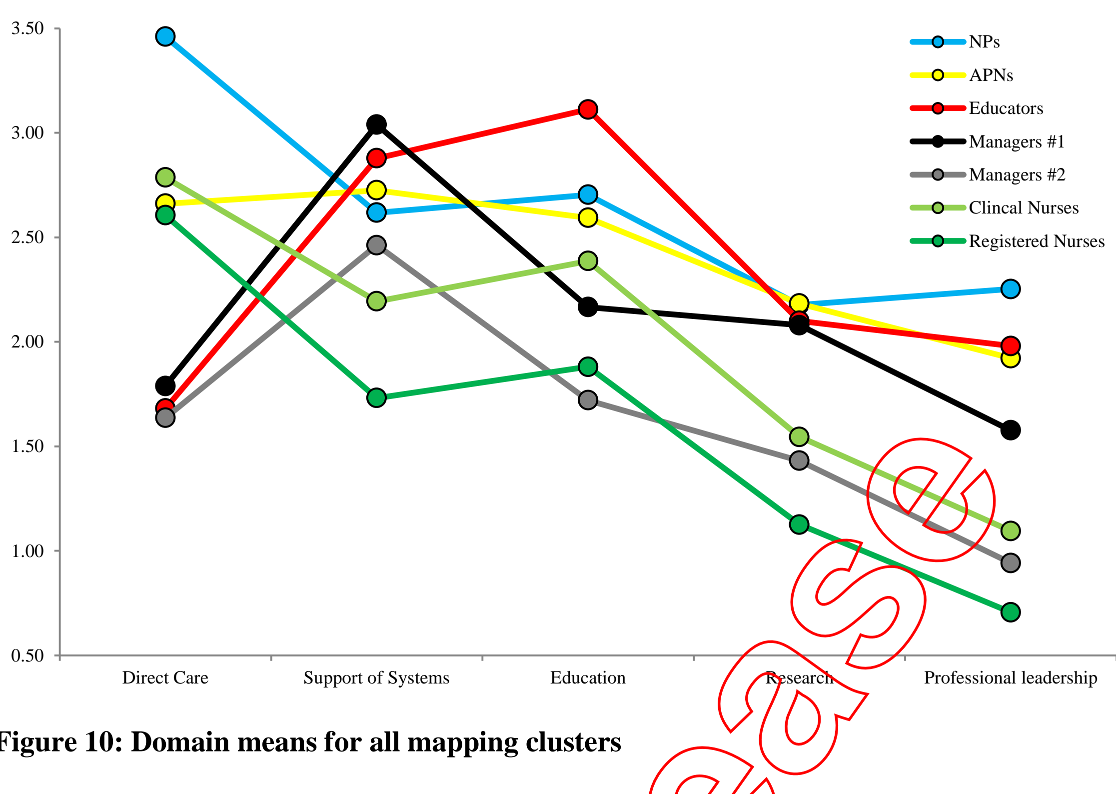

Figure 10: Domain means for all mapping clusters

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Table 19. Cluster Domain Means and ANOVA Results

	Clusters							
	Nurse Practitioners	Advanced Practice Nurses	Educators	Managers #1	Managers #2	Clinical Nurses	Registere d Nurses	F*
Number of Participants	263	580	284	390	43	1344	2758	
Direct Care	3.46	2.66	1.68	1.79	1.64	2.79	2.61	48.99
Support of Systems	2.62	2.73	2.88	3.04	2.46	2.19	1.73	27.11
Education	2.70	2.59	3.11	2.17	1.72	2.39	1.88	48.61
Research	2.18	2.18	2.10	2.08	1.43	1.55	1.13	28.28
Professional Leadership	2.25	1.92	1.98	1.58	0.94	1.10	0.71	32.09

**p*<0.001*

Significant differences were highlighted by post hoc testing of these ANOVAs. For Direct Care, nurse practitioners perform at a level significantly higher than all of the other six groups and advanced practice nurses perform at a level significantly higher than the educators and both manager groups but not the registered and clinical nurses. In the Support of System, nurse practitioners differ significantly from the first manager group and both clinical and registered nurses; advanced practice nurses and educators differ from both clinical and

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registered nurses; clinical nurses are different from all but the mangers Type 2 group and registered nurses are different to all other clusters.

In Education nurse practitioners and advanced practice nurses are significantly different to all other groups except each other; educators are significantly different to all others and both manager clusters are different to all but the clinical and registered nurses. In the Research domain, nurse practitioners, advanced practice nurses, educators and managers #1 are not different to each other but are significantly different to managers #2 and clinical and registered nurses. In the final Domain, Professional Leadership, nurse practitioners are similar only to advanced practice nurses and educators. Managers #1 are also similar to advanced practice nurses and educators. Managers #2 and clinical nurse and registered nurse are similar and are significantly different to the four other clusters.

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CHAPTER FOUR: DISCUSSION

This was a national survey with an overall response of 7,000 registered nurses and registered midwives. There is no record in the literature of primary survey research of nurses and midwives in Australia that has achieved a sample size of this dimension. The success of our recruitment approach was largely due to the support from the ANMF and State and Territory Branches in wide and repeated dissemination of recruitment material and information, and the support from other nursing professional bodies in advertising the survey to their membership. Hereafter this discussion will deal with the registered nurse component of the sample which totalled almost 6,000 respondents.

The size of the sample has enabled a range of analytical methods that provide new knowledge about the structure of the Australian nursing workforce with mapping of titles across state and territory jurisdictions and the practice profile of nursing at various levels. The study has also provided a comprehensive record of Australian nursing position titles that describe the structure of the nursing workforce at state and territory level in 2014.

Demographic Profile

On most measures the survey sample was similar to the Australian registered nurse population. Survey responders were slightly older than the Australian nursing population but sex ratios were similar. The average time in nursing for the sample was around 20 years and average time in their current position was seven years. Whilst one in five respondents worked in the private or NGO sectors the majority worked in the public sector. Nurses in the sample were more likely to work in the hospital setting with almost a third working in the community.

Over half of the nurses surveyed worked in a metropolitan or regional location with just under a third in rural or remote locations. A sizable 15% of nurses worked in a mixed region – over regional boundaries or held positions which were state-wide, such as tele-health or the Royal Flying Doctor Service.

In terms of education profile a quarter of participants had the equivalent of a bachelor of nursing degree with just 10% recording hospital certificate as their highest level of education. Importantly, most survey participants had some form of postgraduate certificate or diploma and nearly 20% of participants had a Master level degree. Just 1% of this clinical nursing workforce had a doctorate.

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Survey participants were members of many professional organisations with over 80% having union membership and many of these also have membership of other professional bodies.

Patterns of Practice

The APRD tool is an advanced practice tool comprising 41 activities grouped into five Domains. Nurses' work activity in position titles at all levels was measured to determine the extent to which the worked on each activity. There were five position titles that were common across most states and territories. We found that each of these position titles had a pattern of activity that was unique to that title and consistent across all jurisdictions.

Of significance we found that the clinical nurse consultant position in all states but SA and NT showed consistently high mean scores across all five domains. This indicates that whilst individual states and territories have developed their own industrial classifications, position titles and career ladders appropriate for their jurisdiction, our research indicates that there is some consistency in the clinical nurse consultant role nationally.

The research findings have allowed identification of the CNC pattern of practice as the benchmark of advanced practice nursing in Australia. This research outcome has important implications for defining and planning the future use of these positions. Furthermore it provides a framework and evidence on which to base definition and delineating of advanced practice nursing as a level of practice for the Australian nursing workforce.

A point of concern is that the results show relatively low scores in the senior clinical roles of CNC and NP in research and professional leadership. For NPs this pattern has remained unchanged since similar findings from a work sampling study conducted in 2009.[28] It is evident from these studies that the most senior nurse clinicians do not prioritise practising leadership and using/conducting research in their practice; both activities being hallmarks of a profession. Furthermore this low profile of research and leadership activities is despite the relatively high rates of masters' level education in the sample; raising questions about the capacity of our current models of postgraduate education to produce leaders.

There is no doubt that the contemporary health care environment is increasingly complex with the dual pressures of sicker, older and more complex patients/consumers and increasing emphasis on documentation related to processes of care to unsure safety and quality. These factors have an impact on nursing work,[29] in short nurses are busier and spending more time on activities unrelated to direct clinical care.[30] The challenges of the contemporary health

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care environment mandate a new maturity in nursing clinical leadership[31] and new thinking about the leadership and research capabilities that are required for future clinical leaders. Thoun[7] asserts that (advanced) practice is conceptualised within the parameters of the knowledge base that guides and informs it. The findings from this research show that the Strong Model of Advanced Practice offers practice content that has the potential to build a conceptual base for education and knowledge development in masters level courses to guide and inform comprehensive graduate capabilities for advanced practice nursing.

Delineating levels of nursing practice by position title

This research has identified the pattern of advanced practice in this sample of Australian nurses. In addition the research identified, by position title, the levels of nursing practice that are above and below the pattern characterised as advance practice. Through identification of the APN practice pattern as signified by uniformly high mean scores across all five APN domains, we identified upper and lower parameters as cut offs of 0.5 of a unit or approximately 2 standard deviations. Consequently we are able to identify position titles in the APN group across all states and territories as:

- All clinical nurse consultants
- WA clinical nurse specialist
- ACT clinical nurse coordinator
- SA nurse clinical practice consultant

Having established *what is* APN we calculated where there are significant differences in all domains for other nursing practice levels and titles. This identified four delineated groups in the Australian nursing workforce:

- Nurse practitioner
- Advanced practice nurse (clinical nurse consultant and like positions),
- Registered nurses and
- Other positions/titles.

The results clearly show that on self-reported measures of clinical activity APN is delineated from NP practice by the statistically significant difference in Domain 1, Direct Care. On other Domains the APN and NP were closer in scores. The clarity of this result provides valuable information for service planners in that our senior clinicians can now be matched more

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appropriately to the needs of specific patient populations and service requirements. Furthermore the findings give substance to the Nursing and Midwifery Board of Australia requirement that graduates of NP courses seeking NP endorsement demonstrate that they have a prescribed period of experience as an APN.

The fourth group that fell below the APN level is made up of 40 titles across all jurisdictions. This group, in contrast to the other three groups is not uniformly matched with each other but have in common that they are above the registered nurse level on one or more Domain scores. In terms of delineating the nursing workforce the registered nurse group and the *Other* group together form a foundation practice profile.

Hence the findings from this research provide an evidence base that Australian nursing workforce can be conceptualised as structured into three bands as follows:

Nurse practitioner: clearly identified by legislated clinical practice profile that extends outside the registered nurse scope of practice. The high level of hybrid clinical activity of the NP is the factor that delineates this role from its APN shared practice profile.

Advanced Practice Nurse: is identified by consistent high levels of activity across all APN Domains. APN clinical service operates at the margin of the registered nurse scope of practice. The high mean scores across all five Domains of the Strong Model indicates the APN practice level that optimises nursing's contribution to population level health care and organisational service potential.

Foundation Practice Nursing: is the largest group characterised by a broad base of clinical and organisational focused nursing practice. Position titles that fall into this band range from beginning level registered nurse to a practice profiles that is at advanced level in one or two discreet Domains of the APRD tool consistent with the service nature of the position title.

Mapping of Nursing Titles across Australian States and Territories

Statistical strategies were used to examine commonalities across the diverse state/territory based position titles of Australian registered nurses. Cluster analysis technique was used as an exploratory tool to determine patterns in practice over the five APRD Domains between state position/titles. The technique mapped out the position/titles into groups with similar patterns of practice. The numbers of clusters, or stop point was determined by expert judgement and visual displays of group similarities on a dendrogram display (see Appendix 4).

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For this study, the point of reference for the stop point in analysis was determined to preserve the characteristic differentiation between nurse practitioner and advanced practice nurse. The outcome was seven groups that were identified as having a particular pattern of practice. These groups and their patterns are as follows:

Cluster 1: is the ***Nurse Practitioner cluster*** this is uniform across all states and also includes the ACT Nurse Coordinator. However the latter has very small number (N=7) and may not be a reliable or accurate portrayal.

Cluster 2: is the ***Advanced Practice Nurse cluster*.** The position titles for this cluster are primarily the clinical nurse consultant (NSW, Qld, ACT, Tas, WA). Cluster 2 also includes five similar titles from ACT, SA, Victoria and WA (see Table 18). This cluster also includes the Victoria nurse researcher, although as discussed below this latter title is represented by low numbers and also may not be a reliable finding.

Cluster 3: is the ***Educator cluster***. This title in various forms was present in all jurisdictions and formed a uniform group, all education titles fell into this group. This is a homogenous group characterised by a practice profile that is high in the Education Domain.

Cluster 4: is the ***Manager Type 1 cluster***. This is a heterogeneous group containing clinical managers, nurse unit managers, other management titles as well as the QLD nurse researcher. They exhibit a pattern with low direct care, very high support of systems and moderate levels of education, research and professional leadership.

Cluster 5: is the ***Manager Type 2 cluster***. This smaller cluster is similar to cluster 4, although all domains are at a lower level. This group is predominantly the nurse manager titles. They are also low on direct care, moderate on the support of systems domain and low in the education, research and professional practice domain. There is a very low *nursing* profile in this cluster.

Cluster 6: is the ***Clinical Nurse cluster.*** This cluster is most heterogeneous of all clusters containing 12 titles such as clinical nurse and clinical nurse specialist. Also included is the registered nurse from the Northern Territory where the Domain means are higher than in other registered nurse positions in other jurisdictions. This cluster is characterised by a moderate Direct Care, Support of Systems and Education Domain scores and low Research and Professional Leadership Domain scores. In review of the practice profile on nurses in this

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band it is likely to typify the specialist nurse and supports Thoun's assertion of the distinction between specialist and advanced nurse.[7]

Cluster 7: is the ***Registered Nurse cluster.*** This cluster represents all registered nurse position titles (except the NT) and a couple of other Victorian titles. This cluster shows a similar pattern of practice across all Domains to the clinical nurse cluster except at a lower level. Direct Care Domain scores are moderate and all other scores are low.

The outcome of mapping nursing titles across all Australian jurisdictions in this study provides an evidence-based characterisation of the Australian nursing and midwifery workforce. These seven clusters and their descriptions bring clarity and structure to the erstwhile confusing and disparate array of nursing positions titles.

The delineation of levels of nursing practice by measuring above and below the APN practice profile provides an instrument to identify three bands of clinical nursing activity as nurse practitioner, advanced practice nurse and foundation practice nurse.

Study Limitations

Participant recruitment for this study yielded sufficient overall numbers to conduct a robust analysis of the practice profile of the Australian nursing workforce. However a limitation of the recruitment strategy and therefore the study was the low numbers of participants in certain groups. The ACT Nurse Coordinator (N=7), the Vic nurse researcher (N=8) and the NT nurse practitioner (N=3) being cases in point. The participants in these groups who responded may not be representative of the stat/territory-wide profile for that position title but may reflect the unique characteristics of a particular employer.

Notwithstanding the high validity and reliability of the APRD tool, the nature of self-completing surveys is that the reliability of the data is dependent upon the accuracy and veracity of the participants' self-scoring in Likert scales and is unable to be controlled by the researcher. This is a further limitation of this research. Follow-up research that uses objective observational data will address this limitation and strengthen the utility of the APRD tool and the Modified Strong Model of Advanced Practice

Conclusion

The Modified Strong Model of Advanced Practice[20] provides a profile of the work activity of advanced practice nursing in Australia. This has been demonstrated in a large scale pilot and

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testing work in Queensland with a sample of over 600 nurses from all positions and now with a national sample of almost 6,000 nurses across Australia. The APRD tool measures the extent to which nurses carry out the APN activities across the five Domains of the Strong Model and was developed to operationalise the Strong Model. It has been used in the Australian context to gain new knowledge and understanding of the Australian nursing workforce. With further customisation this tool has potential application across many spheres of nursing. Individual nurses could use this tool to assess their level of nursing practice in readiness for position applications or promotion. Graduates of an NP degree will apply this tool to demonstrate their advance practice history to gain Nursing and Midwifery Board of Australia NP authorisation. The Modified Strong Model of Advanced practice can provide the conceptual and content framework for APN masters' education and graduate capabilities. The tool will advanced knowledge on patient outcomes from APN clinical care by providing an operational definition of APN and a tool to identify advanced practice.

Now more than at any time in the history of modern health care, effective development and deployment of the nursing workforce is reliant to a great extent on the capacity of nurses at different stages of their professional development and career trajectory to work at different levels of practice. Despite this there is wide confusion and ambiguity related to nursing levels of practice and the international literature is in accord in recognising and reporting this. It is time for the nursing discipline to regain autonomy over nursing service and to conceptualise, categorise and promulgate a rational framework that delineates levels of nursing practice. This in turn will inform education providers to prepare a nursing workforce for the future and enable policy makers and health service managers to fully understand the service potential of nursing for matching clinical nursing service with the clinical need of patients. This document reports research findings that contribute to achieving these goals.

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Appendix V

Midwifery

Demographics & Results

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Profile of Study Participants

The Australian Midwifery population was included in the Answer 4 Nursing and Midwifery survey. There were 502 midwife survey participants who had standardised midwife only position/titles. Elements of the Australian midwifery population formally expressed concern over the inclusion of this profession in the study. In response to this concern whilst also respecting the contribution of the midwives who did participate we have analysed the midwifery data as a separate sample.

Distribution of Sample across States & Territories

Midwives responded from all States and Territories in Australia, with Victoria providing more than 40% of the midwife survey participants. Other good responses were attained from South Australia, Tasmania and the ACT. These results are shown in Table 1.

Table 1: State distribution of participants

	Number of Participants	Percentage
VIC	205	40.8%
NSW	157	31.2%
QLD	43	8.5%
SA	34	6.7%
TAS	24	4.7%
ACT	18	3.5%
WA	17	3.3%
NT	4	0.8%
TOTAL	502	100%

Age and Sex of Participants

Survey respondents recorded their age in 10-year increments. Most respondents covered the 50-59 age groups as demonstrated in Table 2. This profile of age distribution is older than the nursing participants in this study. Participants in WA and the NT were considerably older than other jurisdictions with no or very few midwives in the 20-49 age groups.

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Table 2. Age							
	Number of Participants	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60-69 Years	70 Years and over
VIC	205	9.3%	8.3%	25.4%	42.4%	13.7%	1.0%
NSW	157	7.6%	8.9%	22.3%	46.5%	12.7%	1.9%
QLD	43	7.0%	14.0%	30.2%	41.9%	7.0%	0.0%
SA	34	5.9%	14.7%	20.6%	47.1%	11.8%	0.0%
TAS	24	0.0%	4.2%	37.5%	41.7%	16.7%	0.0%
ACT	18	11.1%	11.1%	16.7%	50.0%	11.1%	0.0%
WA	17	0.0%	5.9%	11.8%	70.6%	11.8%	0.0%
NT	4	0.0%	0.0%	0.0%	75.0%	25.0%	0.0%
Total	502	7.6%	9.2%	24.1%	45.4%	12.7%	1.0%

Most participants were female. This sex ratio ranged from 100% female in the ACT and the NT down to 87% female (or 12% male) in Tasmania. These ratios are higher than those found in the nursing position participants. These results are shown in Table 3.

Table 3: Sex			
	Number of Participants	Female	Male
VIC	205	98.0%	1.9%
NSW	157	98.1%	1.9%
QLD	43	97.7%	2.3%
SA	34	100.%	0.%
TAS	24	87.5%	12.5%
ACT	18	100.%	0.%
WA	17	94.1%	5.9%
NT	4	100.0%	0.0%
TOTAL	502	97.6%	2.4%

Distribution across Workplace Sector

More than 80% of the midwifery participants worked in the public sector with only 12.5% working in the private sector. Only in Queensland, South Australia and the ACT were there any significant proportion of the midwifery workforce within a non-government organisation. Almost 6% of WA midwifery participants were sole traders. This high rate of sole traders in Western Australia was also observed in participants with nursing positions. These results are shown in Table 4.

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Table 4. Workplace Sector							
	Number of Participants	Public	Private	Non-Government Organisation (NGO)	Sole trader	Mixed	Unknown
VIC	205	83.4%	13.7%	0.0%	0.5%	2.4%	0.0%
NSW	157	86.6%	10.8%	0.6%	0.6%	0.6%	0.6%
QLD	43	76.7%	11.6%	4.7%	0.0%	7.0%	0.0%
SA	34	76.5%	14.7%	2.9%	0.0%	2.9%	2.9%
TAS	24	75.0%	12.5%	0.0%	0.0%	4.2%	8.3%
ACT	18	88.9%	5.6%	5.6%	0.0%	0.0%	0.0%
WA	17	70.6%	23.5%	0.0%	5.9%	0.0%	0.0%
NT	4	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	502	82.9%	12.5%	1.0%	0.6%	2.2%	0.8%

Distribution across Workplace Setting

Most midwife participants in this study work within a hospital setting with only 10% working in the community. Just over 3% of midwife participants work over multi-settings. These results are displayed in Figure 1.

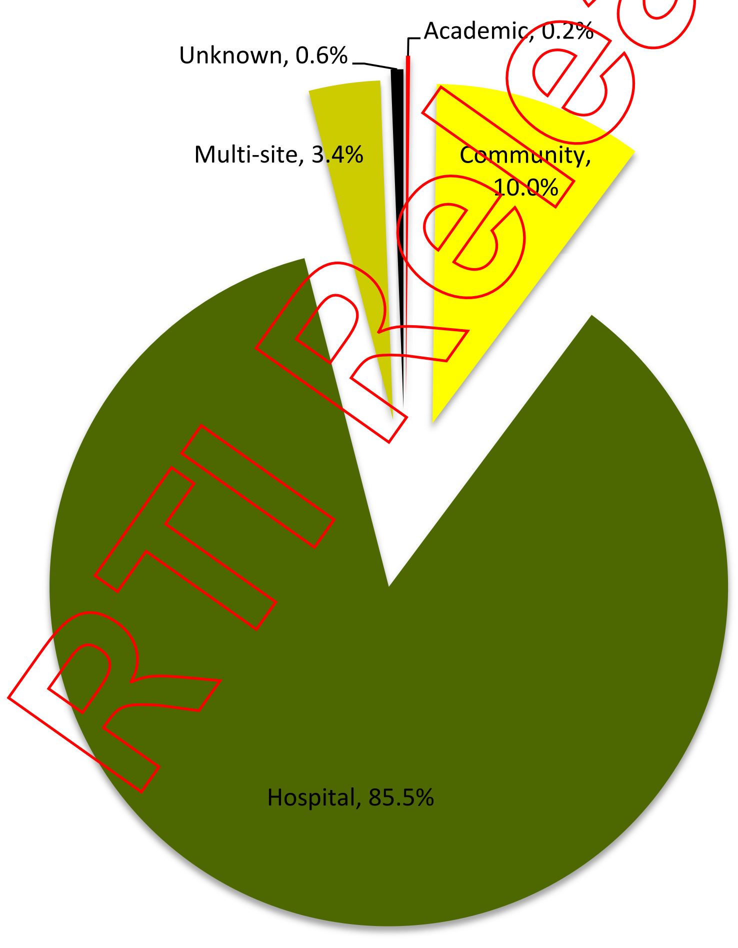

Figure 1: Distribution across workplace settings.

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Workplace Region

Midwifery participants worked mostly within metropolitan and regional areas in Australia. Queensland and Victoria had few survey participants from rural areas than expected. A limited number of midwifery participants in Queensland, New South Wales and Victoria worked over both region zones. These results are displayed in Table 5.

Table 5. Workplace Region

	Number of Participants	Metropolitan and Regional	Rural and Remote	Mixed
VIC	205	91.2%	8.3%	0.5%
NSW	157	80.9%	17.2%	1.3%
QLD	43	83.7%	11.6%	4.7%
SA	34	88.2%	11.8%	0.0%
TAS	24	66.7%	33.3%	0.0%
ACT	18	100.0%	0.0%	0.0%
WA	17	76.5%	23.5%	0.0%
NT	4	0.0%	100.0%	0.0%
TOTAL	502	85.1%	13.7%	1.0%

Highest Education Level of Participants

The highest education qualification of midwifery survey participants is displayed in Table 6. All listed qualifications are in midwifery, nursing or a related health field. Highest education qualifications which are not in nursing or related field are categorised as Other. Over 15% of participants had a higher degree with an additional 37% with postgraduate diplomas or certificates. Just under 20% of participants had completed a Bachelor degree with an additional 18% with a hospital certificate as their highest education qualification. There was a marked variation between States and Territories with participants in New South Wales and Western Australia more likely to have post graduate qualifications than survey participants in Victoria and South Australia.

Table 6. Highest Education

	Number of Participants	PhD	Masters	Post Graduate Diploma	Post Graduate Certificate	BN or equivalent	Hospital Certificate	Other
VIC	205	2.0%	10.7%	28.3%	10.2%	21.5%	18.0%	9.3%
NSW	157	0.0%	22.9%	23.6%	12.1%	14.0%	15.9%	11.5%
QLD	43	0.0%	20.9%	20.9%	11.6%	18.6%	25.6%	2.3%
SA	34	0.0%	5.9%	11.8%	14.7%	32.4%	29.4%	5.9%
TAS	24	0.0%	4.2%	37.5%	12.5%	20.8%	20.8%	4.2%
ACT	18	0.0%	11.1%	33.3%	11.1%	22.2%	16.7%	5.6%
WA	17	0.0%	29.4%	23.5%	17.6%	11.8%	11.8%	5.9%
NT	4	0.0%	25.0%	75.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	502	0.8%	15.5%	25.9%	11.6%	19.1%	18.5%	8.6%

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Years as a Registered Nurse or Midwife

On average, participants had been registered as a nurse or midwife for 24.2 years with a range over 50 years. Most participants have been registered as a nurse or midwife for between 14-34 years (interquartile range).

Years in Current Position

Participants had spent on average 9.2 years (2-13 years interquartile range, total range 40 years) in their current position.

Membership of Professional Organisations

More than 50% of midwifery participants are members of the ANMF with 37% also members of the Australian College of Midwives. Most midwifery respondent held membership of a professional body. Table 7 lists the most common of these organisations. Table percentages are not cumulative since many participants may be members of more than one group.

Table 7: Professional Membership

Professional Organisation	Number	Percentage
Australian Nursing and Midwifery Federation (ANMF)	279	55.6%
Australian College of Midwives (ACM)	187	37.3%
NSW Nurses and Midwives' Association	138	27.5%
Queensland Nurses Union (QNU)	37	7.4%
Australian College of Nursing (ACN)	28	5.6%
College of Remote Area Nurses Australia Inc (CRANAplus)	12	2.4%
Australian College of Neonatal Nurses	8	1.6%
Australian College of Nurse Practitioners (ACNP)	5	1.0%
Australian Primary Healthcare Nurses Association (APNA)	5	1.0%
the Australian College of Mental Health Nurses (ACMHN)	2	0.4%
Australasian Sexual Health & HIV Nurses Association (ASHHNA)	1	0.2%

Midwife Position Titles across Australia

Table 8 list all position titles recorded by midwifery survey participants by state and territory including the number of participants for each position and a percentage for each state.

Table 8: Survey Participant Nursing and Midwifery Position Titles by State

Australian Capital Territory Titles	Number	Percentage
Midwife Consultant	1	5.6%
Midwifery Educator	1	5.6%
Registered Midwife	16	88.9%

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New South Wales Titles	Number	Percentage
Clinical Midwife Consultant	9	5.7%
Clinical Midwife Educator	5	3.2%
Clinical Midwife Specialist	33	21.0%
Midwife Educator	1	0.6%
Midwife Manager	1	0.6%
Midwife Practitioner	3	1.9%
Midwifery Unit Manager	14	8.9%
Registered Midwife	91	58.0%

Northern Territory Titles	Number	Percentage
Registered Midwife	4	100%

Queensland Titles	Number	Percentage
Clinical Midwife	6	14.0%
Registered Midwife	37	86.0%

South Australian Titles	Number	Percentage
Clinical Midwife	6	17.6%
Midwife Clinical Service Coordinator	2	5.9%
Midwife Education Facilitator	1	2.9%
Registered Midwife	25	73.5%

Tasmanian Titles	Number	Percentage
Registered Midwife	24	100%

Victorian Titles	Number	Percentage
Associate Midwife Unit Manager	6	2.9%
Clinical Midwife Consultant	11	5.4%
Clinical Midwife Specialist	58	28.3%
Midwife Unit Manager	3	1.5%
Registered Midwife	127	62.0%

Western Australian Titles	Number	Percentage
Clinical Midwife	7	41.2%
Clinical Midwifery Consultant	1	5.9%
Clinical Midwifery Manager	1	5.9%
Midwifery Manager	1	5.9%
Registered Midwife	7	41.2%

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The Pattern of APN activities according to Midwifery Position/Title

The pattern of domain scores for prominent midwifery positions/titles are shown in figure 2. All of these positions had five or more participants and their domain scores were calculated as previously described for nursing positions. Clinical Midwifery Consultants scored high on every domain. Clinical Midwifery Educators and Midwifery Unit Managers scored high on the first three domains and lower in Research and Professional Leadership. Clinical Midwifery Specialist, Clinical Midwife and Registered Midwife are all characterised with high responses to the Direct Care domain items but lower or moderate responses in the other four domains. The domain means of all midwifery positions across Australia are listed in Table 11.

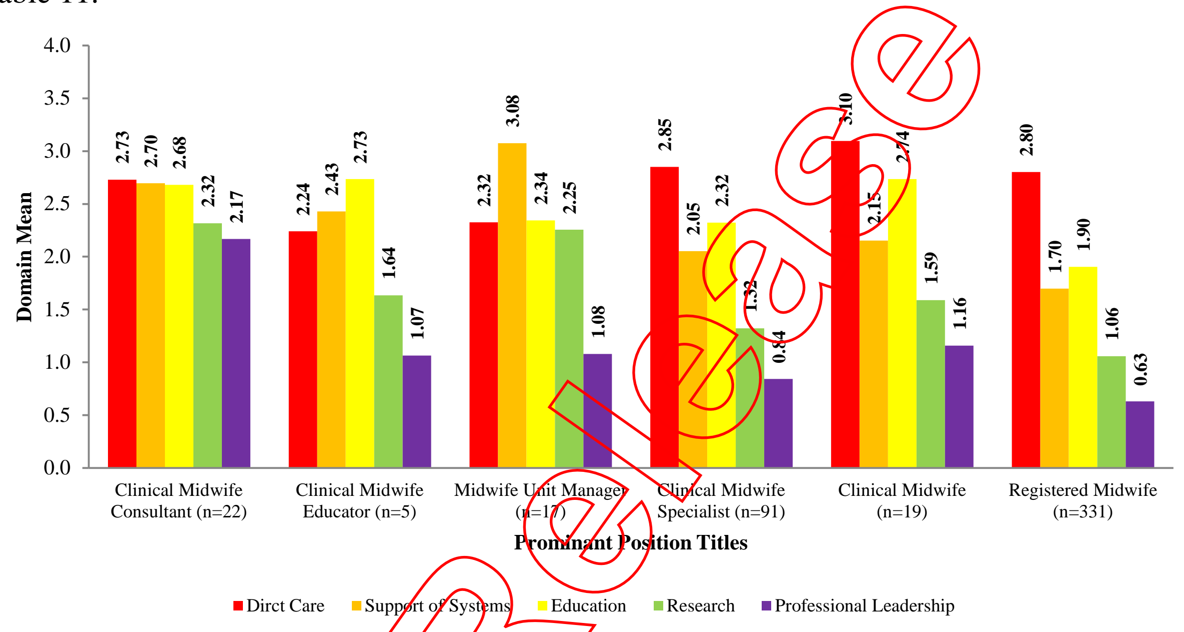

Figure 2: Domain means for five prominent midwifery positions across Australia.

Table 11. Domain Scores for all Midwifery Position Titles

		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Clinical Midwife Consultant*	22	2.73	2.70	2.68	2.32	2.17
Midwife Clinical Service Coordinator*	2	2.64	3.13	2.25	2.50	1.75
Clinical Midwife Educator	5	2.24	2.43	2.73	1.64	1.07
Midwife Education Facilitator	1	0.80	2.75	3.00	1.67	1.00
Midwife Educator	2	1.17	2.82	2.84	3.09	2.50
Midwife Practitioner	3	2.95	1.71	1.72	1.45	1.67
Associate Midwife Unit Manager	6	3.05	2.63	2.72	1.61	1.06
Clinical Midwife Manager	1	4.00	3.38	3.83	1.67	1.50
Midwife Manager	2	1.37	3.88	3.09	3.08	1.84
Midwife Unit Manager	17	2.32	3.08	2.34	2.25	1.08
Clinical Midwife	19	3.10	2.15	2.74	1.59	1.16
Clinical Midwife Specialist	91	2.85	2.05	2.32	1.32	0.84
Registered Midwife	331	2.80	1.70	1.90	1.06	0.63

*Positions in which all domains were within the APN thresholds

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Report of The Australian Nursing/Midwifery Workforce Survey

November 2014

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Executive Summary

This report provides the results of an investigation of the Australian nursing and midwifery workforce that was directed by two broad aims:

i) To map nursing and midwifery titles across Australian jurisdictions according to patterns of clinical practice

ii) To establish an operational framework for differentiating and describing advanced practice nursing for the Australian health service context and future development of the nursing profession.

We conducted a national e-survey of nurses and midwives using the validated Advanced Practice Role Delineation (APRD) tool developed from the Strong Model of Advanced Practice. Participant recruitment was through wide and repeated information dissemination of the study through the ANMF and State and Territory Branches and other membership-defined nursing organisations. We recruited 6,939 participants.

Data analysis included descriptive statistics to describe the features of the sample and the nursing and midwifery position titles listed by state/territory. One way ANOVAs were used to assist in identifying and delineating advanced practice nursing (APN). Cluster analysis was used to map the state/territory-defined nursing position titles based on all five Domain mean scores of the APRD tool.

The results show a sample that is equivalent to the Australian nursing population on age and sex and that works across a range of geographical and service contexts. Nurses and midwives from all states and territories participated in the study. The main study findings are as follows:

1. Advanced practice nursing in Australia is characterised by the practice profile of the Clinical Nurse Consultant (CNC) position title.

2. The practice profile of the nurse practitioner (NP) is delineated from the APN by significantly higher mean scores in the Direct Care Domain.

3. Other levels are delineated as having mean Domain scores at a determined metric below those of the APN.

4. The findings from this research provide an evidence base that Australian nursing workforce can be conceptualised as structured into four bands:
   - **Nurse Practitioner,**
   - **Advanced Practice Nurse**
   - **Domain Specified Nurse**
   - **Registered Nurse**

5. Mapping of all nursing titles (66) across the eight Australian jurisdictions produced **seven cluster groups.** Each cluster was identified as having a pattern of position titles from all states and territories. These groups and their patterns are:
   - **Cluster 1: Nurse Practitioner** cluster is uniform across all states and territories
   - **Cluster 2: Advanced Practice Nurse** cluster is primarily the CNC. Cluster 2 also incorporated five additional titles of practice at this level from ACT, SA, Vic and WA

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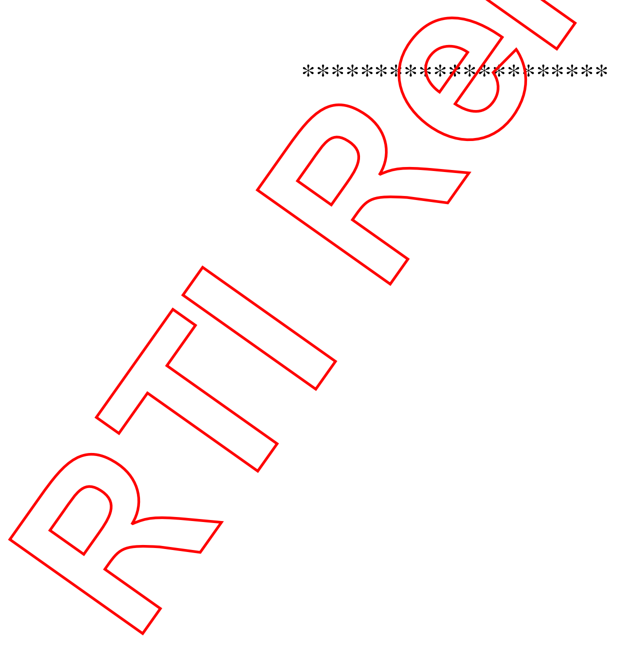
- **Cluster 3: Educator** titles in various forms were in position title lists from all jurisdictions. This is a homogenous group and from all states/territories had high mean scores in the Education Domain.
- **Cluster 4: Manager Type 1** cluster. This group includes clinical type managers across various titles. They are low in Direct Care but show high levels in Support of Systems and moderately high levels in Education, Research and Professional Leadership Domains.
- **Cluster 5: Manager Type 2** cluster. This is a smaller manager group similar to the Type 1 but characterised by lower mean scores across all Domains. There is a very low nursing profile in this group
- **Cluster 6: Clinical Nurse** cluster. This is highly heterogeneous group made up of 12 different titles. The cluster is characterised by moderately high scores across the first three Domains but low in Research and Professional Leadership Domain scores.
- **Cluster 7: Registered Nurse** cluster represents all RN titles and shows a similar pattern of scores across Domains as the Clinical Nurse, except at a lower level.

Conclusion This research has revealed a large and significant body of new knowledge about the Australian Nursing Workforce. Two main findings relate to:

a) Delineation of nursing levels of practice above and below the APN practice profile providing an instrument to identify four primary bands of clinical nursing activity levels

b) Mapping of the diverse state and territory based nursing position titles into seven coherent groups. These seven clusters and their descriptions bring clarity and structure to the erstwhile abundant, confusing and disparate array of nursing position titles across Australia.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CHAPTER ONE: INTRODUCTION

Over the past two decades advanced practice nursing roles have proliferated to fill gaps in the provision of health service across hospital, community and aged care settings. This has become important for health service improvement in a landscape that is increasingly complex with high cost drivers for change that include an aging population, a dramatic increase in chronic disease and pressure on the health budget. Researchers have reported[1] that the creation and growth of nursing roles has been effective in addressing short term problems of service delivery but the consequence has been uncoordinated development of nursing service with a confusing array of practice profiles, titles and roles. Further, this development has occurred in the absence of evidence-informed service planning.[2]

The area of advanced practice nursing (APN) is particularly exposed to *ad hoc* service planning at the local level by service managers and medical specialists and at the macro level by government bodies and health services experts.[3, 4] Furthermore, development of these new roles often progresses without formal and broad-based consultation with the profession[5]. In part this is a consequence of the confusion and lack of consensus related to the meaning of APN. The volume of peer reviewed international literature relating to APN is vast attesting to the quest to progress and refine knowledge about this evolving level of nursing service and the impact on patient outcomes.[6, 7] A consistent theme in the international literature is that APN is ambiguous, lacks universal understanding and is variously defined.[8-10]

In most countries APN is an umbrella term indicating nursing roles and levels above that of the foundation practice of the Registered Nurse (RN). In Australia APN covers a myriad of titles including clinical nurse specialist, clinical nurse consultant and nurse practitioner (NP).[1] In the United States of America (USA) APN includes midwives, nurse anaesthetists, clinical nurse specialists and NPs[11]. Although the APN is applied as a generic descriptor for these diverse roles they do not share a common practice profile and they also differ in the legislative structure that governs practice activity.[11] Recent literature reports increasing calls for delineated and specific regulation and definition of NPs.[13,14]

Some efforts have been made to clarify APN across nations. Thoun[7] recently published a scholarly discussion paper that problematized the distinction between generic APN and the nurse specialist. She proposed that the difference was clearly related to depth, extent and complexity addressed at different level of education.[6] Furthermore, Thoun argues cogently that

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the term advanced characterises *practice* not *nursing;* the latter she asserts being the academic and practice discipline. This gives semantic support and substance to the term advanced practice nursing in contrast to advanced nursing practice. Whilst Thoun's paper makes an important contribution to bringing clarity to the discussion on APN her dissertation does not address the problem of disparate practice profiles and levels that are covered by the term APN.

The UK position statement[15] and the Canadian Nurses Association Position Statement[16] on APN provide generic statements and "nationally agreed elements"[15] or 'characteristics[16] of advanced practice but give no attention to the potential for difference in practice between the nurse practitioner and other non-defined advanced practice patterns. Similarly the International Council of Nurses definition of APN[17] is generic and applies to any senior clinical nursing role that may fall under the umbrella of advanced practice. The many definitions that are offered in these and other publications reflect what we recognise would be elements of advanced practice nursing. They speak to the values and practices easily recognised as central to the best of nursing practice. However, these definitions are not drawn from robust research that takes the question of what is advanced practice to examine the practice of nursing in context.

There are international consequences from the confusion related to APN. Research has shown that compared with standard care, APN achieves higher patient satisfaction, enhanced patient safety, reduced health service cost and improved quality of life.[6,18] However this research has limited application to inform policy and health service planning as there is no stability in the definition, parameters of practice or nomenclature to operationally define APN.

The research reported here is part of a health services research and development program developed over many years. Early research in the program[19] identified and isolated the Strong Model of Advanced Practice[20] from a range of published models and definitions as having potential to delineate the parameters of practice for the APN role in Australia. A survey tool from this model[21] was tested, amended and validated with permission from the copyright holders, for the Queensland context[22-24] and provides a reliable instrument with strong psychometric properties. The Queensland study found significant differences in mean scores for total activities in all APN domains according to the grade and level of nurse. Regression analysis indicated that working in clinical APN roles with higher levels of education were strong predictors of APN activities overall.[24]

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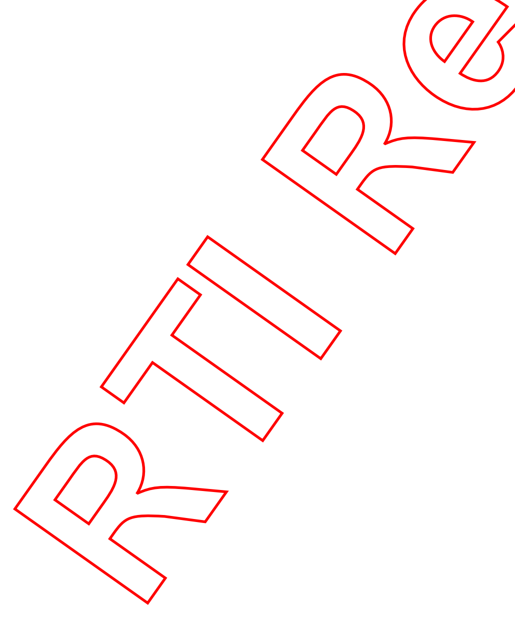
Australia is a Federation of States/Territories which adds an additional layer to the issue of stability in nomenclature of APN. Position classifications/titles are industrially determined and negotiated individually at the state/territory level. This has, over time, resulted in over 90 nursing/midwifery position titles across the eight jurisdictions with no standardised description of the practice profile of these position titles across state and territory borders. The exception to this is the title of nurse practitioner. This role is standardised across the country with national level regulation, title protection, practice standards and practice profile. It is time that other advanced nursing roles and titles that are regulated under the registered nurse scope of practice had the same level of clarity and definition. This will only be possible in the context of a broad based and robust examination and mapping of nursing titles and practice positions across all Australian states and territories.

Accordingly, the study reported here was conducted to achieve two broad goals:

iii) To map nursing titles across Australian jurisdictions according to patterns of clinical practice and

iv) To establish an operational framework for differentiating and describing APN for the Australian health service context and future development of the nursing profession.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This research conducted a national survey of registered nurses and registered midwives in Australia drawing upon previous APN work by the authors.[22-24] Data collection was conducted over a six-week period from February to April 2014. The study aim was to describe the patterns of practice of Australian nurses according to position titles applying the Strong Advanced Practice Role Delineation (APRD) tool.

The study was guided by the following:

1. **Research questions**:

Q1. What is the pattern of advanced practice activity according to levels of practice as defined by nursing/midwifery position title?

Q2. To what extent do Australian registered nurses/midwives in different position titles carry out the activities of APN as itemised in the Modified Strong Advanced Practice Role Delineation tool?

2. **Research objective:**

To map titles of nurses and midwives across the eight Australian jurisdictions

Sample and Recruitment

A population sample of Australian registered nurses and registered midwives who were currently employed in a clinical service environment was eligible for inclusion in the study. At the time of the study there was an estimated population of 252,868 registered nurses, 29,915 registered nurse/midwives and 2,918 midwives working in Australia.[25]

Direct recruitment of survey participants from the population was not possible or financially feasible due to the size of the sample and lack of assured access to a central database of registered nurses and registered midwives. Therefore a multilevel and multimodal recruitment strategy was used. The basis of the recruitment approach was wide and targeted information dissemination and evidence-based strategies based on elements of Dillman's Tailored Design survey method approach.[26]

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The recruitment process was supported by the Australian Nursing and Midwifery Federation (ANMF) State and Territory Branches and other member organisations (details below) and was implemented in stages.

Stage 1: Initial study recruitment

Prior to the study commencement, the project coordinator made phone and email contact with each of the state and territory ANMF State Secretaries to discuss strategies for the sequential pre-notice announcements and distribution of a recruitment flyer to ANMF members. A promotional flyer describing the aims of the study and providing the e-survey hyperlink was developed in collaboration with the marketing team of the NSW Nurses and Midwives Association (See Appendix I for study recruitment material).

A report about the study and its aims was published in the ANMF National and Branch journals and on websites in the months prior to the e-survey 'go live' date and included:

Table 1 Recruitment dissemination sources

ANMF Publication	Publication Date
Australian Nursing and Midwifery Journal	December 2013
Nurse UNCUT blog	March 2014
The Lamp	February 2014
InTouch Bulletin	March 2014
Nursing Review	December 2013 and January 2014
The Collective Perspective	February 2014

A hyperlink to the e-survey was hosted by the ANMF national and state and territory websites and the Australian College of Nurse Practitioner (ACNP) website. To expand exposure of the target population to the study and its aims, additional recruitment outlets included nursing and midwifery professional colleges and associations. Information was disseminated by these organisations via weblinks, eNEWs and other specialty group publications (See Table 2 and Appendix I).

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Table 2 Professional organisations involved in e-survey recruitment

Professional organisation	Promotional Activity
Aged Care Network Brisbane	Item on agenda of quarterly meeting
Australian Nursing & Midwifery Accreditation Council	Recruitment letter emailed to all RNs & RMs on the organisation's 'Reviewer database'
Cardiac Nurses Group	Distribution of promotional flyer at national conference February 2014.
CareSearch Palliative Care Knowledge Network – Nurses Hub	Project information published in the March 2014 version of CareSearch Nurses[Hub]news via the www.caresearch.com.au
Coalition of National Nursing Organisations (CoNNO)	Email notice and project recruitment flyer distributed to membership of more than 50 national nursing organisations
CRANAplus	Published details of the study and flyer in newsletter
Nursing and Midwifery Office Queensland	Circulation of information about the study to networks
Renal Nurses Group	February 2014 Distribution of promotional flyer through the network
Royal Flying Doctor Service (RFDS)	General email to RN/RM staff
The Australian College of Nursing (ACN)	Recruitment Email to ACN membership Promotion in the College e-Newsletters
The Australian College of Nurse Practitioners (ACNP)	Hosted the promotional flyer and hyperlink to e-survey
The Australian Primary Health Care Nurses Association (APNA)	Publication in the December 2013 edition of *Primary Times* along with regular updates posted via eNews updates

Stage 2: Recruitment during data collection

During the six week data collection period, ANMF state and territory branches and other professional organisations continued to coordinate regular reminders to their members via email alerts, e-Bulletins, newsletter articles, industry publications and social media. The project team provided regular progress/status reports to ANMF state/territory secretaries to inform their support with participant recruitment.

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Instrument Development and Testing

The online survey was based on the APRD tool, used and adapted with permission from the authors[22] (See Appendix II).

The e-survey instrument was created in consultation with the High Performance Computing and Research Support team at Queensland University of Technology using *Key Survey* Software. The development of the e-survey instrument was a complex and lengthy process that occurred over a period of three months. This involved development and refinement of the questionnaire in the conversion of the APRD tool to *Key Survey* and testing the reliability and efficiency of the hyperlink. Finally, a pilot test of the e-survey instrument was conducted on a sample of 15 nurses and midwives in a major tertiary referral hospital for time burden, relevance of items and functionality of the hyperlink.

The Modified Strong Advanced Practice Role Delineation tool

The APRD tool identifies five domains which address the main areas of APN practice. The domain titles are Direct Comprehensive Care, Support of Systems, Research, Education and Publication and Professional Leadership. Within each domain are listed a number of activities undertaken by nurses practicing at an advanced level. The APRD questionnaire was previously modified to accommodate the professional and cultural content of Australian nursing and midwifery[23] practice and has undergone validity and reliability testing for use with an Australian nursing population[23-25] The instrument for this e-survey had three sections as follows:

Section A: Demographic data including aged and sex, state/territory currently working, title/position, current classification, number of years as RN/RM, number of years in current position, highest level of education, current practice setting, sector and region of work, and membership of professional organisations.

Section B: The APRD questionnaire comprises 41 items across five Domains of Practice namely: Direct Comprehensive Care (15 activities), Support of Systems (8 activities), Education (6 activities), Research (6 activities), Education and Professional Leadership (6 activities). In each Domain activity, respondents were asked to rate: in their current role, the extent to which they had undertaken the activity, on a 5 point Likert scale, where: 4 = to a very great extent; 3 = to a great extent; 2 = to some extent; 1 = to a little extent; 0=not at all

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Section C: of the tool asked respondents to indicate on the 5 point Likert scale the extent of time they spent working within each of the five domains.

Data Collection

This was a nation-wide electronic survey. Hyperlinks to the host website were provided in all electronic recruitment material, and the survey web address was provided in all print material. Through these media registered nurses and midwives were invited to log on and complete the questionnaire. On entering the website the potential participant was provided with the ethics committee approved study information and consent documents and advised that completion of the questionnaire was taken as consent to participate.

Data Analysis

Data were analysed using SPSS Version 22.[27] Descriptive statistics were used to examine the characteristics of the sample. Data are presented in two ways. Categorical variables presented as counts and percentages and continuous variables presented either as means (standard deviation) or median (minimum and maximum) as appropriate to the distribution of the data.

Domain means for each participant were calculated from the survey responses which were recorded on a scale from 0 to 4. Evaluations of nursing position title at state/territory level were performed with the average of the domain means of all individuals within a position title.

Characteristics of state/territory nursing position titles that were grouped by cluster analysis (see following) were compared with one-way analysis of variance on state/territory nursing position title domain means. The alpha for all tests was set at 0.05. Significant effects were examined with Bonferroni *post hoc* comparisons to control for Type 1 error.

Cluster Analysis

Cluster analysis is an exploratory technique that was used in this study to reveal groups of state-defined nursing position titles that are similar to one another based on all five Domain mean scores (mapping). An agglomerative hierarchical approach was selected which uses a bottom up method where state nursing position titles are nested together as lower order clusters and give rise to increasingly larger higher order clusters. Proximity and dissimilarity measures are used to join titles or groups of titles into clusters based on best match in repeated cycles until all 66 state nursing position titles are in one highest order cluster. In this analysis squared

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Euclidean distances was used as the dissimilarity measure and Ward's method was used as the inter-group proximity measure. Cluster analysis has no goodness-of-fit indices, so the appropriate number of cluster solution was determined using a combination of dendrograms (visual representation of possible groupings) and expert judgment of the researchers. To conserve the separate clustering of the clinical nurse consultants and nurse practitioner groups, clustering was stopped at the point just before these two clustered joined giving rise to seven clusters.

Ethics Approval

The Queensland University of Technology Human Research Ethics Committee provided ethical approval for the study (See Appendix III).

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Profile of Study Participants

A total of 6,939 nurses and midwives completed the survey. Data cleaning was conducted to remove data from ineligible respondents, these included enrolled nurses, nurses not employed and those not working in Australia (n= 342). The remaining data set was split for analysis into nursing (n=5662), midwifery (n=502) and other titles not relevant to analysis (nursing directors, n=154). Some responses recorded positions not included in the relevant state/territory RN/Midwifery classification and career structure, these were removed (n=279).

Reporting of results in this document, with the exception of information in Tables 9 and 10, will focus on analysis of the nursing sample. Analysis of the midwifery sample data is reported in Appendix V

Distribution of Sample across States & Territories

Participants responded from all eight states and territories in Australia. A third of all participants came from Victoria. In NSW, SA and the NT the distribution of the survey participants was similar to the AHPRA published proportions of the Australian nursing population.[24] Response rates from both QLD and WA were lower, while response rates of VIC, TAS and the ACT were all higher than their national distribution of the nursing population. These results are displayed in Table 3.

Table 3: Sample distribution across State & Territory

	Number of Participants	Percentage	AHPRA distribution of nursing population
VIC	1901	33.5%	25.8%
NSW	1740	30.7%	29.4%
QLD	690	12.2%	19.7%
SA	487	8.8%	8.6%
WA	288	5.1%	11.1%
TAS	253	4.5%	2.5%
ACT	199	3.5%	1.7%
NT	101	1.9%	1.2%
TOTAL	5662	100%	100%

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Age and Sex of Participants

Survey respondents recorded their age in 10-year increments. Most respondents covered the 40-59 age groups as demonstrated in Table 4. This profile of age distribution is older than the AHPRA distribution of the nursing workforce employed in Australia. Participants in QLD, WA and the NT were younger than in other states.

Table 4. Age

	Number of Participants	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60-69 Years	70 Years and over
VIC	1901	11.3%	12.6%	24.9%	38.1%	12.6%	0.5%
NSW	1740	9.0%	13.1%	22.5%	41.2%	13.8%	0.5%
QLD	690	5.5%	14.9%	31.7%	39.4%	8.1%	0.3%
SA	487	3.8%	11.1%	25.5%	47.1%	12.1%	0.4%
WA	288	9.0%	16.7%	28.8%	36.5%	9.0%	0.0%
TAS	253	7.1%	13.0%	25.3%	42.7%	11.5%	0.4%
ACT	199	6.0%	15.1%	24.6%	41.2%	12.6%	0.5%
NT	101	7.5%	18.7%	20.6%	35.5%	17.8%	0.0%
Total	5662	8.7%	13.3%	25.2%	40.2%	12.3%	0.4%
AHPRA distribution of nursing population	257,236	16%	23%	25%	24%	11%	1%

Most participants were female, similar to the sex ratios found in the Australian nursing workforce. The ratio of male nurses was higher in the NT compared to the rest of the country. These are shown in Table 5.

Table 5: Sex

	Number of Participants	Female	Male
VIC	1901	92.1%	7.9%
NSW	1740	89.8%	10.2%
QLD	690	87.4%	12.6%
SA	487	87.5%	12.5%
WA	288	92.0%	8.0%
TAS	253	89.7%	10.3%
ACT	199	88.4%	11.6%
NT	101	83.0%	17.0%
TOTAL	5662	90.0%	10.0%
AHPRA distribution of nursing population	257236	88.2%	11.8%

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Distribution across Workplace Sector

Three quarters of all participants worked in the public sector. Overall almost 20% of the participants worked in the private sector with higher proportions in VIC, NSW, SA and TAS. Participants in the NT were more likely to be employed in non-government organisations compared with those in other states and in WA the proportion of sole traders was more than double the national average. These results are illustrated in Table 6.

Table 6. Workplace Sector

	Number of Participants	Public	Private	Non-Government Organisation (NGO)	Sole trader	Mixed	Unknown
VIC	1901	74.3%	20.6%	3.3%	0.5%	1.2%	0.2%
NSW	1740	74.3%	19.3%	5.1%	0.6%	0.6%	0.2%
QLD	690	80.6%	13.2%	4.1%	0.6%	1.4%	0.1%
SA	487	75.3%	18.3%	3.4%	0.4%	2.0%	0.6%
WA	288	74.7%	14.6%	7.3%	1.4%	1.7%	0.3%
TAS	253	75.1%	20.6%	3.2%	0.0%	0.8%	0.4%
ACT	199	81.4%	14.6%	1.0%	1.0%	1.0%	1.0%
NT	101	68.9%	10.4%	17.9%	0.9%	0.9%	0.9%
Total	5662	75.3%	18.4%	4.3%	0.6%	1.1%	0.3%

Distribution across Workplace Setting

Over half of all participants were employed in hospitals with a third working in the community. Six percent worked in aged care settings with another 4% working over multiple settings. These results are displayed in Figure 1.

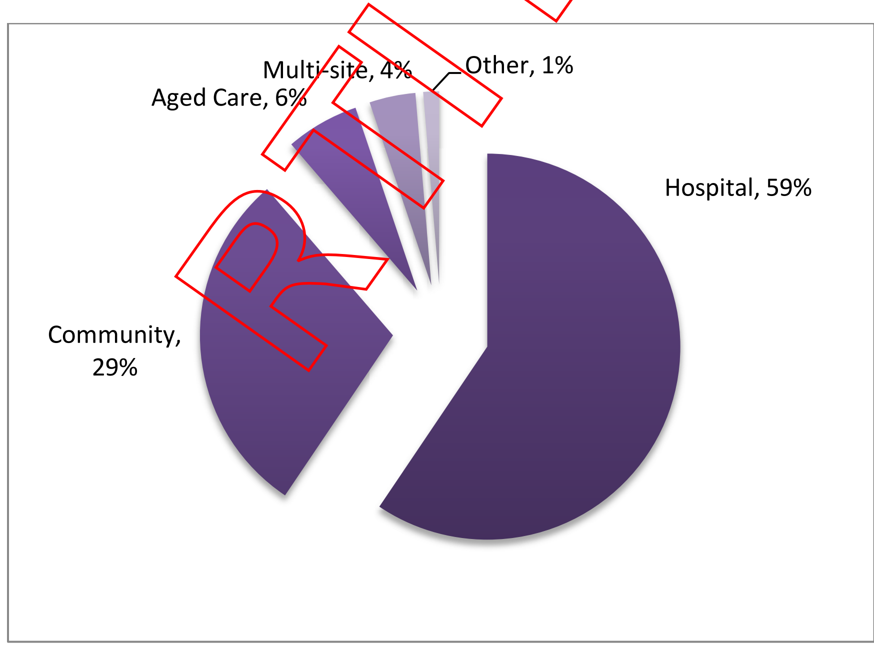

Figure 1: Distribution across workplace settings.

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Workplace Region

Most nurses worked in a regional or metropolitan location and almost a third of participants worked in a rural or remote area. The *mixed* category contained individuals who worked at the boundaries of rural and regional zones and those whose position was state-wide such as the Royal Flying Doctor Service or tele-health. These proportions reflected state population distributions (Table 7).

Table 7. Workplace Region

	Number of Participants	Metropolitan and Regional	Rural and Remote	Mixed
VIC	1901	63.4%	25.7%	10.9%
NSW	1740	47.5%	34.8%	17.7%
QLD	690	41.2%	43.6%	15.2%
SA	487	75.5%	11.9%	12.7%
WA	288	71.9%	15.6%	12.5%
TAS	253	47.0%	38.7%	14.2%
ACT	199	75.4%	24.6%	0.0%
NT	101	20.8%	13.2%	66.0%
Total	5662	56.2%	29.2%	14.6%

Highest Education Level of Participants

Table 8 shows the highest level of education in a nursing related field. The highest education of most participants was either a BN or postgraduate certificate or diploma. Almost 20% of participants had a Masters' degree, with just 0.8% having a doctoral degree. Just over 10% had a hospital certificate as their highest level of education. Participants from QLD, SA, NT and WA were more likely to have postgraduate qualifications than the other states. Hospital certificate as the highest education varied from 16% in TAS to 4.5% in WA. Almost 10% of participants claimed their highest education was not in a nursing related field.

Table 8. Highest Education

	Number of Participants	PhD	Masters	Post Graduate Diploma	Post Graduate Certificate	BN or equivalent	Hospital Certificate	Other
VIC	1901	0.6%	13.9%	24.5%	16.5%	23.4%	11.0%	10.2%
NSW	1740	0.8%	19.3%	12.2%	22.2%	23.6%	12.6%	9.3%
QLD	690	1.2%	25.7%	10.9%	21.9%	22.6%	13.2%	4.6%
SA	487	0.8%	18.3%	22.1%	17.9%	22.1%	12.1%	6.6%
WA	288	1.0%	25.7%	17.4%	22.6%	19.4%	4.5%	9.4%
TAS	253	0.8%	11.9%	19.4%	17.0%	26.5%	16.6%	7.9%
ACT	199	0.5%	25.1%	15.6%	15.6%	23.1%	9.0%	11.1%
NT	101	0.0%	24.5%	26.4%	17.9%	19.8%	5.7%	5.7%
Total	5662	0.8%	18.5%	18.0%	19.3%	23.1%	11.6%	8.7%

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Years as a Registered Nurse

On average, participants had been registered as a nurse for 22.6 years with a range over 50 years. Most participants have been registered for between 11-33 years (interquartile range) and nurses in WA and the NT were registered for shorter time than nurses in other states. These results are illustrated in Figure 2.

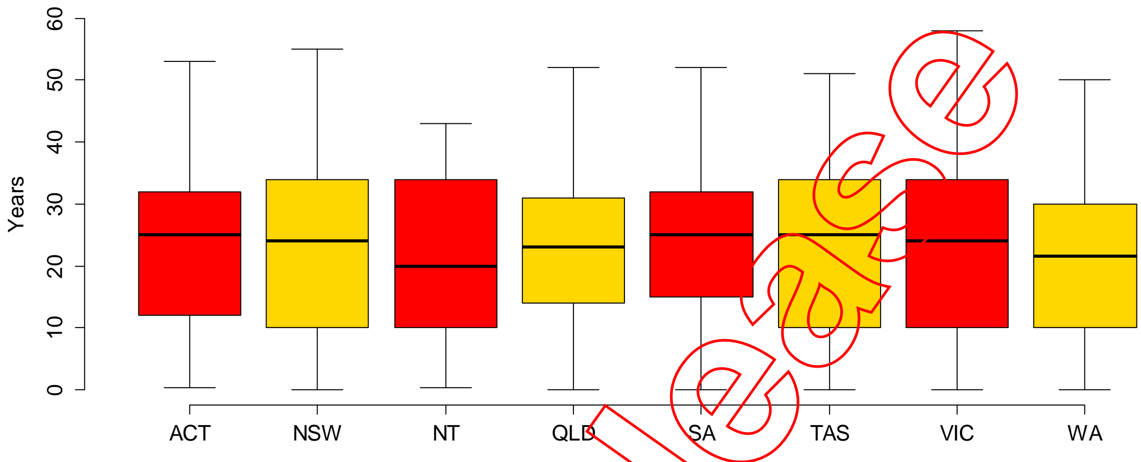

Figure 2: Distribution of years as a RN by State/Territory showing median and range.

Years in Current Position

Participants had spent on average 6.8 years (2-10 years interquartile range) in their current position. Nurses in the NT and WA had spent less time in their current position compared to those in the ACT, NSW, and VIC (see Figure 3).

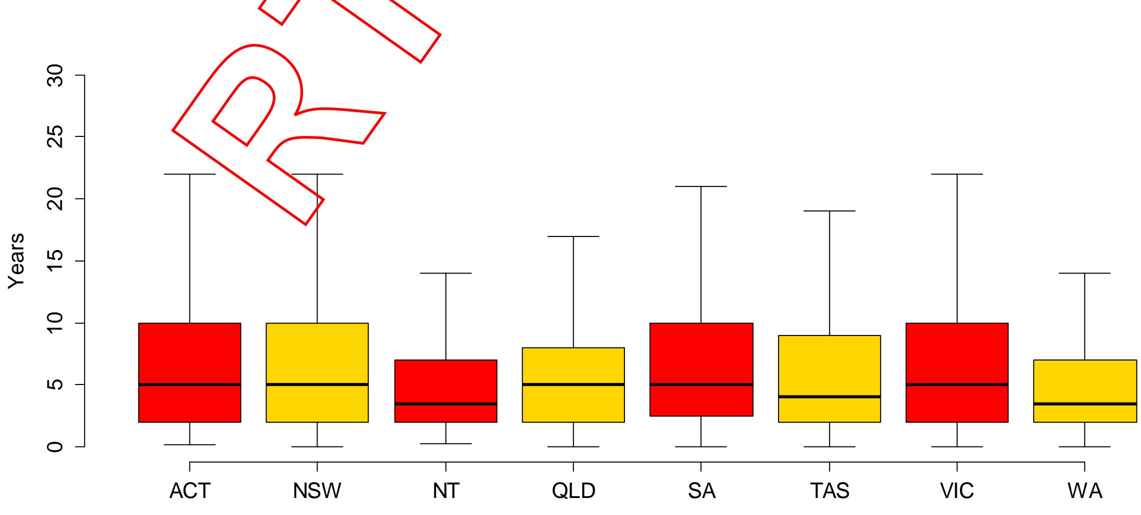

Figure 3: Distribution of years in current position by State/Territory showing median and range.

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Membership of Professional Organisations

Most respondents held membership of a professional body. Table 9 lists the most common of these organisations. Table percentages are not cumulative since many participants were members of more than one group. Over 80% of respondents are members of the Australian Nursing and Midwifery Federation, the NSW Nurses and Midwives' Association or the Queensland Nurses Union.

Table 9: Professional Membership

Professional Organisation	Number	Percentage
Australian Nursing and Midwifery Federation (ANMF)	2706	47.7%
NSW Nurses and Midwives' Association	1436	25.3%
Australian College of Nursing (ACN)	824	14.5%
Queensland Nurses Union (QNU)	577	10.2%
Australian College of Nurse Practitioners (ACNP)	319	5.6%
Australian College of Mental Health Nurses (ACMHN)	218	3.8%
Australian Primary Healthcare Nurses Association (APNA)	212	3.7%
Australian College of Operating Room Nurses (ACORN)	172	3.0%
Australian Wound Management Association (AWMA)	171	3.0%
Australian College of Midwives (ACM)	128	2.3%
College of Remote Area Nurses Australia Inc (CRANAplus)	110	1.9%
Cancer Nurses Society of Australia (CNSA)	106	1.9%
Renal Society of Australasia	102	1.8%
Palliative Care Nurses Australia (PCNA)	81	1.4%
Australasian Sexual Health & HIV Nurses Association (ASHHNA)	78	1.4%
Australian College of Children and Young People's Nurses (ACCYPN)	64	1.1%
Australian College of Neonatal Nurses	37	0.7%
Royal District Nursing Service (RDNS)	31	0.5%
Australasian Hepatology Association	29	0.5%
Thoracic Society of Australia and New Zealand (TSANZ)	22	0.4%
Australasian Cardiovascular Nursing College	19	0.3%
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)	8	0.1%

Nursing Position Titles across Australia

Table 10 shows all position titles recorded by survey participants by state and territory. Positions marked with an asterisk were not included in this analysis. This included midwifery positions that have been analysed as a group separate from nursing. Those participants who recorded a director title were also excluded before analysis as this role is well-defined, mostly non-clinical and has been clearly delineated from APN in previous work.[24] Positions recorded in the 'Other' option that were not listed as possible positions in the relevant state and territory nursing titles lists were also removed.

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Table 10: Survey Participant Nursing and Midwifery Position Titles by State

Australian Capital Territory Position Titles	Number	Percentage
Advanced Practice Nurse	17	7.3%
Assistant Director of Nursing*	8	3.4%
Clinical Nurse	17	7.3%
Clinical Nurse Consultant	9	3.9%
Clinical Nurse Coordinator	14	6.0%
Director of Nursing*	4	1.7%
Midwife Consultant*	1	0.4%
Midwifery Educator*	1	0.4%
Nurse Coordinator	7	3.0%
Nurse Educator	7	3.0%
Nurse Manager	2	0.9%
Nurse Practitioner	11	4.7%
Other *	4	1.7%
Registered Midwife*	16	6.9%
Registered Nurse	115	49.4%

New South Wales Position Titles	Number	Percentage
Assistant Director of Nursing*	1	0.1%
Clinical Midwife Consultant*	9	0.5%
Clinical Midwife Educator*	5	0.3%
Clinical Midwife Specialist*	33	1.7%
Clinical Nurse Consultant	173	8.8%
Clinical Nurse Educator	55	2.8%
Clinical Nurse Specialist	254	12.9%
Deputy Director of Nursing*	2	0.1%
Director of Nursing*	10	0.5%
Midwife Educator*	1	0.1%
Midwife Manager*	1	0.1%
Midwife Practitioner*	3	0.2%
Midwifery Unit Manager*	14	0.7%
Nurse Educator	34	1.7%
Nurse Manager	95	4.8%
Nurse Practitioner	65	3.3%
Nurse Unit Manager	94	4.8%
Other *	63	3.2%
Registered Midwife*	91	4.6%
Registered Nurse	970	49.2%

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Table 10 Continued: Survey Participant Nursing and Midwifery Position Titles by State

Northern Territory Position Titles	Number	Percentage
Nurse Educator	2	1.7%
Nurse Manager	3	2.5%
Nurse Practitioner	3	2.5%
Other *	19	12.5%
Registered Midwife*	4	3.3%
Registered Nurse	93	77.5%

Queensland Position Titles	Number	Percentage
Assistant Director of Nursing*	5	0.6%
Clinical Midwife*	6	0.8%
Clinical Nurse	213	26.8%
Clinical Nurse Consultant	97	12.2%
Director of Nursing*	15	1.9%
Executive Director of Nursing*	1	0.1%
Nurse Educator	48	6.0%
Nurse Manager	11	1.4%
Nurse Practitioner	44	5.5%
Nurse Researcher	8	1.0%
Nurse Unit Manager	54	6.8%
Nursing Director*	17	2.1%
Other *	24	3.0%
Registered Midwife*	37	4.7%
Registered Nurse	215	27.0%

South Australian Position Titles	Number	Percentage
Assistant Director of Nursing*	6	1.0%
Associate Clinical Service Coordinator	42	7.3%
Clinical Midwife*	6	1.0%
Clinical Nurse	110	19.1%
Director of Nursing/Midwifery*	8	1.4%
Nurse Manager	3	0.5%
Nurse Practitioner	31	5.4%
Nurse Clinical Practice Consultant	51	8.8%
Nurse Clinical Service Coordinator	35	6.4%
Nurse Education Facilitator	22	4.0%
Nurse Management Facilitator	17	2.9%
Nursing Director*	10	1.7%
Other *	29	5.0%
Registered Midwife*	25	4.3%
Registered Nurse	179	31.0%

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Table 10 Continued: Survey Participant Nursing and Midwifery Position Titles by State

Tasmanian Position Titles	Number	Percentage
Assistant Director of Nursing*	5	1.7%
Clinical Nurse Consultant	21	7.0%
Clinical Nurse Educator	11	3.7%
Director of Nursing*	6	2.0%
Nurse Manager	16	5.3%
Nurse Practitioner	9	3.0%
Other *	4	1.3%
Registered Midwife*	24	8.0%
Registered Nurse	188	62.5%
Specialist Nurse	8	2.7%

Victorian Position Titles	Number	Percentage
Assistant Director of Nursing*	9	0.4%
Associate Director of Nursing*	1	0.0%
Associate Midwife Unit Manager*	6	0.3%
Associate Nurse Unit Manager	60	2.6%
Clinical Consultant	114	5.0%
Clinical Midwife Consultant*	11	0.5%
Clinical Midwife Specialist*	58	2.6%
Clinical Nurse Specialist	251	11.1%
Clinical Support Nurse	19	0.8%
Community Health Nurse	45	2.0%
Deputy Director of Nursing*	10	0.4%
Director of Nursing*	21	0.9%
District Nurse	15	0.7%
Maternal & Child Health Nurse	212	9.4%
Midwife Unit Manager*	3	0.1%
Nurse Educator	76	3.4%
Nurse Manager	12	0.5%
Nurse Practitioner	47	2.1%
Nurse Researcher	8	0.4%
Nurse Unit Manager	86	3.8%
Nursing Director*	2	0.1%
Other*	118	5.2%
Registered Midwife*	127	5.6%
Registered Nurse	956	42.2%

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Table 10 Continued: Survey Participant Nursing and Midwifery Position Titles by State

Western Australian Position Titles	Number	Percentage
Area Manager	4	1.2%
Assistant Director Nursing*	1	0.3%
Clinical Midwife*	7	2.1%
Clinical Midwifery Consultant*	1	0.3%
Clinical Midwifery Manager*	1	0.3%
Clinical Nurse	67	19.7%
Clinical Nurse Consultant	21	6.2%
Clinical Nurse Manager	14	4.1%
Clinical Nurse Specialist	37	10.9%
Director of Nursing*	1	0.3%
Midwifery Manager*	1	0.3%
Nurse Manager	16	4.7%
Nurse Practitioner	46	13.5%
Nursing Director*	11	3.2%
Other *	22	6.5%
Registered Midwife*	7	2.1%
Registered Nurse	75	22.1%
Staff Development Educator	8	2.4%

*Midwifery and Director Position/Titles not included in further analysis in this report.

The Pattern of APN activities according to Nursing Title

Survey participants responded to each of the 41 items listing advanced practice nursing activities across the five Domains. These responses required the participant to record on a Likert scale the extent to which they carried out each of the activities. The scores were averaged within each of the five domains.

Five position titles were identified as common across most states and territories, these are: nurse practitioner, clinical nurse consultant, nurse educator, nurse manager and registered nurse. The means for each of the five domains for nurses with these titles are shown in Figure 4. Each of these positions shows a unique pattern of activities in the APRD tool.

Clinical nurse consultants score highly on all domains. They are similar to nurse practitioners who also score highly on all domains but with a prominent peak in Direct Care. Nurse educators score low in Research and noticeably in Direct Care but their practice activities peak in education and to a lesser extent in Support of Systems. Nurse managers also score poorly on Direct Care and less also on Education, Research and Professional Leadership but are differentiated by their Support of Systems response. Registered nurses score poorly on most domains except for Direct Care.

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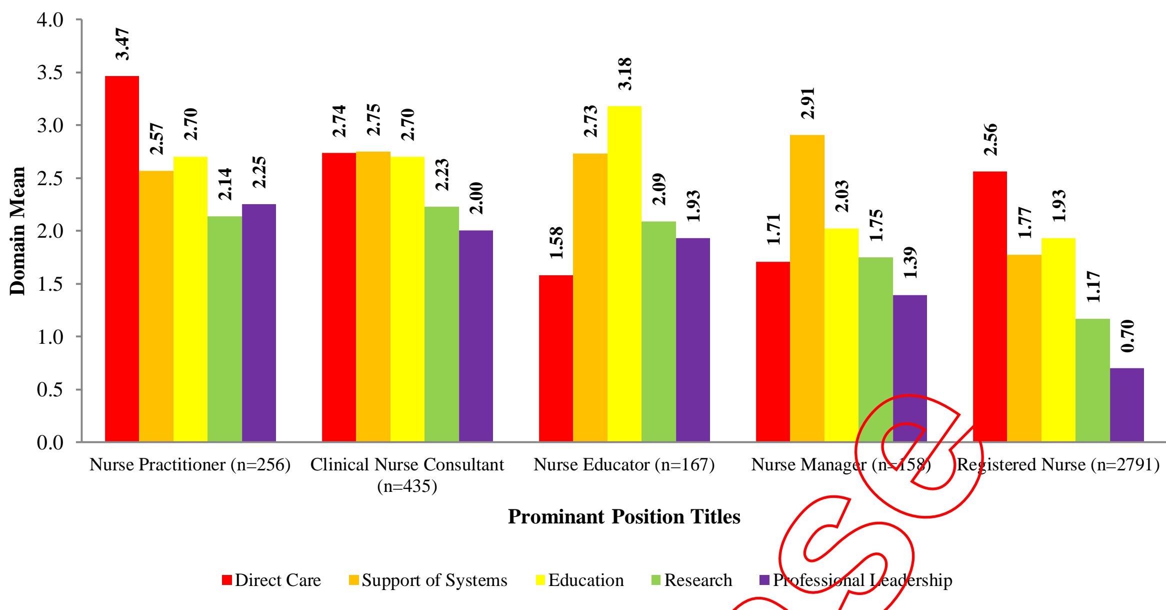

Figure 4: Domain means for five prominent positions across Australia.

Nurse Practitioners

Domain means for each of the eight state and territories nurse practitioner titles were calculated and are displayed in Figure 5. The pattern of advanced practice activities is similar across states and territories with all showing a distinguishing peak for Direct Care. Support of systems, Education and Research score highly and are uniform throughout the country. Professional Leadership does vary but is relatively higher than that of other positions.

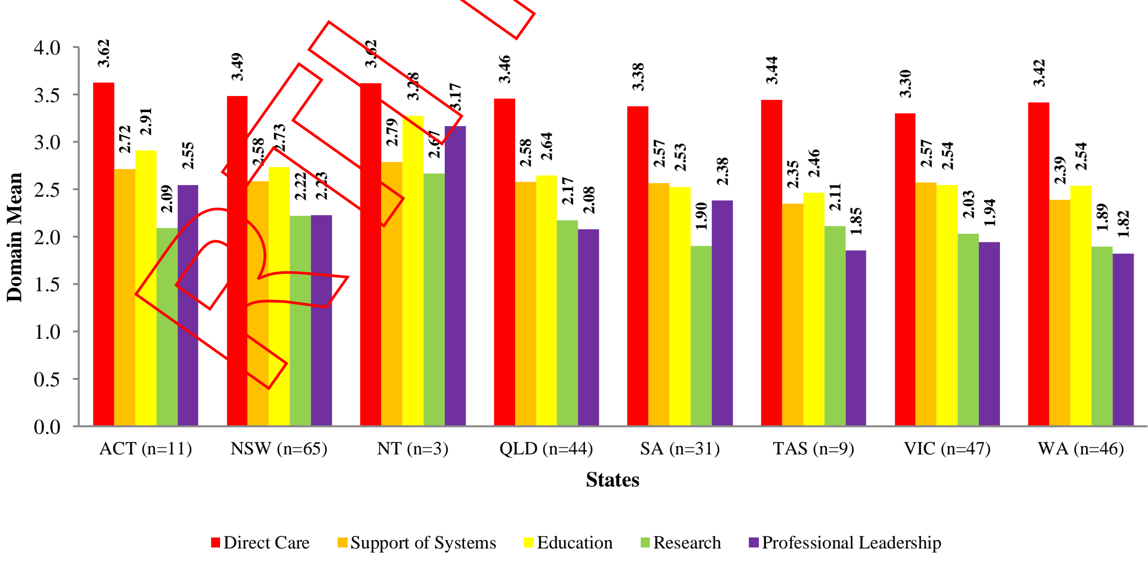

Figure 5: Domain means for nurse practitioner positions by State/Territory.

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Clinical Nurse Consultants

Clinical nurse consultant is a position title in six state and territories. Domain means for each of these positions are shown in Figure 6. Clinical nurse consultants are categorised by their high and even scores on all APN domains which show little variation between these positions across states and territories.

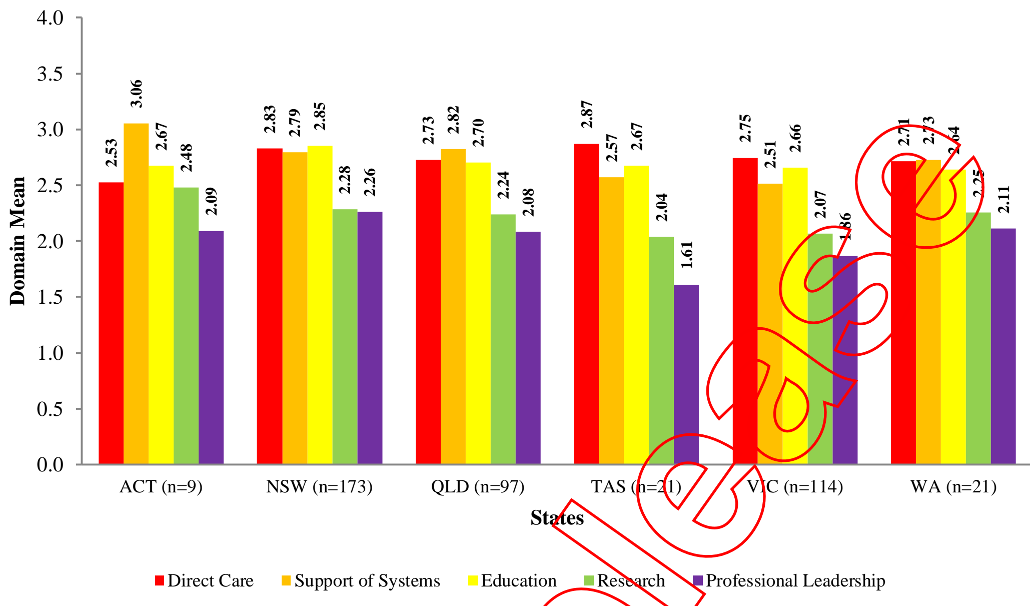

Figure 6: Domain means for clinical nurse consultant positions by State/Territory.

Nurse Educators

The position title nurse educator occurs in four jurisdictions – ACT, NSW, QLD and VIC. The Domain means for these positions are shown in Figure 7. These positions are characterised by low response to Direct Care activities and very high responses to both Support of Systems and Education. Research and Professional Leadership Domain means are reduced compared to Domain means for clinical nurse consultant.

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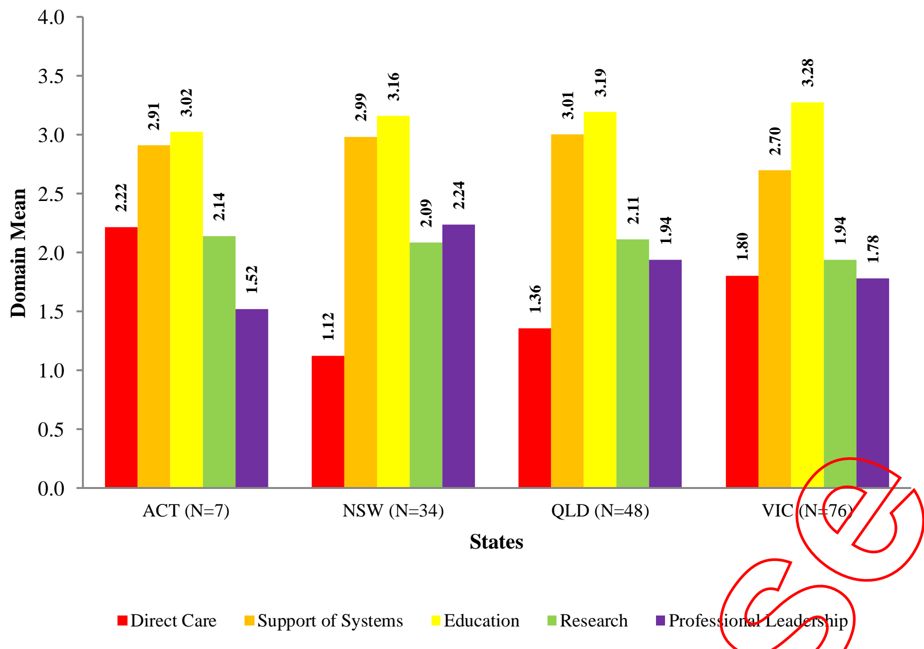

Figure 7: Domain means for nurse educator positions by State/Territory.

Nurse Managers

The position title of nurse manager was found in all states and territories except the NT. The domain means for these seven positions are shown in Figure 8. Similar to nurse educators, nurse managers scored low for Direct Care and high for Support of Systems. For nurse managers the three remaining domains, Education, Research and Professional Leadership were all below values for clinical nurse consultant positions.

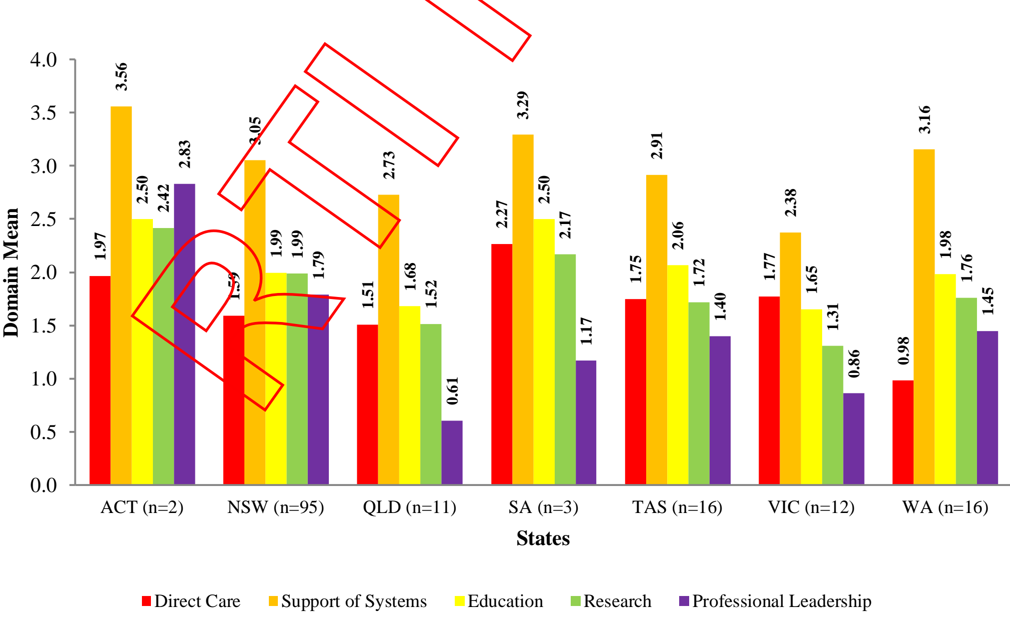

Figure 8: Domain means for nurse manager positions by State/Territory.

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Registered Nurses

All states and territories included the position title registered nurse. These positions scored high responses to Direct Care but low on all other domains. A comparison between the states is shown in Figure 9.

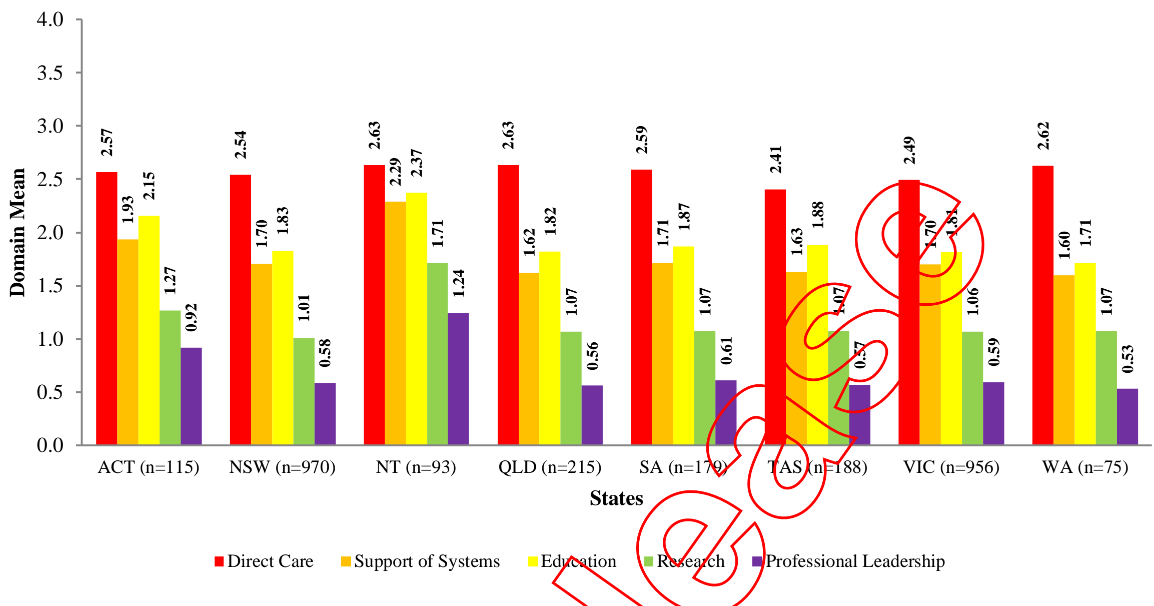

Figure 9: Domain means for registered nurse positions by State/Territory.

The extent to which different nursing titles carry out APN activities

The APRD is an advanced practice tool. That is, activities across all domains are carried out to a great extent by nurses who practice at an advanced level. This research question sought to determine if the tool would delineate advanced practice nurses from nurses practicing at other levels commensurate with titles.

Clinical Nurse Consultant

Analysis for research question 1 shows that advanced practice nursing is typified by the clinical nurse consultant position in all states and territories where the position occurs. Table 11 lists all six of these positions and their domain means. These are identified as APN domain means and their standard deviation and interquartile range of the 435 individuals in these positions are also listed in Table 11.

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Table 11. Calculation of the Advanced Practice Nurse Domain Means

Position		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Clinical Nurse Consultant	9	2.53	3.06	2.67	2.48	2.09
NSW-Clinical Nurse Consultant	173	2.83	2.79	2.85	2.28	2.26
QLD-Clinical Nurse Consultant	97	2.73	2.82	2.70	2.24	2.08
TAS-Clinical Nurse Consultant	21	2.87	2.57	2.67	2.04	1.61
VIC-Clinical Consultant	114	2.75	2.51	2.66	2.07	1.86
WA-Clinical Nurse Consultant	21	2.71	2.73	2.64	2.25	2.11
Means of all CNC individuals APN Domain Means	435	2.77	2.72	2.75	2.21	2.08
Standard deviation		0.85	0.77	0.77	0.87	1.01
Interquartile Range		3.40 - 2.27	3.38 - 2.13	3.33 - 2.17	2.83 - 1.67	2.83 - 1.33

To determine which other positions were comparable to the clinical nurse consultant, a threshold was calculated at 0.5 of a unit below and above the APN domain means. For positions to be considered as equivalent to the advanced practice level of the clinical nurse consultant position, the means of *all* their domains must be within 0.5 of a unit of the APN domain means. These threshold values are listed in Table 12. Our results show that nine positions, including all eight nurse practitioner positions and the ACT nurse coordinator were above the upper APN threshold in the Direct Care domain. All these positions were also above the lower APN threshold. All domain means for these positions are tabled in Table 13.

Table 12. Calculation of the Advanced Practice and Nurse Practitioner Threshold

	Direct Care	Support of Systems	Education	Research	Professional Leadership
	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Upper APN Threshold 0.5 of a Unit above *any* of the domain means	3.27	3.22	3.25	2.71	2.58
APN Domain Means N=435	**2.77**	**2.72**	**2.75**	**2.21**	**2.08**
Lower APN Threshold 0.5 of a Unit below *any* of the domain means	2.27	2.22	2.25	1.71	1.58

Nine positions, including all six clinical nurse consultant positions as well as the ACT clinical nurse coordinator, the SA nurse clinical practise consultant and the WA clinical nurse specialist all had domain means below the upper APN threshold and above the lower APN threshold. The domain means for all these positions are listed in Table 14.

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Table 13. Nurse Practitioners: Positions above the Upper APN Threshold in *any* Domain and above the Lower APN Threshold in *all* Domains						
		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Nurse Coordinator	7	3.41	3.02	2.7	2.5	2.26
ACT-Nurse Practitioner	11	3.62	2.72	2.91	2.09	2.55
NSW-Nurse Practitioner	65	3.49	2.58	2.73	2.22	2.23
NT-Nurse Practitioner	3	3.62	2.79	3.28	2.67	3.17
QLD-Nurse Practitioner	44	3.46	2.58	2.64	2.17	2.08
SA-Nurse Practitioner	31	3.38	2.57	2.53	1.90	2.38
TAS-Nurse Practitioner	9	3.44	2.35	2.46	2.11	1.85
VIC-Nurse Practitioner	47	3.30	2.57	2.54	2.03	1.94
WA-Nurse Practitioner	46	3.42	2.39	2.54	1.89	1.82

Table 14. Advance Practice Nurses: Positions within both the UPPER and LOWER Advanced Practice Domain thresholds for all domains						
		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Clinical Nurse Consultant	9	2.53	3.06	2.67	2.48	2.09
ACT-Clinical Nurse Coordinator	14	2.60	2.95	2.62	2.19	1.92
NSW-Clinical Nurse Consultant	173	2.83	2.79	2.85	2.28	2.26
QLD-Clinical Nurse Consultant	97	2.73	2.82	2.70	2.24	2.08
SA-Nurse Clinical Practice Consultant	51	2.91	2.69	2.49	2.03	1.87
TAS-Clinical Nurse Consultant	21	2.87	2.57	2.67	2.04	1.61
VIC-Clinical Consultant	114	2.75	2.51	2.66	2.07	1.86
WA-Clinical Nurse Consultant	21	2.71	2.73	2.64	2.25	2.11
WA-Clinical Nurse Specialist	37	2.77	2.64	2.46	1.95	1.84

Registered Nurse

The registered nurse position title was in the nursing title structure for all eight states and territories. Table 15 lists all eight state/territory based registered nurse positions and their domain means.

Table 15. Registered Nurses						
Position		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Registered Nurse	115	2.57	1.93	2.15	1.27	0.92
NSW-Registered Nurse	970	2.54	1.70	1.83	1.01	0.58
NT-Registered Nurse	93	2.63	2.29	2.37	1.71	1.24
QLD-Registered Nurse	215	2.63	1.62	1.82	1.07	0.56
SA-Registered Nurse	179	2.59	1.71	1.87	1.07	0.61
TAS-Registered Nurse	188	2.41	1.63	1.88	1.07	0.57
VIC-Registered Nurse	956	2.49	1.70	1.81	1.06	0.59
WA-Registered Nurse	75	2.62	1.60	1.71	1.07	0.53

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***Other* Nurse Titles**

Forty eight nursing titles fell below the lower APN threshold but were, in domains relevant to their title, above the profile of the registered nurse. These include the nurse educator, manager and clinical nurse titles and are listed in Table 16 along with their domain means.

Table 16. Other Position/ Titles

		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
ACT-Advanced Practice Nurse	17	3.01	2.41	2.47	1.78	1.27
ACT-Clinical Nurse	17	2.77	2.15	2.48	1.57	1.32
ACT-Nurse Educator	7	2.22	2.91	3.02	2.14	1.52
ACT-Nurse Manager	2	1.97	3.56	2.50	2.42	2.83
NSW-Clinical Nurse Educator	55	2.05	2.96	3.40	2.12	1.56
NSW-Clinical Nurse Specialist	254	2.79	2.18	2.44	1.42	0.99
NSW-Nurse Educator	34	1.12	2.99	3.16	2.09	2.24
NSW-Nurse Manager	95	1.59	3.05	1.99	1.99	1.79
NSW-Nurse Unit Manager	94	2.32	3.08	2.33	2.09	1.41
NT-Nurse Educator	2	1.40	2.06	3.25	2.17	2.17
NT-Nurse Manager	3	1.84	2.17	1.83	1.11	1.06
QLD-Clinical Nurse	213	2.82	2.13	2.39	1.46	0.92
QLD-Nurse Educator	48	1.36	3.01	3.19	2.11	1.94
QLD-Nurse Manager	11	1.51	2.73	1.68	1.52	0.61
QLD-Nurse Researcher	8	1.24	2.13	1.66	3.08	2.02
QLD-Nurse Unit Manager	54	1.96	3.22	2.25	2.35	1.76
SA-Assoc Clinical Service Nurse	42	2.78	2.22	2.32	1.44	1.06
SA-Clinical Nurse	110	2.77	2.20	2.44	1.50	1.13
SA-Nrs Clinical Service Coordinator	35	2.22	3.14	2.60	2.21	1.97
SA-Nurse Education Facilitator	22	1.37	2.97	3.11	2.04	1.96
SA-Nurse Management Facilitator	17	1.42	2.58	1.72	1.79	1.25
SA-Nurse Manager	3	2.27	3.29	2.50	2.17	1.17
TAS-Clinical Nurse Educator	11	1.61	2.68	3.06	2.29	1.79
TAS-Nurse Manager	16	1.75	2.91	2.06	1.72	1.40
TAS-Specialist Nurse	8	2.93	2.06	2.53	1.73	1.31
VIC-Associate Nurse Unit Manager	60	2.58	2.29	2.33	1.40	0.76
VIC-Clinical Nurse Specialist	251	2.69	2.07	2.37	1.36	0.81
VIC-Clinical Support Nurse	19	2.19	2.73	3.19	1.53	1.31
VIC-Community Health Nurse	45	2.79	1.81	1.96	1.35	1.05
VIC-District Nurse	15	2.81	1.88	1.89	1.16	0.94
VIC-Maternal & Child Health Nurse	212	2.79	2.20	2.18	1.61	1.25
VIC-Nurse Educator	76	1.80	2.70	3.28	1.94	1.78
VIC-Nurse Manager	12	1.77	2.38	1.65	1.31	0.86
VIC-Nurse Researcher	8	2.36	2.08	2.15	2.27	1.52
VIC-Nurse Unit Manager	86	2.50	3.05	2.65	2.05	1.53
WA-Area Manager	4	1.17	3.59	2.08	1.58	1.63
WA-Clinical Nurse	67	2.88	2.13	2.32	1.57	1.06
WA-Clinical Nurse Manager	14	2.10	2.90	2.15	2.00	1.62
WA-Nurse Manager	16	0.98	3.16	1.98	1.76	1.45
WA-Staff Development Educator	8	1.39	3.09	3.06	2.27	2.69

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Delineating Nursing Position Titles by Group

Delineation of Australian nursing position titles with thresholds created four classifications of nursing positions according to their level of advanced practice activities. This included the nurse practitioners, the advanced practice nurses (clinical nurse consultant and like positions), registered nurses and *other* positions/titles. An ANOVA with *post hoc* testing between all four groups for each of the domains was performed to analyse where the significant differences were to be found. Table 17 lists all domain means of the four position/title groupings.

Table 17. Domain Means of Delineated Position Titles

		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Nurse Practitioners	263	3.46	2.62	2.70	2.18	2.25
Advanced Practice Nurses	537	2.74	2.75	2.64	2.17	1.96
Other Positions/Titles	2071	2.10	2.62	2.44	1.84	1.47
Registered Nurse	2791	2.56	1.77	1.93	1.17	0.70
ANOVA (F Sig)		21.04*	10.88*	5.86*	14.98*	20.67*

*p<0.001

Significant differences were highlighted by post hoc testing of these ANOVAs. For Direct Care, nurse practitioners perform at a level significantly higher than all of the other three groups and advance practice nurses perform at a level significantly higher than the other titles. In the Support of System, Education and Research Domains, registered nurses perform at a level significantly below all of the other three groups. In Professional Leadership, nurse practitioners and advanced practice nurses are similar and both are significantly different to both registered nurses and other titles.

Mapping of Australian Nursing Position Titles: Cluster Analysis

Mapping of state nursing position titles was based on the pattern of practice revealed by the five Domain mean scores for each state/territory position titles (n=66). This mapping was performed using cluster analysis statistics; details of this analytic approach are previously described, (see page 13). In order to conserve the separate clustering of the clinical nurse consultant and nurse practitioner groups, the cluster measure was stopped at the point just before these two clustered groups joined giving rise to seven clusters of state/territory nursing position titles which are considered to be equivalent. These clusters and their membership are listed in Table 18 and the dendrogram of the cluster formation is detailed in Appendix IV.

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The Domain means of these seven clusters are displayed in Figure 10 and further detailed in Table 19. The nurse practitioner cluster listed all nurse practitioner titles but also included the ACT nurse coordinator which is echoed in the nurse practitioner delineation threshold. The clinical nurse consultant cluster included all members of the advanced practice delineation thresholds including the SA Nurse Clinical Service Coordinator and the Victorian Nurse Researcher. The third cluster included all education titles characterised by their high responses to the Support of Systems and Education domains and low responses to Direct Care (see Figure 10). Management positions split into two clusters. The first larger grouping consisted of 10 titles that recorded a high response to the Support of Systems Domain with low activity in Direct Care. All other Domains were lower compared with nursing titles above the APN threshold. The second management cluster responded in a similar pattern to the first group, but at a lower magnitude.

The final two clusters were made up of positions with high clinical content. The first of these is a clinical nurse cluster listing 12 positions around the country which can be considered equivalent. Figure 10 shows that the clinical nurse cluster reported high levels of Direct Care and moderate levels of Support of Systems and Education but lower levels of Research and Professional Leadership. The last cluster was made up of mostly registered nurse and responded in a similar pattern to the clinical nurse cluster, but at lower levels.

The seven cluster solution identified and detailed above was further analysed through and ANOVA and post hoc testing to reveal where significant differences between the clusters lay. Details are shown in Table 19.

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Table 18. Cluster Membership for Mapping of State & Territory Nursing Position Titles						
Cluster 1	Cluster 2	Cluster 3	Cluster 4	Cluster 5	Cluster 6	Cluster 7
Nurse Practitioner	Advanced Practice Nurse	Educator	Managers #1	Managers #2	Clinical Nurse	Registered Nurse
ACT-Nurse Coordinator	ACT-Clinical Nurse Consultant	ACT-Nurse Educator	WA-Area Manager	NT-Nurse Manager	WA-Clinical Nurse	ACT-Registered Nurse
ACT-Nurse Practitioner	ACT-Clinical Nurse Coordinator	NSW-Clinical Nurse Educator	WA-Clinical Nurse Manager	QLD-Nurse Manager	ACT-Advanced Practice Nurse	NSW-Registered Nurse
NSW-Nurse Practitioner	NSW-Clinical Nurse Consultant	TAS-Clinical Nurse Educator	WA-Nurse Manager	SA-Nurse Management Facilitator	ACT-Clinical Nurse	QLD-Registered Nurse
NT-Nurse Practitioner	QLD-Clinical Nurse Consultant	VIC-Clinical Support Nurse	NSW-Nurse Manager	VIC-Nurse Manager	NSW-Clinical Nurse Specialist	SA-Registered Nurse
QLD-Nurse Practitioner	SA-Nurse Clinical Practice Consultant	VIC-Nurse Educator	TAS-Nurse Manager		NT-Registered Nurse	TAS-Registered Nurse
SA-Nurse Practitioner	TAS-Clinical Nurse Consultant	NSW-Nurse Educator	NSW-Nurse Unit Manager		QLD-Clinical Nurse	VIC-Community Health Nurse
TAS-Nurse Practitioner	VIC-Clinical Consultant	QLD-Nurse Educator	QLD-Nurse Unit Manager		SA-Associate Clinical Service Nurse	VIC-District Nurse
VIC-Nurse Practitioner	WA-Clinical Nurse Consultant	SA-Nurse Education Facilitator	SA-Nurse Manager		SA-Clinical Nurse	VIC-Registered Nurse
WA-Nurse Practitioner	WA-Clinical Nurse Specialist	WA-Staff Development Educator	VIC-Nurse Unit Manager		TAS-Specialist Nurse	WA-Registered Nurse
	SA-Nurse Clinical Service Coordinator	NT-Nurse Educator	QLD-Nurse Researcher		VIC-Associate Nurse Unit Manager	
	VIC-Nurse Researcher	ACT-Nurse Manager			VIC-Clinical Nurse Specialist	
					VIC-Maternal & Child Health Nurse	

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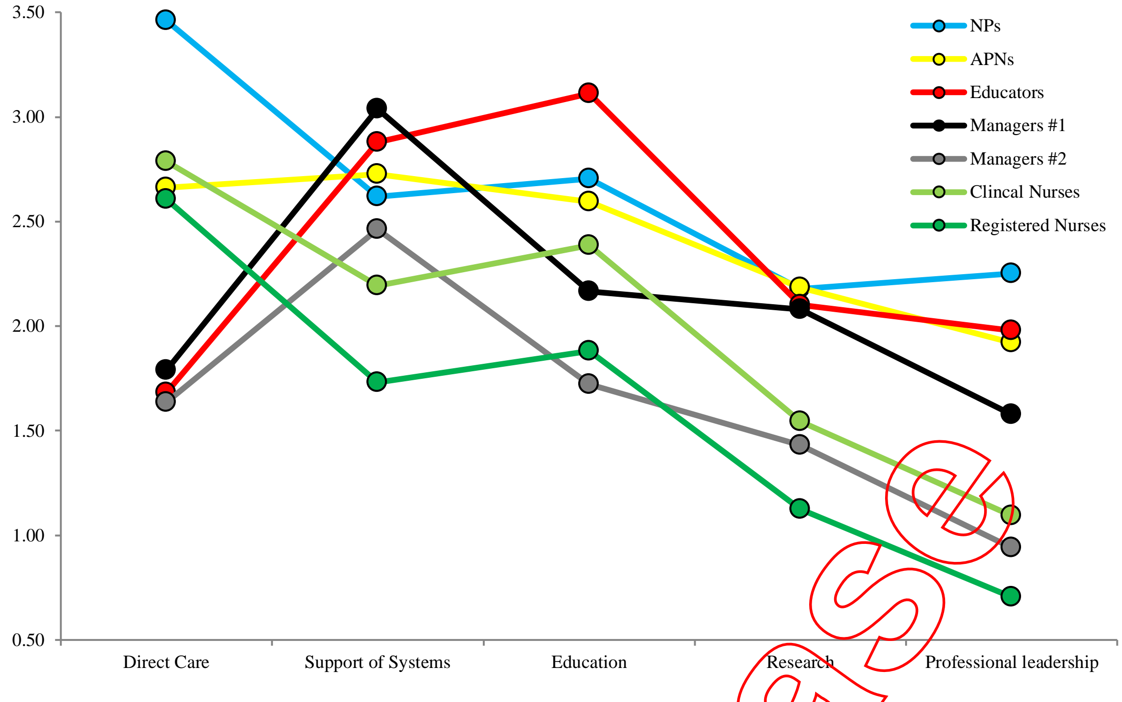

Figure 10: Domain means for all mapping clusters

Table 19. Cluster Domain Means and ANOVA Results

	Clusters							
	Nurse Practitioners	Advanced Practice Nurses	Educators	Managers #1	Managers #2	Clinical Nurses	Registered Nurses	F*
Number of Participants	263	580	284	390	43	1344	2758	
Direct Care	3.46	2.66	1.68	1.79	1.64	2.79	2.61	48.99
Support of Systems	2.62	2.73	2.88	3.04	2.46	2.19	1.73	27.11
Education	2.70	2.59	3.11	2.17	1.72	2.39	1.88	48.61
Research	2.18	2.18	2.10	2.08	1.43	1.55	1.13	28.28
Professional Leadership	2.25	1.92	1.98	1.58	0.94	1.10	0.71	32.09

$*p<0.001$

Significant differences were highlighted by post hoc testing of these ANOVAs. For Direct Care, nurse practitioners perform at a level significantly higher than all of the other six groups and advanced practice nurses perform at a level significantly higher than the educators and both manager groups but not the registered and clinical nurses. In the Support of System, nurse practitioners differ significantly from the first manager group and both clinical and registered nurses; advanced practice nurses and educators differ from both clinical and registered nurses; clinical nurses are different from all but the mangers Type 2 group and registered nurses are different to all other clusters.

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In Education nurse practitioners and advanced practice nurses are significantly different to all other groups except each other; educators are significantly different to all others and both manager clusters are different to all but the clinical and registered nurses. In the Research domain, nurse practitioners, advanced practice nurses, educators and managers #1 are not different to each other but are significantly different to managers #2 and clinical and registered nurses. In the final Domain, Professional Leadership, nurse practitioners are similar only to advanced practice nurses and educators. Managers #1 are also similar to advanced practice nurses and educators. Managers #2 and clinical nurse and registered nurse are similar and are significantly different to the four other clusters.

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CHAPTER FOUR: DISCUSSION

This was a national survey with an overall response of 6,939 registered nurses and registered midwives. There is no record in the literature of primary survey research of nurses and midwives in Australia that has achieved a sample size of this dimension. The success of our recruitment approach was largely due to the support from the ANMF and State and Territory Branches in wide and repeated dissemination of recruitment material and information, and the support from other nursing professional bodies in advertising the survey to their membership. Hereafter this discussion will deal with the registered nurse component of the sample which totalled 5,662 respondents.

The size of the sample has enabled a range of analytical methods that provide new knowledge about the structure of the Australian nursing workforce with mapping of titles across state and territory jurisdictions and the practice profile of nursing at various levels. The study has also provided a comprehensive record of Australian nursing position titles that describe the structure of the nursing workforce at state and territory level in 2014.

Demographic Profile

On most measures the survey sample was similar to the Australian registered nurse population. Survey responders were slightly older than the Australian nursing population but sex ratios were similar. The average time in nursing for the sample was around 20 years and average time in their current position was seven years. Whilst one in five respondents worked in the private or NGO sectors the majority worked in the public sector. Nurses in the sample were more likely to work in the hospital setting with almost a third working in the community.

Over half of the nurses surveyed worked in a metropolitan or regional location with just under a third in rural or remote locations. A sizable 15% of nurses worked in a mixed region – over regional boundaries or held positions which were state-wide, such as tele-health or the Royal Flying Doctor Service.

In terms of education profile a quarter of participants had the equivalent of a bachelor of nursing degree with just 10% recording hospital certificate as their highest level of education. Importantly, most survey participants had some form of postgraduate certificate or diploma and nearly 20% of participants had a Master level degree. Just 1% of this clinical nursing workforce had a doctorate.

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Survey participants were members of many professional organisations with over 80% having union membership and many of these also have membership of other professional bodies.

Patterns of Practice

The APRD tool is an advanced practice tool comprising 41 activities grouped into five Domains. Nurses' work activity in position titles at all levels was measured to determine the extent to which they worked on each activity. There were five position titles that were common across most states and territories. We found that each of these position titles had a pattern of activity that was unique to that title and consistent across all jurisdictions.

Of significance we found that the clinical nurse consultant position in all states but SA and NT showed consistently high mean scores across all five domains. This indicates that whilst individual states and territories have developed their own industrial classifications, position titles and career ladders appropriate for their jurisdiction, our research indicates that there is a level of consistency in the clinical nurse consultant role nationally.

The research findings have allowed identification of the CNC pattern of practice as the benchmark of advanced practice nursing in Australia. This research outcome has important implications for defining and planning the future use of these positions. Furthermore it provides a framework and evidence on which to base definition and delineating of advanced practice nursing as a level of practice for the Australian nursing workforce.

A point of concern is that the results show relatively low scores in the senior clinical roles of CNC and NP in research and professional leadership. For NPs this pattern has remained unchanged since similar findings from a work sampling study conducted in 2009.[28] It is evident from these studies that the most senior nurse clinicians do not prioritise practising leadership and using/conducting research in their practice; both activities being hallmarks of a profession. Furthermore this low profile of research and leadership activities is despite the relatively high rates of masters' level education in the sample; raising questions about the capacity of our current models of postgraduate education to produce leaders.

There is no doubt that the contemporary health care environment is increasingly complex with the dual pressures of sicker, older and more complex patients/consumers and increasing emphasis on documentation related to processes of care to unsure safety and quality. These factors have an impact on nursing work,[29] in short nurses are busier and spending more time on activities unrelated to direct clinical care.[30] The challenges of the contemporary health care environment mandate a new maturity in nursing clinical leadership[31] and new thinking about the

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leadership and research capabilities that are required for future clinical leaders. Thoun[7] asserts that (advanced) practice is conceptualised within the parameters of the knowledge base that guides and informs it. The findings from this research show that the Strong Model of Advanced Practice offers practice content that has the potential to build a conceptual base for education and knowledge development in masters level courses to guide and inform comprehensive graduate capabilities for advanced practice nursing.

Delineating levels of nursing practice by position title

This research has identified the pattern of advanced practice in this sample of Australian nurses. In addition the research identified, by position title, the levels of nursing practice that are above and below the pattern characterised as advanced practice. Through identification of the APN practice pattern as signified by uniformly high mean scores across all five APN domains, we identified upper and lower parameters as cut offs of 0.5 of a unit or approximately 2 standard deviations. Consequently we are able to identify position titles in the APN group across all states and territories as:

- All clinical nurse consultants
- WA clinical nurse specialist
- ACT clinical nurse coordinator
- SA nurse clinical practice consultant

Having established what *APN is* we calculated where there are significant differences in all domains for other nursing practice levels and titles. This identified four delineated groups in the Australian nursing workforce:

- Nurse practitioner
- Advanced practice nurse (clinical nurse consultant and like positions),
- Registered nurse
- Other positions/titles.

The results clearly show that on self-reported measures of clinical activity APN is delineated from NP practice by the statistically significant difference in Domain 1, Direct Care. On other Domains the APN and NP were closer in scores. The clarity of this result provides valuable information for service planners in that our senior clinicians can now be matched more appropriately to the needs of specific patient populations, care complexity and service requirements. Furthermore the findings give substance to the Nursing and Midwifery Board of

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Australia requirement that graduates of NP courses seeking NP endorsement demonstrate that they have a prescribed period of experience as an APN.

The fourth group that fell below the APN level is made up of 40 titles across all jurisdictions. This group, in contrast to the other three groups is not uniformly matched with each other but have in common that they are below the APN level on most Domains and above the registered nurse level on one or more Domain scores. This group, therefore, is characterised by a practice profile that has a high Domain score in a particular field of nursing activity such as education, management, research or clinical specialty. Accordingly for the purpose of this report, the *Other* group is named Domain Specified Nurse.

Hence the findings from this research provide an evidence base that Australian nursing workforce can be conceptualised as structured into four bands as follows:

Nurse Practitioner: clearly identified by legislated clinical practice profile that extends outside the registered nurse scope of practice. The high level of hybrid clinical activity of the NP, as characterised by the very high mean score in the Direct Clinical Care Domain, is the factor that delineates this role from its APN shared practice profile.

Advanced Practice Nurse: is identified by consistent high levels of activity across all APN Domains. APN clinical service operates to the full extent of the registered nurse scope of practice. The high mean scores across all five Domains of the Strong Model indicates the APN practice level that optimises nursing's contribution to population level health care and organisational service potential.

Domain Specified Nurse: The nurse in this band is characterised by high level of activity in a primary area of nursing as defined by a high mean score in one of the five Domains consistent with the service nature of the position title. This group is unlike any other band and, within the group unlike each other in terms of practice profile. They have in common their specialised focus in a single Domain. Titles in this group include educators, researchers, managers, clinical nurses and the NSW clinical nurse specialist.

Registered Nurse: is the largest group with a uniform practice profile that has a high mean score in the Direct Care Domain and to a lesser extent, Education and low scores in all other Domains.

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Mapping of Nursing Titles across Australian States and Territories

Statistical strategies were used to examine commonalities across the diverse state/territory based position titles of Australian registered nurses. Cluster analysis technique was used as an exploratory tool to determine patterns in practice over the five APRD Domains between state position/titles. The technique mapped out the position/titles into groups with similar patterns of practice. The numbers of clusters, or stop point was determined by expert judgement and visual displays of group similarities on a dendrogram display (see Appendix IV).

For this study, the point of reference for the stop point in analysis was determined to preserve the characteristic differentiation between nurse practitioner and advanced practice nurse. The outcome was seven groups that were identified as having a particular pattern of practice. These groups and their patterns are as follows:

Cluster 1: is the ***Nurse Practitioner cluster*** this is uniform across all states and also includes the ACT Nurse Coordinator. However the latter has very small number (N=7) and may not be a reliable or accurate portrayal.

Cluster 2: is the ***Advanced Practice Nurse cluster*.** The position titles for this cluster are primarily the clinical nurse consultant (NSW, Qld, ACT, Tas, WA). Cluster 2 also includes five similar titles from ACT, SA, Victoria and WA (see Table 18). This cluster also includes the Victoria nurse researcher, although as discussed below this latter title is represented by low numbers and also may not be a reliable finding.

Cluster 3: is the ***Educator cluster***. This title in various forms was present in all jurisdictions and formed a uniform group, all education titles fell into this group. This is a homogenous group characterised by a practice profile that is high in the Education Domain.

Cluster 4: is the ***Manager Type 1 cluster***. This is a heterogeneous group containing clinical managers, nurse unit managers, other management titles as well as the QLD nurse researcher. They exhibit a pattern with low direct care, very high support of systems and moderate levels of education, research and professional leadership.

Cluster 5: is the ***Manager Type 2 cluster***. This smaller cluster is similar to cluster 4, although all domains are at a lower level. This group is predominantly the nurse manager titles. They are also low on direct care, moderate on the support of systems domain and low in the education, research and professional practice domain. There is a very low *nursing* profile in this cluster.

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Cluster 6: is the ***Clinical Nurse cluster.*** This cluster is most heterogeneous of all clusters containing 12 titles such as clinical nurse and clinical nurse specialist. Also included is the registered nurse from the Northern Territory where the Domain means are higher than in other registered nurse positions in other jurisdictions. This cluster is characterised by a moderate Direct Care, Support of Systems and Education Domain scores and low Research and Professional Leadership Domain scores. In review of the practice profile on nurses in this band it is likely to typify the specialist nurse and supports Thoun's assertion of the distinction between specialist and advanced nurse.[7]

Cluster 7: is the ***Registered Nurse cluster.*** This cluster represents all registered nurse position titles (except the NT) and a couple of other Victorian titles. This cluster shows a similar pattern of practice across all Domains to the clinical nurse cluster except at a lower level. Direct Care Domain scores are moderate and all other scores are low.

The outcome of mapping nursing titles across all Australian jurisdictions in this study provides an evidence-based characterisation of the Australian nursing and midwifery workforce. These seven clusters and their descriptions bring clarity and structure to the erstwhile confusing and disparate array of nursing positions titles.

The delineation of levels of nursing practice by measuring above and below the APN practice profile provides an instrument to identify four bands of clinical nursing activity as Nurse Practitioner, Advanced Practice Nurse, Domain Specified Nurse and Registered Nurse.

Study Limitations

Participant recruitment for this study yielded sufficient overall numbers to conduct a robust analysis of the practice profile of the Australian nursing workforce. However a limitation of the recruitment strategy and therefore the study was the low numbers of participants in certain groups. The ACT Nurse Coordinator (N=7), the Vic nurse researcher (N=8) and the NT nurse practitioner (N=3) being cases in point. The participants in these groups who responded may not be representative of the state/territory-wide profile for that position title but may reflect the unique characteristics of a particular employer.

Notwithstanding the high validity and reliability of the APRD tool, the nature of self-completing surveys is that the reliability of the data is dependent upon the accuracy and veracity of the participants' self-scoring in Likert scales and is unable to be controlled by the researcher. This is a further limitation of this research. Follow-up research that uses objective observational data

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will address this limitation and strengthen the utility of the APRD tool and the Modified Strong Model of Advanced Practice

Conclusion

The Modified Strong Model of Advanced Practice[20] provides a profile of the work activity of advanced practice nursing in Australia. This has been demonstrated in a large scale pilot and testing work in Queensland with a sample of over 600 nurses from all positions and now with a national sample of almost 6,000 nurses across Australia. The APRD tool measures the extent to which nurses carry out the APN activities across the five Domains of the Strong Model and was developed to operationalise the Strong Model. It has been used in the Australian context to gain new knowledge and understanding of the Australian nursing workforce. With further customisation this tool has potential application across many spheres of nursing. Individual nurses could use this tool to assess their level of nursing practice in readiness for position applications or promotion. Graduates of an NP degree will apply this tool to demonstrate their advance practice history to gain Nursing and Midwifery Board of Australia NP authorisation. The Modified Strong Model of Advanced practice can provide the conceptual and content framework for APN masters' education and graduate capabilities. The tool will advanced knowledge on patient outcomes from APN clinical care by providing an operational definition of APN and a tool to identify advanced practice.

Now more than at any time in the history of modern health care, effective development and deployment of the nursing workforce is reliant to a great extent on the capacity of nurses at different stages of their professional development and career trajectory to work at different levels of practice. Despite this there is wide confusion and ambiguity related to nursing levels of practice and the international literature is in accord in recognising and reporting this. It is time for the nursing discipline to regain autonomy over nursing service and to conceptualise, categorise and promulgate a rational framework that delineates levels of nursing practice. This in turn will inform education providers to prepare a nursing workforce for the future and enable policy makers and health service managers to fully understand the service potential of nursing for matching clinical nursing service with the clinical need of patients. This document reports research findings that contribute to achieving these goals.

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Appendix I

Participant Recruitment Material

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Pre-recruitment flyer

Scoping Advanced Practice Nursing: A National Survey

To: All registered nurses and midwives!

Do you want to join your colleagues in influencing the structure of the Nursing and Midwifery workforce for the future?

In mid-February 2014 we will be conducting a National eSurvey of Nurses and Midwives.

To ensure that all registered nurses, midwives and nurse practitioners have the opportunity to participate in this ambitious and important study we will provide details regarding the survey link over the next few weeks. **So watch this space!**

We look forward to you joining us to make this a successful and influential project. If you have any questions about the survey, please email Project Coordinator Marg Adams m5.adams@qut.edu.au

Kind Regards,

Glenn Gardner, Professor of Clinical Nursing,

Queensland University of Technology (QUT)

Christine Duffield, Professor of Nursing and Health Services Management, University of Technology Sydney (UTS)

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Promotional Flyer developed with support of the NSW Nurses and Midwives Association

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Article in December 2013 Australian Nursing and Midwifery Journal

Innovations in midwifery care deliver results

New models of midwifery care based on continuity of care with a privately practicing midwife are delivering positive results in New South Wales and Queensland.

The models were discussed at a midwifery forum at Southern Cross University on the Gold Coast in November.

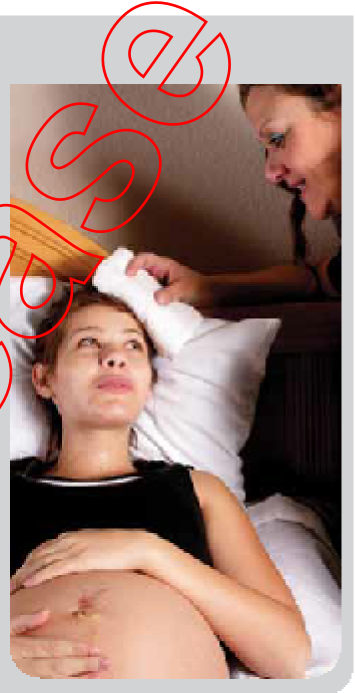
The University's Professor of Midwifery Kathleen Fahy said the Mullumbimby Birthing Service in northern NSW was leading the way with a stand-alone midwife lead continuity of care case load model. "They have about 250 births a year with six midwives who provide that care. It's been operating for a number of years with highly successful outcomes. We have more women wanting to get into it than we can accept."

Professor Fahy said the service recently completed a one year pilot on home births, which delivered outstanding results. The service did 28 home births during the year with all of the babies born with very high Apgar scores of 9 or above. "Nobody transferred in labour, the post-partum haemorrhage rate was much lower than the local hospital, although no oxytocin was used and no syntocinon was used in the third stage of labour, so the post-partum rate was around 5% and the local hospital would have been between 15% and 20%."

Professor Fahy said the results support other current research that showed home birth is as safe for babies, and safer for women, under the right conditions. That is, when the women and babies who can birth at home safely are carefully selected and the midwives are connected to the main health service, as is the case at the Mullumbimby Birthing Centre.

"What is not safe is when women birth at home without a professional midwife or with a midwife who doesn't assess carefully the wellbeing of the baby throughout labour, or when the woman has known complications," said Professor Fahy.

Professor Fahy said a number of privately practicing midwives in Queensland now have admitting rights to at least four public hospitals and believes that the number will continue to grow. "We've got much lower rates of home birth than New Zealand and Britain but I think that will change now because the evidence is finally in about under what circumstances it's safe to have a home birth."



Defining advanced practice nursing

By Glenn Gardner and Christine Duffield

Australia is preparing for an ambitious and inclusive study into advanced practice nursing and midwifery.

Nurses and midwives currently working in the Australian health system know about the confusion surrounding the title of advanced practice nursing and that the meaning of advanced practice is ambiguous, lacks consistency and is variously defined.

The many definitions that are offered reflect elements of advanced practice nursing. They speak to the values and practices that we all recognise as central to the best of nursing and midwifery practice. But these definitions are not drawn from robust research that takes the question of what is advanced practice to the Australian nursing and midwifery population.

One advanced practice role that does have certainty, definition and evidence based standards is the nurse practitioner. This is a specific level and type of practice that is protected and defined by a legislative and practice framework. But this role differs in many ways from other advanced practice roles particularly in the access to practice privileges that are outside the registered nurse scope of practice.

The challenge now is to break the nexus between advanced practice and specific nursing/midwifery roles and titles. Further we need to delineate advanced practice from the foundation practice of the registered nurse and the advanced extended practice of the nurse practitioner.

The authors have been researching and publishing on this topic for several years. Their research has examined and described the practice of advanced practice nurses, surveyed registered nurses and midwives in Queensland and developed a validated tool that will measure and define advanced practice in nursing and midwifery.

The next important stage will be conducted early in 2014 and will survey all Australian registered nurses and midwives. This will be a national census that will achieve two objectives:

i) To map the titles and roles of advanced practice nursing across the eight Australian states and territories;

ii) To delineate advanced practice from the foundation practice of the registered nurse/midwife and the advanced extended practice of the nurse practitioner.

This planned survey is essential for Australian nursing and midwifery to achieve clarity for the professions and the health industry relating to the service capability of different levels of practice. It also has implications for nursing and midwifery clinicians in career planning and postgraduate education options.

The national census will allow every nurse and midwife in Australia the opportunity to participate in this defining research.

If you would like more information about the survey you can contact:

Glenn Gardner at: ge.gardner@qut.edu.au or Christine Duffield at: Christine.Duffield@uts.edu.au

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Survey to help define advanced roles

By Amie Larter | January 20, 2014 | News

Study aims to clear up confusion, provide data for nurses and schools. By Amie Larter.

Australian nurses will soon have the opportunity to help answer the question, "What exactly is advanced practice nursing (APN)?"

Starting February 19, clinical nurses and midwives can participate in a 15-minute survey that will examine activities nurses and midwives undertake in different positions, titles and grades across Australia.

Professor Glenn Gardner from Queensland University of Technology's Faculty of Health, School of Nursing, and professor Christine Duffield, from the University of Technology, Sydney, hope defining APN will clear up current industry and patient confusion.

The survey, which rounds up a seven-year program of study on this topic for the team, has the backing of the ANMF and various other industry organisations.

"We are hoping to survey all clinical nurses and midwives in Australia to be able to examine what they do and then classify the positions that are advanced practice," Gardner said.

"It's really describing it as a level of practice, rather than a role."

The team believes the results will provide national bodies with the information to standardise the names for nursing classifications across all states and territories, as well as the tools to better plan the nursing workforce.

It will also give individual nurses and midwives a tool so they can evaluate their own profile, and be able to demonstrate they are practising at an advanced level.

Universities will also benefit, gaining information for developing courses and to inform current or potential students about educational options for an APN career.

"This [confusion] is not just common to Australia, it is an international problem," Gardner confirmed. "We hope to provide practical information that has an impact on the way we use nursing in the health discipline in the future."

Nurses will be able to access the survey on the national and state ANMF websites or by visiting survey.qut.edu.au/f/179050/1289/

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RTI Release

DOH-DL 15/16-032 RTI Document 389

Article in December 2013 edition *Nursing Review*

nursingreview.com.au http://www.nursingreview.com.au/2013/12/advanced-practice-nursing-the-missing-link/

Advanced practice nursing: the missing link

Nursing Review December 10, 2013

The authors are preparing to survey all Australian nurses early in 2014 in an attempt to define the evolving discipline of advanced practice nursing and resolve the many ambiguities and confusions that beset it. By Glenn Gardner and Christine Duffield.

"This planned survey is essential if Australian nursing is to achieve clarity for the profession and the health industry relating to the service capability of different levels of nursing practice."

Australian nursing is a complex tangle of expertise, roles, levels and titles. Sorting through the meaning of these titles and levels is difficult for those of us in the profession; to colleagues in other health professions, patients and the community it can be utterly incomprehensible.

Take for example the following scenario, which will be familiar to many nurses and some midwives. A patient presents to a specialist outpatient clinic and is greeted by a nurse.

Jason: Hello, Mrs Tyler, I'm Jason. I'm a clinical nurse consultant and I'll be co-ordinating your care during your treatment here at the hospital.

Mrs Tyler: What's a clinical nurse consultant?

Jason: Well, I'm an expert nurse with postgraduate university qualifications and lots of experience with patients who have your health problem.

Jason organises a range of services for Mrs Tyler and arranges for her to return in a week to have her medication reviewed after blood results are through.

A week later, the patient presents again at the clinic and is greeted by a different nurse.

Sandra: Hello, Mrs Tyler, my name is Sandra, I'm a nurse practitioner. I'm going to talk with you about your blood result and then we'll go over your medication and talk about your diet.

Mrs Tyler: So you must be very experienced and educated – are you the same as Jason?

Sandra: Well… yes and no.

By now Mrs Tyler is confused and she has not yet been confronted with greetings of "I'm your nurse for today" or "I'm just going to take your observations and the RN will be with you soon". And so on.

The fictitious Mrs Tyler represents a growing healthcare consumer population of people who are old, chronically ill and increasingly dependent on healthcare. The healthcare landscape has changed significantly over the past 40 years and nursing has changed in response. Nurses are playing key roles in the health service reform agenda, developing innovative service models and roles that draw upon advanced and extended skills; these have come to be labelled advanced practice nursing.

The number and titles related to these roles have proliferated. While these innovations have been effective in addressing short-term service problems, the consequence of uncoordinated development at this level is that advanced practice nursing has a confusing array of titles and roles. At the same time there is scant information available about the service capability of this level of nursing practice.

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This issue is a problem internationally. The volume of literature on advanced practice nursing is vast, attesting to the need to advance and refine knowledge about this evolving level of nursing service. A consistent theme in the international literature is that advanced practice nursing is ambiguous, lacks universal understanding and is variously defined. In Australia there is an added complexity as each state and territory uses different nomenclature for roles and titles that are considered advanced practice.

A particular point in this discussion is the ambiguity about the nurse practitioner and advanced practice nursing. Australian nurse regulators moved early to standardise the nurse practitioner role. Consequently, it is recognised as a specific level and type of nursing service with regulation and a legislative framework that extend nursing practice activities beyond the legislated parameters of the registered nurse. No such clarity exists for other nursing roles that involve advanced practice within the practice scope of the registered nurse.

The challenge now is to break the nexus between advanced practice and specific roles and titles, and to delineate advanced practice from the foundation practice of the registered nurse and the advanced extended practice of the nurse practitioner.

We have been researching and publishing on this topic for several years. We examined the practice of a random sample of nurses in nominated advanced practice roles. The findings from that study showed that advanced practice activities were able to be identified and measured. Furthermore the results showed that all nurses in the study worked across the same broad areas of practice. We followed this study with a state-wide survey of registered nurses and midwives in Queensland. From this we validated our tool and showed that advanced practice could be delineated from other levels of nursing.

We are now preparing for our most ambitious and inclusive study into advanced practice nursing. Our aim is to use our previously validated instrument to survey all Australian registered nurses and midwives. This will be early in 2014 and it will amount to a national census that will achieve two objectives:

1. We will map the titles and roles of advanced practice nursing in all eight Australian states and territories.

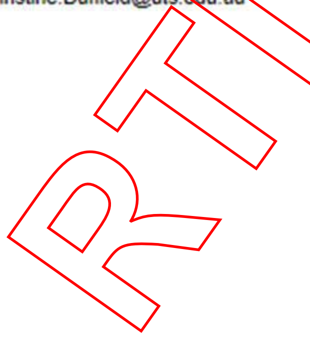
2. We will delineate advanced practice from the foundation practice of the registered nurse and the advanced extended practice of the nurse practitioner

In conducting this survey we have extensive and high level support. The Australian Nursing and Midwifery Federation is funding the survey and making available essential facilities to support information dissemination and data collection. Additionally, the Australian Nursing and Midwifery Accreditation Council is supporting this survey by drawing upon its extensive nursing networks to assist with recruitment for survey participation.

This planned survey is essential if Australian nursing is to achieve clarity for the profession and the health industry relating to the service capability of different levels of nursing practice. It also has implications for nursing and midwifery clinicians in career planning and postgraduate education options.

Many definitions of advanced practice nursing are offered and most of these make sense as they speak to the values and practices that we all recognise as central to the best of nursing practice. But none of them are drawn from robust research that takes the question of what advanced practice consists of for the Australian nursing and midwifery population. Our national census will do this. Every nurse and midwife in Australia will have the opportunity to participate in this defining research.

If you would like more information about the survey you can contact Glenn Gardner at ge.gardner@qut.edu.au or Christine Duffield at Christine.Duffield@uts.edu.au



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ACT Branch promotion of survey link in February edition of ‘*The Collective Perspective*”

PAGE 4

News In Brief

ENTERPRISE BARGAINING UPDATE

Public Sector Agreement

- The Public Sector Agreement is currently out for consideration and voting as the *Collective Perspective* goes to print.

QEII

- The process is nearing completion.

Catholic Care

- Negotiations are continuing.

Kankinya

- The owners remain reluctant to bargain at this stage.

Anglicare – Ginninderra Gardens and Brindabella Gardens

- Anglicare are reluctant to bargain at this stage in their sale process.

BUPA

- Negotiations are continuing.

CJJH

- Negotiations are in the preliminary phase, as the Agreement does not expire until 1 March 2014. A members' meeting to discuss a log of claims was held 21 January 2014.

ScopingAdvanced Practice Nursing: A National Survey

ALL REGISTERED NURSES AND MIDWIVES:

Are you currently employed in a clinical service environment and interested in joining your colleagues to develop a nursing and midwifery workforce for the 21st century?

We invite you to participate in a 15 minute online survey.

The study aims to define advanced practice nursing (APN) by examining the activities undertaken by nurses and midwives in different positions, titles and grades across Australia.

The study will go live on 19 February 2014 from the following link:**http://survy.qut.edu.au/f/179050/1289**

Alternatively you can also access the survey link via **http://anmf.org.au**.

The project is being conducted by Professor Glenn Gardner (Queensland University of Technology) and Professor Christine Duffield (University of Technology, Sydney).

If you have any questions about the survey, please email Project Coordinator **Marg Adams** at **m5.adams@qut.edu.au**

Australian Nursing & Midwifery Federation
AUSTRALIAN CAPITAL TERRITORY

The Collective Perspective

February 2014

HESTA An Industry SuperFund

Maurice Blackburn Lawyers

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Preparing Nurses for the Future of the Deadly Dust

Lung Foundation Australia has engaged a Nurse Educator to research, develop and deliver a national online nurses' education program in the area of asbestos related disease (ARD).

The program which included a special focus on malignant pleural mesothelioma (MPM) was piloted last year with ten nurses from around Australia.

Australia has the highest incidence of mesothelioma per capita in the world with 606 deaths attributed to mesothelioma in 2011.

Although the current epidemic of mesothelioma is closely associated with past occupational exposure to asbestos, there is increasing evidence that a third, non-occupational wave of mesothelioma cases has developed, with a projected increase of 79% in mesothelioma cases by 2020.

The new nurse education program objectives include online, face-to-face and practical clinical components.

The nurses, from around Australia, who completed the pilot developed specialised knowledge and skills to empower them to coordinate, support and provide best quality care and information to patients and carers with ARD/MPM within their multidisciplinary teams.

This helps patients diagnosed with ARD/MPM and their carers by:

- Improving and fostering coordinated care
- Providing highly skilled specialised nurses in the field
- Providing disease specific resources and material
- Raising awareness of asbestos-related diseases in Australia
- Advocating for specialised nursing care for patients and families affected by ARD/MPM

The program outcomes included:

- development of ten highly trained nurses around Australia who will provide mentorship to their colleagues
- a tight-knit team with a passion, knowledge and specialised skills to care for patients and families impacted by ARD/MPM
- awareness and support provided to ARD/MPM patients and their families in a timely fashion
- acknowledgement and understanding by the nurses of legal entitlements/ compensation for this unique group

The program will become available through Lung Foundation Australia following endorsement by the Australian College of Nursing later this year.

Authorised by Jenny Miragaya Branch Secretary 24 January 2014

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ACT Branch Letter of Support

ABN: 41 698 088 660
President: A. Rosborough
Secretary: J. Miragaya

Dear Member ANMF ACT Branch

Queensland University of Technology and University of Technology, Sydney are undertaking an important study into the activities and level of nursing and midwifery practice in different positions, titles and grades. The study is a survey open to **all Australian registered nurses and midwives** currently employed in a clinical/health care environment.

The online survey http://survey.qut.edu.au/f/179050/1289 is open now (Wednesday 19 February 2014 until Sunday 6 April 2014) and members are encouraged to contribute their views to ensure that the clinical work and scope of practice of ACT nurses and midwives is well represented in the results.

This survey is essential to understand the definition/meaning of advanced practice for the professions of nursing and midwifery in Australia and for the health industry to understand the service capability of different levels of practice. It also has implications for nursing and midwifery clinicians when considering postgraduate education options and their career planning.

Eminent nursing academics Professor Glenn Gardner (Queensland University of Technology) and Professor Christine Duffield (University of Technology, Sydney) are conducting the study.

The study's findings will be critical to informing the ANMF and employers on changes needed to our career structure to reflect contemporary clinical practice.

Please don't miss the opportunity to contribute to this important study; **it is in its final weeks**. You could also contribute by circulating the attached recruitment flyer through your networks and professional contacts.

Yours sincerely

Athalene Rosborough
Branch President

OFFICE: 3/36 Botany Street, Phillip ACT 2606
PHONE: 02 6282 9455
EMAIL: anmfact@anmfact.org.au

POSTAL: PO Box 1995, Woden. ACT 2606
FAX: 02 6282 8447
WEB: www.anmfact.org.au

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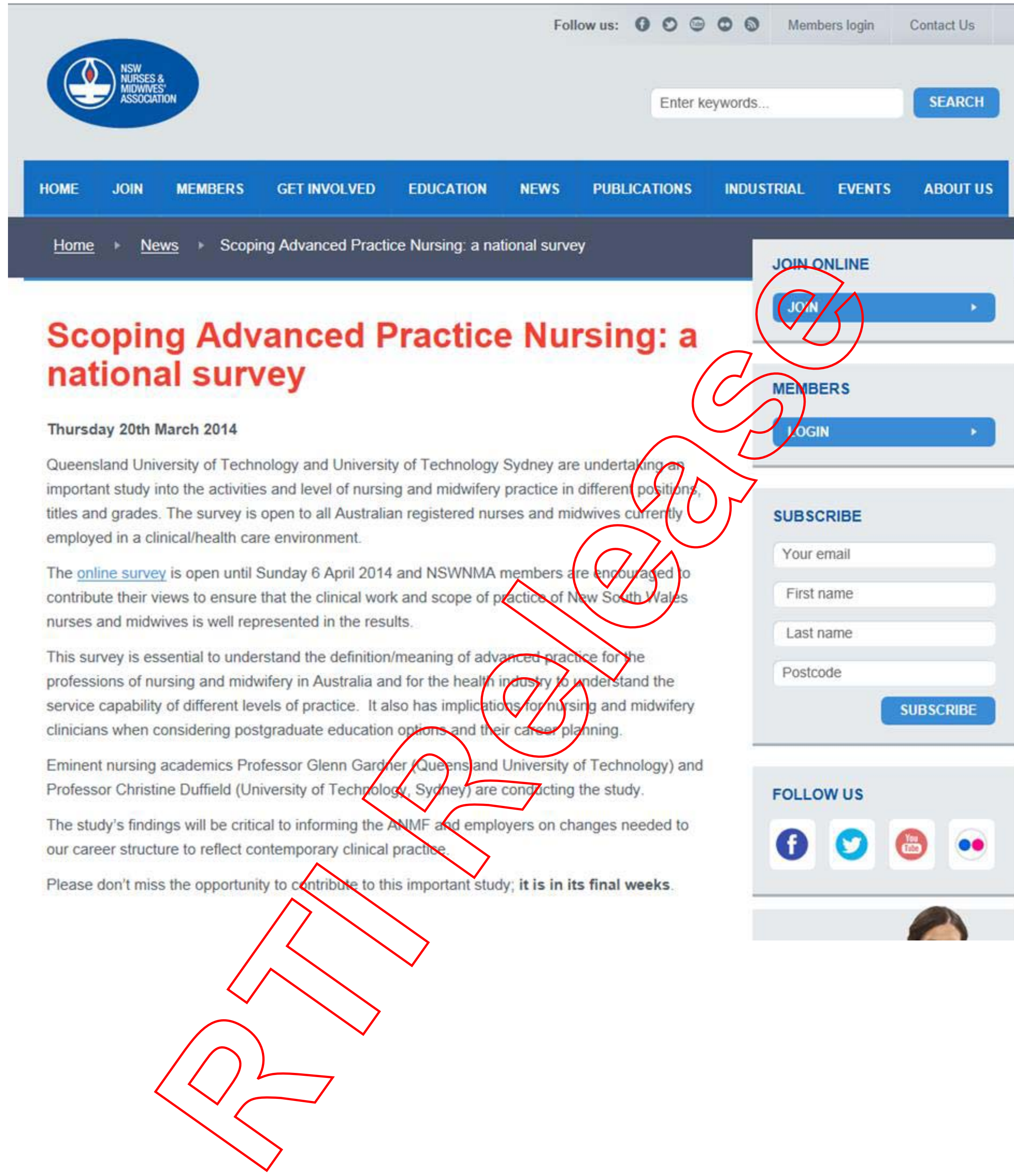
NSW promotion of the survey via UNCUT blog



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NSW NURSES & MIDWIVES' ASSOCIATION

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Home ▸ News ▸ Scoping Advanced Practice Nursing: a national survey

Scoping Advanced Practice Nursing: a national survey

Thursday 20th March 2014

Queensland University of Technology and University of Technology Sydney are undertaking an important study into the activities and level of nursing and midwifery practice in different positions, titles and grades. The survey is open to all Australian registered nurses and midwives currently employed in a clinical/health care environment.

The online survey is open until Sunday 6 April 2014 and NSWNMA members are encouraged to contribute their views to ensure that the clinical work and scope of practice of New South Wales nurses and midwives is well represented in the results.

This survey is essential to understand the definition/meaning of advanced practice for the professions of nursing and midwifery in Australia and for the health industry to understand the service capability of different levels of practice. It also has implications for nursing and midwifery clinicians when considering postgraduate education options and their career planning.

Eminent nursing academics Professor Glenn Gardner (Queensland University of Technology) and Professor Christine Duffield (University of Technology, Sydney) are conducting the study.

The study's findings will be critical to informing the ANMF and employers on changes needed to our career structure to reflect contemporary clinical practice.

Please don't miss the opportunity to contribute to this important study; **it is in its final weeks**.

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JOIN ▸

MEMBERS

LOGIN ▸

SUBSCRIBE

Your email

First name

Last name

Postcode

SUBSCRIBE

FOLLOW US

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SA Branch Promotion article "*intouch*" March 2014"

Pictured: Glenn Gardner

STUDY TO CLEAR CONFUSION ON ADVANCED PRACTICE NURSING AND MIDWIFERY

What is the difference between a specialist nurse, a nurse practitioner and advanced practice nurse or midwife?

Researchers from Queensland and Sydney aim to survey as many of Australia's 250,000 Registered Nurses, Nurse Practitioners and Midwives as possible to find the answers.

Sponsored by the ANMF, the project aims to achieve consistency over the title of advanced practice nursing Australia-wide to enable educators, employers, regulators, nurses and midwives to have clearly defined roles across all States.

Study leader, Clinical Nursing Professor Glenn Gardner of the Queensland University of Technology (QUT), says it is a topic she has been researching with University of Technology Sydney (UTS) Centre for Health Services Management Professor Christine Duffield, and others, for about eight years.

Prof Gardner said advanced practice nursing and midwifery meanings were currently ambiguous, lacked consistency and were variously defined.

"We know the nurses that move into positions we call advanced practice nursing are called a variety of things including clinical nursing consultants (CNCs) or clinical nursing specialists (CNSs), but there's building confusion certainly within Australia and internationally," she said.

"The many definitions that are offered reflect elements of advanced practice nursing. They speak to the values and practices that we all recognise as central to the best of nursing and midwifery practice. But these definitions are not drawn from robust research that asks the question of what is advanced practice to the Australian nursing and midwifery population."

Survey participants will be asked questions about a broad range of activities across clinical and non-clinical areas of their practice.

Objectives of the national survey are to:

- Map the titles and roles of advanced practice nursing across the eight Australian states and territories.
- Delineate advanced practice from the foundation practice of the registered nurse and midwife and the advanced extended nurse practitioner.

Prof Gardner said the challenge for the study was to break the nexus between advanced practice and specific nursing and midwifery roles and titles.

"We need to delineate advanced practice from the foundation practice of the registered nurse and the advanced extended practice of the nurse practitioner," she said.

"This planned survey is essential for Australian nursing and midwifery to achieve clarity for the professions and the health industry relating to the service capability of different levels of practice. It also has implications for nursing and midwifery clinicians in career planning and postgraduate education options."

ANMF (SA Branch) members who are registered nurses or midwives are strongly encouraged to participate in this defining research, with a report due to be published around September 2014.

The survey is available at http://survey.qut.edu.au/f/179050/1289 until April 6 or alternatively by the link on our website at www.anmfsa.org.au

More information on the survey and project can be gained through the project coordinator Marg Adams on m5.adams@qut.edu.au

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Promotion via the Australian College of Nursing eNewsletter

The Australian Nursing/Midwifery Workforce Survey

A message from the CEO

Within the nursing profession in Australia and the workplace there is often much discussion and, at times, confusion about what constitutes advanced practice. Glenn Gardner FACN and Christine Duffield FACN are undertaking critical research to assist the profession in gaining clarity on this issue. This will be of great value as we move forward with changing roles and service models and in ensuring we can see nurses providing care to the full extent of their individual capability. Please see the following information from Glenn and Christine, and I urge those of you in clinical practice to participate in this important research.

Debra Thoms FACN (DLF)

Have you heard about The Australian Nursing/Midwifery Workforce Survey?

We are conducting an e-survey to investigate the activities and level of nursing and midwifery practice in different positions, titles and grades. The survey is open to all Australian registered nurses and midwives currently employed in a clinical/health care environment.

The survey findings will help clarify the definition/meaning of advanced practice for the profession of nursing and for the health industry to better understand the service capability of nursing. It also has implications for nurses when considering postgraduate education options and career planning.

But we need many, many nurses to participate in the survey.

How can you help? If you work in a clinical service environment, you can complete the short 10-15 minute survey by logging on to the following link; http://survey.qut.edu.au/f/179050/1289. You can also help by circulating this email through your networks and professional contacts.

If you have any questions about the survey, please email Project Coordinator Marg Adams at m5.adams@qut.edu.au. QUT Ethics Approval Number: 1300000748

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Dear Colleague

SCOPING ADVANDED PRACTICE NURSING: A NATIONAL SURVEY

The Australian Nursing and Midwifery Accreditation Council (ANMAC) is supporting research that is being conducted to define the practice parameters of advanced practice nursing/midwifery. Access to evidence based definitions and evaluation frameworks for advanced practice in Australia will contribute to ANMAC's capacity to prepare clear nursing and midwifery education program accreditation standards that have reliable operational definitions.

The project is being conducted by Professor Glenn Gardner (Queensland University of Technology) and Professor Christine Duffield (University of Technology, Sydney) and is funded by the Australian Nursing and Midwifery Federation.

The study is a national e-survey of nurses and midwives. The aim is to discover and define the activities and level of nursing and midwifery practice in different positions, titles and grades nationally. Ethics approval has been obtained from both participating universities [Queensland University of Technology Ethics approval no.1300000748].

This survey is essential to understand the definition/meaning of advanced practice for the professions of nursing and midwifery in Australia and for the health industry to understand the service capability of different levels of practice. It also has implications for nursing and midwifery clinicians when considering postgraduate education options and their career planning.

A Snowball sampling strategy is being used to recruit registered nurses and midwives across all Australian states and territories. I have attached a recruitment flyer that has information on the study and instructions for access to the questionnaire.

To ensure that every eligible nurse and midwife has the opportunity to participate in this defining research, we are seeking your support to participate in the survey yourself and pass on the attached recruitment flyer to registered nurse, nurse practitioner and midwife colleagues in your networks.

The 'go live' date for the survey is 19 February 2014 to 6 April 2014.

Kind regards

Amanda Adrian

Amanda Adrian
CHIEF EXECUTIVE OFFICER
AUSTRALIAN NURSING AND MIDWIFERY ACCREDITATION COUNCIL
30 January 2014

Attachment:

- Recruitment flyer – *Scoping Advanced Practice Nursing: A National Survey*

20140130_APN_ANMAC_survey_email_to_assessors.docx

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DOH-DL 15/16-032 RTI Document 397

Advanced Practice Nursing: A title, a role or level of practice?

Australia is preparing for an ambitious and inclusive study into advanced practice nursing and midwifery.

Nurses and midwives currently working in the Australian health system know about the confusion surrounding the title of advanced practice nursing and that the meaning of advanced practice is ambiguous. The many definitions that are offered reflect elements of advanced practice nursing but are not drawn from robust research that takes the question of what is advanced practice to the Australian nursing and midwifery population.

The problem is particularly relevant for nurses working in primary health care where practice by necessity often draws on advanced skills and knowledge but there is no mechanism or framework available for nurses to demonstrate their advanced level of practice.

One advanced practice role that does have certainty, definition and evidence-based standards is the nurse practitioner. This is a specific level and type of practice that is protected and defined by a legislative and practice framework. But this role differs in many ways from other advanced practice roles particularly in the practice scope that is outside the registered nurse scope of practice.

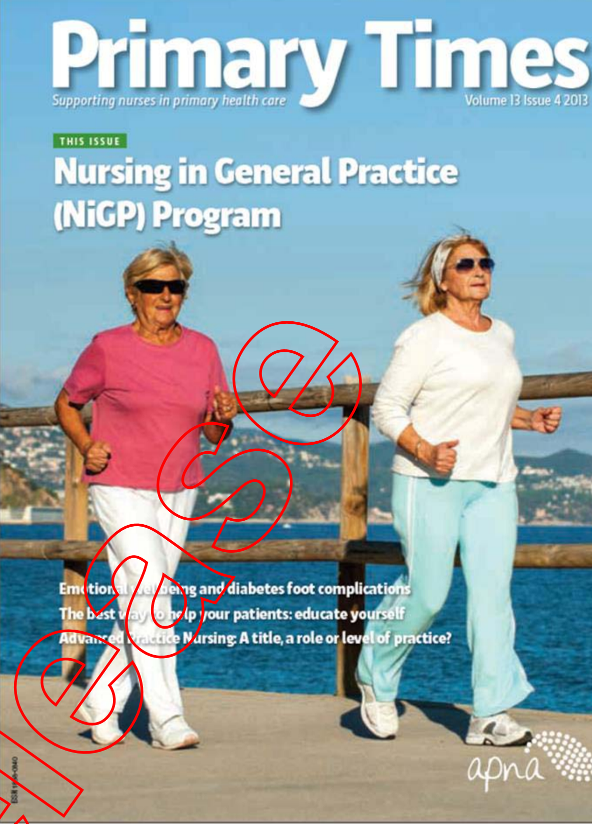
The challenge now is to break the nexus between advanced practice and specific nursing/midwifery roles and titles.

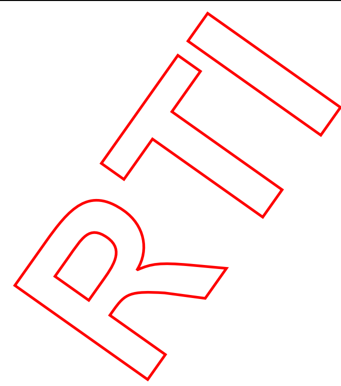
Early in 2014 there will be a national survey of all Australian registered nurses and midwives. This survey will achieve two objectives:

I. To map the titles and roles of advanced practice nursing across the eight Australian states and territories, and
II. To delineate advanced practice from the foundation practice of the registered nurse/midwife and the advanced extended practice of the nurse practitioner.

This planned survey is essential for Australian nursing and midwifery to achieve clarity for the professions and the health industry relating to the service capability of different levels of practice. It also has implications for nursing and midwifery clinicians career planning and postgraduate education options.

The national census will allow every nurse and midwife in Australia the opportunity to participate in this defining research. There will be further informati about the survey in the new year through the *Primary Times* and other publications. Meanwhile, if you woul like more information about the survey you can conta Glenn Gardner by emailing ge.gardner@qut.edu.au o Christine Duffield by emailing christine.duffield@uts.edu.au.

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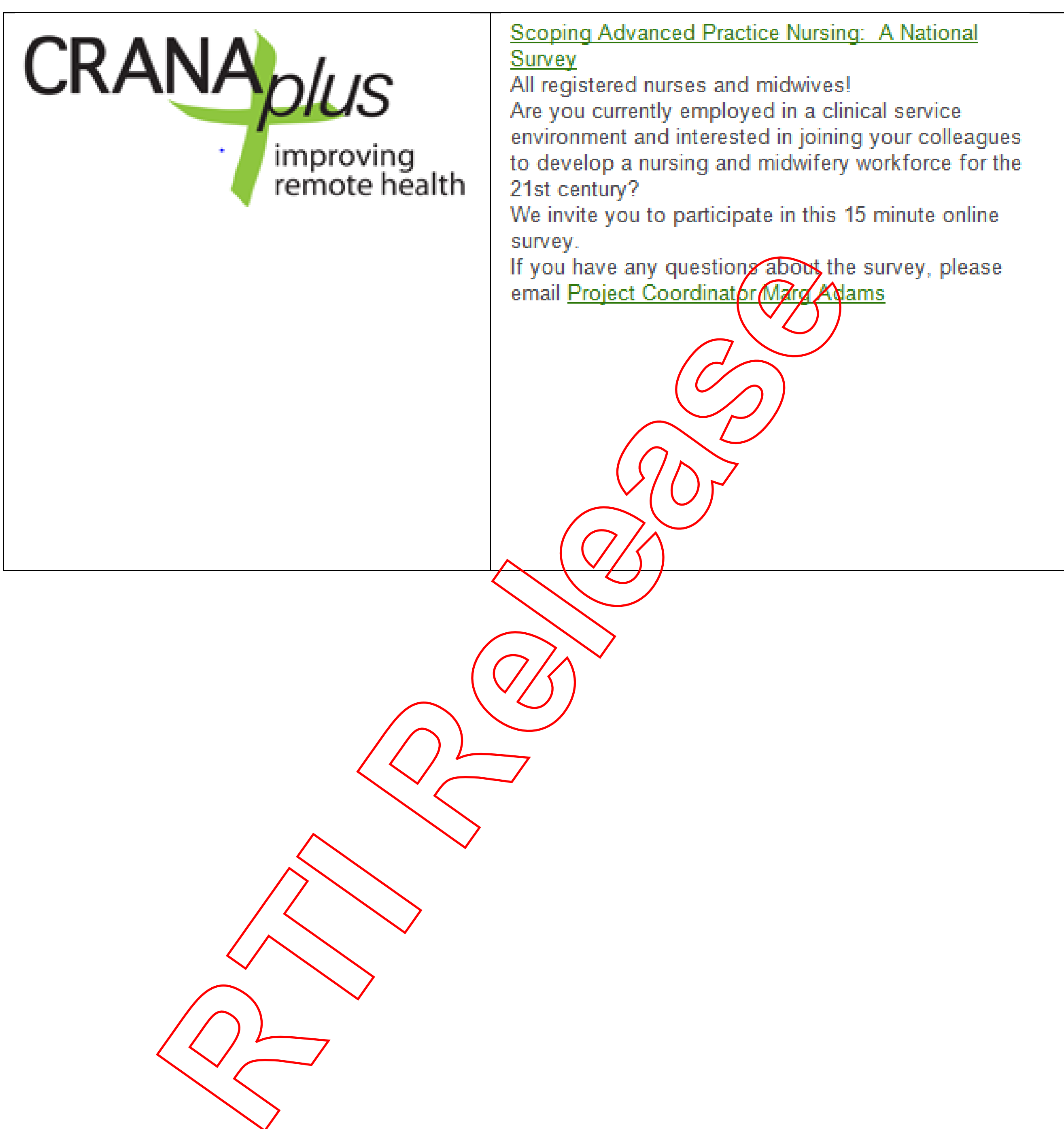
CRANAplus hosted the hyperlink and details of the survey in weekly eNewsletters



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Promotion of the study and survey link via CareSearch nurses Hub news March

CareSearch
nurses[HUB]news

March 2014 www.caresearch.com.au

The nurses[HUB]news keeps you in touch with what's happening. Find out about:

- Case Study: Rural and Remote
- Pharmacy update: Clonazepam
- Service Profile: Territory Palliative Care, Central Australia
- Project Summary: Carers' perspectives on, and expectations of, the use of long-term home oxygen therapy for the treatment of refractory breathlessness.

What's new!

Close the Gap – Progress and Priorities Report 2014

This Progress and Priorities report finds that achieving Aboriginal and Torres Strait Islander health and life expectancy equality by 2030 is a possibility. The Close the Gap Campaign Steering Committee is advocating to ensure policy continuity in critical areas of the national effort to close the gap, and to also take further steps in building on and strengthening the existing platform.

Research study

The Australian Nursing and Midwifery Federation (ANMF) are conducting a survey of all Australian registered nurses and midwives currently employed in a clinical service environment. This study is being led by Professor Glenn Gardner (Queensland University of Technology) and Professor Christine Duffield (University of Technology, Sydney) and is essential to understanding the definition of advanced practice for the professions of nursing and midwifery in Australia. It also has implications for nursing and midwifery clinicians when considering postgraduate education options and their career planning. The survey is open until April 6, 2014. Contact Marg Adams for further information: 07 3138 1930 m5.adams@qut.edu.au or read the study flyer for more information.

Conferences

The 'Living, Dying & Grieving Well' Palliative Care Victoria Conference 2014 will be held on 31 July – 1 August.

The PCNA 2014 conference has updated its program. You can see the program on the conference website.

Did you know?

The Lowitja Institute (Australia's National Institute for Aboriginal and Torres Strait Islander Health Research has its own search tool (search filter) that provides easy access to Aboriginal and Torres Strait Islander health literature on PubMed.

Something to read

Ishikawa H, Ogihara N, Tsukushi S, Sakamoto J. Withdrawal from Dialysis and Palliative Care for Severely Ill Dialysis Patients in terms of Patient-Centered Medicine. Case Rep Nephrol. 2013; 2013:761691. Epub 2013 Dec 4.

The authors cite a case of a dementia patient with end stage chronic kidney disease (CKD) who had peritoneal dialysis (PD) as renal replacement therapy. They describe the difficulties encountered, including a burden on caregivers and the treatment complications. They considered that palliative care prior to intensive care may have been an optional treatment, however were unable to confirm the patient's preference for end-of-life care due to his dementia. The patient's family accepted withdrawal from dialysis (WD). The authors concluded that the end-of-life care they provided contributed to a peaceful and dignified death and that although intensive care based on assessment of disease is important, there is a limitation to care. They concluded that WD and palliative care are acceptable options for care of our patients in the terminal phase of their lives.

Somewhere to visit

The Australian Indigenous Health*InfoNet* is an innovative Internet resource that aims to inform practice and policy in Indigenous health by making research and other knowledge readily accessible. In this way, we contribute to 'closing the gap' in health between Indigenous and other Australians. Palliative care information can also be sourced here.

Newsletter basics

Follow this link to subscribe to, or email newsletter@caresearch.com.au to unsubscribe from the newsletter. The next edition will be sent on Wednesday 16 April 2014. To share something, please email caresearch@flinders.edu.au

You can view all the CareSearch promotional resources and download an order form here.

CareSearch is funded by the Australian Government Department of Health.

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Australian College of Nurse Practitioners hosted survey on homepage

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Appendix II

Survey Instrument

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APN Role Delineation Tool

Section A: Demographic Data

Please answer each of the following questions by clicking on the most appropriate response.

1. What is your age group:	**2.** What is your sex:
☐ 20-29yrs ☐ 30-39yrs ☐ 40-49yrs ☐ 50-59yrs ☐ 60-69yrs ☐ 70yrs and over	☐Male ☐Female
****3.** Indicate the State/Territory where you work: ☐QLD → QLD survey ☐NSW → NSW survey ☐VIC → VIC survey ☐ACT → ACT survey ☐TAS → TAS survey ☐SA → SA survey ☐WA → WA survey ☐NT → NT survey **Participants will click on their State or Territory then progress to State/Territory specific Q4 and Q5 and rest of survey.	****4.** Please indicate your current title/position: ☐ Qld – appendix 1 (page 9) ☐ NSW – appendix 2 (page 10) ☐ VIC – appendix 3 (page 11) ☐ ACT – appendix 4 (page 12) ☐ TAS – appendix 5 (page 13) ☐ SA – appendix 6 (page 14) ☐ WA – appendix 7 (page 15) ☐ NT – appendix 8 (page 16)
****5.** Please select your current classification: ☐ Qld – appendix 1 (page 9) ☐ NSW – appendix 2 (page 10) ☐ VIC – appendix 3 (page 11) ☐ ACT – appendix 4 (page 12) ☐ TAS – appendix 5 (page 13) ☐ SA – appendix 6 (page 14) ☐ WA – appendix 7 (page 15) ☐ NT – appendix 8 (page 16)	**6.** Please type the number of years as Registered Nurse/Midwife: ……………………………Years **7.** Please type the number of years in current position: ……………………………Years

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8. What is your highest level of education	**9.** Please indicate your current practice setting:
☐ Hospital Certificate ☐ TAFE Certificate ☐ Diploma ☐ BN or equivalent ☐ Post Graduate Certificate ☐ Post Graduate Diploma ☐ Masters ☐ PhD ☐ If education is in a field other than nursing – Please specify: …………………………………………	☐ Community ☐ Hospital ☐ Aged Care ☐ Academic ☐ Other – Please specify: ………………………………………………..
10. What sector are you currently working in: ☐ Public ☐ Private ☐ Non-Government Organisation (NGO) ☐ Sole Trader ☐ Other – Please specify	11. Please indicate your region of work: ☐ Metropolitan ☐ Regional ☐ Rural and Remote ☐ Other – Please specify
12. Are you a member of the following association/s or organisation/s? If yes, select all that apply. ☐ No ☐ Yes ☐ Australian College of Nurse Practitioners (ACNP) ☐ Australian Primary Healthcare Nurses Association (APNA) ☐ Australian Nursing and Midwifery Federation (ANMF) ☐ NSW Nurses and Midwives' Association ☐ Queensland Nurses Union (QNU) ☐ Australian College of Nursing (ACN) ☐ Australasian Sexual Health & HIV Nurses Association (ASHHNA) ☐ College of Remote Area Nurses Inc. (CRANAplus) ☐ Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) ☐ Australasian Hepatology Association	☐ Royal District Nursing Service (RDNS) ☐ Australian College of Operating Room Nurses (ACORN) ☐ Australian College of Neonatal Nurses ☐ Australian College of Children and Young People's Nurses (ACCYPN) ☐ Australian Wound Management Association (AWMA) ☐ Cancer Nurses Society of Australia (CNSA) ☐ Palliative Care Nurses Australia (PCNA) ☐ Renal Society of Australasia ☐ Thoracic Society of Australia and New Zealand (TSANZ) ☐ Australian College of Mental Health Nurses Inc. (ACMHN) ☐ Australian College of Midwives ☐ Other – please specify…….

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Section B: APN Activities

For each of the following activities, please indicate the extent of time, in your **current position**, that you would spend on each one, by placing a tick in the corresponding box. The scale for Section B is as follows:

4 = To a very great extent; 3 = To a great extent; 2 =To some extent; 1 = To a little extent; 0 = Not at all.

Item from QNC Study tool (43items): Section B Item 3		Very great extent	Great extent	Some extent	Little extent	Not at all
DOMAIN 1: DIRECT COMPREHENSIVE CARE		**4**	**3**	**2**	**1**	**0**
1.1	Conduct and document patient history and physical examination					
1.2	Assess psychosocial, cultural and religious factors affecting patient needs					
1.3	Make a medical diagnosis within specialty scope of practice and practice guidelines					
1.4	Identify and initiate required diagnostic tests and procedures					
1.5	Gather and interpret assessment data to formulate plan of care					
1.6	Perform specialty-specific care and procedures					
1.7	Assess patient/family response to therapy and modify plan of care based on response					
1.8	Communicate plan of care and response to patient/family					
1.9	Provide appropriate education (counselling) to patient & family					
1.10	Document appropriately on patient record					
1.11	Serve as a consultant in improving patient care and nursing/midwifery practice based on expertise in area of specialisation					
1.12	Facilitate the process of ethical decision making in patient care					
1.13	Coordinate interdisciplinary plan for care of patients					
1.14	Collaborate with other services to optimise patient's health status					
1.15	Facilitate efficient movement of patient through healthcare system					

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SECTION B: APN ACTIVITIES	Very great extent	Great extent	Some extent	Little extent	Not at all
DOMAIN 2: SUPPORT OF SYSTEMS	**4**	**3**	**2**	**1**	**0**
2.1 Consult with others regarding conduct of projects or presentations					
2.2 Contribute to, consult or collaborate with other healthcare personnel on recruitment and retention activities					
2.3 Participate in strategic planning for the service, department or hospital					
2.4 Provide direction for and participation in unit/service quality improvement programs					
2.5 Actively participate in the assessment, development, implementation, and evaluation of quality-improvement programs in collaboration with nursing/midwifery leadership					
2.6 Provide leadership in the development, implementation, and evaluation of standards of practice, policies and procedures					
2.7 Serve as a mentor					
2.8 Advocate the role of the nurse/midwife					
2.9 Serve as a spokesperson for nursing/midwifery and the health facility when interacting with other professionals, patients, families, and the public					

SECTION B: APN ACTIVITIES	Very great extent	Great extent	Some extent	Little extent	Not at all
DOMAIN 3: EDUCATION	**4**	**3**	**2**	**1**	**0**
3.1 Evaluate education programs and recommend revision as needed					
3.2 Serve as educator and clinical preceptor for nursing/midwifery and/or medical students, staff, and/or others					
3.3 Identify learning needs of various populations and contribute to the development of educational programs/resources					
3.4 Serve as informal educator to staff while providing direct care activities					
3.5 Facilitate professional development of nursing/midwifery staff through education					
3.6 Provide appropriate patient and family education					

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SECTION B: APN ACTIVITIES		Very great extent	Great extent	Some extent	Little extent	Not at all
DOMAIN 4: RESEARCH		**4**	**3**	**2**	**1**	**0**
4.1	Conduct clinical research					
4.2	Participate in audits to monitor and improve quality of patients care practices					
4.3	Contributes to identification of potential funding sources for the development and implementation of clinical projects/programs					
4.4	Uses research evidence to guide practice and policy changes					
4.5	Identify the clinical data that needs to be collated and available in information systems for nursing and midwifery research and quality assurance projects					
4.6	Collaborate with Information Specialists in the design of information systems for research and quality assurance projects in nursing and midwifery					

SECTION B: APN ACTIVITIES		Very great extent	Great extent	Some extent	Little extent	Not at all
DOMAIN 5: PUBLICATION AND PROFESSIONAL LEADERSHIP		**4**	**3**	**2**	**1**	**0**
5.1	Disseminate nursing/midwifery knowledge through presentation or publication at local, regional, national and international levels					
5.2	Serve as a resource or committee member in professional organisations					
5.3	Serve as a consultant to individuals and groups within the professional/lay communities and other hospitals/institutions					
5.4	Represent nursing/midwifery in institutional/community forums focused on the educational needs of various populations					
5.5	Represent a professional nursing/midwifery image at institutional and community forums					
5.6	Collaborate with other healthcare professionals to provide leadership in shaping public policy on healthcare					

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Section C: Domains of Practice

Previous research has identified the activities of an APN fall within **five domains of practice**.

Now that you have examined the activities of an APN and after reading the explanation of each domain of practice below, **please indicate the extent of time you spend working within each domain, by ticking the corresponding box**. The scale for Section C is as follows:

4 = To a very great extent; 3 = To a great extent; 2 =To some extent; 1 = To a little extent; 0 = Not at all.

DOMAIN OF PRACTICE	Very great extent	Great extent	Some extent	Little extent	Not at all
	4	3	2	1	0
Domain 1: Direct, Comprehensive Care Activities carried out on behalf of individual patients, focusing on their specific needs. These are 'hands on' activities such as procedures, assessments, interpretation of data, providing physical care and patient counselling.					
Domain 2: Support of Systems Activities that support systems that promote innovative patient care and facilitate the optimal progression of patients through the healthcare system. Role advocacy is also an important component of systems support.					
Domain 3: Education Activities involving the dissemination of current scientific knowledge to caregivers and students to enhance their knowledge. Also, education is the provision of information to inform the public and enable them to cope with illness, as well as to promote wellness. This domain incorporates a wide variety of activities including education of undergraduate and graduate students, informal staff development, education of house staff, and formal presentations to other healthcare professionals.					
Domain 4: Research Activities that support the generation of knowledge and the integration of research findings into clinical practice. Such activities support a culture of practice that challenges the norm and strives to find better ways to provide care, based on research. This domain also promotes the use of creativity and innovative problem-solving strategies to answer clinical questions.					
Domain 5: Publication and Professional Leadership Activities that allow for sharing and dissemination of knowledge within an area of expertise that is beyond the individual's institutional setting. It extends beyond the confines of the workplace and requires commitment to the profession and to the profession's public. The activities within this domain are intended to promote the nursing and healthcare profession.					

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Appendix 1: Queensland Questions 4 & 5

3. Please indicate place of work:	**4.** Please select your current title/position:
☐QLD ⟶ QLD survey	☐ Registered Nurse ☐ Registered Midwife ☐ Clinical Nurse ☐ Clinical Nurse Consultant ☐ Nurse Educator ☐ Nurse Researcher ☐ Nurse Unit Manager ☐ Nurse Practitioner ☐ Assistant Director of Nursing/Nursing Director ☐ Director of Nursing ☐ District Director of Nursing ☐ Executive Director of Nursing ☐ Other – Please specify……………....
5. Please select your current nursing/midwifery classification: ☐Grade 1 ☐Band 1 ☐Pay point 1 ☐Grade 2 ☐Band 2 ☐Pay point 2 ☐Grade 3 ☐Brand 3 ☐Pay point 3 ☐Grade 4 ☐Band 4 ☐Pay point 3 ☐Grade 5 ☐Pay point 4 ☐Grade 6 ☐Pay point 5 ☐Grade 7 ☐Pay point 6 ☐Grade 9 ☐Grade 10 ☐Grade 11 ☐Grade 12 ☐Other – Please specify………………	

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Appendix 2: New South Wales Questions 4 & 5

<table>
<tr>
<td>

3. Please indicate place of work:

☐NSW ⟶ NSW survey

</td>
<td>

4. Please select your current title/position:

☐ Registered Nurse
☐ Registered Midwife
☐ Clinical Nurse Specialist
☐ Clinical Midwife Specialist
☐ Clinical Nurse Consultant
☐ Clinical Midwife Consultant
☐ Clinical Nurse Educator
☐ Clinical Midwife Educator
☐ Nurse Educator
☐ Midwife Educator
☐ Nurse Unit Manager
☐ Midwifery Unit Manager
☐ Nurse Manager
☐ Midwife Manager
☐ Nurse Practitioner
☐ Midwife Practitioner
☐ Registered Mothercraft Nurse
☐ Other – Please specify……………..

</td>
</tr>
<tr>
<td>

5. Please select your current nursing/midwifery classification:

☐ 1st Year	☐Grade 1	☐Level 1
☐ 2nd Year	☐Grade 2	☐Level 2
☐ 3rd Year	☐Grade 3	☐Level 3
☐ 4th Year	☐Grade 4	
☐ 5th Year	☐Grade 5	
☐ 6th Year	☐Grade 6	
☐ 7th Year	☐Grade 7	
☐ 8th Year	☐Grade 8	
☐ 9th Year	☐Grade 9	

☐Other – Please specify……………..

</td>
<td></td>
</tr>
</table>

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Appendix 3: Victoria Questions 4 & 5

3. Please indicate place of work:	**4.** Please select your current title/position:
☐VIC → VIC survey	☐ Registered Nurse ☐ Registered Midwife ☐ Clinical Consultant A-E ☐ Clinical Nurse Specialist ☐ Clinical Support Nurse ☐ Clinical Midwife Specialist ☐ Nurse Unit Manager ☐ Director of Nursing ☐ Deputy Director of Nursing ☐ Assistant Director of Nursing ☐ Nurse Educator ☐ District Nurse ☐ Occupational Health Nurse ☐ Community Health Nurse ☐ Nurse Practitioner candidate ☐ Nurse Practitioner ☐ Other – Please specify…………………..
5. Please select your current nursing/midwifery classification: ☐Grade 2 ☐Year 1 ☐Grade 3A ☐Year 2 ☐Grade 3B ☐Year 3 ☐Grade 4A ☐Year 4 ☐Grade 4B ☐Year 5 ☐Grade 5 ☐Year 6 ☐Grade 6 ☐Year 7 ☐Grade 7 ☐Year 8 ☐Year 9 ☐Year 10 ☐Other – Please specify………………	

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Appendix 4: ACT Questions 4 & 5

<table>
<tr>
<td>3. Please indicate place of work:

☐ACT ⟶ ACT survey</td>
<td>4. Please select your current title/position:
☐ Registered Nurse
☐ Registered Midwife
☐ Nurse Practitioner
☐ Clinical Nurse
☐ Nurse Educator
☐ Nurse Coordinator
☐ Advanced Practice Nurse
☐ Clinical Nurse Coordinator
☐ Assistant Director of Nursing
☐ Director of Nursing
☐ Director of Midwifery
☐ Midwife Consultant
☐ Midwifery Educator/Nurse Manager
☐ Other – Please specify……………………</td>
</tr>
<tr>
<td>5. Please select your current nursing/midwifery classification:
☐Level 1 ☐Year 1 ☐Grade 1
☐Level 2 ☐Year 2 ☐Grade 2
☐Level 3 ☐Year 3 ☐Grade 3
☐Level 4 ☐Year 4 ☐Grade 4
☐Level 5 ☐Year 5 ☐Grade 5
☐Year 6 ☐Grade 6
☐Year 7
☐Year 8

☐Other – Please specify………………</td>
<td></td>
</tr>
</table>

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Appendix 5: TAS Questions 4 & 5

<table>
<tr>
<td>3. Please indicate place of work:

☐TAS ⟶ TAS survey</td>
<td>4. Please select your current title/position:
☐ Registered Nurse
☐ Registered Midwife
☐ Clinical Nurse Consultant
☐ Staff Development Nurse
☐ Specialist Nurse
☐ Clinical Nurse Educator
☐ Nurse Manager
☐ Nurse Practitioner
☐ Assistant Director of Nursing – clinical
☐ Assistant Director of Nursing – management
☐ Assistant Director of Nursing – staff development
☐ Chief Nursing Officer
☐ Director of Nursing
☐ Other – Please specify……………………..</td>
</tr>
<tr>
<td>5. Please select your current nursing/midwifery classification:
☐Level 1 ☐Grade 1
☐Level 2 ☐Grade 2
☐Level 3 ☐Grade 3
☐Level 4 ☐Grade 4
☐Level 5 ☐Grade 5
☐Grade 6
☐Other – Please specify………………..</td>
<td></td>
</tr>
</table>

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Appendix 6: SA Questions 4 & 5

<table>
<tr>
<td>3. Please indicate place of work:

☐SA ⟶ SA survey</td>
<td>4. Please select your current title/position:
☐ Registered Nurse
☐ Registered Midwife
☐ Clinical Nurse/Midwife
☐ Associate Clinical Service Coordinator
☐ Nurse/Midwife Clinical Service Coordinator
☐ Nurse/Midwife Clinical Practice Consultant Nurse/
☐ Nurse/Midwife Education Facilitator
☐ Nurse/Midwife Management Facilitator
☐ Nurse/Midwife Practitioner
☐ Nursing/Midwifery Director
☐ Director of Nursing/Midwifery
☐ Other – Please specify…………….</td>
</tr>
<tr>
<td>5. Please select your current nursing/midwifery classification:
☐Level 1 ☐1st increment
☐Level 2 ☐ 2nd increment
☐Level 3 ☐ 3nd increment
☐Level 4 ☐ 4th increment
☐Level 5 ☐ 5th increment
☐Level 6 ☐ 6th increment

☐Other – Please specify……………….</td>
<td></td>
</tr>
</table>

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WA Questions 4 & 5

3. Please indicate place of work:	**4.** Please select your current title/position:
☐WA ——→ WA survey	☐ Registered Nurse ☐ Registered Midwife ☐ Clinical Nurse ☐ Clinical Midwife ☐ Staff Development nurse ☐ Staff Development midwife ☐ Area Manager ☐ Clinical nurse manager ☐ Clinical midwifery manager ☐ Clinical nurse specialist ☐ Clinical midwifery specialist ☐ Clinical nurse consultant ☐ Clinical midwifery consultant ☐ Nurse manager ☐ Midwifery manager ☐ Staff development educator ☐ Nurse practitioner ☐ Nursing director/co-director ☐ Midwifery director/co-director ☐ Other – Please specify……………………
5. Please select your current nursing/midwifery classification: ☐Level 1 ☐1st increment ☐Level 2 ☐2nd increment ☐Level 3 ☐3rd increment ☐Level 4 ☐4th increment ☐Level 5 ☐Level 6 ☐Level 7 ☐Level 8 ☐Level 9 ☐Level 10 ☐Other – Please specify………………	

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NT Questions 4 & 5

3. Please indicate place of work: ☐NT ⟶ NT survey	**4.** Please select your current title/position: ☐ Registered Nurse ☐ Registered Midwife ☐ Nurse Practitioner ☐ Other – Please specify……………..
5. Please select your current Nursing Level: ☐Nurse 2 ☐Nurse 3 ☐Nurse 4 ☐Nurse 5 ☐Nurse 6 ☐Nurse 7 ☐Nurse 8 ☐Other – Please specify………………	

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Appendix III

Ethics Approval Documents

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University Human Research Ethics Committee

HUMAN ETHICS APPROVAL CERTIFICATE

NHMRC Registered Committee Number EC00171

Date of Issue: 27/11/13 (supersedes all previously issued certificates)

Dear Prof Glenn Gardner

A UHREC should clearly communicate its decisions about a research proposal to the researcher and the final decision to approve or reject a proposal should be communicated to the researcher in writing. This Approval Certificate serves as your written notice that the proposal has met the requirements of the *National Statement on Research involving Human Participation* and has been approved on that basis. You are therefore authorised to commence activities as outlined in your proposal application, subject to any specific and standard conditions detailed in this document.

Within this Approval Certificate are:

* Project Details
* Participant Details
* Conditions of Approval (Specific and Standard)

Researchers should report to the UHREC, via the Research Ethics Coordinator, events that might affect continued ethical acceptability of the project, including, but not limited to:

(a) serious or unexpected adverse effects on participants; and
(b) proposed significant changes in the conduct, the participant profile or the risks of the proposed research.

Further information regarding your ongoing obligations regarding human based research can be found via the Research Ethics website http://www.research.qut.edu.au/ethics/ or by contacting the Research Ethics Coordinator on 07 3138 2091 or ethicscontact@qut.edu.au

If any details within this Approval Certificate are incorrect please advise the Research Ethics Unit within 10 days of receipt of this certificate.

Project Details

Category of Approval: Human Negligible-Low Risk

Approved From: 27/11/2013 **Approved Until:** 1/02/2016 (subject to annual reports)

Approval Number: 1300000748

Project Title: Scoping advanced practice nursing: A national survey

Experiment Summary: This study will investigate, define and classify advanced practice nursing in Australia. A cross sectional survey of Australian registered nurses/midwife (RNs/Ms) will be conducted to explicate levels of roles and activities of RNs/Ms in the context of everyday practice.

Investigator Details

Chief Investigator: Prof Glenn Gardner

Other Staff/Students:

Investigator Name	Type	Role
Prof Christine Duffield	External	Partner Investigator
Mrs Margaret Adams	Internal	Project Manager

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University Human Research Ethics Committee

HUMAN ETHICS APPROVAL CERTIFICATE

NHMRC Registered Committee Number EC00171

Date of Issue: 27/11/13 (supersedes all previously issued certificates)

Conditions of Approval

Specific Conditions of Approval:
No special conditions placed on approval by the UHREC. Standard conditions apply.

Standard Conditions of Approval:
The University's standard conditions of approval require the research team to:

1. Conduct the project in accordance with University policy, NHMRC / AVCC guidelines and regulations, and the provisions of any relevant State / Territory or Commonwealth regulations or legislation;

2. Respond to the requests and instructions of the University Human Research Ethics Committee (UHREC);

3. Advise the Research Ethics Coordinator immediately if any complaints are made, or expressions of concern are raised, in relation to the project;

4. Suspend or modify the project if the risks to participants are found to be disproportionate to the benefits, and immediately advise the Research Ethics Coordinator of this action;

5. Stop any involvement of any participant if continuation of the research may be harmful to that person, and immediately advise the Research Ethics Coordinator of this action;

6. Advise the Research Ethics Coordinator of any unforeseen development or events that might affect the continued ethical acceptability of the project;

7. Report on the progress of the approved project at least annually, or at intervals determined by the Committee;

8. (Where the research is publicly or privately funded) publish the results of the project is such a way to permit scrutiny and contribute to public knowledge; and

9. Ensure that the results of the research are made available to the participants.

Modifying your Ethical Clearance:
Requests for variations must be made via submission of a Request for Variation to Existing Clearance Form (http://www.research.qut.edu.au/ethics/forms/hum/var/var.jsp) to the Research Ethics Coordinator. Minor changes will be assessed on a case by case basis.

It generally takes 7-14 days to process and notify the Chief Investigator of the outcome of a request for a variation.

Major changes, depending upon the nature of your request, may require submission of a new application.

Audits:
All active ethical clearances are subject to random audit by the UHREC, which will include the review of the signed consent forms for participants, whether any modifications / variations to the project have been approved, and the data storage arrangements.

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Appendix IV

Cluster Analysis Details & Dendrogram

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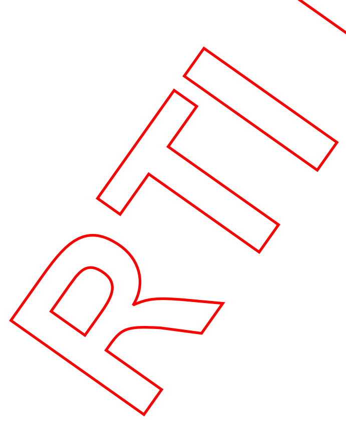
Dendrograms present the results of a cluster analysis graphically and mathematically where state nursing position titles are grouped together at various levels of similarity. The nodes of the dendrogram represent clusters at different steps of the analyses. The length of the horizontal lines provide pictorial clues about the strength of the clustering. Long horizontal lines indicate more distinct separation between the clusters. In this agglomerative hierarchical cluster analysis dendrogram, all single observations (state nursing position titles, n=66) eventually will merge into one cluster at the final step. Since cluster analysis does not provide any criteria for selecting the optimal solution for the number of clusters to be retained along with the cluster tree, the choice of the appropriate number of clusters is subjective. In this analysis, to conserve the separate clustering of the clinical nurse consultants and nurse practitioner groups, clustering was stopped at the point just before these two clustered joined giving rise to seven clusters.



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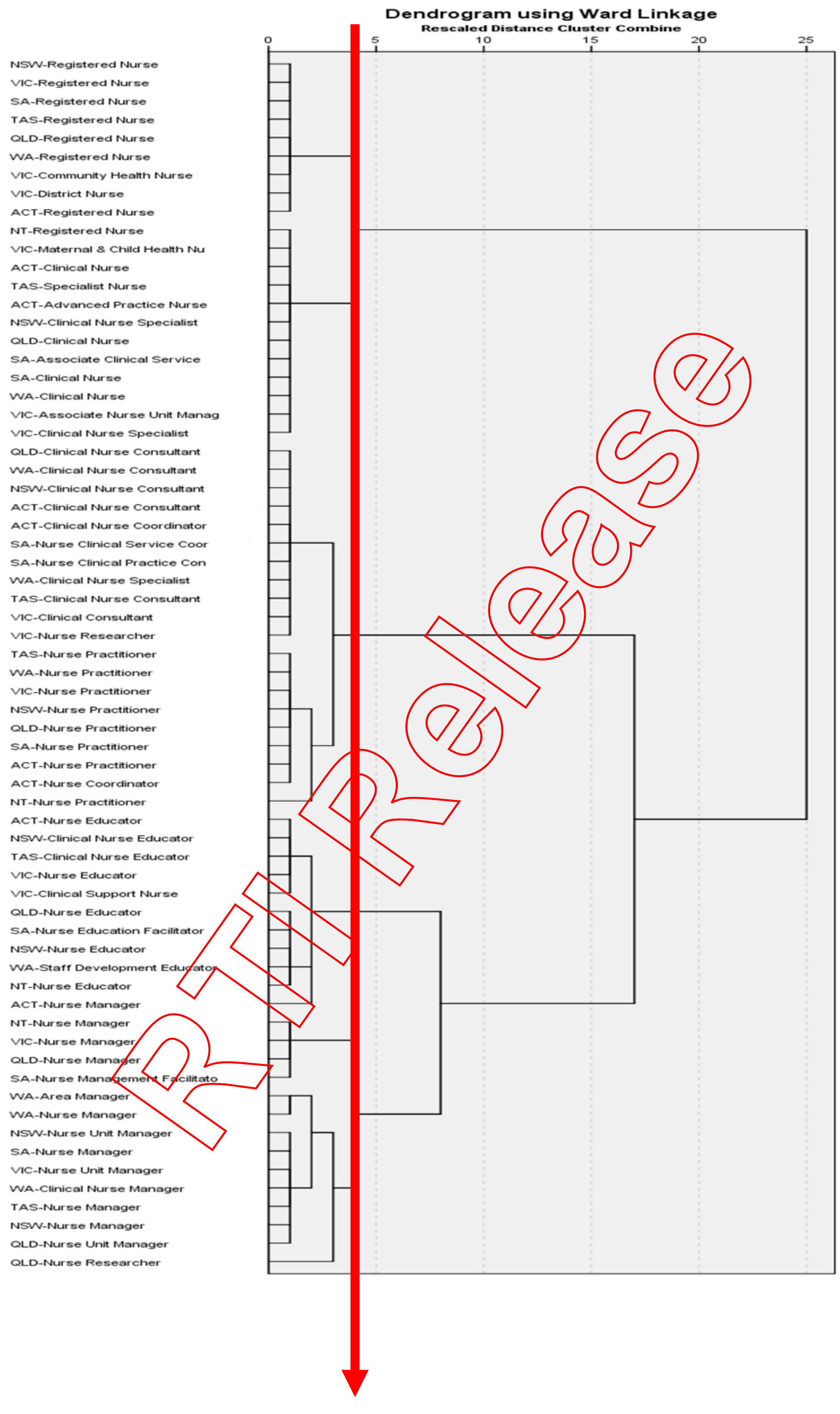

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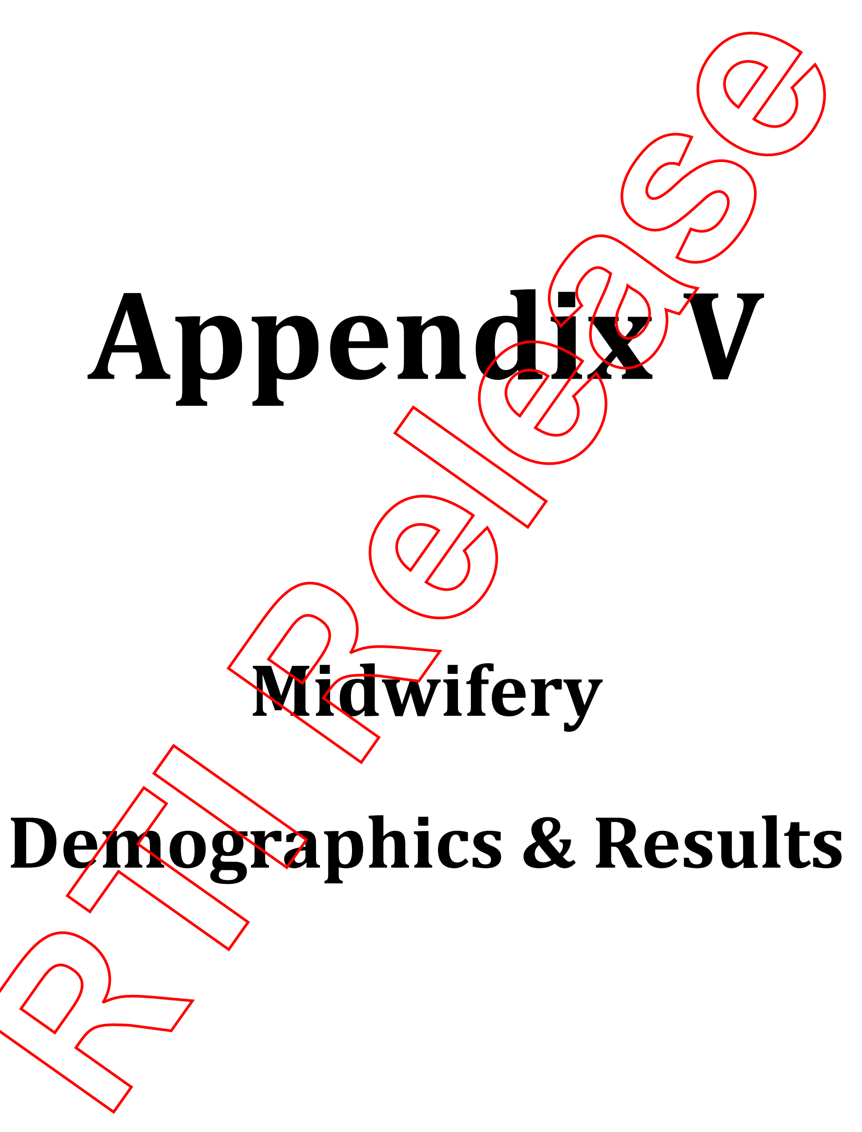
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Appendix V

Midwifery

Demographics & Results

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Profile of Study Participants

The Australian Midwifery population was included in the Answer 4 Nursing and Midwifery survey. There were 502 midwife survey participants who had standardised midwife only position/titles. Elements of the Australian midwifery population formally expressed concern over the inclusion of this profession in the study. In response to this concern whilst also respecting the contribution of the midwives who did participate we have analysed the midwifery data as a separate sample.

Distribution of Sample across States & Territories

Midwives responded from all States and Territories in Australia, with Victoria providing more than 40% of the midwife survey participants. Other good responses were attained from South Australia, Tasmania and the ACT. These results are shown in Table 1.

Table 1: State distribution of participants

	Number of Participants	Percentage
VIC	205	40.8%
NSW	157	31.2%
QLD	43	8.5%
SA	34	6.7%
TAS	24	4.7%
ACT	18	3.5%
WA	17	3.3%
NT	4	0.8%
TOTAL	502	100%

Age and Sex of Participants

Survey respondents recorded their age in 10-year increments. Most respondents covered the 50-59 age groups as demonstrated in Table 2. This profile of age distribution is older than the nursing participants in this study. Participants in WA and the NT were considerably older than other jurisdictions with no or very few midwives in the 20-49 age groups.

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Table 2. Age							
	Number of Participants	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60-69 Years	70 Years and over
VIC	205	9.3%	8.3%	25.4%	42.4%	13.7%	1.0%
NSW	157	7.6%	8.9%	22.3%	46.5%	12.7%	1.9%
QLD	43	7.0%	14.0%	30.2%	41.9%	7.0%	0.0%
SA	34	5.9%	14.7%	20.6%	47.1%	11.8%	0.0%
TAS	24	0.0%	4.2%	37.5%	41.7%	16.7%	0.0%
ACT	18	11.1%	11.1%	16.7%	50.0%	11.1%	0.0%
WA	17	0.0%	5.9%	11.8%	70.6%	11.8%	0.0%
NT	4	0.0%	0.0%	0.0%	75.0%	25.0%	0.0%
Total	502	7.6%	9.2%	24.1%	45.4%	12.7%	1.0%

Most participants were female. This sex ratio ranged from 100% female in the ACT and the NT down to 87% female (or 12% male) in Tasmania. These ratios are higher than those found in the nursing position participants. These results are shown in Table 3.

Table 3: Sex			
	Number of Participants	Female	Male
VIC	205	98.0%	1.9%
NSW	157	98.1%	1.9%
QLD	43	97.7%	2.3%
SA	34	100.%	0.%
TAS	24	87.5%	12.5%
ACT	18	100.%	0.%
WA	17	94.1%	5.9%
NT	4	100.0%	0.0%
TOTAL	502	97.6%	2.4%

Distribution across Workplace Sector

More than 80% of the midwifery participants worked in the public sector with only 12.5% working in the private sector. Only in Queensland, South Australia and the ACT were there any significant proportion of the midwifery workforce within a non-government organisation. Almost 6% of WA midwifery participants were sole traders. This high rate of sole traders in Western Australia was also observed in participants with nursing positions. These results are shown in Table 4.

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Table 4. Workplace Sector							
	Number of Participants	Public	Private	Non-Government Organisation (NGO)	Sole trader	Mixed	Unknown
VIC	205	83.4%	13.7%	0.0%	0.5%	2.4%	0.0%
NSW	157	86.6%	10.8%	0.6%	0.6%	0.6%	0.6%
QLD	43	76.7%	11.6%	4.7%	0.0%	7.0%	0.0%
SA	34	76.5%	14.7%	2.9%	0.0%	2.9%	2.9%
TAS	24	75.0%	12.5%	0.0%	0.0%	4.2%	8.3%
ACT	18	88.9%	5.6%	5.6%	0.0%	0.0%	0.0%
WA	17	70.6%	23.5%	0.0%	5.9%	0.0%	0.0%
NT	4	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	502	82.9%	12.5%	1.0%	0.6%	2.2%	0.8%

Distribution across Workplace Setting

Most midwife participants in this study work within a hospital setting with only 10% working in the community. Just over 3% of midwife participants work over multi-settings. These results are displayed in Figure 1.

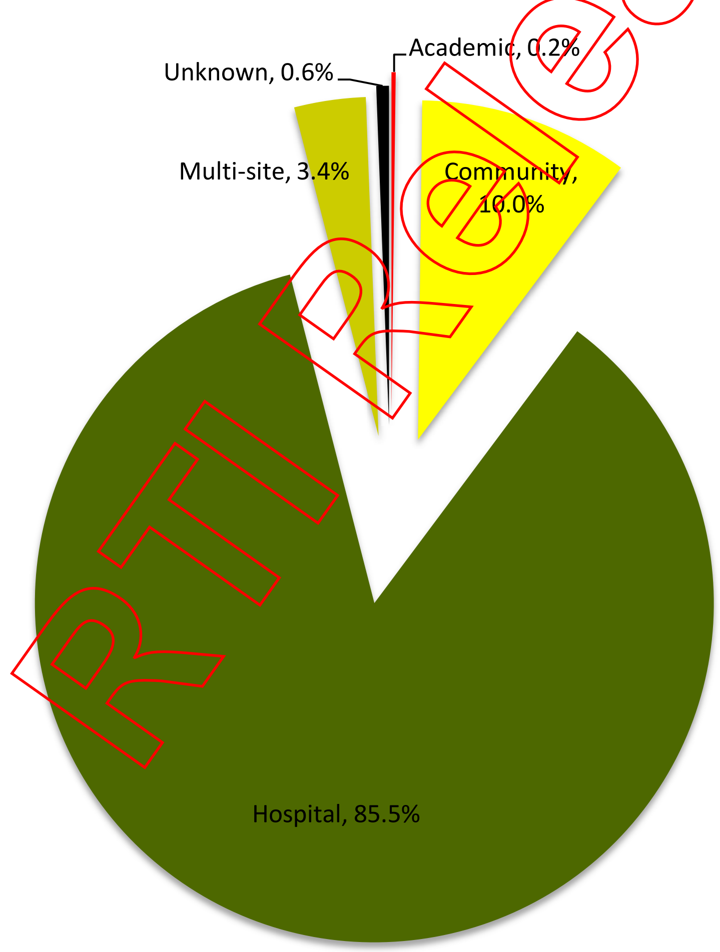

Figure 1: Distribution across workplace settings.

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Workplace Region

Midwifery participants worked mostly within metropolitan and regional areas in Australia. Queensland and Victoria had few survey participants from rural areas than expected. A limited number of midwifery participants in Queensland, New South Wales and Victoria worked over both region zones. These results are displayed in Table 5.

Table 5. Workplace Region

	Number of Participants	Metropolitan and Regional	Rural and Remote	Mixed
VIC	205	91.2%	8.3%	0.5%
NSW	157	80.9%	17.2%	1.3%
QLD	43	83.7%	11.6%	4.7%
SA	34	88.2%	11.8%	0.0%
TAS	24	66.7%	33.3%	0.0%
ACT	18	100.0%	0.0%	0.0%
WA	17	76.5%	23.5%	0.0%
NT	4	0.0%	100.0%	0.0%
TOTAL	502	85.1%	13.7%	1.0%

Highest Education Level of Participants

The highest education qualifications of midwifery survey participants is displayed in Table 6. All listed qualifications are in midwifery, nursing or a related health field. Highest education qualifications which are not in nursing or related field are categorised as Other. Over 15% of participants had a higher degree with an additional 37% with postgraduate diplomas or certificates. Just under 20% of participants had completed a Bachelor degree with an additional 18% with a hospital certificate as their highest education qualification. There was a marked variation between States and Territories with participants in New South Wales and Western Australia more likely to have post graduate qualifications than survey participants in Victoria and South Australia.

Table 6. Highest Education

	Number of Participants	PhD	Masters	Post Graduate Diploma	Post Graduate Certificate	BN or equivalent	Hospital Certificate	Other
VIC	205	2.0%	10.7%	28.3%	10.2%	21.5%	18.0%	9.3%
NSW	157	0.0%	22.9%	23.6%	12.1%	14.0%	15.9%	11.5%
QLD	43	0.0%	20.9%	20.9%	11.6%	18.6%	25.6%	2.3%
SA	34	0.0%	5.9%	11.8%	14.7%	32.4%	29.4%	5.9%
TAS	24	0.0%	4.2%	37.5%	12.5%	20.8%	20.8%	4.2%
ACT	18	0.0%	11.1%	33.3%	11.1%	22.2%	16.7%	5.6%
WA	17	0.0%	29.4%	23.5%	17.6%	11.8%	11.8%	5.9%
NT	4	0.0%	25.0%	75.0%	0.0%	0.0%	0.0%	0.0%
TOTAL	502	0.8%	15.5%	25.9%	11.6%	19.1%	18.5%	8.6%

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Years as a Registered Nurse or Midwife

On average, participants had been registered as a nurse or midwife for 24.2 years with a range over 50 years. Most participants have been registered as a nurse or midwife for between 14-34 years (interquartile range).

Years in Current Position

Participants had spent on average 9.2 years (2-13 years interquartile range, total range 40 years) in their current position.

Membership of Professional Organisations

More than 50% of midwifery participants are members of the ANMF with 37% also members of the Australian College of Midwives. Most midwifery respondent held membership of a professional body. Table 7 lists the most common of these organisations. Table percentages are not cumulative since many participants may be members of more than one group.

Table 7: Professional Membership

Professional Organisation	Number	Percentage
Australian Nursing and Midwifery Federation (ANMF)	279	55.6%
Australian College of Midwives (ACM)	187	37.3%
NSW Nurses and Midwives' Association	138	27.5%
Queensland Nurses Union (QNU)	37	7.4%
Australian College of Nursing (ACN)	28	5.6%
College of Remote Area Nurses Australia Inc (CRANAplus)	12	2.4%
Australian College of Neonatal Nurses	8	1.6%
Australian College of Nurse Practitioners (ACNP)	5	1.0%
Australian Primary Healthcare Nurses Association (APNA)	5	1.0%
the Australian College of Mental Health Nurses (ACMHN)	2	0.4%
Australasian Sexual Health & HIV Nurses Association (ASHHNA)	1	0.2%

Midwife Position Titles across Australia

Table 8 list all position titles recorded by midwifery survey participants by state and territory including the number of participants for each position and a percentage for each state.

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Table 8: Survey Participant Nursing and Midwifery Position Titles by State		
Australian Capital Territory Titles	Number	Percentage
Midwife Consultant	1	5.6%
Midwifery Educator	1	5.6%
Registered Midwife	16	88.9%
New South Wales Titles	Number	Percentage
Clinical Midwife Consultant	9	5.7%
Clinical Midwife Educator	5	3.2%
Clinical Midwife Specialist	33	21.0%
Midwife Educator	1	0.6%
Midwife Manager	1	0.6%
Midwife Practitioner	3	1.9%
Midwifery Unit Manager	14	8.9%
Registered Midwife	91	58.0%

Table 10 Continued: Survey Participant Nursing and Midwifery Position Titles by State		
Northern Territory Titles	Number	Percentage
Registered Midwife	4	100%
Queensland Titles	Number	Percentage
Clinical Midwife	6	14.0%
Registered Midwife	37	86.0%
South Australian Titles	Number	Percentage
Clinical Midwife	6	17.6%
Midwife Clinical Service Coordinator	2	5.9%
Midwife Education Facilitator	1	2.9%
Registered Midwife	25	73.5%
Tasmanian Titles	Number	Percentage
Registered Midwife	24	100%
Victorian Titles	Number	Percentage
Associate Midwife Unit Manager	6	2.9%
Clinical Midwife Consultant	11	5.4%
Clinical Midwife Specialist	58	28.3%
Midwife Unit Manager	3	1.5%
Registered Midwife	127	62.0%
Western Australian Titles	Number	Percentage
Clinical Midwife	7	41.2%
Clinical Midwifery Consultant	1	5.9%
Clinical Midwifery Manager	1	5.9%
Midwifery Manager	1	5.9%
Registered Midwife	7	41.2%

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The Pattern of APN activities according to Midwifery Position/Title

The pattern of domain scores for prominent midwifery positions/titles are shown in figure 2. All of these positions had five or more participants and their domain scores were calculated as previously described for nursing positions. Clinical Midwifery Consultants scored high on every domain. Clinical Midwifery Educators and Midwifery Unit Managers scored high on the first three domains and lower in Research and Professional Leadership. Clinical Midwifery Specialist, Clinical Midwife and Registered Midwife are all characterised with high responses to the Direct Care domain items but lower or moderate responses in the other four domains. The domain means of all midwifery positions across Australia are listed in Table 11.

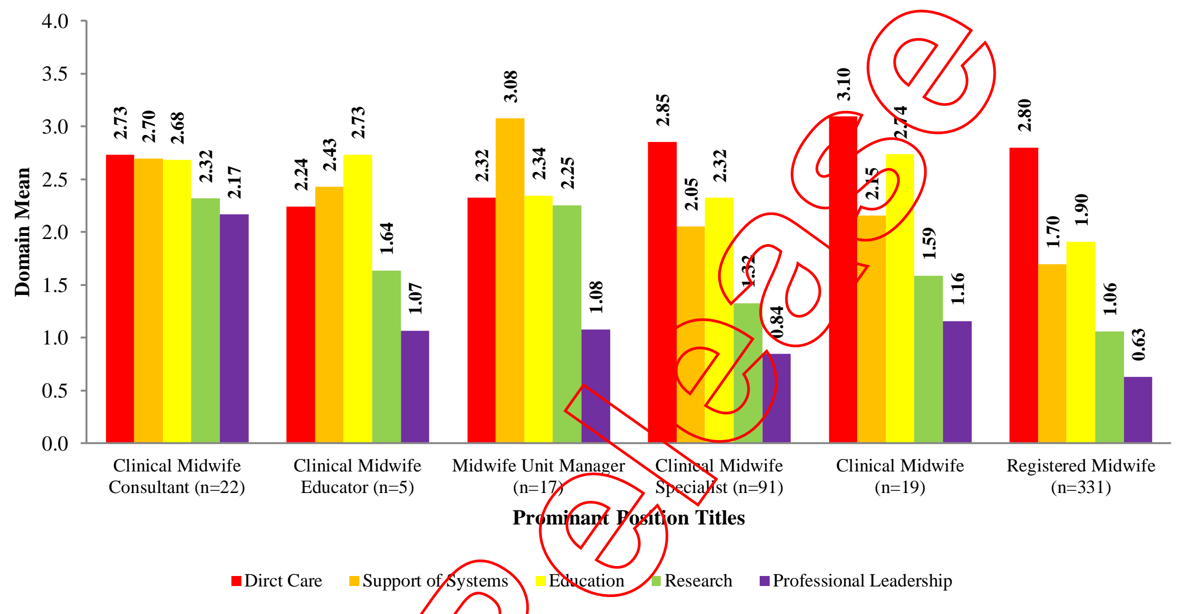

Figure 2: Domain means for five prominent midwifery positions across Australia.

Table 11. Domain Scores for all Midwifery Position Titles

		Direct Care	Support of Systems	Education	Research	Professional Leadership
	N	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5
Clinical Midwife Consultant*	22	2.73	2.70	2.68	2.32	2.17
Midwife Clinical Service Coordinator*	2	2.64	3.13	2.25	2.50	1.75
Clinical Midwife Educator	5	2.24	2.43	2.73	1.64	1.07
Midwife Education Facilitator	1	0.80	2.75	3.00	1.67	1.00
Midwife Educator	2	1.17	2.82	2.84	3.09	2.50
Midwife Practitioner	3	2.95	1.71	1.72	1.45	1.67
Associate Midwife Unit Manager	6	3.05	2.63	2.72	1.61	1.06
Clinical Midwife Manager	1	4.00	3.38	3.83	1.67	1.50
Midwife Manager	2	1.37	3.88	3.09	3.08	1.84
Midwife Unit Manager	17	2.32	3.08	2.34	2.25	1.08
Clinical Midwife	19	3.10	2.15	2.74	1.59	1.16
Clinical Midwife Specialist	91	2.85	2.05	2.32	1.32	0.84
Registered Midwife	331	2.80	1.70	1.90	1.06	0.63

*Positions in which all domains were within the APN thresholds

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Project Title: A state wide study quantifying the core role functions of Nurse and Midwifery Unit Managers (NUMs) and exploring best practice models of professional clinical leadership

Final Report

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Date: 13th January, 2012

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PART 1

SECTION 1 - BACKGROUND TO THE REPORT

1.0 Project Description

Building on previous qualitative research, namely *Review of the Nurse Unit Manager Role, Final report (*Queensland Health, 2008) and *"Take the lead": Strengthening the nursing/midwifery unit manager's role across NSW: Report Phase One* (NSW Health, 2008), this project aimed to collect quantifiable data to help clarify the core tasks within the role of Nurse Unit Managers (NUMs). While the above studies collected qualitative material on the administrative load surrounding the work of the NUM, they did not produce verifiable quantitative measures to assist policy makers in making decisions about how NUMs can optimally undertake their clinical leadership roles. Nor did these studies systematically identify what might constitute best practice models of professional clinical leadership for NUMs that will support high quality patient outcomes.

1.1 Background

The NUM role is widely regarded as the lynch-pin of health care organisations. The Queensland Health (2008) review of the NUM role highlighted that a lack of support and an overburdening of extraneous administrative tasks has resulted in NUMs having a further reduced clinical leadership focus. NUMs surveyed as part of the review of the NUM role felt they are crisis managing from day to day and experienced role conflict as a result of a desire to be more clinically based yet unable to do so with their heavy administrative burden. Of those surveyed, 37% identified that they frequently consider leaving the NUM position (Queensland Health, 2008). The lack of role clarity further impacts on NUMs by increasing the ambiguity surrounding the core functions of the role (Queensland Health, 2008). These findings are consistent with national and international research, and reflect the global experiences of the front-line nurse manager role over a number of years (Garling, 2008; Bolton and Roy, 2004). The current study is the next logical step in providing evidence needed to inform policy changes.

1.2 Significance

There is support throughout the literature of the core role NUMs play in the provision of strong clinical leadership and the resultant impact on patient outcomes (Wong and Cummings, 2007). Therefore, realignment of the NUM role to clinical leadership is essential to ensure the safe and reliable delivery of care, and provision of patient focused care. The *Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (Garling, 2008) also supports this view, recommending a redesign of the NUM role allowing a 70% focus on clinical duties and the transfer of a range of administration, transactional and management duties to other staff or a clinical assistant to the NUM. In response to this recommendation, NSW implemented approximately 500 Clinical Support Officers across the state to support the NUM role. This was seen as a strategy to enable NUMs to focus on coordinating and improving patient care and service delivery (Garling, 2008).

Strong leadership exerts a positive relationship on patient outcomes through the creation of a positive work environment with subsequent retention of skilled staff and staff satisfaction (Cummings, et al., 2010). It is widely recognised that the next few years in Queensland will see an exodus of nurses from the workforce due to retirement, worsening existing nurse shortages

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(Queensland Health and Queensland Nurses Union, 2007). So, this study was designed to help inform the development of appropriate strategies to retain staff within the workforce, but also act as an attraction strategy. Consequently, the main research questions for this project were as follows:

1.3 Research Questions

1. What comprises a NUM day, i.e. the working day to complete all responsibilities in terms of how much time is spent on various tasks and duties that take them away from professional clinical leadership roles?

2. What constitutes potential models of best practice in professional clinical leadership for NUMs?

1.4 Study Design

In order to answer these questions, this research used a two part, mixed methods approach. The first part comprised a quantitative study that developed a diary template and an email survey (EXCEL format) to collect demographic data and record the working day of NUMs. The second part was a qualitative study that used focus groups to explore best practice examples in professional clinical leadership. Both parts have been undertaken and reported in a way that does not identify participants to protect their anonymity.

1.5 Layout of the Report

The report is in **three** parts.

Part 1

Section 1 - Introduction to the Report

Part 2

Section 1 - The Email Survey outlining the data collection and methods used for the study.
Section 2 - Demographic Data containing information on respondents including the settings in which they work and the facility types covered by the study.
Section3 - Training and Qualifications containing information relating to training and mentoring support and level of qualifications held by NUMs.
Section 4 - Work Related Matters containing about intentions to leave the profession, organisational support received in the role, and feedback in the role.
Section 5 - Diary Tasks containing diary entry information as well as the Importance and Delegation scales data.
Section 6 - Conclusion.

Part 3

Focus Group Study and Best Practice

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PART 2

SECTION 1 – THE EMAIL SURVEY

1.0 Survey Design

It was originally intended to conduct a two-stage survey, with a diary component in which times could be recorded against various tasks followed by an on-line survey to collate this material and link it to other demographic and work-related information. It was eventually decided that the survey had to be contained in one document for ease of completion and for accuracy of recording responses. Hence an Excel based instrument was developed containing a questionnaire and diary component and distributed via email. Originally, the study was to capture five days of activity in a diary format which was then reduced to three, non-consecutive days and then finally to a one day diary entry. The survey was modified in length during the data collection phase. No hard copy versions were sent to NUMs to complete though this might need to be considered in a future study given the evidence on differences in response rates amongst professional groups (Shih and Fan, 2008).

1.1 Sample

The sample for the quantitative study was to have used random sampling of all NUMs in Queensland (N=844). As the study proceeded it became evident that recruiting all NUMs would be impossible because no single mail list (email or otherwise) could be obtained by the Research Team. To overcome this problem, it was decided to enlist District Directors of Nursing (DDONs) to email the surveys to all their NUMs and for them to also do the relevant follow-ups using emails prepared by the Research Team. There is some anecdotal evidence to suggest that the initial email with the survey attached and the subsequent follow-up emails were not always sent to NUMs. Relying on convenience sampling produced unexpected problems that will need to be addressed in any future study. All four main work settings (Metropolitan, Regional, Remote and Rural) were represented in the sample.

An incentive was also offered by the *Acting Chief Nursing and Midwifery Officer* and this is generally, though not universally (Shih and Fan, 2009), considered to be a positive way of improving response rates, though the size of the incentive has been long noted as being critical (Bonk and Fallesen, 2010; *HowTo.gov*, 2011). As **Table 1** shows, two (2) Districts that could have completed additional surveys in the second survey round failed to do so. The highest number of surveys submitted by a District was 29 out of a possible 154 for Metro South though this was not the highest percentage overall. Eight (8) NUMs elected to submit anonymous surveys by not filling in the question identifying their District. No anonymous option was offered for this question. In total 180 Permanent NUMs and 53 Acting NUMs completed useable surveys giving us 223 respondents in our study.

1.2 Completion Rate of Survey

In this study, it was not possible to accurately estimate the response rate because we did not know how many NUMs received the email invitation to respond to the survey. On that basis, we use the term 'completion rate' to more accurately reflect the nature of data that we collected (Eysenbach, 2004). **Table** 1 shows the completion rate for the overall survey based on Queensland Health Districts. We achieved a completion rate of 26.42% if we accept that the total population is 844 NUMs in Queensland, but given the variations in distribution, it is quite likely that we had a much higher true response rate. Apart from this, there were several factors that may have affected the level of response to the survey, including the length and complexity of the survey instrument

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(Brent, 2010; *HowTo.gov*, 2011; *SurveyMonkey*, undated), some pre-survey issues (Lee, Hu and Toh, 2004), the fact that two other surveys were being conducted that were highly relevant to the same group at the same time (Barrios et al., 2011), and issues with distributing the survey by Queensland Health. With respect to this last point, it is interesting to note that the Districts with the largest number of NUMs tended to have the lowest completion rate (r = -.57; p < .01). This apparently reflected distribution problems, especially in metropolitan districts, although there may also be higher motivation to participate in this type of research in the smaller districts. Despite this range of problems, the overall completion rate was still quite respectable when compared with similar email surveys within organisations (Sheehan, 2001; Sax, Gilmartin, and Bryant, 2003; Bonke, 2005; Greenberg et al., 2005; McAuliffe, DiFrancesco and Reed, 2007; Shih and Fan, 2009; Bonk and Fallesen, 2010) and across populations where response rates can be low as 10% to15% (*HowTo.gov*, 2011). In summary, the completion rate for this survey is quite consistent with other surveys and although it does limit the overall confidence in the results, they still provide a reasonably good estimate of how NUMs view their employment situations.

Table 1 Surveys Completed

District	Number of NUMs	Number of First Surveys	Number of Second Surveys	Completion Rate
Cairns & Hinterland (Regional)	57	7	12	33.33%
Cape York (Rural and Remote)	3	1	1	66.67%
Central QLD (Regional)	58	5	5	17.24%
Central West (Rural and Remote)	3	3	0	100.00%
Children's (Metro District)	23	3	13	69.57%
Darling Downs and West Moreton (Regional)	122	13	15	22.95%
Gold Coast (Metro District)	66	14	0	21.21%
Mackay (Regional)	24	8	3	45.83%
Metro North (Metro District)	170	6	9	8.82%
Metro South (Metro District)	154	17	12	18.83%
Mt. Isa (Rural and Remote)	10	5	2	70.00%
South West (Rural and Remote)	7	4	1	71.43%
Sunshine Coast (Metro District)	54	2	18	37.04%
Townsville (Regional)	56	12	11	41.07%
Torres Strait (Rural and Remote)	0	1	0	0.00%
Wide Bay - Bundaberg (Regional)	12	2	2	33.33%
Wide Bay - Hervey Bay (Fraser Coast) (Regional)	25	1	7	32.00%
Anonymous survey		5	3	
TOTAL	**844**	**109**	**114**	**26.42%**

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1.3 Questionnaire

The questionnaire was divided into the following parts, with the red text indicating sections where data had to be entered by participants. This report follows the format of the questionnaire in discussing the findings.

- Endorsement by Chief Nursing and Midwifery Officer, Queensland Health
- Ethics Consent
- Instructions
- Demographic Characteristics
- Training and Preparation for your NUM role (two sections for NUMs and Acting NUMs)
- Qualifications
- Intention to Leave NUM Role
- Level of Support in your NUM Role
- Level of Feedback in your NUM Role
- Diary Entry Information
- Summary of Diary Data
- Forwarding Completed Survey

The full questionnaire is not attached, however **Table 2** contains the twenty-five (25) main task items for the diary entry. Obtaining the diary information was a key reason for undertaking the study. Each main task item contained various sub-tasks. In total, NUMs were asked to comment on 93 task items. Administration (12) and Communication (11) had the highest number of sub-task items.

Table 2 Main Task Items in the Diary Entry

Administrative (12) Admitting/Discharging (2) Assets Management (3) Assisting Doctors (2) Assisting Others (1) Change Management (1) Clinical Leadership (6) Complaints Management (3) Conflict Management (1)	Communicating (11) Data and Knowledge Management (4) Errands (1) Financial Management (6) General Management (3) Human Resource Functions (6) Indirect Care (3) Meetings (3)	Patient Care (6) Patient Safety (3) Performance Management (3) Quality Improvement (3) Supplies (2) Teaching and Education (3) Workplace Health and Safety (2) Workforce Planning (2) Other Tasks Not Mentioned (1)

NUMs were also asked to rank each sub-task item in terms of its *Importance* and whether or not it was able to be *delegated*. The results for these items are described in the relevant tables in *Section 5* of the report.

The questionnaire was designed drawing mainly on the two earlier reports from NSW Health and Queensland Health (see page 1) to assist later comparisons, and used a composite set of questions about demographics. The survey did not contain independently-validated scales for most of the questions but used *SurveyMonkey's* (undated) on-line guide for developing a five point Likert Scale. The Importance and Delegation scales were developed in an unpublished PhD by Jo-An

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Baber (2006). We believe the diary entry task questions are original and form the basis of a tool that can be further refined in future studies. NUMs were asked to allocate minutes per day spent on the relevant sub-tasks. As stated above, in the first survey this covered three non-consecutive days and in the second, it was reduced to one day only. NUMs were also invited to give comments on various sections of the survey. These responses will be analysed at a later stage using lexical analysis. The relevant task items are described in more detail in the tables and findings that follow.

1.4 Data Collection

The email survey opened in mid-June 2011 and closed on 4th October, 2011, and was administered through a secure Griffith University email address. Initially, the survey was to close in mid-July but due to delays associated with obtaining ethics approval it was extended twice over the remaining period. In August it was decided to re-design the survey so that NUMs only had to complete a one day diary entry. This accommodated the response from NUMs that they were unlikely to find sufficient time to complete the detailed diary entry beyond one day.

1.5 Data Analysis

The data has been analysed both within categories and across categories depending on the specific information being considered. For example, for some questions we give numbers and percentages within a category such as Metropolitan, Regional, Remote and Rural and at other times provide results across the whole data set. As we did not use a probability sampling method we consider this study to be exploratory and the basis for a further, more comprehensive study. It was always intended that the report would contain only descriptive statistics.

1.6 Ethics

There were several difficulties encountered in obtaining site specific ethics approval from Queensland Heath organisations even though this research was deemed to be a low risk project. This meant that the roll-out of the email survey was staggered throughout Queensland and delayed in some districts.

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SECTION 2 - DEMOGRAPHIC DATA

2.0 Introduction

This section of the report covers demographic data as well as information relating to facilities and setting in which NUMs work. The modal answers are generally highlighted in pink.

2.1 Key Demographic Data

Table 3 shows that: 92.4% of the NUMs in he sample worked full-time; 54.7% managed units that had 11-30 beds; 50.7% supervise between 21 to 50 staff; 61.4% came from regional or rural settings; and 74.9% of the NUMs work in hospitals.

Table 3 Demographic Details

Question 1 - Are you employed as:	Full Time	Job Share Arrangement	Part Time	No Response
N =	206	2	6	9
Percentage =	92.4%	0.9%	2.7%	4.0%

Question 2 - How many beds do you typically manage:	1 - 10	11 - 30	31 - 50	51 - 75	75 +	Not Applicable	No Response
N =	26	122	20	2	3	19	31
Percentage =	11.7%	54.7%	9.0%	0.9%	1.3%	8.5%	13.9%

Question 5 - What number of staff (i.e. headcount) do you supervise:	10 or less	11 to 20	21 to 50	51 to 100	101 to 150	151 to 200	No Response
N =	20	33	113	40	7	1	9
Percentage =	9.0%	14.8%	50.7%	17.9%	3.1%	0.4%	4.0%

Question 9 - What setting do you work in:	Metro	Regional	Rural	Remote	No Response
N =	70	87	50	8	8
Percentage =	31.4%	39.0%	22.4%	3.6%	3.6%

Question 10 - In which facility type do you work:	Comm-unity	Residential/ Aged Care	Community Health	Mental Health	Hospital	Other	No Response
N =	14	3	17	9	167	4	9
Percentage =	6.3%	1.3%	7.6%	4.0%	74.9%	1.8%	4.0%

2.2 Length of time in Profession and Setting

Table 4 shows that the majority of NUMs who responded to the question (N=214) said they had been in the profession for between 21 and 40 years (128 or 67.3%) and were working mainly in

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Metropolitan and Regional settings. This pattern would be expected given the level of training and experience associated with attaining a NUM position.

Table 4 How Long Been in Profession (in Years) and Setting

Years	Metro	Regional	Remote	Rural	Total
< 5	2(2.9%)	0(0.0%)	0(0.0%)	1(2.0%)	**3(1.4%)**
5-10	5(7.1%)	0(0.0%)	2(25.0%)	7(14.0%)	**14(6.5%)**
11-20	12(17.1%)	20(23.3%)	1(12.5%)	9(18.0%)	**42(19.6%)**
21-30	29(41.4%)	37(43.0%)	3(37.5%)	18(36.0%)	**87(40.7%)**
31-40	20(28.6%)	23(26.7%)	1(12.5%)	13(26.0%)	**57(26.6%)**
>40	2(2.9%)	6(7.0%)	1(12.5%)	2(4.0%)	**11(5.1%)**
Total	**70 (100%)**	**86 (100%)**	**8 (100%)**	**50 (100%)**	**214 (100%)**
NR=	**9**				

2.3 Age at Time of Filling in Survey and Facility Type

Most NUMs who answered the question (N= 213) stated that their age was in the 49-59 years age range (162 or 76.1%). Again this reflects the years of training and experience that is required before taking up a NUM role. **Table 5** shows that the majority of these NUMs also worked in a hospital setting. It also highlights an ageing workforce and the challenges with filling NUM positions in years to come.

Table 5 Age at Filling in Survey and Facility Type

Age (Years)	Community	Residential Aged care	Community Health	Mental Health	Hospital	Other	Total
≤ 25	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	1(0.6%)	0(0.0%)	1(0.5%)
26-29	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	4(2.4%)	0(0.0%)	4(1.9%)
30-39	2(14.3%)	0(0.0%)	4(23.5%)	1(11.1%)	25(15.1%)	0(0.0%)	32(15.0%)
40-49	3(21.4%)	1(33.3%)	6(35.3%)	6(66.7%)	76(45.8%)	1(25.0%)	93(43.7%)
50-59	9(64.3%)	1(33.3%)	6(35.3%)	2(22.2%)	48(28.9%)	3(75.0%)	69(32.4%)
60-64	0(0.0%)	1(33.3%)	1(5.9%)	0(0.0%)	12(7.2%)	0(0.0%)	14(6.6%)
65-70	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)
> 70	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)
Total	**14 (100%)**	**3 (100%)**	**17(100%)**	**9(100%)**	**166(100%)**	**4(100%)**	**213(100%)**
NR=	**10**						

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2.4 Age at Filling in Survey and Setting

As **Table 6** indicates, the Metropolitan and Regional settings had the oldest population of NUMs, with 25% and 29% respectively having respondents in the 50-59 years age group. Rural areas have 22% of their NUMs in the 40-49 years age group and this was the highest percentage for them. If the 60-64 Years age group is added to the Metropolitan and Regional figures then more than 30% of their NUMs are in the over 50 age group, posing significant challenges for labour market renewal and retention.

Table 6 Age at Filling in Survey and Setting

Age (Years)	Metro	Regional	Remote	Rural	Total
≤ 25	0(0.0%)	0(0.0%)	0(0.0%)	1(2.0%)	1(0.5%)
26-29	1(1.4%)	0(0.0%)	0(0.0%)	3(6.0%)	4(1.9%)
30-39	10(14.3%)	12(14.0%)	2(25.0%)	8(16.0%)	32(15.0%)
40-49	31(44.3%)	39(45.3%)	2(25.0%)	22(44.0%)	94(43.9%)
50-59	25(35.7%)	29(33.7%)	3(37.5%)	12(24.0%)	69(32.2%)
60-64	3(4.3%)	6(7.0%)	1(12.5%)	4(8.0%)	14(6.5%)
65-70	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)
> 70	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)
Total	**70 (100.0%)**	**86 (100.0%)**	**8 (100.0%)**	**50 (100.0%)**	**214 (100%)**
NR=	**9**				

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SECTION 3 - TRAINING AND QUALIFICATIONS

3.0 Introduction

This part of the report contains information relating to training and mentoring support and level of qualifications held by NUMs in both nursing and other management related areas.

3.1 Training Prior to Taking Up the NUM's Role

Table 7 shows that over half (N=107 or 59.4%) of those occupying full-time NUM roles at the time of survey had not received any training for the role. The figure is lower for those who occupy acting roles with only 30.2% (N=16) reporting no training prior to taking up the role. The norm for those who did receive some training was 1-3 days and this was consistent across both groups. A very small percentage of respondents reported receiving 6-10 days training (6.6% for full-time and 9.5% for acting NUMs).

Table 7 Period of Training Received Prior to Taking up NUM's Role

What was the period of training you received prior to taking up your current NUM position:	No training	Half a day	1 day	2 - 3 days	4 - 5 days	6- 10 days	> 10 days	No Response
N =	107	6	22	23	9	6	6	1
N Percentage =	59.4%	3.3%	12.2%	12.8%	5.0%	3.3%	3.3%	0.6%
What was the period of training you received prior to taking up your current position as an acting NUM:	**No training**	**Half a day**	**1 day**	**2 to 3 days**	**4 to 5 days**	**6 to 10 days**	**More than 10 days**	**No Response**
N =	16	11	7	12	2	2	3	0
N Percentage =	30.2%	20.8%	13.2%	22.6%	3.8%	3.8%	5.7%	0.0 %

3.2 Satisfaction with Training Received for Current NUM Position

A relatively high proportion of permanent NUMs are very unsatisfied or unsatisfied with the level of training they received for preparing them for their current positions (N= 64 and 36.4%) while a large number also stated that the question was not relevant to them (N= 48 and 27.3%). Similar trends were noted for Acting NUMs who answered this question though they seem to be more satisfied than their permanent counterparts. However, it should be noted that the numbers are not high for either group (see **Table 8**).

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Table 8 Satisfaction with Training Received for Current NUM Position

	Permanent NUM	Acting NUM
Very unsatisfied	28(15.9%)	7(13.5%)
Mostly unsatisfied	36(20.5%)	9(17.3%)
Neutral on this point	39(22.2%)	13(25.0%)
Mostly satisfied	19(10.8%)	10(19.2%)
Very satisfied	6(3.4%)	3(5.8%)
Not applicable	48(27.3%)	10(19.2%)
Total	**176 (100%)**	**52(100%)**
NR=	**4**	**1**

3.3 Part of Formal Organisational Mentor Program while NUM

As **Table 9** shows, a very high proportion of NUMs who answered this question stated that they have not been part of any formal mentor program in their organisation while being a NUM (above 90% for both groups).

Table 9 Part of Formal Organisational Mentor Program while NUM

	Permanent NUM	Acting NUM
Yes	11(6.2%)	4(7.5%)
No	166 (93.8%)	49(92.5 %)
Total	**177 (100%)**	**53 (100%)**
NR=	**3**	**0**

3.4 How Satisfied that Mentor Program Prepared You for NUM for Position

Given the fact that few NUMs had any involvement in a mentoring program while being a NUM, it is not surprising that their level of satisfaction with a mentor program mirrors the figures shown in **Table 10**. Of those who responded, over 70% stated that the question did not apply to them. There is a high proportion of non-responses to this question for Permanent NUMs (35).

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Table 10 Satisfaction with Mentoring Program for NUM Position

	Permanent NUM	Acting NUM
Very unsatisfied	5(3.4%)	3(6.7%)
Mostly unsatisfied	8(5.5%)	4(8.9%)
Neutral on this point	15(10.3%)	4(8.9%)
Mostly satisfied	7(4.8%)	0(0.0%)
Very satisfied	3(2.1%)	2(4.4%)
Not applicable	107(73.8%)	32(71.1%)
Total	**145(100%)**	**45(100%)**
NR=	**35**	**8**

3.5 Qualifications

Table 11 shows that a total of 41.7% of NUMS have university qualifications at graduate level in nursing, midwifery or health science (nursing related). A total of 26.91% of NUMs have post-graduate qualifications in a nursing / midwifery discipline specific area. This represents significant levels of higher degree qualifications for NUMs in this study.

Table 11 Highest Nursing/Midwifery Qualification Held

Qualification	N	%	Total %
Hospital Trained Nurse	27	12.11%	**30.49%**
Hospital Trained Midwife	4	1.79%	
Midwifery Endorsement	6	2.69%	
Nursing Certificate	7	3.14%	
Other Accredited Course/Program (Certificate/Diploma)	24	10.76%	
Bachelor of Nursing	69	30.94%	**41.70%**
Bachelor of Health Science	21	9.41%	
Bachelor of Midwifery	3	1.35%	
Post Graduate Certificate	20	8.97%	**26.91%**
Post Graduate Diploma	16	7.17%	
Masters	21	9.42%	
Masters (Honours)	3	1.35%	
PhD	0	0.00%	
NR=	**2**	**0.9%**	**0.9%**
Total	**223**	**100.0%**	

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Consistent with this, **Table 12** indicates a significant number of NUM's have undertaken independent study in management:

- TAFE Certificate and Diploma –9.41%
- Bachelor Degree or Honours – 4.03 %
- Post graduate studies – 20.21%

In addition to this a further 42.59% have undertaken electives as part of their nursing degree or various Commonwealth or clinician training programs including in service management training.

A small number of NUMs (14.35%) indicated that this question was not applicable to them and a further twenty-one (21) did not respond to it. Even so, the results presented in Tables 11 and 12 show a commitment to further education among the NUMs who participated in this survey.

Table 12 Highest Management Qualification Held

Qualification	N	%	Total %
Electives in Nursing Degrees	21	9.41%	**42.59%**
Queensland Health/Commonwealth Programs	22	9.87%	
Clinicians Development Education Service (CDES) Training	8	3.58%	
In Service Management Training	44	19.73%	
TAFE Certificate in Management	5	2.24%	**9.41%**
TAFE Diploma in Management	16	7.17%	
Bachelor Degree (Management, Business, Administration, Commerce or Health Management)	9	4.03%	**4.03%**
Bachelor (Honours)	0	0.00%	
Graduate Certificate	24	10.77%	**20.21%**
Graduate Diploma	9	4.05%	
Masters	12	5.39%	
Masters (Honours)	0	0.00%	
PhD	0	0.00%	
Not applicable	**32**	**14.35%**	**14.35%**
No response	**21**	**9.41%**	**9.41%**
Total	**223**	**100.00%**	**100.00%**

3.6 Satisfaction with Support to Undertake Further Management Education

Table 13 shows that a relatively high proportion of NUMs is satisfied (68 or 30.49%) or very satisfied (27 or 12.5%) with the support given to them by their organisations to undertake further management education. Nonetheless, roughly a quarter of NUMs indicated they were dissatisfied with the support they received for further management education.

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Table 13 Satisfaction with Support to Undertake Further Management Education

	Number	Percentage
Very unsatisfied	15	6.70%
Mostly unsatisfied	41	18.38%
Neutral on this point	64	28.69%
Mostly satisfied	68	30.49%
Very satisfied	27	12.15%
Not applicable	6	2.69%
N=	**221**	**99.10%**
NR=	**2**	**0.90%**
Total	**223**	**100.0%**

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SECTION 4- WORK RELATED MATTERS

4.0 Introduction

This part of the report contains information about intentions to leave the profession, organisational support received in the role as well as feedback in the role.

4.1 Intention to Leave

Table 14 shows that 32.7% (N=73) of those surveyed stated that they are likely or very likely to consider leaving their NUM positions in the next 12 months. This figure is 5% lower than the figure quoted in 2008 by Queensland Health (see page 3), but remains a substantial proportion of the NUMs. We have not as yet analysed whether or not the responses are skewed to regional and rural work settings but the composition of our sample suggests this might be the case.

Table 14 Numbers and Percentage of Staff who are Considering Leaving

How likely to consider leaving your NUM position in the next 12 months:	Employed as:				Total
	Full Time	Job Share Arrangement	Part Time	No Response	
Number	**206**	**2**	**6**	**9**	**223**
Percentage	**92.4%**	**0.9%**	**2.7%**	**4.0%**	**100.0%**
Very unlikely	49(23.8%)	(1)50.0%	2(33.3%)	3(33.3%)	**55(24.7%)**
Unlikely	49(23.8%)	0.0%	0.0%	1(11.1%)	**50(22.4%)**
Neutral on this point	32(15.5%)	0.0%	0.0%	1(11.1%)	**33(14.8%)**
Likely	36(17.5%)	0.0%	2(33.3%)	1(11.1%)	**39(17.5%)**
Very likely	29(14.1%)	0.0%	2(33.3%)	3(33.3%)	**34(15.2%)**
Not applicable	5(2.4%)	(1)50.0%	0.0%	0.0%	**6(2.7%)**
No Response	6(2.9%)	0.0%	0.0%	0.0%	**6(2.7%)**

Table 15 shows that the main reasons for leaving the NUM position are because of *stress related to the job* and *excessive workload and hours*. These findings are consistent with the two previous reports that inform this study (*Review of the Nurse Unit Manager Role, Final report (*Queensland Health, 2008) and *"take the lead": strengthening the nursing/midwifery unit manager's role across NSW: Report Phase One* (NSW Health, 2008). They are also supported by the data in the Diary Tasks that capture for the first time in a quantifiable way the high levels of administration and fragmentation associated with the NUM's role.

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Table 15 Ranking of Reasons to Leave NUM Position

Ranking	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
Stress related to job	14	16	5	8	1	1	0	1	1	2
Excessive workload / hours	19	14	8	1	3	1	1	4	1	2
Lack of recognition by staff	2	2	5	4	11	3	2	3	3	2
Lack of recognition by direct supervisor	4	7	8	4	1	2	1	1	0	2
Pay	4	5	6	4	2	3	1	5	3	0
Lack of career opportunities	4	6	4	4	1	2	5	2	3	1
Lack of support from line manager	2	4	5	7	4	1	3	1	1	2
Family life balance / commitment	9	3	10	5	3	4	1	2	2	1
Lack of engagement with role	0	5	1	3	3	3	3	3	2	2
Other	14	3	2	1	0	0	0	3	0	5

4.2 Level of Support

Table 16 reveals that the percentage of NUMs receiving no support in information technology was 73.1%, closely followed by HRM with 65% of NUMS indicating no support. While 57.4% of NUMs were not provided with 'other Grade 7 staff' support in the last month, another 40.3% were provided with some support from other Grade 7 level staff. Of note, no Administrative support from an AO was provided for many NUMs (51.1%), however, 47.6% did receive some support. It may be entirely appropriate that 73% of NUMs have no IT support in the last month, and that experienced NUMs may require no HRM support, depending on what arises. These findings need to be further examined in light of whether or not the NUMs perceived that they actually required support in these areas and at what levels.

The highest level of support (21-40 hours) is the AO support given to 14.3% of NUMs. The highest level of support in the 1-5 hour category is from a Business Manager (39.9%) followed by HRM (32.7%), Grade 7 Level Staff (32.3%), AO support (28.7%) and IT (22.9%). The size of a facility and its location or setting is likely to affect the interpretation of these figures.

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Table 16 Levels of Support

What level of Administrative Officer/AO support do you receive to assist you:	None	1-5 hour / week	6-10 hours / week	11-20 hours / week	21-30 hours/ week	31-40 hours/ week	No Response
N=	**114**	**64**	**6**	**4**	**15**	**17**	**3**
N Percentage=	**51%**	**28.7%**	**2.7%**	**1.8%**	**6.7%**	**7.6%**	**1.3%**

What level of additional support do you receive from other Grade 7 level staff:	None	1-5 hours / week	6-10 hours / week	11-20 hours / week	21-30 hours/ week	31-40 hours/ week	No Response
N=	**128**	**72**	**3**	**2**	**3**	**10**	**5**
N Percentage=	**57.4%**	**32.3%**	**1.3%**	**0.9%**	**1.3%**	**4.5%**	**2.2%**

What amount of support do you receive from a business manager to assist you:	None	1-5 hours / week	6-10 hours / week	No Response
N=	**126**	**89**	**2**	**6**
N Percentage=	**56.5%**	**39.9%**	**0.9%**	**2.7%**

What level of support do you receive from HRM in managing your unit(s):	None	1-5 hours / week	6-10 hours / week	No Response
N=	**145**	**73**	**2**	**3**
N Percentage=	**65.0%**	**32.7%**	**0.9%**	**1.3%**

What level of IT support do you receive in managing your unit(s):	None	1-5 hours / week	6-10 hours / week	No Response
N=	**163**	**51**	**1**	**8**
N Percentage=	**73.1%**	**22.9%**	**0.4%**	**3.6%**

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4.3. Level of Feedback

One of the key findings of the survey was the relatively high level of dissatisfaction expressed towards the effectives of the PAD review process. As **Table 17** shows, 40.3% of NUMs surveyed strongly disagreed or disagreed that the PAD process was effective. Furthermore, 21.1% were neutral on the point, which suggests that the PAD is not doing its job as far as NUMs are concerned.

Table 17 Level of Feedback

Question 45 - I have regular 6 monthly reviews of my PAD with my manager and these are effective:	Strongly disagree	Mostly disagree	Neutral	Mostly agree	Strongly agree	Not applicable	No Response
N =223	50	40	47	51	24	7	4
Percentage =	22.4%	17.9%	21.1%	22.9%	10.8%	3.1%	1.8%

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SECTION 5 - DIARY TASKS

5.0 Introduction

This part of the report contains information on the diary tasks, including facility and setting data as well as the Importance and Delegation scales data.

5.1 Diary Entry Main Tasks

The diary entry information is presented first to contextualise the remaining data sets. As shown in **Table 18** by far the greatest *percentage of total time* spent by NUMs was on tasks related to Administration (19.0%) followed by Communicating (16.32%). A significant gap exists between the next three areas: Clinical Leadership (9.19%), Human Resource Functions (7.62%) and Meetings (7.21).

Table 18 Diary Entry Data for Main Tasks

Overall Survey Diary Results	
Number	**223**
Administrative	19.09%
Admitting/Discharging	1.33%
Assets Management	2.37%
Assisting Doctors	1.92%
Assisting Others	0.81%
Change Management	1.84%
Clinical Leadership	9.19%
Complaints Management	1.71%
Conflict Management	0.65%
Communicating	16.32%
Data and Knowledge Management	3.66%
Errands	0.10%
Financial Management	3.76%
General Management	1.99%
Human Resource Functions	7.62%
Indirect Care	2.97%
Meetings	7.21%
Patient Care	5.60%
Patient Safety	1.67%
Performance Management	1.40%
Quality Improvement	1.51%
Supplies	0.93%
Teaching and Education	2.79%
Workplace Health and Safety	1.11%
Workforce Planning	1.12%
Other Tasks Not Mentioned	1.32%

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5.2 Tasks and Setting and Percentage of Time

When tasks are compared across the four main settings of the study, the Administrative tasks typically took the highest percentage of time. Conflict Management is also uniformly high relative to other tasks. Clinical Leadership is more prevalent in the Metropolitan and Remote settings, while Human Resource Management takes up more time relative to other tasks in Remote settings only. So, the patterns of time commitments observed in **Table 19** are different across the different settings.

Table 19 Tasks and Setting and Percentage of Time

Overall survey diary results	Metro	Regional	Remote	Rural
Number	70	87	8	50
Administrative	16.78%	20.21%	11.86%	21.37%
Admitting/Discharging	1.23%	0.92%	0.24%	2.31%
Assets Management	2.08%	2.78%	1.69%	2.12%
Assisting Doctors	2.19%	1.48%	0.61%	2.67%
Assisting Others	0.95%	0.61%	0.85%	1.06%
Change Management	2.07%	1.87%	1.09%	1.53%
Clinical Leadership	11.35%	7.95%	12.35%	8.33%
Complaints Management	1.74%	2.14%	0.00%	1.26%
Conflict Management	0.76%	0.52%	0.97%	0.73%
Communicating	17.44%	16.99%	10.65%	15.06%
Data and Knowledge Management	3.19%	4.11%	0.36%	3.80%
Errands	0.06%	0.07%	0.00%	0.23%
Financial Management	3.53%	4.19%	1.45%	3.75%
General Management	1.06%	2.42%	3.75%	2.04%
Human Resource Functions	7.61%	6.87%	13.08%	8.26%
Indirect Care	3.17%	2.52%	7.75%	2.90%
Meetings	8.17%	7.55%	9.81%	4.89%
Patient Care	5.83%	4.65%	5.93%	6.80%
Patient Safety	1.83%	1.54%	1.57%	1.57%
Performance Management	1.70%	1.26%	2.66%	1.06%
Quality Improvement	1.47%	1.23%	1.94%	1.52%
Supplies	0.69%	1.08%	1.82%	0.94%
Teaching and Education	2.36%	2.74%	3.51%	3.44%
Workplace Health and Safety	0.68%	1.50%	0.73%	1.07%
Workforce Planning	1.09%	1.07%	0.73%	0.62%
Other Tasks Not Mentioned	0.97%	1.73%	4.60%	0.66%

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5.3 Task and Time (in Minutes per Day)

The total average minutes per day involved in undertaking these tasks are as follows: Administration – 119.21 minutes; Communicating – 101.93 minutes; Clinical Leadership – 57.4 minutes; Human Resource – 47.1 minutes and Meetings – 45.01 minutes (see **Table 20**). When the overall results are tallied, NUMs are only devoting a relatively small proportion of their time to Clinical Leadership. The data also suggests significant task fragmentation within the NUM role which is amplified when the sub-tasks are examined.

Table 20 Average Minutes per Day per Task

Task	Average number of minutes per task
Number of responses	**223**
Administrative	119.21
Admitting/Discharging	8.34
Assets Management	14.79
Assisting Doctors	11.98
Assisting Others	5.05
Change Management	11.48
Clinical Leadership	57.41
Complaints Management	10.67
Conflict Management	4.06
Communicating	101.93
Data and Knowledge Management	22.85
Errands	0.61
Financial Management	23.47
General Management	12.42
Human Resource Functions	47.61
Indirect Care	18.57
Meetings	45.01
Patient Care	34.96
Patient Safety	10.46
Performance Management	8.72
Quality Improvement	9.46
Supplies	5.81
Teaching and Education	17.45
Workplace Health and Safety	6.95
Workforce Planning	7.00
Other Tasks Not Mentioned	8.21
Total	**624.47**

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5.4 Sub-Tasks

Table 21 provides a closer look at the five main task areas and the sub-tasks under each of them. In Administration, the sub-tasks are heavily skewed around rosters (30.81%) and payroll (31.27%). Under Communication, it is responding to emails that takes up a high percentage of time (29.55%) followed by dealing with phone calls (21.7%).

With respect to ***Clinical Leadership*** (a key focus of this study), by far the highest proportion of time spent is on acting as a ward/shift co-ordinator (36.3%), a significant part of clinical leadership in a NUM's role, followed by trouble-shooting problems with staff (19.28%). Together, advising staff regarding patient care, and developing staff by empowering them to make sound clinical and resource decisions, also account for a considerable proportion of the NUM's time (32.57%) within the sub-tasks. The least amount of time is spent on supervising or undertaking complex and basic procedures (11.74%).

By far the greatest proportion of time spent on Human Resources involves several tasks related to rostering (45.76%). However, attending meetings (84.92%) comprised the main sub-task under this area.

When the sub-tasks are viewed from the perspective of the *percentage of total time* they consume, attending meetings (6.12%), responding to/ checking/ writing emails (4.82%), undertaking payroll paperwork (3.98%), taking or making phone calls (3.55%), recording/ retrieving information on/from the computer (3.45%), and acting as ward/shift co-ordinator (3.34%) have the highest percentage overall.

Table 21 Diary Entry for Five Main Sub-Tasks

Administration	**% Administration Time**	**% Total Time**
Organising accommodation, transport and/or travel	3.23%	0.62%
Updating master roster (shift changes, sick leave, etc.)	17.31%	3.30%
Recording/retrieving information on/from the computer	18.07%	3.45%
Dealing with information on the ward computer system	5.57%	1.06%
Assessing and recording patient's dependency	2.83%	0.54%
Making outpatient identification bracelets and notes	0.71%	0.13%
Admitting/discharging patient from unit - paperwork, HBCIS	1.57%	0.30%
Supervising or making out duty rosters	13.51%	2.58%
Delivering or collecting patient's notes/reports	0.80%	0.15%
Undertaking payroll paperwork (i.e. AVACs, leave requests, movement forms)	20.84%	3.98%
Payroll enquiries	10.43%	1.99%
Filing paperwork	5.13%	0.98%
Total	**100.00%**	**19.09%**
Communication	**% Communication Time**	**% Total Time**
Supervising or supporting patients by explaining procedures, reassuring or teaching a patient	3.20%	0.52%
Demonstrating ward systems, i.e. bed, on call and TV system	0.12%	0.02%
Communicating with medical staff re: patient care	6.43%	1.05%

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Taking or making phone calls	21.77%	3.55%
Teaching how to develop a positive feedback culture to staff	2.18%	0.36%
Providing advice for staff and/or patients	7.69%	1.26%
Sharing management information with your staff	7.27%	1.19%
Responding to/checking/writing emails	29.55%	4.82%
Giving advice on telephone calls	4.15%	0.68%
Liaising with direct line manager re issues affecting the unit	7.46%	1.22%
Providing support to staff members (i.e. debriefing, listening, counselling)	10.18%	1.66%
Total	**100.00%**	**16.32%**
Clinical Leadership	**% Clinical Leadership Time**	**%Total Time**
Supervising or undertaking complex procedures	5.80%	0.53%
Supervising or undertaking basic procedures	5.97%	0.55%
Act as ward/shift coordinator	36.37%	3.34%
Provide advice to staff regarding patient care	17.23%	1.58%
Trouble shooting problems with staff	19.28%	1.77%
Assisting and empowering staff with making sound clinical and resourcing decisions	15.34%	1.41%
Total	**100.00%**	**9.19%**
Human Resource Functions	**% Human Resource Time**	**% Total Time**
Recruitment of new staff - preparation of advertisement, request to fill paperwork, job descriptions, interview questions	12.90%	0.98%
Recruitment of new staff - interview, selection report paperwork, criminal history check, referee check, informing unsuccessful applicants	19.05%	1.45%
Formulating and/or reviewing nursing roster, ensuring compliance with relevant awards and legislation	22.90%	1.75%
Ensuring adequate staffing and skill-mix available for shifts on daily basis	22.86%	1.74%
Supporting staff professional development (booking courses, approving paperwork)	10.17%	0.78%
Completing performance appraisal and development (PAD) tool with staff	12.13%	0.92%
Total	**100.00%**	**7.62%**
Meetings	**% Meetings Time**	**% Total Time**
Attending meetings	84.92%	6.12%
Arranging meetings (i.e. ward meetings, CN meetings) or unit planning days	7.58%	0.55%
Typing up minutes of meetings	7.50%	0.54%
Total	**100.00%**	**7.21%**

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5.5 Payroll and Rostering

However, one aspect of this data that attracted our attention is that payroll and rostering appeared in a couple of different main tasks areas in **Table 21** and when grouped and tallied, the *percentage of total time* allocated to this collection of sub-tasks is significant. As **Table 22** shows, nearly 19% of the total of a NUM's time is taken up with payroll and rostering.

Table 22 Payroll and Rostering

Payroll and Rostering	Percentage of Total Time
Updating master roster (shift changes, sick leave, etc.)	3.30%
Supervising or making out duty rosters	2.58%
Undertaking payroll paperwork (i.e. AVACs, leave requests, movement forms)	3.98%
Payroll enquiries	1.99%
Act as ward/shift coordinator	3.34%
Formulating and/or reviewing nursing roster, ensuring compliance with relevant awards and legislation	1.75%
Ensuring adequate staffing and skill-mix available for shifts on daily basis	1.74%
Total	**18.68%**

5.6 Clinical Governance

Clinical governance covers those core functions that entail clinical leadership, patient safety, and quality improvement that are fundamental to the NUM's role. As such, effective clinical governance ensures that NUMs can focus on the clinical roles for which they are recognised as being key to improving health outcomes, including patient focused care as well as staff retention and satisfaction. **Table 23** shows the percentage of time spent by NUMs on clinical governance related tasks with *act as ward/shift coordinator* taking up the most significant percentage of time (27.0%). However, the overall percentage of total time these tasks consume is relatively low (12.3) in terms of the importance of these tasks for the successful performance of the NUM role.

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Table 23 Clinical Governance and Task Percentage and Time

Task Group	Task	Percentage of Clinical Governance Time	Percentage of Total Time
Clinical Leadership	Supervising or undertaking complex procedures	4.31%	0.53%
Clinical Leadership	Supervising or undertaking basic procedures	4.43%	0.55%
Clinical Leadership	Act as ward/shift coordinator	27.00%	3.34%
Clinical Leadership	Provide advice to staff regarding patient care	12.79%	1.58%
Clinical Leadership	Trouble shooting problems with staff	14.32%	1.77%
Clinical Leadership	Assisting and empowering staff with making sound clinical and resourcing decisions	11.39%	1.41%
Patient Safety	Managing Patient incident, review PRIME and follow up	10.54%	1.31%
Patient Safety	Conduct patient safety audits as per local PSQ Unit guidelines	1.82%	0.23%
Patient Safety	HEAPS/RCA involvement	1.17%	0.14%
Quality Improvement	Involvement with accreditation (i.e. maintaining Quality Register, collating and providing supporting documentation, etc.)	3.35%	0.42%
Quality Improvement	Assist with development of unit/organisational policies and procedures	4.65%	0.58%
Quality Improvement	Conduct audits as per local Quality Unit guidelines (i.e. Controlled Drug audits)	4.23%	0.52%
		100.00%	**12.38%**

5.7 Importance and Delegation Scales

The Importance and delegation scales were examined to identify items that contained at least 100 or more responses (i.e., 44.84% of possible responses from the total sample size). Many of the items in the scales were not completed because NUMs had to evaluate the importance of tasks across all items. It appears that providing this additional information became a major impost for many respondents.

Table 24 shows that on the importance scale, the most immediate and pressing tasks (scale of 5) are those that relate to clinical leadership and in particular, providing advice to staff regarding patient care (N= 47 and 44.3%) and trouble-shooting problems with staff (N=55 and 43.3%). The

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next most pressing tasks (scale of 4) are in administration and relate to undertaking payroll paperwork (N=81 and 52.9%) and updating the master roster (N=80 and 52.3%). Communicating and meetings also show relatively high percentages (scale 4).

Table 25 shows the delegation scale**.** Updating rosters and providing advice to staff regarding patient care, are the only two areas that are evenly spread between delegating to the next senior person (scale 4) and not able to be delegated (scale 5). The remaining items are all identified by at least 50% of the respondents as not being able to be delegated. The three items that are least able to be delegated are responding to emails etc. (N=124 and 84.99%), attending meetings (N=97 and 74.6%), and taking or making phone calls (N=85 and 59.4%). The reasons why tasks cannot be delegated are complex and can range from not having a person to delegate to even if the NUM could do so, to refusing to delegate a task even if it is possible. Furthermore, delegation can also be affected by other factors such as length of service and qualifications (Saccomanos and Pinto-Zipp, 2011). Our survey did not explore the reasons behind why delegation could or could not occur or organisational policies or practices that prohibit or enable delegation of tasks.

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Table 24 Importance Scale and Main Results

1. Not important –need not be done
2.Neither Important nor Unimportant- it may be useful but is not necessary
3.Important – it should be done later
4.Very Important – it should be done now
5. Extremely Important – it must be done right now

	Administrative				Clinical Leadership			Communicating		Meetings
	Updating master roster (shift change, sick leave, etc.)	Recording/ retrieving information on/from the computer	Undertaking payroll paperwork (i.e. AVACs, leave requests, movement forms)	Payroll enquiries	Provide advice to staff Regarding patient care	Trouble shooting problems with staff	Assisting and empowering staff with making sound clinical and resourcing decisions	Taking and/ or making phone calls	Responding to/checking/ writing emails	Attending meetings
1.	1(0.7%)	1(0.8%)	1 (0.7%)	3 (2.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (1.4%)
2	1(0.7%)	13 (10.8%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	2 (1.6%)	1 (0.9%)	12 (8.1%)	18 (11.6%)	15 (10.5%)
3.	28(18.3%)	55 (45.8%)	28 (18.3%)	36 (30.0%)	10 (9.4%)	13 (10.2%)	14 (13.0%)	36 (24.3%)	79 (51.0%)	32 (22.4%)
4.	80(52.3%)	38 (31.7%)	81 (52.9%)	45 (37.5%)	49 (46.2%)	57 (44.9%)	50 (46.3%)	70 (47.3%)	40 (25.8%)	68 (47.6%)
5.	43(28.1%)	13 (10.8%)	42 (27.5%)	36 (30.0%)	47 (44.3%)	55 (43.3%)	43 (39.8%)	30 (20.3%)	18 (11.6%)	26 (18.2%)
N=	153	120	153	120	106	127	108	148	155	143
NR=	13	18	15	12	15	14	9	19	16	26

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Table 25 Delegation Scale and Main Results

1. Delegated to anyone who can be trained
2.Can be delegated to someone in the nursing area such as an Administrative Officer (OA)
3. Can be delegated to someone in the nursing area such as an Enrolled Nurse
4. Can be delegated to someone who reports directly to you such as the next senior RN
5. Not able to be delegated as I am the only one who can do it

	Administrative				**Clinical Leadership**			**Communicating**		**Meetings**
	Updating master roster (shift change, sick leave, etc.)	Recording/ retrieving information on/from the computer	Undertaking payroll paperwork (i.e. AVACs, leave requests, movement forms)	Payroll enquiries	Provide advice to staff Regarding patient care	Trouble shooting problems with staff	Assisting & empowering staff with making sound clinical and resourcing decisions	Taking and/ or making phone calls	Responding to/checking/ writing emails	Attending meetings
1.	16 (10.8%)	10(8.9%)	23(15.9%)	19(16.7%)	2(2.0%)	5(4.2%)	3(3.0%)	7(4.9%)	0 (0.0%)	1(0.8%)
2.	24(16.2%)	15(13.4%)	25 (17.2%)	14(12.3%)	3(3.0%)	3(2.5%)	4(4.0%)	5(3.5%)	4(2.7%)	2(1.5%)
3.	12(8.1%)	17 (15.2%)	6(4.1%)	3(2.6%)	22(21.8%)	13(10.8%)	10(9.9%)	15(10.5%)	3(2.1%)	7(5.4%)
4.	49 (33.1%)	16 (14.3%)	33 (22.8%)	22(19.3%)	37(36.6%)	30(25.0%)	33(32.7%)	31 (21.7%)	15(10.3%)	23(17.7%)
5.	47 (31.8%)	54(48.2%)	58(40.0%)	56(49.1%)	37(36.6%)	69(57.5%)	51(50%)	85(59.4%)	124(84.9%)	97(74.6%)
N=	148	112	145	114	101	120	101	143	146	130
NR=	20	25	23	16	18	20	14	24	24	40

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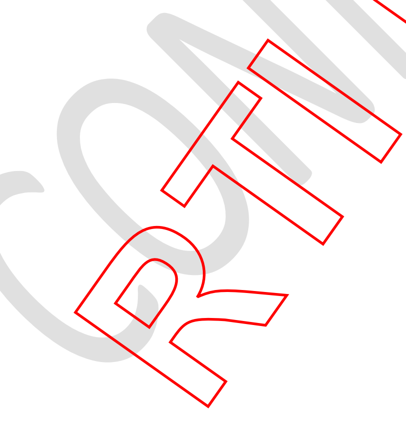
SECTION 6 – CONCLUSION PART 2

The study provides very important findings across the data set. The key ones are:

- NUMs are not satisfied with levels of training and mentoring that are being provided for them in their NUM roles.
- NUMs are a group of professionals who have high levels of professional qualifications and are increasingly gaining management related credentials.
- Work related stress and excessive workload remain the two key reasons why NUMs are considering leaving the profession.
- NUMs are not happy with the PDA system.
- A high proportion of NUMs' time is taken up with dealing with tasks related to payroll and rosters.
- Clinical leadership is not given the time that is required to ensure that NUMs are able to perform at the level that is required of them to meet their own professional and system-wide requirements.
- Clinical governance is not give the time required to ensure that professional and system-wide requirements are met.
- NUMs do not feel they can delegate many of the tasks that take them away from clinical leadership.

The report provides important information on differences across facilities and settings and in particular in relation to the ageing workforce and the need for workforce planning.

The diary information is the most extensive hard evidence collected of its kind in Australia and provides a sound basis for developing a more refined tool for further investigation. It also provides the type of information that is needed to assist policy makers and decision makers to improve how NUMs perform their tasks and the areas where critical attention is needed to support, attract and retain NUMs.



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PART 3

FOCUS GROUPS – BEST PRACTICE

1.0 Background

In addition to the quantifiable data collected by survey to help clarify the core functions of the role of NUMs (in Part 2 of this report), qualitative data was also sought to assist policy makers in making decisions about how NUMs can optimally undertake clinical leadership roles. The qualitative data was sought to systematically identify what might constitute best practice models of professional clinical leadership for NUMs that will support high quality patient outcomes.

This second part of the research was conducted independently from the first part. The qualitative data collection researchers who conducted the focus groups were not privy to any results of the online survey aspect of the research; the analyses were kept completely separate and no discussions divulging any contents of either set of results occurred between the staff involved in the different parts.

1.1 Methodology

Participants for the focus groups were identified by Queensland Health as 'best practice' or excellent NUMS. The selection of NUMs was undertaken by DDONs and in selected districts to ensure that metro, regional, remote and rural were represented. The selection of a NUM by the DDON had to take into account the following:

1. *Someone you would judge to be a high performer and who you feel is held in high regard by others in the District in terms of their NUM role.*
2. *Someone who you believe is an excellent role model for other NUMs in the District.*
3. *Someone who is capable of representing the views of all NUMs in the District and has the credibility to be seen as an excellent spokesperson on issues affecting NUMs.*

With the assistance of Ms Louise Chesby from Queensland Health, seven focus groups were arranged across metropolitan, regional, rural and remote districts. Focus groups interviews began on 12 September and the remainder were completed by 26 October, 2011. A total of 25 NUMs were interviewed from hospitals in locations ranging from Brisbane to Cairns. The large majority of participants were female, representing the Australian nursing population, with participants having experience in their NUM roles ranging from less than one month through to more than 20 years. The focus groups were conducted face-to-face in the majority of cases, but a few long-distance focus groups were conducted using videoconferencing facilities.

An Information Sheet was presented to each focus group participant at the start of the session, to enable each participant to understand the rationale and basis for the research. The research was explained by the Griffith University staff and introductions between all participants were arranged. The same seven general prompt questions were asked of the focus group participants in each focus group, namely:

1. *You have a stressful and demanding job. What are the key issues that create these situations in your day to day activities?*
2. *What have you developed in order to best manage the demands of the job?*
3. *What have you developed in order to best manage the stressors of the job?*

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4. *Are there other factors associated with your role of NUM that need to be understood so that others can gain insight to the position and how best it can be managed?*
5. *Are there aspects of the job that with the right structure and support could be delegated to others?*
6. *How would you were personally develop someone for the position of NUM so that they had the attributes and abilities to best deal with the job?*
7. *What else do you feel is important in succeeding as a NUM that we haven't discussed?*

The focus groups were conducted on the basis that no participant would be identified. All focus groups had two researchers present with one acting as a facilitator and the other taking notes etc. All researchers are experienced in conducting focus groups and used a standardised protocol for each focus group session. Each member of each focus group gave permission to voice-record their sessions, and the recordings were later transcribed by a professional transcription service, for analysis by the research team. An initial general thematic analysis and identification of themes was conducted by the facilitators, with further analysis performed using Leximancer software to assist with research rigour and objectivity.

1.2 Observations of the Interview Context

The researchers noted that on several occasions, participants who were scheduled to attend did not attend and the reason provided was that they could not be released from their duties. There was a notable difference between the metropolitan and other districts. In the Brisbane areas, most participants attended and even stayed after the allotted time to add further points or continue discussions. In the other areas, this situation was not repeated. For example, the researchers observed that in the remote areas, the NUMS were constantly interrupted by their mobile phones, which they had apologised for before the focus groups started with the explanation that this was likely to occur but that there was nobody else to take the calls. Also, these remote NUMs looked and sounded exhausted, and several commented that they had 'nobody to help' them with the job. This was supported by comments at each focus group about lack of training opportunities outside of the Brisbane area, while such opportunities were available to those in Brisbane and surrounds. The stress levels appeared high within several groups, both metropolitan and remote, and when asked, they reported there is a lack of succession planning, which adds to this challenge.

Another observation was the perception of fear or concern expressed by focus group participants about their anonymity, but there was greater fear expressed by the non-Brisbane groups. A few participants remarked that they were concerned that participating in the focus groups or contributing to the research might negatively affect their careers and therefore, the confidentiality safeguards of the project had to be clearly explained and emphasised prior to obtaining their involvement.

1.3 Data Analysis and Results

Initially all seven transcripts were reviewed and key themes identified by the research team both separately and then through cross-checking each other's analysis. It was decided to verify the themes independently by using Leximancer software. The key themes that emerged from the Lexical analysis support the initial thematic analysis but allows for connections to be made between the key concepts in a way that is not easy to do through other methods. The advantage of this method is that it allows for both content analysis and ethnographic analysis of the text behind a set of codes (Wilkinson, 2011).

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In computer-aided lexical analysis, each word forms the unit of analysis (Krippendoff, 1980). Leximancer Version 3.5 was used to analyse the data. Leximancer's learning capability puts similar words into groups automatically as synonyms, and each generated group is then represented as a 'concept' (Smith, 2003). A concept is a collection of words that travel together; these groups are achieved in Leximancer through the use of both implicit and explicit means, therefore, the actual word does not have to appear in the sentence for the concept to be identified, allowing concepts to be automatically coded in a grounded fashion (Smith & Humphreys, 2006). This form of analysis is empirically rigorous and provides a useful complement to ideas developed through more traditional forms of thematic analysis.

At this point, concepts are grouped into clusters and circled into themes. These themes are named by the most prominent concept held within the group and is represented by the largest dot in this theme. The researcher, by using the concept map, rank-ordered concept lists and text query options, can gain insight into the concepts, the themes and their relationships. Through the semantic structuring of the data the map produces a visual representation that includes the strength of association between the concepts and their interaction.

After Leximancer identified concepts, the researcher validated and interpreted the meanings behind the concepts and the interconnections between these concepts and themes. The initial lexical analysis identified 46 concepts. The first requirement of the interpretation is the removal of concepts that were of a general rather than meaningful nature; in this case 23 concepts were removed. These deleted concepts included names of some respondents, and language individuals used to express or emphasise themselves or situations such as 'thinking', 'feel', 'probably', 'sure', 'stuff' and 'things'. This left the 23 concepts presented in Table 1 (below).

Table 26 Summary of Final Concepts from the Lexical Analysis of the Focus Group Data

Word-Like	Count	Relevance	Word-Like	Count	Relevance
Time	189	100%	13. Unit	63	33%
Staff	173	92%	14. Ward	63	33%
Clinical	136	72%	15. Patients	56	30%
Work	132	70%	16. Nursing	55	29%
People	130	69%	17. Support	54	29%
Role	105	56%	18. Different	52	28%
NUM	81	43%	19. Working	46	24%
Nurses	80	42%	20. Management	39	21%
NUMS	77	41%	21. Care	36	19%
Nurse	71	38%	22. Patient	36	19%
Person	66	35%	23. Difficult	34	18%
Job	65	34%			

The concepts presented in Table 26 range from a count of 189, the highest count - for 'time', to 34, the lowest - for 'difficult'. While there are some concepts that are more prevalent than others, each has enough occurrences to be important to the analysis. While the number of times a concept appears is relevant in understanding aspects of the strength of the concept, the analysis is more complex in that these concepts are then clustered into themes. These themes and the connection to concepts within the themes are provided in the following concept map provided as Figure 1 (below).

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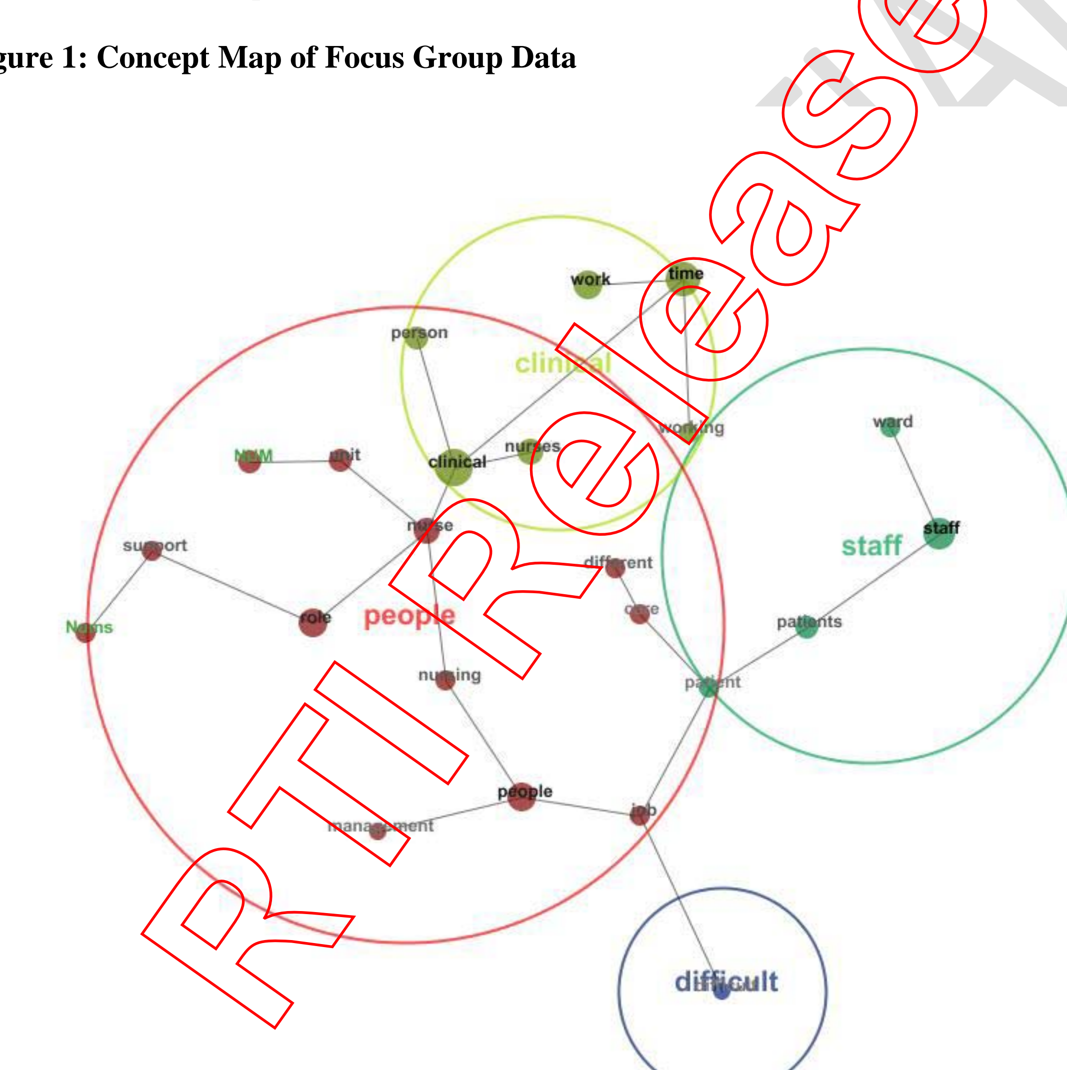
1.4 The Four Themes Developed Through Lexical Analysis

Figure 1 presents the four major themes identified by Leximancer. In order of significance, these themes are 'people', 'difficult', 'staff' and 'clinical'. Here the 'people' theme represents the human nature of the position and the complexity that all these human aspects bring. In the first instance, this theme represents ideas such as the constant pressure of dealing with individuals as seen in the statement: "*But that impacts them because sometimes you can have 20 people in your office in one day trying to sort out some of those issues, and that's good, but sometimes it doesn't help either*." This themes ranges through to the inclusion of comments on how NUMs are trying to address these type of people-issues through inclusion, "Y*eah, I am a really big one on empowering people, because I learnt very, very quickly that I was sinking and I was not floating at all*." In the following sections, each of these themes are combined with observations from the independent thematic analysis to provide a more complete representation of what the participants saw as the crucial components of effective work as a NUM.

Figure 1: Concept Map of Focus Group Data



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1.5 The Theme 'People'

The first theme, 'people', is central and connected to the other three themes because of the demands of the job and the confusion over clinical, administrative, managerial and patient roles and responsibilities. One participant summarised this situation in the following way:

> *I think when you are a manager too, though, people respond differently to you and some of the behaviour that comes up, you go, oh my God, when I worked with them I never knew they were like that. Like some, oh, my God.*

This cultural shock and role confusion was often discussed in terms of what it is to be a nurse and nursing as a profession, plus the NUM's position losing focus on clinical and patient care and being forced more and more towards the position of administration, finance, HR, problem-solving and being an all-round interventionist with little or no explicit training in these areas.

One approach to improve management emphasised nursing as a profession within the units and linked this to clinical care. So some of the NUMs attempt to bring staff within the unit together on a regular basis to discuss, plan and develop deeper and trusting relationships, in a manner analogous to how they may manage clinical care itself. While all saw this as important, not all have the same level of success with this process, not even with trying to bring the clinical team together (NUM and Clinical Nurses).

> *That unfortunately, went by the by over the last couple of years, two or three years I would say because of the fact that you can't get them off-site. You cannot get them off and you can't get 10 people off for a whole day.*

Many felt that the ability to do this on a monthly basis was a valuable and important part of their role, not only providing leadership but enhancing planning and communication, as well as both staff and patient outcomes, through mutually defined and developed understanding.

Interestingly, NUMs who worked in hospitals located more than 45 minutes from Brisbane had fewer difficulties in having these meetings and providing access to training seemed to diminish. It appears that working in the regional settings made these possibilities more available. Alternatively, it could be that the regional staff had lower expectations of what types of meetings they could have, and so were more likely to be satisfied with informal, *ad hoc* interactions, as shown by the following quote.

> *And it ended up being once every two months because, as X said, it's – people – I think the perception is when you're in rural, you just sit on the phone and you don't have much happening, but there's so much happening because you're, again, multi-tasking and got millions of hats to wear. And so we had a net – we just did our own informal networking group, and that was one way that you just – sometimes two heads is better than one, just to realise you're not alone and that everyone's feeling the same way.*

What these examples demonstrate is one of the key reasons why the 'people' theme is directly linked to the singular theme of 'difficult' via the concept of the 'job'. Participants valued their interactions with people, but typically reported that managing those interactions was one of the most difficult components of the NUMs' role. Nonetheless, it appears to be a consistent finding that NUMs found that their investment in effectively communicating with their teams, especially about how best to improve the manner in which their teams operated, contributed to more effective performance of both the NUM and their staff.

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1.6 The Theme 'Difficult'

The type of comment that was common in the 'difficult' theme was the following simple statement; "*And that's -that's difficult*." The job is difficult because of human interactions, both personally and professionally, that these individuals have to deal with on a day to day basis. Linking 'people', the 'job', 'difficult' and the 'patient' together, we regularly heard examples such as the following being discussed by participants.

> *It's not across the board. There's no consistency, and so that's - makes it very difficult because if you could have that consistency across the units, across divisions, we'd be all on the same page, but I'm afraid that doesn't happen.*

and

> *So that's on a day-to-day basis, that's difficult, and like I said, there's not been any process put in place to help us make some of those decision or support us through this. There's no workplace instructions, there's no -it's just a - "This is the issue - just deal with it", and this is the outcome - this is the outcome we expect - and this is what you've got to fix.*

As indicated both role stress and role ambiguity, compounded by unpredictable and inconsistent operations, underlies many of the comments made by this group. These factors appear to be the source of many of these 'difficult' issues that are often outside NUMs' control and influence. This compounds time pressures as NUMs attempt to address these outcomes without the process and support systems seemingly in place. In general, NUMs indicate that in most cases support is lacking. There are pockets where local hospital or district initiatives have been developed to address this but the participants indicated that this was rare. In some cases, NUMs joked of the joy of acting as DON or other higher positions so they could have a break and get a rest. That is, the systems in place appear to this group to be a source of pressure rather than assistance, especially with respect to performance standards:

> *Sometimes you can do it well, but sometimes you just can't, and that's - that's difficult too. You know, I think that's seen as sometimes as a - that you're not doing your job as effectively as you should because you haven't achieved this particular number.*

The response that would be expected in this theme of difficult people is present but not as significant as the perceived lack of systems, support structures and training in managerial and administrative areas.

Another factor associated with the 'Difficulty' theme was the effect of working in non-metropolitan areas. Only a short distance from Brisbane, individuals report much higher levels of stress and lack of opportunity than their city counterparts. The following quote is typical of the issues faced by NUMs who are trying to manage clinical, administrative, managerial and organisational functions while being a mentor, counsellor and support to their Staff.

> *But coming from a rural area, it has a bit of a different feel on it. One of my stresses is that I have so many different hats; that makes it difficult to fit into your day what you need to get out of it.*

What was also consistent as requests from most in the focus groups for development in the above areas themselves, as except for a small number from Brisbane who had some very effective if limited training, most had been self-taught. In other words, the NUMs reported that training on

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key areas, especially on how to manage the complexity, ambiguity, inconsistency and performance demands they faced, was useful. On the other hand, the NUMs reported that hospital efforts taken to rationalise competing demands on NUMs were valuable, because it reduced the level of confusion experienced. Likewise, the NUMs' own ability to recognise which demands were most important when conflicting demands arose was helpful, something that they gained from having, the opportunity to clarify demands with others.

1.7 The Theme 'Staff'

The link for 'difficult' and 'people' themes to 'staff' is the transference of people, profession and job issues into the classic and regular activities of people in their work function and assuming the role of staff as indicated in the last quotes in the difficult theme. Here NUMs are attempting to have their nursing teams develop an understanding of organisational requirements and the need to meet these requirements in a way that allows staff to see how these requirements are consistent with patient care.

> *But it's also really good that the staff see that someone else is doing it, so there's not quite that division, "Well, look what the NUM has rostered us." It actually is, like, for someone on the floor is making these decisions.*

As the above quote indicates when methods of inclusion and job sharing are used these actions bring clarity to these units or wards. It is more than just talking – there is also the demonstration of commitment that the NUMs found to be useful in creating commitment in their staff. However, the size and complexity of the staffing arrangements were often commented on as being an issue that interfered with effective staff management:

> *So there's that big inequality, like I have 65 staff, and the fact that I can't get everything – like their PADs for example. I mean, there's no way that I can get everybody's performance and development plan organised.*

What the NUMs reported was that they had to find alternative ways of achieving their goals, in part by delegating tasks. Several NUMs identified that this was not just a factor for managing their own workload – it actively developed their staff and helped gain their empathy and commitment. This was consistent with the other key discussion under the 'staff' theme, which was the importance of managing priorities and how this impacted on staff, the ward and patients and their care.

> *So ensuring that my priorities – ensuring that that runs smoothly, that the staff are coping with that, that – just that everything probably is running smoothly. That's my priority in my day-to-day stuff.*

And

> *So how do I manage? I manage – the way I'm trying to manage all these stresses. At the moment my priority is keeping my staff morale up.*

Clearly, the effective NUMs were not focused simply on procedures and priorities but were also attending to the people side of health care. Helping staff cope and keeping up staff morale were integrated with a concern for good systems and performance, using action learning skills to develop and engage staff where possible. This extended to the NUMs treatment of themselves, in that the participants also repeatedly mentioned their own efforts to manage their workloads and improve their abilities. In the context of a difficult and demanding role, the NUMs represented in

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the focus groups gave a number of examples of their own adaptive skills which appear to draw on their professional nature as providers of care, with concerns for both evidence based practice and continual learning.

The focus that several of the NUMs used to establish this platform for their own and their staff development is patient care, which leads to the clinical area. This was particularly important as often NUM's expressed a conflict between their administrative and clinical roles, a factor discussed in more detail in the final theme.

1.8 The Theme 'Clinical'

There are three distinct aspects to the 'Clinical' theme, reflecting the confusion for NUMs between their administrative and clinical roles, and the role of clinical nurses. This is a further manifestation of the recurring role ambiguity and confusion for NUMs. Adding to this is the requirement for NUMs to focus on the maintenance and importance of clinical standards.

The role ambiguity and confusion between the clinical and administrative requirements of the position is represented in these typical comments:

> *I think for me there is ambiguity, with that mix between that clinical and administration: how much clinical do you give? I guess when everything has fallen to pieces you have to spend a lot of time on the floor.*

and

> *I steal from my clinical time to do all of this other stuff and that's sad because you are not on the floor, being seen.*

This stress was present at different levels across all focus groups. Therefore, the link between the NUM and the clinical nurse, and how this is managed is important to the development of a strong nursing team. If this is not understood and dealt with effectively it manifests in the following divide:

> *Those clinical nurses, they're treated as glorified registered nurses when really, they are clinical nurses, they're supposed to be experts on the clinical floor and some NUMs argue with that - me included - of not delegating things to them and letting them be responsible if something isn't right.*

When this relationship is developed and understood, this group appears to form an effective management team, where the role of the NUM is to develop, empower and lead this team.

> *I don't actually – I would say that my team, unless they relieve me, they have no idea of the stress that – and of the demands that are on the NUM role until they actually do your role and when they do, the clinical nurses that actually are game to put their hand up - - -*

In other words, it is crucial for NUMs to develop a relationship where aspects of clinical and administration can be handed over to the clinical nurse group.

> *So if they do clinical incidents they see, "Well, we've had this many falls - go and have a look at the charts and look - the falls haven't - falls risk hasn't been done." So it's starting to make that correlation between what actually happens clinically on the floor and why we have systems in place to do it.*

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and

> *it gives the CNs an awareness of what you actually do, how it works, and so I have a CN who does the roster. I have a CN who does all my clinical incidents.*

This relationship can be so strong and important to the effective management of some of these groups that those that have embraced the process (out of necessity) make statements such as, "*They're learning. Without that clinical facilitator, I'd just pack it in and go home, really*." When this process is embedded and developed, it becomes integrated into the NUMs' own learning process, such as the following report, "*I do a 360 survey and my staff – I did the emerging clinical leaders' program, the 12-month course through Queensland Health, which was the most awesome course I've ever done*."

Therefore, while a key area of stress and confusion, the clinical role can be managed. The constant need for management and organisational training is important for both those in the NUM and Clinical Nurse's role. This joint training is important as effectiveness increases when the NUM and Clinical Nurses act as a management team with the NUM as the team leader.

1.9 Best Practice

In summary, there were several factors that appear to be consistent among the exemplary NUMs who participated in the qualitative research, and contributed to their performance. These include:

- Effective communication with teams about operation matters, but more importantly about how to improve team functioning.
- Local support systems that provide coherent and consistent policies, systems and procedures, and rationalising competing demands on NUMs.
- Adequate resourcing, as demonstrated by the greater capacity of the metropolitan NUMs to access staffing and other resources, and their consequently greater capacity to achieve higher quality outcomes.
- High quality training and mentoring, especially on how to manage complex, ambiguous and demanding situations, including skills in recognising the relative priority of conflicting demands.
- Effective staff leadership including clarifying and explaining organisational policies, demonstrating good work practices, leading by example, and delegating and developing promising staff members.
- Continually learning from available sources, such as training courses, reading, conversations with fellow professionals, and listening to their own staff.
- Managing themselves by ensuring that their skills were up to date, and that they negotiated demands on their time down to appropriate levels.

1.10 Conclusion

The qualitative lexical analysis provided four key themes 'People', 'Difficult', 'Staff' and 'Clinical'. The key findings within these themes are that the position of NUM carries a high level of role stress and role confusion. The role stress is to do with the difficulty of the job including the demands and complexity, these people are time poor, have to be multi-skilled, have high

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communication and leadership skills while being administrative adept. However, few have reported receiving formal training in these areas, with this training being more likely for Brisbane based NUMs and less likely for those in regional districts. When this training is provided it is received in a positive vein. The key issue in the time poor area is the need to find time so that NUMs and Clinical staff can meeting on a monthly basis for at least ½ a day off the job to discuss and develop the job and the unit/wards performance.

This outcome relates directly to role ambiguity as NUMs being nurses first miss the ability to be involved in direct nursing activities. While still being at the coal-face this group is at arms' length, yet still in sight of the professional activities that brought them to nursing, a profession of which they are all very proud. It appears where the NUM and Clinical Nursing staff can develop an effective management team that issues are lessened and great effectiveness and performance is achieved within this team environment. That said, this group also need administrative support in the areas of meeting preparation, minute taking, filing, copying and so on, as it was stated by all involved that this could be a shared resource but was a missing and essential resource.

The level of stress experienced by the NUMs should not be underestimated, and it was the one issue that participants were most concerned about. This was such a sensitive issue that some of the regional participants would not allow their comments on this matter to be recorded, however they were willing to tell us of several anecdotes in which NUMs had experienced particularly extreme stress-related outcomes.

Even so, the effective NUMs who participated in these focus groups demonstrated a level of professional integrity by which their espoused clinical values were reflected in their management practices. On a personal note, the research team were impressed with the standards that the NUMs maintained in the midst of what appear to be very challenging circumstances. That level of professionalism gave us cause for optimism about the current and future outcomes in the areas under their management, and we are happy to commend their best practices.

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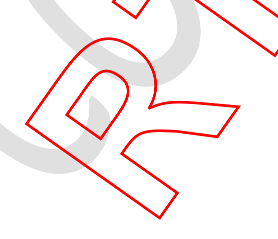

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Nursing and Midwifery Office
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Nurse Unit Manager Project

Strengthening the leadership capacity and capability of our nurse leaders

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Governance

The *Nurse Unit Manager Phase II Project* maintained quality governance processes through the steering committee comprising of Queensland Health and Queensland Nurse Union representatives.

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This report does not address all elements of nurse unit manager practice and assumes that individual managers are responsible for:

- discussing issues with relevant persons in an environment that is culturally appropriate and which enables respectful confidential discussion
- advising nurses and midwives of their choice and ensure informed consent is obtained
- meeting all legislative requirements and maintaining standards of professional conduct
- documenting in accordance with mandatory and local requirements.

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1. Executive Summary

This report details the findings from the Nurse Unit Manager Project Phase II, which commenced in July 2010. The Nurse Unit Manager (NUM) plays a pivotal role in the provision of safe, quality patient care, and influencing patient and staff satisfaction by creating a positive culture within their work areas. They are the lynch-pins of the health-care system and perform an essential role providing a supportive environment which promotes nursing and midwifery retention. In view of the projected nursing and midwifery shortages in coming years, it is essential that every effort is made to support the leadership development of this critical role, to enhance retention of nursing and midwifery staff in the future.

In 2008, the *Review of the Nurse Unit Manager Role Report*[1] highlighted a range of issues causing dissatisfaction and role stress for NUMs throughout Queensland Health (QH), including insufficient training and preparation to undertake the role, ambiguity of core role functions, extraneous tasks limiting the clinical leadership role of the NUM, and lack of succession planning for clinical nurses and clinical midwives (CNs and CMs) into the role. At the same time, the NUM role was described as becoming increasingly unattractive due to CNs and CMs earning less when acting in the NUM role, which has greater responsibility, compared with their substantive role with shift penalties.

In order to address these issues and explore strategies to strengthen the NUM role, the Nursing and Midwifery Office Queensland (NMOQ) initiated the NUM Project Phase II. It is important to note that consultation throughout this project has validated the findings of the *Review of the Nurse Unit Manager Role Report* as still being current today.

The NUM is a key leadership role within the nursing and midwifery stream however nurses and midwives in these roles identified that they received little or no training prior to commencing in the role. Provision of targeted leadership and management development programs throughout QH is a critical element in supporting and preparing nurses for the unique challenges of the role. By ensuring appropriate development into the role, QH is creating a platform of successful nursing and midwifery leadership and recognises the significant contribution the NUM role makes to the organisation.

Strategies identified through this project to support the NUM role include:

- provision of leadership and management development programs for those in the role, and also those aspiring to the role
- utilisation of succession management strategies outlined in the NUM Succession Framework to improve preparedness for the role
- clarification of the core functions and expectations of the NUM role through the NUM Core Functions Framework
- creation of structured orientation processes, including handover and orientation time for the role

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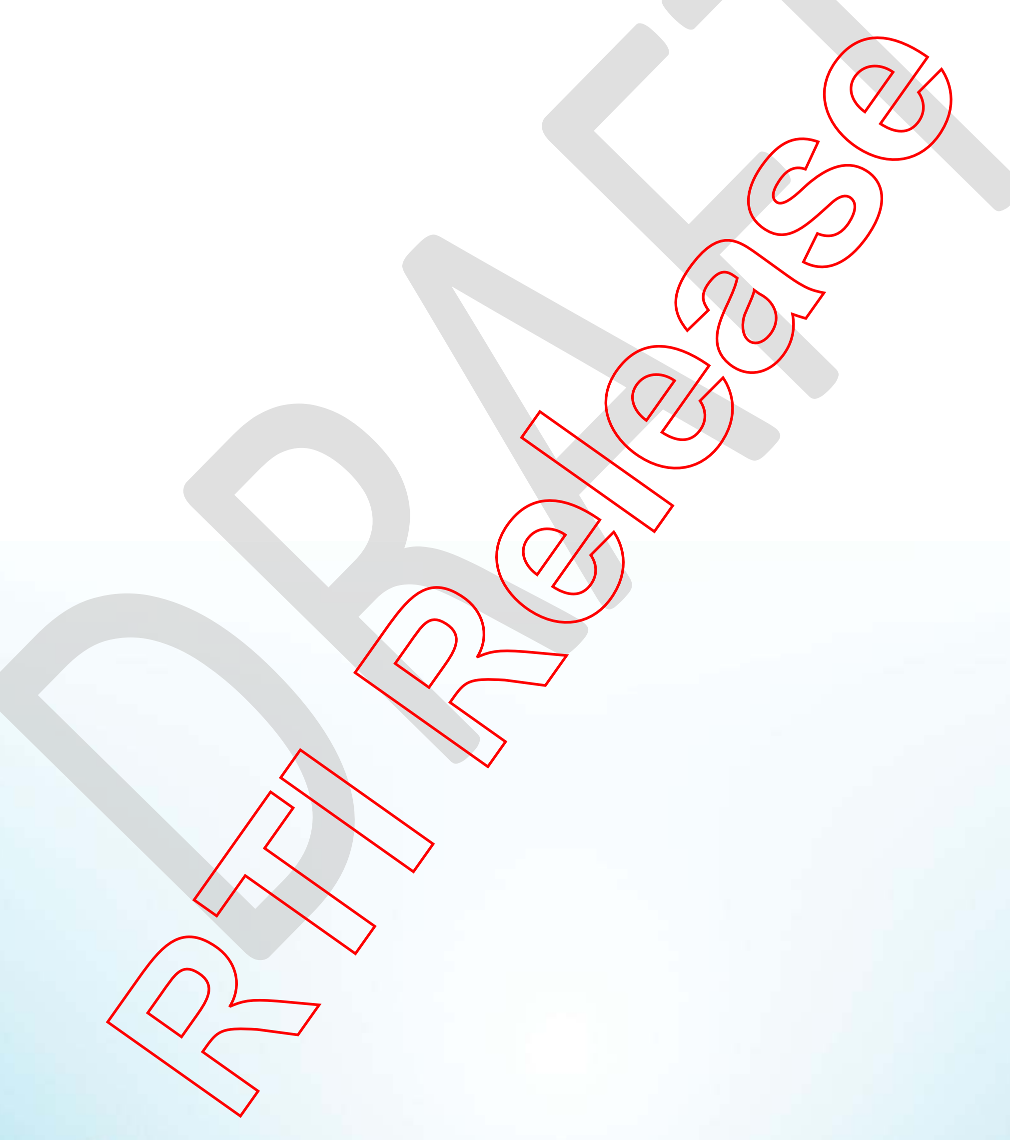
- refocusing of the NUM role on clinical leadership through identification of extraneous tasks undertaken by the NUM and promotion of delegation of these tasks to appropriate personnel.

Similar bodies of work have been undertaken throughout several interstate jurisdictions, in particular the New South Wales *'Take the Lead'* project[2], with implemented strategies consistent with those being proposed in this report.



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1. Principles

The Principles documented below have resulted from extensive consultation with key stakeholders throughout QH to determine the most appropriate strategies to support the NUM role. A principle can be defined as "an accepted or professed rule of action or conduct, or a fundamental doctrine or tenet; a distinctive ruling opinion"[1]. Section 4 provides detailed enabling strategies for implementation of these principles at corporate, district and individual levels.

Principle 1 ***Support the clinical leadership and governance role of the NUM***
Principle 2 ***Implement quality frameworks and models of professional practice to support the NUM role***
Principle 3 ***Develop NUM leadership and management capabilities to ensure skills, knowledge and attributes are in place to perform the role***
Principle 4 ***Provide sufficient preparation, training and succession planning for the NUM role***
Principle 5 ***Consider incentives which recognise the leadership and governance accountabilities of the role with a view to promoting retention of existing NUMs and attraction of future nursing and midwifery leaders***
Principle 6 ***Support job-sharing arrangements and flexible rostering practices for all NUMs, in line with QH Human Resource Policies C4 - Work-Life Balance[3] and B59 – Job Sharing[4]***

[1] Definition taken from http://dictionary.reference.com/browse/principle (accessed 3 August 2011)

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2. Introduction

The NUM is widely regarded as the lynch-pin of health care organisations and plays a pivotal role in the provision of safe, quality patient care, creating a positive culture within their work areas, and improving patient and staff satisfaction. However nurses and midwives entering this position generally do so with limited training or preparation for the role, as indicated through both anecdotal feedback from NUMs and from existing literature regarding the role and its global equivalents.

The NUM project – Phase II was established in July 2010 to address the recommendations and issues stemming from the '*Review of the Nurse Unit Manager Role'* project, and aimed to address these by:

- clarifying the NUM role through identification of the core role functions
- exploring strategies to reduce the extraneous tasks undertaken by the NUM, enabling a refocus of the role on clinical leadership
- reviewing existing training material and consolidating these resources into structured succession planning and training packages for the role and
- developing a standardised NUM orientation process.

The QH Strategic Plan 2011-2015[5] highlights the need to develop strategies to deliver employee development programs which include management development. Focus of these programs has been general in nature rather that targeted to specific roles The establishment of a standardised orientation process and training programs for both existing and future NUMs addresses this strategic priority and demonstrates value for our highly skilled workforce through provision of professional development opportunities.

Many NUMs have expressed their dissatisfaction with the increasing administrative burden associated with their role. Throughout extensive consultation, the implementation of the new payroll system was overwhelmingly identified by NUMs as creating significant additional administrative workload. The new payroll system and its associated issues have highlighted the pivotal role NUMs play in leading and supporting their teams. The majority of NUMs participating in the research identified unsustainable levels of administrative tasks required to support the payroll failures and ensure their teams are not adversely affected.

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3. Background

In 2007, the Nursing Interest Based Bargaining (NIBB) report on *Workforce Recruitment and Retention* was completed. This report recommended the NUM role as one of the key roles for further review[6].This recommendation was framed in terms of defining the scope of the NUM role and making recommendations regarding the future scope of the role. The report identified the following:

- lack of preparation for the role is a significant source of stress for those in the role
- NUMs are experiencing greater pressure to take on more duties (creating a "tug of war" between managerial and clinical duties)
- considerable time is spent on administrative tasks which could be done by administrative staff
- the scope of the role has expanded over the last 10 years
- the role generally has no administrative assistance[6]

As a result of this report, the *Review of the Nurse Unit Manager Role* project was established. This targeted report highlighted a lack of support and an overburdening of extraneous administrative tasks with NUMs moving further away from a clinical leadership focus[1]. NUMs surveyed as part of the project felt they were 'crisis' managing from day to day and were experiencing role conflict as a result of a desire to be more clinically based but being unable to do so because of their heavy administrative burden. Of those surveyed, 36% identified that they frequently considered leaving the position[1]. Lack of role clarity was seen to further impact on NUMs, as there was increasing ambiguity about what constitutes the core functions of the NUM. These findings are consistent with national and international research, and reflect the global experiences of the front-line nurse manager role[2 7].

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4. Project Research Methodology

4.1. Research Design and Data Collection Tools

Exploration of the issues related to the role of the NUM included a range of strategies to gain stakeholder engagement and to validate information obtained from the *Review of the Nurse Unit Manager Role* report. Primary focus was on a qualitative systematic approach to gain knowledge and develop strategies for the improvement of the NUM role and increase retention capacity.

Table 1: Data collection methods

Data Collection / Communication Tool	Approximate Participant rate
NUM information sessions	200
NUM discussion forum on QHEPS	2500 hits
NUM newsletter 3 monthly	3 newsletters – November2010, February 2011, June 2011
NUM Project webpage	228 hits
Focus Groups	369
Reference Group	17 members. Monthly meetings during life of project
Steering Committee	10 members. 3 monthly meetings and more frequently near finalisation of project
Literature Reviews	Not applicable

4.1.1. NUM Information Sessions

Preliminary NUM information sessions were conducted throughout the Brisbane metropolitan area, Gold Coast, Kingaroy and Dalby as face-to-face meetings and via video-conference across sixteen districts. Existing networks and meetings were used where possible to minimise the time impact for nursing and midwifery staff. Approximately 200 nursing and midwifery personnel (primarily NUMs, but also involving other Grade 7 positions and Nursing Directors) attended the various sessions.

Information collected from these sessions has been used to inform the development of the NUM Core Functions Framework and the NUM Succession Framework – key documents delivered through this project.

Questions facilitated in these sessions are included in Table 2 below.

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Table 2: NUM Information Session Questions

Clinical Leadership	Training and preparation
How would you define clinical leadership in terms of your NUM role?	Have you got access to local programs on leadership and management?
Do you feel you are the clinical leaders within your work area?	Are these programs well utilised by CNs/CMs and NUMs?
Has anyone got the balance right between the clinical leadership, management and administrative components of the role?	What works well/doesn't work well?

4.1.2. NUM Discussion Forum on QHEPS

The NUM forum was established in July 2010, in an attempt to share information and seek feedback on various aspects of the project, in particular the key documents produced. While there have been no posts from nursing and midwifery staff to date, the site has recorded a large number of hits (approximately 2500) since it commenced. The forum was updated on a periodic basis as milestones of the project were delivered. It provided information relating to project updates, documents for review and feedback, and to facilitate the NUM Newsletter distribution.

4.1.3. NUM Newsletter

The NUM Newsletter was developed to communicate information relating to the project to key stakeholders throughout QH. Due to the target audience and their limited time available to read documents, the newsletter was designed to provide small snippets of information based around 3 key areas: Core Functions of the NUM role; Training Resources (inclusive of orientation needs and succession planning strategies); and Refocusing the NUM role on clinical leadership. The newsletters were produced 3 monthly, and also provided links to the NUM project webpage and discussion forum.

4.1.4. NUM Project webpage

The NUM Project webpage was developed to provide a "one-stop shop" for information relating to the NUM role in QH. Key components of the webpage include:

- training resources section, including the NUM Succession Framework
- orientation resources section
- core Functions framework
- NUM newsletters
- links to related projects and important documents

The webpage was highlighted through the QHEPS Spotlight and "What's New" sections, enabling stakeholders and interested parties who had not heard of the

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NUM Project to find out more information and make contact with the Project manager.

4.1.5. Focus groups

Focus groups were conducted over 9 weeks from January 2011 to March 2011 in partnership with the *Nursing and Career Structure Refinement and Enhancement Project* and involved face-to-face sessions. A number of videoconference and teleconference sessions were also necessary due to geographical distances between participating sites. Nurses from all grades attended the focus groups, however the primary focus for this project were NUMs and other grade 7 nursing and midwifery staff (n=193), clinical nurses and midwives (n=109) and nursing directors/directors of nursing (n=67). Table 2 details the facilities that participated in the focus groups.

Table 3: Focus group participating facilities

Participating Facilities	
Metropolitan	**Regional, Rural and Remote**
Princess Alexandra Hospital	Hervey Bay and Maryborough
The Prince Charles Hospital	Bundaberg Hospital
Royal Brisbane and Women's Hospital	Nambour Hospital and Sunshine Coast Health Service District
Moreton Bay Nursing Clinic	Townsville Health Service District
Metro South Primary and Community Health Services	Rockhampton and Central Queensland Health Service District
Metro North Primary and Community Health Services	Mount Isa Health Service District
Children's Health Service	Mackay Health Service District
Queen Elizabeth II Hospital	Kingaroy Hospital
Ipswich Hospital	South West Health Service District
Offender Health Services	
Retrieval Services Queensland	

During these focus groups, information was provided about the NUM project. It was interesting to note there were some districts that had not heard of the NUM project 6 to 9 months after commencement. This highlighted some issues relating to:

- distribution of the NUM Newsletter
- challenges communicating across such a large organisation

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- information not being shared throughout the organisation.

The focus groups provided an opportunity to update all stakeholders on the progress of the project, and to inform those who had not heard about it regarding its purpose and aims.

4.1.6. District Director of Nursing Workshop

The District Director of Nursing (DDON) workshop was conducted in February 2011 to discuss the NUM role in clinical leadership; provide an update on the project and to discuss the role of the nursing director in supporting the NUM. The workshop was well attended with 14 DDONs present. It was scheduled immediately following the DONMAC meeting to allow those travelling from rural and remote locations to attend.

A range of issues was discussed during this meeting, such as:

- clinical leadership
- administrative tasks and support for the NUM role
- NUM workload
- organisational support (particularly peer networks and DON support)
- succession management strategies and mentoring; and
- training requirements for the role.

From this workshop stemmed the *NUM Research Project* which is discussed in further detail in section 6.1.4

4.1.7. Other forums

The project manager presented at the Mental Health NUM Forum and attended the Transforming Care Forum in June 2011 to facilitate a discussion table. These forums provided additional opportunities to share information on the NUM project to improve visibility and awareness.

Information about the project and its expected outcomes was submitted to the Queensland Nurses Union in July 2011 for inclusion in the union newsletter "The Queensland Nurse' to increase awareness about the project.

4.2. Reference Group and Steering Committee

4.2.1. Reference Group

Members of this group were either nominated by their DDON, or through identification of interested parties during the initial NUM information sessions. The group consisted of the following representatives within QH:

12 NUMs from metropolitan, regional and rural locations, across acute, mental health and community settings

- nursing director from large regional facility
- nursing director education from large regional facility

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- workplace relations principal advisor
- workforce planning and coordination unit principal advisor.

The group met on a monthly basis to progress the outcomes laid out in the project plan – including development of the *Nurse Unit Manager Core Functions Framework*; providing advice on training requirements for the NUM role; development of the *Nurse Unit Manager Succession Framework*; development of the *Nurse Unit Manager Orientation Checklist*; and to provide expert advice and feedback to the project manager.

Over the course of the project, some NUMs withdrew from the group due to limited availability, leaving 9 NUMs to continue their involvement with the group.

4.2.2. Steering Committee

The NUM steering committee was established to provide expert guidance and strategic advice to the project manager regarding the project.

The steering committee consisted of:

- 3 District Directors of Nursing DDONs (2 of whom were the sponsors of this project)
- NUM representative from a large metropolitan facility
- Nursing Director – Workforce and careers, Nursing and Midwifery Office Queensland
- Assistant Director of Nursing – Nursing Classification and Career Structure Refinement and Enhancement Project
- Senior HR Advisor – Nursing Classification and Career Structure Refinement and Enhancement Project
- Workplace Relations Principal Advisor
- Director, Workforce Planning and Coordination Unit
- Professional Officer Queensland Nurses Union.

The steering committee met 3 monthly over the course of the project, with more frequent meetings scheduled towards the end of the project.

4.3. Literature Reviews

Literature reviews were conducted on two main topics: clinical leadership and succession planning.

The *Literature Review: the Nurse Unit Manager Role in Clinical Leadership* (Appendix A) focused on the impact of clinical leadership on patient satisfaction, staff satisfaction, patient safety and clinical governance.

The *Key Elements, Enablers and Barriers to Success of a succession Planning Program* (Appendix B) focused on enablers and barriers to effective succession planning and the role of the nursing director in supporting succession programs for NUMs.

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5. Discussion of Key Issues

The following key issues were identified through the *Review of the Nurse Unit Manager Role Report*[1] and have been validated throughout this project as being an accurate reflection of the current views of NUMs in QH:

- An overburdening of extraneous tasks which are shifting the focus of the NUM role away from clinical leadership – coupled with the administrative tasks which have increased as a result of the new payroll system implementation in 2010.
- Insufficient training and preparation for the role, including succession planning and orientation.
- Role ambiguity about the core role functions of the NUM position within QH.
- Perceived unattractiveness of the role by CNs and CMs due to additional responsibility and stress in the NUM role, and perceived insufficient remuneration commensurate with the leadership and governance role of the NUM.

5.1. Refocusing the NUM role on Clinical Leadership

5.1.1. The NUM as Clinical Leader

The *Review of the Nurse Unit Manager Role Report*[1] acknowledged that NUMs throughout QH want to refocus the role on clinical leadership, which was echoed by NUMs in New South Wales (NSW) through the *Take the Lead* project – designed to strengthen the Nursing and Midwifery Unit Manager (N/MUM) role in NSW[2].

Clinical leadership is poorly defined by the literature however feedback from NUMs on their definition of clinical leadership throughout the preliminary information sessions can be translated to clinical governance principles. Clinical governance is defined by the United Kingdom National Health Service as "… a framework through which organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"[8] . There is widespread agreement that clinical leaders are critical to effective clinical governance[9]. Therefore, clinical leadership and clinical governance are inextricably linked.

Much of the project discussions with NUMs across QH focused on the role of the NUM in improving standards of care through empowering their teams to make sound clinical judgments and decisions. Clinical governance is aimed at raising patient satisfaction; improving collaborative relationships and efficiency within and across teams; increasing job satisfaction of professionals; improving clinical outcomes; and reducing significant events[10]. Therefore when we discuss realignment to clinical leadership we are also referring to clinical governance.

The NUM role is identified throughout the literature as being pivotal to the provision of safe and reliable patient care, to staff and patient satisfaction, and to the improvement of patient outcomes[11] [12] [13]. It is acknowledged that NUMs play an indirect role in the reduction in adverse events through creating a supportive, "no-blame" culture, and encourage reporting of incidents[12].

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The increasing administrative load of NUMs has resulted in reduced visibility in the unit and subsequent unavailability to supervise, mentor and support their staff[14]. This has resulted in dissatisfaction amongst nursing and midwifery staff and the NUMs themselves. The provision of strong clinical leadership at the ward level has had a positive impact on improving standards of care, the environment, skill mix and staff retention, whilst also contributing to reduced patient complaints and improved patient safety[11 12].

It is evident that NUMs positively influence patient outcomes through the provision of a positive, supportive working environment, in which staff are empowered to make decisions relating to patient care and where they are actively encouraged to identify adverse events so that improvements in patient care can be achieved. NUMs set a climate of accountability and responsibility and as the clinical leaders are paving the way for improved clinical governance.

Three key strategies have been addressed through this project to assist with realignment of the NUM role with clinical leadership:

1. clarifying the core functions and responsibilities of the NUM role in QH
2. identifying extraneous tasks undertaken by the NUM and support mechanisms to reduce these tasks
3. support from Nursing Directors.

5.1.2. Core Role Functions for Nurse and Midwifery Unit Managers

NUMs previously identified through the Review of the Nurse Unit Manager Role project[1] that the core responsibilities and accountabilities of the role were no longer clear to those individuals in the role, a view also supported by N/MUMs in NSW[2]. It has been globally acknowledged that the NUM role (or equivalent title) has grown in scope over the past 10 or more years, with a significant shift in the focus of the role away from the clinical domain to a more managerial focus[6 15]. With the rapidly increasing number of clinical nurse and midwifery consultants (CNCs and CMCs) throughout QH (38% from March 2009)[16] this managerial shift has been further reinforced, in particular in services or departments where both NUMs and CNCs/CMCs are employed. However there is still recognition and support throughout most institutions within QH of the need for NUMs to maintain a strong clinical leadership role within their work areas.

The *Nurse Unit Manager Core Functions Framework* was developed to provide role clarity for NUMs throughout QH (Appendix C). Information was collected from a range of documents and feedback from NUMs (both directly through the project, and from the *Review of the Nurse Unit Manager Role Project*[1]). It was agreed during discussions with NUMs throughout QH that there were core functions or responsibilities that all NUMs were expected to perform, regardless of their geographical location or setting. Table 4 identifies the four key domains in which the NUM performs their role.

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Table 4: Domains of the NUM role

Domains of the Nurse and Midwifery Unit Manager Role
1. Clinical Management
2. Clinical Leadership and Governance
3. People Management
4. Business Management

This framework can be used to discuss role expectations for new or acting NUMs, and to guide performance appraisal and development for the NUM role. The framework will be linked to all NUM position descriptions, to ensure consistency of core role expectations across QH.

5.2. Extraneous tasks undertaken by the NUM

5.2.1. Administrative tasks and support

A range of extraneous tasks were identified from both this project and the *Review of the Nurse Unit Manager Role Project* 1 as being undertaken by the NUM, which do not necessarily require the specialist skill set or experience of this advanced practice nursing and midwifery role. Many of these tasks (identified in table 5) centre on administrative duties, which could be delegated to administrative staff with the commensurate skills to perform these duties.

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Table 5: Administrative tasks undertaken by the NUM

Area	Tasks Undertaken
Roster management	Updating leave planner
	Inputting roster
	Updating roster changes
	Checking published roster report
Payroll activities	Faxing/emailing AVACs and payroll forms
	Payroll enquiries
	Completing payroll forms (i.e. movement/higher duties, leave, staff commencement)
General administrative tasks	Preparing agendas and typing minutes for unit meetings
Recruitment processes	Sending letters to applicants
	Getting selection panels together
	Organising rooms and times
	Reference checks

These tasks are within the scope of the administration support officer role, classified at administration officer 3 (AO3) level. Appendix D: *Administration Support Officer (AO3 Job Description Key Accountabilities)* identifies the key accountabilities for this role.

A small cohort of NUMs was asked during the project to estimate the amount of time they spend per day on administrative tasks that could be undertaken by an administration officer (AO) or another role. The time estimated was 1.5 to 2 hours per day, involving tasks such as those identified above. Table 6 provides a cost comparison of the NUM undertaking these tasks versus an AO3.

Table 6: Cost comparison NUM vs AO3

Classification	Hourly rate	Hours worked	Yearly total
NUM Year 3	$49.26	1.5 hours/week	$16,846
AO3 Year 4	$29.07	1.5 hours/week	$9,941

*(Costs are base rate comparisons only.

Hourly rates taken from the Nursing stream wage rates webpage , payable as from 1 April 2011 and the Administrative stream wage rates webpage, District Health Service award, payable from 1 September 2010 both accessed 10 August 2011).

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Further information will be obtained through the Final Report in January 2012 of the NUM Research Project conducted through Griffith University regarding NUM time spent on extraneous tasks, along with consideration of possible delegated tasks and to whom these tasks may be delegated. As mentioned previously, the NUM plays a critical role in the provision of quality, safe patient care. By redirecting the extraneous tasks NUMs currently undertake and thereby providing more time for NUMs to perform their clinical leadership role, patient care can be enhanced. This is difficult to quantify in terms of dollars saved, however it must be recognised that reduction in adverse events and improved staff retention carry significant cost savings to the organisation.

Outcomes of recent studies into the implementation of administrative support for the NUM role, or equivalent, have identified the following benefits to both patients and the organisation:

- reduction in administration time for NUMs
- positive impact on patient care
- positive impact in relation to support for other roles (allied health personnel, educators, doctors, etc)17
- allowing more time for clinical leadership (both in relation to patient care and supporting staff)
- improvements in work life balance, morale and satisfaction of ward managers (WM) and staff resulting in a reduced intention to leave the WM role
- improved quality of patient care and patient safety through increased presence of WM in the ward, and ability to address poor practice and implement corrective strategies in a more timely manner, and
- increased compliance with auditing, reporting and mandatory training of staff[18].

5.2.2. Other support

Other roles within the organisation may offer some level of support to NUMs in order to perform their role efficiently. Feedback from NUMs has highlighted Business Managers and other nursing and midwifery roles as providing supportive roles to NUMs.

5.2.2.1. Business Managers

Business Managers who work closely with NUMs assist in application of the financial management accountabilities of the role in relation to:

- financial management of the unit/department
- providing advice and guidance when formulating and reviewing budgets
- analysing budget variances
- financial reporting requirements.

It is widely identified that NUMs are appointed into their positions because of their strong clinical abilities however rarely are provided any knowledge or training in relation to the additional skills of people and business management required to perform the role[19 20 21]. Business managers can be instrumental in facilitating the

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transition of new NUMs to their financial management responsibilities through meeting to discuss expectations and answering any questions the NUM may have in relation this area. The QH finance education team are developing a cost centre manager training package to support this essential element of the role of all line managers, and view the business managers as fundamental to this process in terms of support and training.

5.2.3. Nursing Roles

Nurse managers (NMs) have been identified throughout project consultation as playing a supportive role to NUMs, particularly in larger settings where NMs are employed across divisions or service lines. NMs are employed in a range of roles throughout QH, including:

- divisional support for senior nursing and midwifery staff (Scorecard development; HTER list updating; new works and maintenance requests; quality and safety)
- recruitment
- patient flow
- bed management.

Each role provides some assistance to NUMs to reduce the extraneous tasks and administrative duties required of the role, enabling time to provide clinical leadership within their work areas.

The assistant in nursing (AIN) role has been identified as potentially able to provide support for the NUM in relation to equipment maintenance requests and follow-up, and maintenance of stocks and stores within clinical areas. This role has been in place in some areas for some time and anecdotal feedback suggests it has had a positive impact on NUM and nursing and midwifery time spent on these tasks, allowing a refocus on clinical care and coordination.

5.3. NUM Research Project

During the project, In order to obtain more in-depth data, a collaborative project between the Nursing and Midwifery Office Queensland (NMOQ) and Griffith University the *NUM Research Project* was commenced. It aimed to identify how NUMs are managing to balance the administrative demands of their work with their clinical leadership role, with a view to quantifying the core tasks NUMs perform. The research collected data to inform important trends and patterns, as well as exploring best practice models of clinical leadership.

Research methodology included a self-reporting diary of a NUMs working day; a questionnaire to collect demographic data and additional information about the role and training and support structures currently in place; and focus groups to identify what is best practice in relation to clinical leadership.

The first phase of this research, which involves the diary and questionnaire, commenced in early July 2011. The findings of this research (Addendum 1) inform the implementation of recommendations stemming from this report. The diary includes a range of NUM tasks

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identified through other projects[1 2]. NUMs identified the time spent on each task, the level of importance assigned to the task and the ability to delegate the task to another staff member.

The second phase of the research included focus groups with select NUMs throughout all districts of QH. NUMs were selected based on their 1) experience in the role, 2) focus on role model, 3) ability to represent other NUMs, and 4) demonstration of a high level of performance in the NUM role.

Eight focus groups were held mid September to October 2011 utilising differing communication methods (face-to-face and videoconferencing) to ensure representation of NUMs from different settings and contexts within QH. Six focus groups were conducted face-to-face at the following locations:

- Gold Coast
- Brisbane (2 to be held for Metro North, Metro South and Royal Children's Hospital)
- Caboolture
- Toowoomba
- Nambour

For other districts, DDONs nominated one NUM from each district, inclusive of rural and remote NUMs, to be involved in one of two videoconference focus groups. Numbers will be limited to 5 NUM participants per focus group.

The findings of the research project also inform nursing and midwifery leaders as to how best to support NUMs to undertake clinical leadership roles within their work areas.

5.4. Quality Frameworks

A range of quality initiatives exist within QH to support the provision of safe patient care, improved service delivery and the capacity-building of clinicians. Anecdotal feedback from NUMs involved in these initiatives highlight the benefits in terms of improved unit efficiencies, staff ownership of influencing and directing change, and reduced NUM time spent on change management due to staff being more involved and leading the change process.

The Practice Partnerships Model (The Prince Charles Hospital) supports the NUM role in maintaining visibility in the unit at critical times, in order to maintain a clinical leadership focus within their work area. This is achieved through minimising or eliminating non-clinical meetings until after 12:30pm, enabling the NUM to participate in rounds, support the coordination of patient flow through clinical areas, and be available for staff at designated times of the day. All administrative work and meetings are conducted after this time.

Transforming Care and Practice Partnerships utilise hourly "rounding" on patients to facilitate improved patient care, which in turn has had positive benefits of reduction in call bells, reduced adverse events and improved patient and staff satisfaction[22].

Productive Wards and Transforming Care are international programs which aim to redirect time and resources for patient care, reducing extraneous tasks undertaken by nursing and midwifery staff, and the interdisciplinary team. Both programs incorporate four similar principles for managing change to facilitate the above outcome:

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- patient focused care
- safety and reliability of patient care
- staff empowerment and teamwork
- process improvement through redesign.

Both programs are currently conducted within QH, and are facilitated through the Centre for Healthcare Improvement (CHI). Transforming Care has been linked with significant cost savings (estimated at approximately $5million over three years in 13 units who implemented the framework) in terms of reduced staff turnover, falls and unit overtime[23].

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6. Principles: Possible Future Options

6.1. **Principle 1:** Clinical leadership and governance

'Support the clinical leadership and governance role of the NUM'

The burden of administrative tasks currently undertaken by NUMs reduces the focus of a clinical leadership and governance role within their work areas. NUMs carry both corporate and clinical governance responsibilities and require support enabling them to perform these vital functions. As effective clinical leadership and clinical governance is associated with increased staff and patient satisfaction and subsequent improvement in patient outcomes and reduced adverse events[11 12 13] it is essential that NUMs maintain and enhance this as a core function of their role. Many NUMs identify anecdotally that they have difficulty in achieving effective oversight of clinical care within their rostered hours

The *Review of the Nurse Unit Manager Role* report[1] highlighted a lack of clarity surrounding the core functions and expectations of the role throughout QH, as well as a desire by NUMs to refocus the role on clinical leadership

Ambiguity surrounding the clinical leadership and governance role of the NUM is increasing with the rising number of CNC positions (38% increase since March 2009 – 22% CNCs and 16% Clinical Midwifery Consultants) who also have a role in maintaining and improving clinical standards but do not take on the overall responsibility for clinical governance

Anecdotal feedback from NUMs reflects approximately 1.5-2 hours per day of NUM time is consumed with administrative work.

6.1.1. Possible Future Options

To support a refocus on clinical leadership and governance, suggested options of both a strategic and operational nature include:

6.1.1.1. Strategic

- Align the NUM Core Functions Framework to the NUM Position Description and revised generic level statements for new applicants to the NUM role or new employees to QH.
- Through the NUM research project, identify activities currently undertaken by NUMs that could be devolved or delegated to increase NUM role efficiency and to release time to perform their clinical leadership role.

6.1.1.2. Operational

- Provide the *Nurse Unit Manager Core Functions Framework* to all new NUMs with recruitment information and discuss with all new and acting NUMs to ensure consistency of expectations.
- Incorporate the *Nurse Unit Manager Core Functions Framework* into the PAD process and NUM Succession Framework to identify learning needs and formulate

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a development plan based on the key accountabilities and competencies of the position.

- Lead the refocus of the NUM role on clinical leadership through prioritisation of administrative or clinical support for the role (i.e. AINs may be employed to support the NUM role in maintaining stocks and stores and ordering equipment).
- Evaluate existing support structures for the NUM role and identify areas where support is required. An AO could be used across 3 to 4 wards providing support to NUMs and nursing and midwifery staff in those areas, enabling the NUM to reallocate those 1.5-2 hours to providing clinical leadership and assisting with the coordination of care within their work units.
- When developing a unit service profile and allocating nursing and midwifery resources utilising the Business Planning Framework, classify a major component of NUM hours as 'indirect' with hours added to the formula for identifying 'Productive Hours'.
- Utilise effective rostering practices to ensure sufficient skill mix and staff available to enable the NUM to perform an indirect role overseeing the coordination of care, instead of being counted in the direct nursing and midwifery hours for the unit.

6.2. **Principle 2:** Quality Frameworks and Models

'Implement quality frameworks and models of professional practice to support the NUM role'

It is widely recognised that the next few years in Queensland will see an exodus of nurses from the workforce due to retirement[6], worsening existing nurse shortages. Nurses and midwives have expressed throughout project consultation that limited training and preparation for such a challenging position reduces the attractiveness of the NUM role. Strategies such as leadership development aim to retain staff within the workforce, but also act as an attraction strategy, as the organisation is seen to invest in the development of their staff and value their potential[24].

Current nursing leadership literature contains recommendations regarding areas for competency for nursing and midwifery leaders, including:

- finance, budgeting and the business of health care
- leadership practices, behaviours and skills
- use of self in communication skills and personal effectiveness[25].

QH currently offers a range of frameworks which address all of these areas, however there is no targeted statewide nursing and midwifery leadership framework. Table 7 below provides a list of current frameworks to support quality practice in the NUM role

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Table 7: Quality Frameworks

QH Healthcare Culture and Leadership Service Framework
NHS Leadership Qualities Framework
QH Rostering Framework - Best Practice Framework for rostering nursing personnel
QH Clinical Governance Framework
QH Business Planning Framework – a tool for nursing workload management
Building Blocks of Lifelong Learning – a framework for nurses and midwives in Queensland
Financial and Performance Management Standard
National Safety and Quality Health Service Standards
Changing Models of Care Framework
QH Strategic Plan 2011-2015
QH Nursing and Midwifery Specialisation Framework
National nursing and midwifery standards
Models of nursing and midwifery unit management
Nurse Unit Manager Core Functions Framework

With the implementation of the new local health and hospital networks as part of the national health reform agenda, there is an increasing drive to devolve training to the networks. Availability of training programs is variable currently within the districts however there are a range of options to consider for those who do not currently have leadership and management programs. Alternatives for both leadership and management development are provided below, including options for rural and remote locations. These options are provided as a guide only, and may vary depending on access to resources.

6.2.1. Possible Future Options

6.2.1.1. Strategic

- Refocus the NUM role on clinical leadership through identification clarification of core functions and expectations of the NUM role through the NUM Core Functions Framework.

6.2.1.2. Operational

- Utilise NUM Core Functions Framework and quality frameworks to identify and plan professional and clinical development activities through the performance appraisal and development process.

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- Develop standardised protocols for implementation of quality frameworks which underpin the NUM role.
- Collaborate with other districts/facilities who have implemented quality frameworks such as '*Productive Ward*' and '*Transforming Care*' for information-sharing and advice on how to implement these initiatives.

6.3. **Principle 3:** Leadership and Management

'Develop NUM leadership and management capabilities to ensure skills, knowledge and attributes are in place to perform the role'

The NUM is a key leadership role within clinical units, however staff in these roles receive little or no training prior to commencing in the role.

Nurses and midwives account for approximately 40% of the QH workforce, however no state-wide QH nursing and midwifery leadership program is currently offered. Both Medical and Allied Health streams have designated leadership programs for their respective streams, funded and facilitated at a corporate level.

Coaching plays an important part in the role of the NUM. Cultural change, effective problem solving and improved performance can be more effectively empowered through fostering a coaching framework.

6.3.1. Current Leadership Options

The literature identifies successful leadership development programs as offering a blended learning approach to facilitate leadership development[26] [27]. This includes strategies such as workshops, role shadowing, coaching, reflective practice, stretch opportunities and secondments.

Various departments and districts within QH offer leadership programs and resources for staff, and these are separated in Table 7 below. For more information regarding each program, please refer to Appendix E.

Table 8: QH Leadership Programs

Service/Department	Resources Provided	Information
Healthcare Culture and Leadership Service (HCLS)	Emerging Clinical Leaders Program (ECLP)	12 month program
		20 nursing and midwifery places per year
		Blended learning (workshops, coaching, action planning)
	Leadership workshops (based on NHS Leadership	Can be undertaken during annual HCLS workshop program, or districts can arrange

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	Qualities Framework)	local workshops
	Panel Agreement	List of suppliers who design, develop and deliver leadership programs, training materials and coaching
	NHS Self-directed learning modules and self-assessment tool	Can be utilised within the performance appraisal and development process
Metro South Health Service District*	Emerging Leader Program and the Developing Leader Program	To assist Grade 5 and 6 nurses in leadership
Townsville Health Service District*	Nursing Leadership Program	A resource for line managers
Central Queensland Health Service District*	Aspiring Nurse Leaders Workshop	

*Further information and contact details about these programs are available by contacting the district nursing director of education.

6.3.2. Current Management Options

As mentioned previously, NUMs are generally appointed to their position on the basis of their strong clinical skills and demonstrated leadership ability. However, they have little to no training in the skills required to manage budgets, the operational responsibilities of their role, and the human resources management aspects of the role. Therefore it is essential to equip nurses with the skills necessary to perform the NUM role.

The Management Capability Development Program (MCDP) offered by the Capability Unit provides managers and leaders with a range of workshops, assessment tools and self-directed learning modules to facilitate management and leadership development. The MCDP aligns with the QH Leadership and Management Framework (Appendix F) which highlights the management capabilities required of new and existing managers within QH.

The following table indicates the workshops offered under the MCDP. For more information on these workshops please refer to Appendix G.

Table 9: Corporate MCDP workshops*

Targeted Skills	Workshop Offered
People Management	Sailing into Supervision Managing Your People Practical People Management

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	Multidisciplinary RN Team Leaders Care Course
Business Management	Managing your Business Program Developing Excellence in Business Program Institute of Public Administration Australia online courses (QH has corporate membership)
Change Management	Managing Organisational Change

Table 10: District management workshops*

District	Workshop Offered
Central Queensland Health Service District	Managers' Boot Camp and Managers' Afternoon Sessions (also offered via videoconference links to rural sites)
Metro South Health Service District	Management Program
Logan Hospital (through the Metro South Institute of TAFE)	Diploma of Management. The MSIT are able to travel state-wide and will tailor a program to suit the needs of individual organisations/districts

Table 11: Combined Leadership and Management Programs*

District	Workshop Offered
Princess Alexandra Hospital	NUM Succession Planning Program and the Developing Leader Program
Wide Bay Health Service District	Level 2 to 4 Registered Nurses Program
Gold Coast Health Service District	Manager Capability Development Program

*Further information and contact details about these programs are available on the NUM Project website under the "Nurse Unit Manager Resources".

6.3.3. Current Rural and Remote Options

Contact Human Resources Coordination - Capability Unit for course materials and/or *'Train the Trainer'* options for their suite of workshops Central Queensland HSD People and Culture Learning and Development Unit provide an excellent examples of how district-wide training can be facilitated, through the use of face-to-face

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sessions where possible, and videoconferencing as an alternative to minimise travel time and costs.

Some current options for utilising leadership and management development resources are included in table below:

Table 12: Leadership and Management Resource Utilisation for Rural and Remote

Collaborating groups of NUMs complete the HCLS Leadership modules to increase learning and understanding and provide support for one another, utilising content experts as required.
Regional videoconference or teleconference networks for NUMs with a standard agenda with a 'whip around' of all NUMs at the end of the agenda
ClinEdQ nursing and midwifery web portal as a medium for locating shared documents, resources, and discussion with other NUMs in the district that are not accessible in person.
Share Leadership and Management development program resources developed by other districts
videoconference and distance education to support education for NUMs
Divisional Human Resource Services – Corporate for course materials and/or Train the Trainer options from their suite of workshops.
Utilise workshops already in place for nurses and midwives aspiring to the NUM role through liaison with facilitators from larger facilities: • recruitment and selection training • Business planning framework • PRIME and patient safety (HEAPS and RCA if available) • Delegation skills • Managing difficult behaviour • Rostering practices and skill mix stratification

6.3.4. Possible Future Options

6.3.4.1. Strategic

- Through Nursing and Midwifery leadership, promote access to resources and courses for nursing and midwifery leadership development as a priority area, demonstrating Queensland Health's commitment to the career development and skills acquisition of these pivotal clinical nurse leaders.

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- Nursing and Midwifery Office Queensland implement strategies that foster NUM engagement and sharing of innovative models of professional practice and building of collegial networks.
- Nursing and Midwifery Office, Queensland (NMOQ) through DONMAC promote and monitor ongoing implementation of district leadership development programs for the NUM.

6.3.4.2. Operational

- procure the services of approved providers (through HCLS) to design, develop and deliver leadership and management programs inclusive of coaching targeted to nurse unit manager
- utilise the panel arrangements offered through the Healthcare Culture and Leadership Service (HCLS) to procure the services of select providers to design, develop and deliver leadership and management programs inclusive of coaching
- provide funded training days and/or support professional development leave to attend leadership development programs, participate in coaching sessions or NUM skills development workshops as identified in the NUM Succession Framework

6.4. **Principle 4:** Preparation for the role of NUM

'Provide sufficient preparation, training and succession planning for the NUM role'

Transformational leadership is developed and exhibited more successfully in a supportive environment of trust, integrity, fairness, high expectations, recognition and setting of clear goals[28]. A range of strategies have been identified throughout the literature as well as this and other projects mentioned previously. Succession planning, mentoring and/or coaching, peer support and networks, nursing director support and effective orientation are integral to the success of the NUM role.

NUMs and CNs/CMs have highlighted that succession planning is relatively non-existent their facilities, primarily due to time constraints. The skills gap between transitioning from a CN to a NUM is significant and requires new knowledge and skills development prior to commencing in the role. For this reason many CNs/CMs are reluctant to take up the role permanently.

Evident from discussions with CNs/CMs are the varied orientation time provided for the NUM role (ranging from a few hours through to 2 weeks depending on the area/facility/district in which people work).

6.4.1. Succession Management

Succession planning has been identified throughout the literature as a key strategy for business success and is almost non-existent in healthcare organisations[24 29 30]. It shifts the focus from reactive management to proactive, and focuses on forecasting

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organisational needs through incorporating succession management strategies into organisational strategic planning. However, in order for succession planning to be effective, support of the process must be provided by executive and senior leaders[27 29 31]. The risk of not providing succession planning for this pivotal role is identified by Kirby and DeCampli, who discuss that a lack of nursing leaders has a direct impact on organisational performance, including quality of patient care, fiscal stability and patient/family satisfaction[19].

Anecdotal feedback from NUMs and nursing and midwifery staff highlights a relative lack of succession management throughout QH. Reasons cited for this include lack of time on the part of both the NUM and CNs/CMs for mentoring, coaching and role shadowing, as well as limited opportunities and funding for workshop or program attendance. Limited staffing resources reduce the ability of CNs and CMs to take time out from their clinical duties to work with the NUM and learn on the job, while the NUM is working to capacity fulfilling all other responsibilities of the role. However, interestingly, most NUMs identified through the discussions on clinical leadership that succession planning is a fundamental part of their role and they would like to do this more if they could free up time elsewhere.

The benefits of succession planning are clear:

- reduced recruitment and orientation costs by recruiting from within the organisation
- improves transition time into the role and maintains productivity levels
- ensures continuity of service delivery and enhances organisational stability
- demonstrates a clear commitment to career development and professional advancement
- shows value of human resources and willingness to invest in staff, and
- ensures a deep pool of talented individuals is available in the organisation[24 27 29 32].

A range of strategies are outlined throughout the literature in terms of sound succession management principles. These strategies include mentoring and coaching, role shadowing, secondment opportunities, stretch assignments, job rotation and training.

The *Nursing Unit Manager Succession Framework* (Appendix H) was developed as part of this project to clearly articulate the principles of succession management and to provide a pathway for nursing and midwifery staff aspiring to the NUM role. It is anticipated that districts will incorporate the NUM Succession Framework into conversations with nursing and midwifery staff regarding development opportunities, and to facilitate discussions regarding what approaches to succession management best suit the individual.

A cultural shift to a coaching culture can enhance succession. Through coaching conversations staff are empowered to identify issues and consider solutions to resolve these issues, thereby increasing their decision making and critical thinking skills. At the same time, this strengthens capacity and capability within the workforce. This cultural shift cannot occur in isolation at the NUM level, but must be promoted and role modelled by senior nursing and midwifery leaders.

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By viewing the time spent on mentoring or coaching as integral to the development of nurses and midwives, significant long term investment is likely to result and also reduce the NUM time spent on dealing with performance issues.

Succession is also fostered by supporting the development of CNs/CMs through workshop attendance, secondment opportunities and the ability to act into the NUM role during periods of absence.

Ingraining succession into the unit culture can be progressed by CNs/CMs undertaking the self-assessment tools offered by HCLS and the MCDP to identify learning needs and document personalised development plans to build capability.

The performance appraisal and development process also provides an excellent avenue for discussing and promoting career aspirations with a view to identifying talent early and starting to develop leadership capabilities.

6.4.2. Mentoring and coaching

Mentoring and coaching have been identified as essential strategies to support leadership development[20 24 26 27 31 32]. NUMs who have provided feedback through this project on their experiences of being involved in a mentoring relationship highlight the benefits of this process in terms of sharing experience and knowledge, providing support and advice, and providing a platform to test new ideas. The Queensland Health Mentoring Framework for Nurses can be utilised to support mentoring relationships and provides information for establishing and maintaining this relationship[34]. Provision of a mentor for all new and acting NUMs is a worthwhile strategy to support development into the role.

6.4.3. Peer support and networks

NUMs previously identified the desire for peer networking opportunities, to enable support and sharing of ideas[1]. This has been further reinforced throughout consultation with NUMs over the course of this project. Peer support has been cited throughout the literature on the NUM role (or equivalent) as being one of the most valuable development strategies implemented for the role[35 36].

Statewide forums currently exist for NUMs to meet and discuss innovations in their workplace (i.e. Transforming Care forums) and issues affecting particular specialties (i.e. perioperative NUM forum, mental health NUM forum). Some organisations have established meetings specifically for NUMs to network with other NUMs and to meet regularly with their nursing director. NUMs in Central Queensland Health Service District have set up videoconference links between sites where only one NUM exists to facilitate peer support and to share ideas and knowledge.

Collaboration and communication between NUMs can inspire and promote positive NUM experiences. Statewide forums if planned effectively can cultivate increased networking and a focus on building partnerships. NUMs considered a state-wide NUM forum useful to facilitate sharing of innovative models of professional practice and support collegial networking.

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6.4.4. The Role of the Nursing Director

The nursing director plays an essential role in supporting and building the leadership and management capacity of their NUMs. Both consideration (mutual trust, respect, warmth, rapport) and structure (organisation and definition of group activities) are required by nursing directors to influence the performance outcomes of NUMs[37]. Not only will the nursing director need to articulate the expectations of the NUM as defined by the NUM core functions framework, they will also need to support the skills acquisition necessary to undertake the role. At the same time, promoting and role modelling a coaching culture is essential to embedding coaching within the organisation to facilitate leadership development. Support of succession planning for the role is critical to the success of strategies identified throughout this report, and the nursing director remains a central point in this process to enable success.

6.4.5. NUM Orientation

Structured orientation programs for clinicians new to a clinical area are widely recognised as essential to support new employees and ensure safe patient care[36]. Nurses who move into the NUM role are generally those with strong clinical skills however they receive very little in the way of effective leadership and management training[19]. Assuming new NUMs will be competent from day 1 can lead to feelings of incompetence and failure and may lead to dissatisfaction and role transition problems[36].

It is also recognised through the scant literature available that nurse manager orientation and preparation is poorly structured and rarely offers the guidance and support required for staff new to this pivotal role[19 38]. NUMs anecdotally reported throughout the NUM project of the scant orientation provided to them prior to commencing in the role (i.e. 1 to 2 hours in some cases). Many also claim there is no funding for handover or orientation for CNs/CMs into their role, resulting in CNs/CMs being expected to undertake the role with minimal preparation or handover. This is a significant issue in terms of recruitment into the role, and for attracting staff to backfill the position. Anecdotally, NUMs and CNs/CMs express that the CN/CM generally undertakes a “caretaker” role only, and is unable to perform all aspects of the role due to their lack of knowledge and preparation for the role. This results in the NUM returning from leave to a backlog of additional work which has been left unattended in their absence.

A range of resources have been collated or developed through this project to assist orientation to the role, including a *Nurse Unit Manager Orientation Checklist*, *Nurse Unit Manager Succession Planning Resource Guide* and line manager induction manuals and resource guides. These resources are all available through the NUM Project webpage on QHEPS.

The *Nurse Unit Manager Orientation Checklist* was developed by revising and amending an existing document kindly supplied by Fraser Coast Integrated Mental Health Service. The checklist has been incorporated into a package for NUM development titled *Foundations of the Nurse Unit Manager Role – Strengthening the capacity and capability of our nursing and midwifery leaders*. This package includes

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the *Nurse Unit Manager Core Functions Framework*, Nurse Unit Manager Succession Framework and the *Nurse Unit Manager Orientation Checklist* and has been designed to provide information pertinent to the role to support preparation and identification of learning needs for the role. This package is available through the NUM Project webpage on QHEPS, and each document can be printed individually or as the complete package. The checklist can support discussions with line managers regarding development needs and can be linked with the PAD.

NUM resource guides and orientation manuals have been developed to support the orientation to the role. The *Nurse Unit Manager Succession Planning Resource Guide*, developed at the Princess Alexandra Hospital, is designed to be adapted to a range of contexts, and provides information for new and acting NUMs on key contacts, links to Human Resources policies and guidelines, and general advice regarding aspects of the role. The *Nurse Manager Orientation (ICU)* was developed by the Statewide ICU network and provides information specific to NUMs working within this critical care area. However, this manual has been adapted for use outside of the ICU setting.

Line Manager guides have been created by Townsville Health Service District and The Prince Charles Hospital. These guides are generic in nature, however have been added to provide additional information which may be of use to new and acting NUMs.

6.4.6. Possible Future Options

6.4.6.1. Strategic

- Consider a clinical nurse/midwife – clinical management classification in the *Nursing Classification and Career Structure* to promote succession planning and delineation of a career pathway to the NUM role.
- Create structured orientation processes, including handover from previous incumbent and allocated orientation time for the NUM role.
- Update a revised NUM succession planning framework.
- Update and revise the QH nursing and midwifery mentoring framework.
- Develop a QH nurse unit manager succession protocol which standardises the training and orientation processes for the NUM role.

6.4.6.2. Operational

- Support existing NUMs and nursing directors/directors of nursing to undertake the *Coaching Skills for Leaders* workshop to promote a cultural shift towards coaching conversations.
- Create structured orientation processes, including handover from previous incumbent and allocated orientation time for the NUM role.

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- Allocate time for mentorship and coaching of potential NUMs who are undertaking a Clinical management portfolio, job shadowing opportunities or completion of core skills training.
- Incorporate the NUM Succession Framework into all units / facilities / district services to support and prepare Clinical Nurses for the NUM role
- Implement the Nursing and Midwifery Mentoring Framework as a tool for the ongoing development of all new NUMs.
- Implement local peer networks to provide collegial support for NUMs in isolated roles/locations and those new to or acting in the role. NUMs with a particular interest in peer support could be asked to champion this idea, with support from administration staff to set up links, contact lists, etc.
- Standardise the development, monitoring and reporting of nursing and midwifery exit interviews (from Grade 1 to Grade 7), with a view to evaluating the impact of leadership development and additional support provided for the NUM role.
- Incorporate training days into all unit / facility / district workforce plans to ensure knowledge and skills are developed and / or remain current and to ensure time is allocated for mentorship and coaching of potential NUMs who are undertaking a clinical management portfolio, job shadowing opportunities or completion of core skills training.
- Implement NUM orientation resources developed or identified through the NUM project.
- Ensure that orientation/handover time requirements are based on the experience and prior preparation of the newly appointed NUM or acting NUM.

6.5. **Principle 5:** Incentives for Retention

'Consider incentives which recognise the leadership and governance accountabilities of the role with a view to promoting retention of existing NUMs and attraction of future nursing and midwifery leaders'

The NUM role is viewed as unattractive to nursing and midwifery staff due to a range of factors. Anecdotally, many NUMs state that CNs) and CMs are reluctant to act into the NUM role due to insufficient remuneration associated with increased responsibility and hours worked. Due to penalty shifts, CNs and CMs may be earning more in their substantive role than they can earn in the NUM role. This is a disincentive to performing the role. At the same time, CNs and CMs also highlight the additional responsibility of the NUM role in terms of performance management of staff and lack of preparation for the role as impacting upon their willingness to undertake the role. Many NUMs throughout QH have highlighted the inequities which exist between the different Grade 7 roles and also between NUM positions, in terms of accountabilities and responsibilities of the role.

The *Review of the Nurse Unit Manager Role Report* highlighted 36% of NUMs were thinking of leaving their position[1]. This is a significant concern, at a time when workforce shortages

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are pending, and when nursing and midwifery staff are anecdotally describing the role as unattractive in terms of career progression. *Stichler* identifies concerns regarding the projected shortage of NUMs in coming years due to a range of factors, in particular the retirement of baby-boomers, alternative leadership options (non-management roles), and the recognition by younger nurses of the high stress role of the NUM without significant financial rewards in comparison to clinical roles[20].

Role stress and burnout have been identified as increasing the potential for nurse managers to leave their role[41]. It has been identified that NUMs currently accrue time off In Lieu (TOIL) for additional hours worked however have difficulty in reclaiming this time due to no backfill. If they take TOIL with no backfill a backlog of work awaits their return, resulting in accumulation of further additional hours to catch up on this work on top of their usual duties. TOIL is not recorded or reported formally or consistently at present therefore the true number of hours accrued by NUMs is unclear.

Building hardiness and providing resilience training are strategies that may assist in reducing burnout and stress associated with the NUM role, increasing job performance and satisfaction and having a positive impact on patient outcomes[21]. By reducing stress and building resilience, the NUM role may appear more attractive to nurses who are seeking career progression, and also improve longevity in the role, retaining these highly skilled leaders. It is essential to address the other areas of the role which increase role stress (such as inability to provide support through clinical leadership and an overburdening of extraneous tasks) in order to create a more evenly balanced role which provides leadership and governance within the work unit.

Strategies such as transition to retirement and job-sharing opportunities promote retention of skilled staff currently in the NUM role and allow for a progressive transition of knowledge and skill for the new NUM. One study of nurse manager stress and work complexity found that nurse managers in a job-share arrangement verbalised more confidence in their abilities and achieved a high level of performance which translated into role innovation and exceeding performance expectations for staff and patient satisfaction[42].

6.5.1. Possible Future Options

6.5.1.1. Strategic

- Refocus NUM role on clinical leadership through identification of extraneous tasks undertaken by the NUM and promotion of delegation of these tasks to appropriate personnel.
- Consider the development of a Job Evaluation Methodology which bands the NUM role based on the variations in responsibilities and accountabilities of the individual NUM position including accounting for the complexities of the role within areas such as:
  - FTE/headcount
  - setting: community and primary health care, acute care, community mental health, residential/aged care
  - geographical location: rural, remote, metropolitan, regional

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- Support structures: administrative support, other Grade 7 roles within the setting
- Budget and operational responsibilities.

6.5.1.2. Operational

- Implement formal TOIL arrangements (in line with *QH Human Resource Policy C46 Time off in Lieu (TOIL)*[43]) for recording, reporting, monitoring and addressing issues related to TOIL.

6.6. **Principle 6:** Flexibility and Work Life Balance

'Support job-sharing arrangements and flexible rostering practices for all NUMs, in line with QH Human Resource Policies C4 – work life Balance and B59 – Job Sharing'

Providing a flexible approach to work arrangements for NUMs aids retention as well as supporting the reduction in burnout and stress related leave. Providing job sharing can provide better coverage overall of a unit with tasks designed where particular skills are complementary are acknowledged. In many cases, job sharing a position can lead to more productivity than a single person in a position.

By viewing tasks of a job in a different way and supporting complementary strengths, the splitting or sharing of the NUM position can improve morale overall, retain skills, knowledge and expertise, reduce turnover and unplanned leave, and demonstrate value for the person in the role.

Previous reports have shown that job-sharing may be particularly useful for NUMs transitioning into retirement or returning from maternity leave

6.6.1. Possible Future Options

6.6.1.1. Strategic

- Incorporate strategies endorsed through the work arrangements project currently being conducted as part of the EB7 projects to promote work-life balance and innovative and flexible rostering practices.

6.6.1.2. Operational

- Focus HR protocol development for NUMs on strategies that reduce stress related to pace of work, hours of work and role functions in line with HR Policies C4 Work Life Balance and B59 Job Sharing.

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7. Conclusion

The strategies highlighted throughout this report and below will facilitate retention of skilled NUMs and attraction of CNs and CMs to the role. Throughout the project consultation NUMs have reported the need for line managers and nursing and midwifery executives to consider job-sharing opportunities and flexible rostering as potential strategies to improve the attractiveness of the NUM role, and to retain nursing and midwifery leaders currently in the role.

The NUM role is regarded as the lynch-pin of healthcare organisations, however it is a role at significant risk due to an inability to recruit and retain personnel. The NUM as clinical leader is integral to sound clinical and corporate governance, to creating a positive workplace culture, to increased patient and staff satisfaction, and to better patient outcomes. Extraneous tasks which currently shift the focus of the role away from clinical leadership must be addressed and delegated to appropriately skilled personnel, freeing the NUM to provide support and guidance to their team. Utilisation of quality frameworks which support capacity building and enhance safe and efficient patient care assist the NUM in maintaining a clinical leadership focus within their work area. Preparation and training for the role are essential to promote retention and attraction to the role. Provision of leadership and management development programs, along with structured orientation and succession planning processes, is essential to support development into, and effective performance of this pivotal role. Clarification of the core role functions provides support for development plans of those aspiring to, or new to the role, and discussions regarding expectations of the role. Retention and attraction can be further enhanced through utilisation of effective rostering practices and work-life balance policies. In addition, consideration of remuneration strategies to recognise the governance and leadership role of the NUM is needed as it is critical to building resilience within the NUM workforce to meet the challenges of this demanding role.

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8. Appendices

Appendix A:	Literature Review: The Nurse Unit Manager Role in Clinical Leadership
Appendix B:	Literature Review: Key Elements, Enablers and Barriers of a Succession Planning Program
Appendix C:	Nurse Unit Manager Core Functions Framework
Appendix D:	Administration Support Officer (AO3 Job Description Key Accountabilities)
Appendix E:	Leadership Programs (additional information)
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Appendix G:	Management Programs (additional information)
Appendix H:	Nurse Unit Manager Succession Framework
Appendix I:	Nurse Unit Manager Implementation Model

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Appendix A

Literature Review: The Nurse Unit Manager Role in Clinical Leadership

The Influence of nurse unit managers in a clinical leadership role on patient safety and outcomes, and patient and staff satisfaction

Clinical leadership defined

There is currently no clear definition of "clinical leadership" in the literature. Davidson and Elliot (2006) highlight nursing leadership as being responsible for the care and safety of patients and a need for monitoring service and individual outcomes. Bondas (2006) goes further to suggest that nursing leadership creates an evidence-based nursing culture which thrives to provide excellent nursing care. Emotional intelligence (EI) can play a factor in developing strong teams and is evident in sound clinical leadership. EI leaders demonstrate the following attributes:

- Skills of sensing others' feelings
- Handling relationships effectively
- Authentic empathy and therefore build trust within the team
- Good role model
- Empowering
- Self-awareness
- Self-motivation
- Foster healthy work environment
- Excellent listener
- Optimize interpersonal relationships (Akerjordet and Severinsson 2008)

O'Rourke, as cited in Davidson and Elliot (2006) defines the visionary clinical leader as being a mentor, supervisor, supportive of colleagues, inspirational to others, and demonstrating clinical excellence and a positive attitude.

Clinical leadership or clinical governance? The conundrum

There is widespread agreement that clinical leaders are critical to effective clinical governance (The Victorian Quality Council 2005). Clinical governance is defined as "… a framework through which [NHS] organizations are accountable for continually improving the quality or their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Davidson and Gray 1998). The Australian Council on Healthcare Standards (ACHS) defines clinical governance as "… the system by which … managers and clinicians share responsibility and are held accountable for patient care, minimizing risks to consumers and for continuously monitoring and improving the quality of clinical care" (2004).

Much of the discussions with NUMs across Queensland during the project focused on the role of the NUM as improving standards of care through empowering their teams to make sound clinical judgments/decisions. Clinical governance is aimed at raising patient satisfaction; improving collaborative relationships and efficiency within and across teams; increasing job satisfaction of professionals;

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improving clinical outcomes; and reducing significant events (accessed from http://www.smmgp.org.uk/html/newsletters/net015.php 30th August 2010).

The literature surrounding clinical leadership highlights a number of key themes, which appear to link closely with the concept of clinical governance, namely:

- Empowering staff to make sound clinical decisions
- Impact on patient safety
- Patient satisfaction
- Staff satisfaction and a positive work environment
- Visible leadership

Patient Safety

Strong nursing leadership is linked to a healthier and safer work environment for both patients and staff. Nurses are the 'sentinels' of the health care system, utilizing local knowledge to influence changes to improve patient care, and identifying near misses (Warburton 2009). According to Hiscock and Shuldham (2008) leadership is one of the most critical factors to the provision of good, safe and dignified care.

Essential to the provision of safe care is the reporting of incidents and the creation and support of a no-blame culture. Firth-Cozens and Mowbray (2001) highlight the effects of an environment which supports identifying of adverse events as improving standards of care through identification of issues. Nurse leaders who instill trust in the team through provision of a supportive environment create a no-blame culture in which staff are open to recognizing and reporting adverse events as a means of improving patient care and service delivery. Those leaders who are authoritarian and dictatorial in their leadership style lead poorer performing teams, in which less errors are identified (Firth-Cozens and Mowbray 2001).

This evidence is further supported by Anderson et al (cited in Wong and Cummings 2007) who found a significant relationship between positive leadership practices (i.e. open communication, participation in decision making, and relationship orientated leadership) and reduced prevalence of adverse events. Another study by Houser (also cited in Wong and Cummings 2007) found an indirect, though significant, relationship between leadership and reduced patient falls and medication errors – this relationship was through the provision of an environment which promoted retention of staff and therefore increased staff expertise and stability.

Staff satisfaction and positive work environment

The literature reviewed by Wong and Cummings (2007) found a relationship clearly existed between the provision of a positive working environment on both staff satisfaction and subsequent patient outcomes. Leadership characteristics which led to this positive environment and increase staff satisfaction included: increasing information flow within the unit; facilitating interpersonal connections among staff; providing appropriate human and material resources to support nurses in the provision of patient care; and support for making informed decisions regarding patient care (Wong and Cummings 2007).

By providing a more positive work environment, staff are more inclined to stay in an organization where supportive and transformational leadership exists, creating a more stable workforce and subsequently improved skill mix and staff expertise. This retention of skilled staff ultimately leads to the provision of safer patient care.

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Nurses working for highly emotionally intelligent leaders experience less emotional exhaustion, better emotional health, greater collaboration and teamwork with physicians and increased job satisfaction than those working for dissonant leaders – [pace-setting and commanding leadership style] (Akerjordet and Severinsson 2008).

Aiken, as cited in Duffield et al (2007) showed that hospitals with strongly supportive work environments have significantly lower mortality rates than others.

Patient Satisfaction

In two of the three studies reviewed by Wong and Cummings (2007) there was an increase in patient satisfaction associated with positive leadership behaviours. This could be related to increased job satisfaction of nurses impacting upon the provision of nursing care to patients.

Firth-Cozens and Mowbray (2001) highlighted the results of a large survey of patient satisfaction which indicated that patient satisfaction correlated highly with cheerfulness, friendliness and sensitivity of staff. The emotional well-being of staff is therefore clearly related to promoting a more satisfied patient experience. At the same time it was recognized that stressed staff produce inferior care (Firth-Cozens and Mowbray 2001), in particular relating to the effects of fatigue on decision making, and the impact of stress and insomnia on errors. Firth-Cozens therefore hypothesise that one important way in which leaders can influence patient care and satisfaction is through their leadership and management of teams, and the resultant effect this has on levels of stress experienced by team members.

Visible leadership

Firth and Mowbray (2001) acknowledge the need for leaders to be visible, in order to identify gaps in the system and areas to improve service delivery. The Victorian Quality Council's paper on developing the clinical leadership role in clinical governance highlighted that visible and active clinical leaders create a safety and quality program that achieves positive and sustainable improvements for patients (2005).

Duffield et al (2007) highlight the increasing administrative load of Nursing Unit managers (NUMs) as resulting in reduced visibility in the unit and subsequent unavailability to supervise, mentor and support their staff. This has resulted in dissatisfaction amongst both nursing staff and the NUMs themselves. The authors also identified the role of the 'modern matron' in the UK as providing strong clinical leadership at the ward level, which has had a positive impact on improving standards of care, the environment, skill mix and staff retention, whilst also contributing to reduced patient complaints and improved patient safety (Duffield et al 2007).

Newman (2005) highlighted the need for leaders to be visible, in particular the need for good visibility (i.e. currently NUMs feel they are visible for the wrong reasons, such as fixing problems or dealing with difficult staff). Bad visibility perceived negatively by staff, as opposed to good visibility of doing the rounds and saying 'how's the day going, what's happening?".

Conclusion

It is apparent that nurse managers positively influence patient outcomes, however not in a direct fashion. By providing a positive, supportive working environment for staff, in which they are empowered to make decisions relating to patient care and where they are actively encouraged to identify adverse events so

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that improvements in patient care can be achieved, nurse managers are setting a climate of accountability and responsibility. As the clinical leaders nurse managers are paving the way for improved clinical governance. Patient satisfaction is correlated with staff satisfaction, and staff satisfaction in turn promotes a safer work environment for patients with reduced patient incidences and medication errors. Staff satisfaction can be directly related to leadership styles, and those leaders with high emotional intelligence and demonstrate transformational leadership create more satisfied work teams.

Therefore, nurse managers influence patient outcomes through the provision of a positive work environment which promotes a more satisfied workforce and the retention of skilled staff, ultimately improving the provision of high standards of care.

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Appendix B

Literature Review: Key Elements, Enablers and Barriers to Success of a Succession Planning Program

Why should we succession plan?

Bolton and Roy (2004)

- Reduced recruitment and orientation costs, minimising time-to-fill for vacancies
- Enhances orderly transitions to role and maintains productivity levels
- Provides for systematic development of new and emerging leadership competencies
- Encourages staff ownership of their own professional growth
- Powerful retention strategy
- Creates a culture that supports career advancement and instills worker loyalty

Brunero, Kerr and Jastrzab (2009)

- Demonstrates clear organisational commitment to career development and professional advancement
- Ensures continuity of service delivery and enhances organisational stability

Redman (2006)

- Acts as magnet to attract talented individuals
- Shows value of human resources and willingness to invest in staff
- Ensures deep pool of talented individuals available in the organisation with local knowledge organisation and who show commitment to organisation's mission, vision, values and culture

Enablers	Barriers
• Using existing training resources reduces cost to organisation of developing new programs • Multi-faceted communication methods • Succession planning to be incorporated into organisational strategic plan (Collins & Collins 2007) • Focus on strengthening current and future organisational capacity (Cadmus 2006) • Focused, skill-based education in association with coaching and mentoring (Redman 2006) • Recognition within the organisation of the pivotal role of NUM • Partnerships with HR & Education departments key to success (Cadmus) • Support & commitment of nurse executives and other organisational senior leaders (Cadmus 2006, Redman 2006) • Develop coaching culture (prefer coaching over mentoring) – Cadmus • Peer support/networks (Paliadelis et al 2007) • Learn "on the job" from more experienced managers (Paliadelis et al, Groves 2006) –	• Financial impact (facilities/districts bear cost for training & backfill) • Time – provision of offline time for CNs, new/acting NUMs • Time – NUM time scarce to provide mentoring support & role shadowing. Day-to-day factors take precedence • Staffing issues –workforce shortages, called back on floor if sick leave, limited senior nurses to backfill offline time • Access to face-to-face workshops for rural/remote areas • Limited availability to all staff, concerns re not being considered, may become de-motivated • Time-consuming process (Collins & Collins 2007) • NUMs perceptions/language/actions may make role appear unattractive • Lack of support structures/processes from nurse to NUM

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mentoring and networking programs vital to success • Organisational support and commitment for education (Gallo 2007) • Leadership development program hardwired throughout the organisation (Gallo) • Shadowing managers to understand more about the role and enabling actual involvement in the future position (Coughlin and Hogan 2008, Collins and Collins)	
Mentoring Program • Coaching & mentoring by senior leadership essential (Redman, Gallo, Paliadelis et al) • Exposure to management world supported by formal program – nurtures & aids future leader development (Coughlin & Hogan 2008) • Organisational support essential to better prepare NUMs for the role, in terms of assistance with admin & managerial aspects of the job (NSW Health 2001)	• Takes time to establish mentoring relationships • Lack of formal mentor training/understanding of how to be a mentor/mentee

Developing succession planning programs

Brunero et al (2009)

CNM Learning competencies

- Advanced leadership ability
- Bed management principles
- Human resource management
- Financial management
- Organisational and advanced problem-solving and decision making skills

NUM Learning competencies:

- Patient access
- Staff and human resource management
- Financial management
- Patient safety and improvement
- Occupational health and safety
- Leadership

Other elements of program:

- Interview process – structured set of questions to ascertain knowledge/understanding of the role; own professional goals; provided learning and feedback opportunity
- Designated time within nurses working day used to participate in interview
- Orientation handbooks for each role formulated (all nurse leader roles) – assists in relieving position, quick reference to critical information on the role

Redman (2006)

Key elements in effective leadership succession planning program

- Commitment of board & senior administration team to concept and value of succession planning
- Assessment of linchpin leadership positions (both managerial and clinical) in terms of competencies, desired qualities of individuals in these roles and future needs

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- Assessment of individuals in organisation in terms of leadership capabilities or potential
- Gap analysis between existing and future needs and current talent pool
- Design and implementation of leadership development program including both generic and individualised components (i.e. assigned projects, professional learning opportunities)
- Implementation of mentoring program to provide coaching and career guidance
- Periodic evaluation, and improvement as needed, of succession planning program and process

Managers role in leadership development

Groves (2006)

- Managers are instrumental in developing the leadership pipeline
- Organisations task leaders with teaching responsibilities and facilitating workshops to actively encourage learning and knowledge sharing
- Facilitates systems thinking & ability to problem solve complex, systemic problems
- Promotes cultural understanding across business units & provides cross-functional learning experiences
- Successful marrying of leadership development with succession planning processes achieved through active utilisation of managerial personnel

Mentoring

- Mentors more likely to experience range of positive outcomes, including enhanced job performance, greater promotions, organisational commitment & job satisfaction, personal learning, and reduced turnover intentions
- Multiple mentors associated with improved managerial career success, through greater access to network of highly experienced leaders

Organisational culture of leadership development

- Acquisition of leadership skills facilitated by visible senior leadership support, immediate supervisor support, and organisational culture that values learning and development
- Managers must assume primary responsibility for building the organisation's leadership capacity
- One organisation requires managers to talk with staff individually during performance review regarding career aspirations
- One organisation requires all managers, as part of their performance review, to identify 2 people to develop – senior leadership then talks with those people re career possibilities in the organisation & assess their interest
- Incorporating leadership development & succession planning responsibilities into managerial job expectations and performance appraisal criteria provide effective means for ensuring succession planning is top priority for managers at all levels

Committing resources

Bolton and Roy (2004)

- Succession planning cannot occur without budgeted resources and time commitment for the ongoing development and growth of staff
- Funding of ongoing education, supporting staff enrolled in post-graduate programs and financial support for leadership advancement programs
- Easy to make sound business case for succession planning based on return on investment – eliminates recruitment & orientation costs, maintains productivity, respond quickly to market demands
- HR literature reveals that eliminating a single recruitment at the middle management level saves 75% - 125% of annual salary for that position

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Appendix C

Nurse Unit Manager Core Functions Framework

Clinical management and coordination	
Accountability	**Task**
Promote a patient-focused approach to patient care	▪ Lead, direct and coordinate care in the ward/unit ▪ Facilitate and lead collaborative teams in the safe and reliable delivery of patient care ▪ Oversight clinical care in units ▪ Maintain skill-mix levels to ensure safe patient care through effective rostering ▪ Promote a client service ethos
Promote client engagement through fostering of client relationships	▪ Identify, establish and maintain effective internal and external client relationships ▪ Lead the resolution of complex, sensitive or contentious client issues ▪ Use patient, carer and family feedback to inform patient care service delivery
Ensure all staff are aware of ethical standards of behaviour and ANMC Code of Ethics	▪ Promote, role model and monitor ethical behaviour and Queensland Public Service Code of Conduct ▪ Be open and receptive to reports of unethical behaviour and act appropriately to resolve these issues ▪ Seek advice as appropriate and follow QH policy and guidelines
Maintain standards of professional practice	▪ Enable a culture of life-long learning, development and improvements in contemporary nursing/midwifery practice for the unit ▪ Maintain knowledge of contemporaneous nursing/midwifery practice ▪ Promote standards of practice for all nursing/midwifery staff that meet the ANMC competency standards, Queensland Health (QH), Health Service District and organisational policies and procedures ▪ Participate in the development and implementation of standards, policies and procedures for the clinical specialty which reflect current trends and best practice patient care standards ▪ Enable nursing/midwifery staff to maintain safe and effective competencies ▪ Function in accordance with legislative and common law affecting nursing/midwifery practice
Promote the importance of quality processes to the improvement of patient care and service delivery	▪ Constantly review and improve processes in collaboration with the clinical team ▪ Establish a "no-blame" culture in which staff feel comfortable reporting patient incidents, with a view to improving patient care and service delivery ▪ Utilise patient incident reports to seek improvements in patient care processes ▪ Actively look for innovative solutions that improve service delivery and reduce waste and rework ▪ Establish and maintain processes to facilitate performance improvements ▪ Maintain productive and documented evidence of regular staff meetings ▪ Investigate nursing/midwifery practice complaints and patient complaints
Promote the use of evidence and research into nursing/midwifery care	▪ Undertake research projects as identified and/or guided by the Nursing/Midwifery Director and other key personnel ▪ Utilise current and evidence based practice for the development and revision of patient care services ▪ Communicate relevant research findings to the nursing/midwifery team and interdisciplinary colleagues ▪ Promote staff involvement in identifying opportunities for research, and participating in conducting research and evidence based practice projects within the unit

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Clinical leadership	
Accountability	**Task**
Act as a role model for staff throughout the organisation	▪ Be an exemplary role model for the professions of nursing and midwifery ▪ Demonstrate comprehensive nursing/midwifery leadership and act as a mentor for staff ▪ Act as a resource person for staff in the unit, organisation or other district facilities
Empower staff to make sound clinical decisions	▪ Manage ward/unit staff to facilitate growth and development ▪ Involve staff in planning the operational and strategic plan for the unit ▪ Delegate decision making to the most effective level ▪ Mentor and support the considered decisions made by staff ▪ Create an empowering environment that enables the development of critical thinking and decision making skills ▪ Demonstrate independent decision making and problem solving skills, acting as role model and coach for other staff
Provide leadership to build a high-functioning, high-performing team	▪ Create direction and purpose through establishing a shared vision for the unit/ward ▪ Achieve organisational goals through effective teamwork ▪ Support the ongoing development of teams ▪ Encourage and role model behaviours that support teamwork ▪ Contribute to interdisciplinary consultation and decision-making processes ▪ Work collaboratively with peers, partners and within the team to sustain relationships and enhance outcomes

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People management	
Accountability	**Task**
Promote awareness regarding the impact of trust and open communication on organisational culture	▪ Develop and implement actions from culture surveys ▪ Manage issues in an open and honest way ▪ Ensure own decision-making is transparent and fair ▪ Ensure all documentation and meetings of a sensitive nature are kept confidential
Understand the importance of open communication amongst the interdisciplinary team	▪ Demonstrate open and honest communication at all times ▪ Communicate and advocate to others on behalf of the team ▪ Communicate and use shared visions, missions and values to enhance the quality of the work environment and influence others ▪ Ensure all communication and documentation channels are effective and efficient
Promote appropriate conflict management according to organisational policies and procedures	▪ Support staff to deal constructively with workplace conflict ▪ Ensure grievances are managed effectively ▪ Participate in problem solving in matters relating to the ward/unit ▪ Support staff to resolve performance issues in their teams ▪ Develop team skills in communication regarding complex, sensitive or contentious issues
Create a positive working environment which promotes retention of skilled staff, and attracts new staff	▪ Genuinely value staff and their contributions ▪ Ensure feedback provided to staff is relevant, specific and timely ▪ Develop performance and development plans to promote ongoing learning and skills acquisition ▪ Provide opportunities for staff to respond to feedback in a non-judgemental manner
Actively promote the development of self and staff	▪ Seek opportunities to coach others ▪ Promote and enable own and colleagues' professional development ▪ Create, implement and actively monitor development plans for self and staff ▪ Ensure all staff have current performance appraisals and development plans ▪ Recognise and nurture talent through the establishment of succession management practices within the work unit
Actively lead change through promotion of change management principles	▪ Be open to, and embrace, change ▪ Actively look to implement change that will improve patient care, the workplace environment or work processes ▪ Utilise sound change management principles and guidelines to promote staff participation and acceptance of change ▪ Promote a culture of critical thinking in which staff challenge the status quo and actively look for areas for improvement ▪ Lead change through quality and service improvement activities and the development of better practice

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Business management	
Accountability	**Task**
Utilise sound business planning principles which align with organisational imperatives	▪ Develop business, operational and workforce plans in alignment with strategic priorities and objectives ▪ Undertake proactive workforce planning including recruitment and retention of competent staff ▪ Identify and plan resource budgeting needs utilising the Business Planning Framework model in collaboration with Nursing/Midwifery Directors and Clinical Unit staff ▪ Be actively involved in the budget build process for work unit, to ensure identification of resourcing needs and promote budget accountability ▪ Establish work models that motivate staff while better meeting patient outcomes
Promote efficient utilisation of all available resources within the work unit to meet budgetary goals and enable consistent and safe service delivery	▪ Allocate resources in a way that is transparent and balances satisfying service need and controlling costs ▪ Ensure the delivery of safe and reliable care is achieved through the efficient management of human and material resources ▪ Ensure rosters are effective and cost-efficient to meet the needs of the unit and staff, and are aimed at the provision of safe patient care ▪ Analyse and report on budget variances and work unit performance utilising a balanced scorecard approach, incorporating HR, Financial, Quality and Safety, and Unit Specific indicators to inform discussions
Utilise sound corporate governance principles in relation to workplace and patient safety	▪ Assist others with their understanding and compliance with legislative and policy requirements ▪ Implement workplace health and safety systems that improve staff and patient safety ▪ Monitor and maintain a safe environment for patients, staff and visitors ▪ Work collaboratively with workplace health and safety team to maintain a safe working environment ▪ Report and follow up incidents and accidents promptly
Develop an awareness of risk management processes within the unit	▪ Incorporate risk management into planning, decision making, performance reporting, analysis, quality and safety ▪ Ensure staff are rostered according to the relevant award and industrial agreements
Promote utilisation of project management skills to facilitate project success	▪ Follow formal project management processes for major projects ▪ Implement, monitor and review progress of projects and objectives
Ensure efficient information management processes exist within the work area	▪ Enable access to quality, timely and appropriate information in a clinical, administrative and public setting ▪ Establish accurate record keeping processes

Documents which have assisted developing the content of this framework include:

- *Townsville Health Service District Nursing Role Accountabilities*
- *Queensland Health Leadership and Management Framework*
- *NSW Health "take the lead" project A Conceptual Framework: The Nursing/Midwifery Unit Manager Role*

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Appendix D

Administration Support Officer (AO3 Job Description Key Accountabilities)

- Fulfil the accountabilities of this role in accordance with Queensland Health's core values, as outlined above
- Complete general administration and secretarial duties including mail, typing, formatting, photocopying, data entry, filing (both manually and electronically) and travel arrangements whilst maintaining a neat and tidy work area
- Contribute to the organisation of meetings, interviews, training sessions and training days, including catering arrangements and room bookings
- Attend and perform secretariat duties in meetings and disseminate minutes and other information within the area when required
- Assist staff and clients in the work unit as requested and respond to general customer inquiries over the phone, email and in person including diary and email management for senior staff as instructed
- Contribute to development of databases and spreadsheets, complete data entry and maintain accuracy and integrity of information in databases and produce and action reports when requested
- Monitor non clinical supplies and order stock as well as monitoring repairs and maintenance of office equipment in the department
- Prepare and update doctors and nurses rosters, liaising with appropriate professional staff
- Disseminate information to the staff as directed.

***Adapted from a job description for an AO3 position in a large metropolitan hospital within QH**

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Appendix E

Leadership Programs (additional information)

Healthcare Culture and Leadership Service

1. The Emerging Clinical Leaders Program (ECLP) offered by the Healthcare Culture and Leadership Service (HCLS) provides a comprehensive leadership program incorporating the strategies identified above. Currently there are 60 places per year in the 12 month program, with 2 intakes per year of 30 participants from a variety of healthcare streams. Feedback from NUMs who have participated in the ECLP have been very positive, however have suggested more places would be beneficial to develop more nursing and midwifery leaders. Evaluation data from the ECLP suggests that 40% of ECLP participants would have sought other employment if the program had not been available. HCLS estimates that the return of investment in running the program is approximately $2.2million (based on replacing only 50% of those staff at a cost of $100,000 per year), in terms of saving on recruitment and replacement costs. HCLS cover the cost of the core program (including facilitator costs, executive coaching, accommodation for 2 nights of the residential workshop, venue hire and catering) however local funding needs to be sourced for travel, additional accommodation and backfill costs.

2. The HCLS also provides a Panel Arrangement Agreement of suppliers who design, develop and facilitate leadership and management programs and training materials, and provide executive coaching services at an agreed price for an agreed period of time. Districts can access this agreement and information regarding how to procure the services of a supplier to develop and deliver training programs through the HCLS webpage http://qheps.health.qld.gov.au/betterworkplaces/leadership/panel/howto.htm

3. A variety of leadership workshops relevant to the NUM role are also offered throughout QH districts, including: Inspiring Leadership; Coaching Skills for Leaders; Delivering the Service; Personal Leadership Qualities; Setting the Direction for Leaders; and Energising from Conflict. http://qheps.health.qld.gov.au/betterworkplaces/home.htm

4. Self-directed learning modules and self-assessment tool based on the National Health Service Leadership Qualities Framework are also available on the HCLS intranet site, for those areas who have limited access to workshops.

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Appendix F

Queensland Health

Leadership and Management Framework

Leadership		
Personal Qualities *: self belief; self awareness; self management; drive for improvement; personal integrity	**Setting Direction** *: seizing the future; intellectual flexibility; broad scanning; political astuteness; drive for results	**Delivering the Service***: leading change through people; holding to account; empowering others; effective and strategic influencing; collaborative working
People Management		
Organisational Culture 1: demonstrate behaviours that align with the organisational values of caring for people, leadership, respect and integrity	**Organisational Culture 2**: develop and implement action plans from culture surveys; confront issues in an open an honest way that builds trust and respect	**Organisational Culture 3**: create a value-based culture; live the organisational values through behaviours; create a supportive and respectful work environment
Ethical Standards 1: model ethical behaviour in accordance with the Queensland Health Code of Conduct; deal with unethical behaviour in a timely and constructive manner	**Ethical Standards 2**: promote, role model and monitor ethical behaviour; be open and receptive to reports of unethical behaviour; obtain independent advice regarding potential ethical conflicts	**Ethical Standards 3***: maintain the highest standards of ethical behaviour; model commitment to openness, honesty and inclusiveness; support ethical behavioural systems throughout the organisation
Communication 1: convey information in a clear and unambiguous manner; overcome barriers to effective communication; listen effectively; identify own communication style	**Communication 2**: represent the unit/area effectively; prepare and edit official correspondence and communication; convey organisational information; adapt personal style to suit audience	**Communication 3***: adopt appropriate strategies to gain support and influence others; communicate effectively in the public domain and with senior boards and external stakeholders
Conflict Management 1: manage workplace conflict constructively; follow Queensland Health grievance policies; obtain support for management of complex cases	**Conflict Management 2**: support subordinates to deal constructively with workplace conflict; ensure grievances are managed effectively; implement strategies that encourage collaborative relationships	**Conflict Management 3**: actively manage conflict across organisational boundaries and throughout the health sector to achieve collaborative and constructive outcomes
Performance Feedback 1: provide direct and timely feedback; initiate performance improvement programs when necessary; recognise good work	**Performance Feedback 2**: support direct reports to resolve performance issues in their teams; demonstrate a commitment to improved performance and the achievement of organisational goals	**Performance Feedback 3***: create and sustain a high performance culture; create and support organisational recognition processes
Development 1: induct and orientate all new staff; conduct Performance Appraisal and Development processes with all staff; support skill development of staff	**Development 2**: seek opportunities to coach others; participate actively in self development opportunities; create implement and actively monitor development plans for self and staff	**Development 3***: create an organisation that supports and values continuous learning; embrace coaching and mentoring for self and others
Building Teams 1: appreciate diversity in team members; utilise team member's strengths to achieve team goals; promote team identity and inclusiveness	**Building Teams 2**: create direction and purpose; achieve operational goals through effective teamwork; support the ongoing development of teams; encourage behaviours that support teamwork	**Building Teams 3**: build effective strategic teams that role model desirable team behaviours; achieve organisational outcomes and commitment through teamwork at the executive level
Leading Change 1: lead change effectively at the local level; communicate the reasons for change and support people through change	**Leading Change 2**: embrace change; actively look to implement change that will improve the workplace environment or work processes; support change efforts	**Leading Change 3***: communicate a compelling vision for change; build coalitions to guide and collaboratively achieve real change
Attraction and Retention 1: recruit staff in accordance with Queensland Health and Whole of Government directives, policies and guidelines	**Attraction and Retention 2**: create a local environment where people want to come to work; genuinely value staff and their contributions	**Attraction and Retention 3**: identify strategic priorities and initiatives to address future talent requirements; position Queensland Health as an organisation that attracts national and international talent
Client Engagement 1: maintain effective communication channels with clients, consumers and patients; resolve difficult client situations; escalate issues that cannot be resolved locally	**Client Engagement 2**: identify, establish and maintain effective internal and external client relationships; lead the resolution of complex client issues; promote a client service ethos	**Client Engagement 3***: lead an organisational culture that embraces constructive engagement with internal and external stakeholders
Business Management		
Business Planning 1: implement business and operational plans at the local level; align team activities with business priorities	**Business Planning 2**: develop business, operational and workforce plans in alignment with strategic priorities and objectives	**Business Planning 3***: create strategic plans that meet departmental and whole of government priorities and position the department to meet future challenges
Organisation Design 1: review and adapt job roles to ensure they meet service delivery priorities	**Organisation Design 2**: adjust structures to enable seamless service delivery and effective use of resources	**Organisation Design 3**: create organisational structures that facilitate effective management whilst maximising service outcomes
Service Delivery 1: implement service models that make best use of available staff.; implement services to enable improved health of at risk populations	**Service Delivery 2**: establish work models that motivate staff while better meeting patient outcomes; implement strategies that enable patients and consumers to access integrated services	**Service Delivery 3***: create health service networks that operate across public and private providers so that patients and consumers experience a comprehensive and integrated service
Quality Improvement 1: apply the principles of quality and continuous improvement; use quality tools to improve local processes	**Quality Improvement 2**: constantly review and improve processes; implement quality improvement systems; actively look for innovative solutions that improve service delivery and reduce waste and rework	**Quality Improvement 3***: support a research and evidence-based culture that facilitates rapid uptake of best practice to drive improvement, innovation and efficiency across the system.
Financial Management 1: identify the impact of labour and non-labour costs on budgets; manage local expenditure within budget; identify savings and efficiencies where possible; use cost centres and account codes correctly; authorise the procurement of resources in accordance with Queensland Health policy and personal delegations	**Financial Management 2**: establish budgets; develop financial plan for unit; allocate resources in a way that is transparent and balances satisfying service need and controlling costs; understand the principles of accrual accounting; ensure areas of responsibility have the physical resources to achieve their operational requirements	**Financial Management 3**: develop, interpret, monitor and analyse trend data in organisational financial and establishment reports; forecast, monitor and manage revenue and expenditure; develop strategic procurement plans; ensure the organisation has the health infrastructure to meet demand in population growth areas
Corporate Governance 1: locate, identify and comply with legal, legislative and policy requirements appropriate to area of control; promote workplace health and safety as a team and individual priority; support physical and psychological safety in the workplace	**Corporate Governance 2**: assist others with their understanding and compliance with legal, legislative and policy requirements; implement workplace health and safety systems that improve staff and patient safety	**Corporate Governance 3**: lead the development of policies and practices that support ongoing changes in service delivery and service delivery models; lead an organisational culture that supports physical and psychological safety
Decision Making 1: make decisions in accordance with Queensland Health policies and personal delegations	**Decision Making 2**: delegate decision making to the most effective level; support considered decisions made by subordinates	**Decision Making 3**: create a culture of empowered decision making; remove unnecessary bureaucracy from decision making processes
Risk Management 1: apply the principles of risk management as outlined in Queensland Health's Integrated Risk Management Framework	**Risk Management 2**: ability to incorporate risk management into planning, decision making, performance reporting, analysis, quality and safety	**Risk Management 3**: champion risk management within portfolio of responsibility; promote the view that everyone is a risk manager
Project Management 1: utilise project management methodologies; adopt project management processes appropriate for the scale of project to be undertaken	**Project Management 2**: follow formal project management processes for major projects; implement, monitor and review progress of projects against objectives	**Project Management 3**: adopt project governance systems; formally approve, monitor and review major organisational projects
Information Management 1: ensure team members have the information systems that enable them to operate effectively; utilise technology to build efficiencies and assist in information sharing in clinical and administrative settings; maintain records	**Information Management 2**: access quality, timely and appropriate information in a clinical, administrative and public setting; monitor scope and compliance of clinical practices in health services in a comprehensive manner; establish record keeping processes	**Information Management 3**: create an information technology environment that enables efficient use of resources and streamlines processes; adopt an open and transparent approach to public reporting of Queensland Health activity

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Appendix G

Management Options (additional information)

People Management workshops

The Sailing into Supervision and Managing Your People workshops have been designed for new managers and existing/experienced managers respectively. The content of these workshops is the intellectual property of QH and train-the-trainer workshops are being offered to encourage districts to begin running these workshops at a local level. The Managing Your People workshop is a 2 day course covering the capabilities required for Existing managers as follows:

- communication
- performance feedback and development
- building teams
- organisational culture and leading change

Business Management workshops

The Bouncing into Business and Managing Your Business workshops have been designed as above for new and existing managers. Similarly, it is anticipated that these workshops will be devolved to the districts to run in future. The Managing Your Business workshop is a 2 day course which covers the following core areas:

- Financial Management (Financial Management Framework, Accrual Accounting, Managing Budgets and Cost Centres)
- Performance Management & Accountability
- Business Planning or Business Case Preparation
- Decision Making (plus analytical & decision making tools)
- Risk Management (including Governance, Internal Controls, Procurement, Gifts & Benefits)
- Information Management

Managing Organisational Change workshop

This workshop been developed to successfully deliver QH's change agenda and support employees through change. The workshop is currently available through the Capability Unit, however local workshops are also offered by Learning and Development Units within some districts.

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Appendix H

Nurse Unit Manager Succession Framework

Succession Management principles to be utilised throughout process	Level (as per QH Leadership & Management Framework)	Choose from these programs/activities/resources (refer to Appendix for more information)	Programs covering all aspects
▪ Mentoring ▪ Work shadowing ▪ Coaching ▪ Acting roles ▪ Stretch opportunities/ assignments ▪ Peer support networks with other NUMs ▪ Debrief sessions with DONs ▪ PAD and individualised plan review ▪ NUM Resource/ Orientation Guides	**Key area: Workforce Management, Planning and Development**		▪ Wide Bay Health Service District – Level 2 to Level 4 Nursing Development Program ▪ Princess Alexandra Hospital – NUM Succession Planning Program ▪ Gold Coast Health Service District – Manager Capability Development Program ▪ Management Capability Development Program – Harvard ManageMentor Cafe Materials ▪ Post graduate courses in Clinical Leadership and/or Health Management
	1 & 2 1 & 2 1 1 & 2	▪ Recruitment and Selection workshop ▪ Business Planning Framework ▪ Work with BPF trainer to draft unit service profile and staffing requirements ▪ Team Building workshops	
	Key area: People management		
	1 2 1 & 2 1 & 2	▪ Management Capability Development Program – Sailing into Supervision workshops – Managing Your People workshops – Harvard ManageMentor modules ▪ Healthcare Culture and Leadership Service – Energising from Conflict workshops ▪ Local workshops/programs ▪ Attendance Management workshops ▪ Performance Management workshops ▪ People and Culture Unit – Tools/guidelines to facilitate learning	
	Key area: Business management		
	1 & 2 1 2 1 & 2 1 & 2 1	▪ Management Capability Development Program – Harvard ManageMentor modules – Bouncing into Business workshops (in development phase) – Managing Your Business workshops – Managing Organisational Change workshop ▪ Business Planning Framework workshop ▪ Meet with Business manager to discuss role and requirements relating to financial management	
	Key area: Clinical leadership		
	1 & 2 1 & 2	▪ Healthcare Culture and Leadership Service – NHS Leadership Qualities Framework – Leadership workshops – Emerging Clinical Leaders Program ▪ Local Leadership programs	

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Appendix I

Nursing and Midwifery Development Implementation Model

Principle	Actions
Principle 1: Support the clinical leadership and governance role of the NUM	Strategic
	• Align the NUM Core Functions Framework to the NUM Position Description and revised generic level statements for new applicants to the NUM role or new employees to QH • Research and identify activities currently undertaken by NUMs for devolution or delegation
	Operational
	• Provide the NUM Core Functions Framework to all new NUMs with recruitment information and discuss with all new and acting NUMs • Incorporate the NUM Core Functions Framework into the PAD process and NUM Succession Framework • Prioritise administrative support for the role • Evaluate existing support structures and identify areas where increased support is necessary.
Principle 2: Implement quality frameworks and models of professional practice to support the NUM role e.g. Transforming Care program, Productive Wards, Going Lean in Health Care, Practice Partnerships model	Strategic
	• Refocus the NUM role on clinical leadership through identification clarification of core functions and expectations of the NUM role through the NUM Core Functions Framework
	Operational
	• Utilise existing frameworks and resources to support the identify an plan professional and clinical development activities through the performance appraisal and development process • Develop standardised protocols for implementation of quality frameworks which underpin the NUM role • Collaborate with other districts/facilities who have implemented quality frameworks such as Productive Ward and Transforming care for information-sharing and advice on how to implement these initiatives • Obtain executive support to promote sustainability and embedding of models of NUM practice change to facilitate improved patient outcomes, and patient and staff satisfaction

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Principle 3: Develop NUM leadership and management capabilities to ensure skills, knowledge and attributes are in place to perform the role.	Strategic
	• Fund and implement a range of QH Nursing and Midwifery scholarships targeting Nursing and Midwifery Leadership Development for the NUM role • Nursing and Midwifery Office implement strategies that foster NUM engagement and sharing of innovative models of professional practice and building of collegial network • Nursing and Midwifery Office and the Directors of Nursing and Midwifery Advisory Committee support and monitor ongoing implementation of district leadership development programs for the NUM role
	Operational
	• Procure the services of select providers (through HCLS) to design, develop and deliver leadership and management programs inclusive of coaching targeted to Nurse Unit Managers • Provide funded support / leave to participate in leadership development programs/ coaching sessions /NUM skills development workshops as identified in the NUM Succession Framework
Principle 4: Provide sufficient preparation, training and succession planning for the NUM role	Strategic
	• Develop a QH Nursing Unit Manager Succession Protocol which standardises the training and orientation processes for the NUM role. • Consider a clinical nurse/clinical midwife – clinical management stream to be reflected in the *Nursing Classification and Career Structure* to promote succession planning and delineation of a career pathway to the NUM role • create structured orientation processes, including handover from previous incumbent and allocated orientation time for the NUM role • update a revised NUM succession planning framework • update and revised QH nursing and midwifery mentoring framework • develop a QH nurse unit manager succession protocol which standardises the training and orientation processes for the NUM role
	Operational
	• Support existing NUMs and nursing directors to undertake the Coaching Skills for Leaders workshop to promote a cultural shift towards coaching conversations • Incorporate NUM training into all unit / facility / district workforce plans • Allocate time for mentorship and coaching of potential NUMs who are undertaking a Clinical management portfolio, job shadowing opportunities or completion of core skills training

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	• Incorporate *Mentoring* as an action in all NUM performance and appraisal development plans. • Implement NUM orientation resources developed or identified through the NUM project • Ensure that orientation/handover time requirements are based on the experience and prior preparation of the newly appointed NUM or acting NUM. • Implement local peer networks to provide collegial support for NUMs in isolated roles/locations and those new to or acting in the role.
Principle 5: Consider incentives which recognise the leadership and governance accountability of the role with a view to promoting retention of existing NUMs and attraction of future nursing leaders	Strategic
	• Refocus NUM role on clinical leadership through identification of extraneous tasks undertaken by the NUM and promotion of delegation of these tasks to appropriate personnel • Develop a Job Evaluation Methodology which bands the NUM role based on the variations in responsibilities and accountabilities of the individual NUM position including accounting for the complexities of the role within areas such as: ○ FTE/headcount ○ setting: community and primary health care, acute care, Community Mental Health , residential/aged care ○ geographical location: rural, remote, metropolitan, regional ○ support structures: administrative support, other Grade 7 roles within the setting ○ budget and operational responsibilities
	Operational
	• Implement formal TOIL arrangements (in line with *QH Human Resource Policy C46 Time off in Lieu (TOIL))* for recording, reporting, monitoring and addressing issues related to TOIL
Principle 6: Job-sharing arrangements to be supported for all NUMs, in line with the QH Human Resource Policy C4 - Work-Life Balance and B59 – Job Sharing	Strategic
	• Incorporate strategies endorsed through the Work Arrangements Project
	Operational
	• Focus HR protocol development for NUMs on strategies that reduce stress related to ○ knowledge and experience ○ pace and hours of work ○ morale ○ role and function ○ work life balance

Prepare Train Mentor NUM Leader Capability Leadership Governance

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Queensland Nurses' Union

NURSE & MIDWIFE UNIT MANAGER (N/MUM) RESEARCH PROJECT (2011)

Report

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Executive Summary

The purpose of the Queensland Nurses Union (QNU) Nurse/Midwife Unit Manager (N/MUM) Research Project, 2011, as directed by the Council of the QNU, is to assist the QNU to inform Queensland Health (QH) Enterprise Agreement (EB) Number 8 negotiations with respect to any changes required to the role, responsibility, and span of control of the N/MUM role and its inter-relationship with roles in other streams of the nursing and midwifery career structure.

Conditions affecting nursing and midwifery workforce planning, recruitment and retention have been subject to decades of reviews and recommendations, and markedly in Queensland Health since the 1999 QH *Ministerial Taskforce – Nursing Recruitment and Retention*. With selected achievements hard won, this planning continues. Pressures now apply for keeping pace with changes, and in limiting the instability of delays in delivering strategies that work.

The recurring and unresolved concerns of nurses and midwives in Queensland are well known. These are currently priortised by the Nursing and Midwifery Implementation Group (NaMIG) as the key strategic reference group of QH and the QNU, committed to completing priority projects (EB6, 2006; EB7, 2009).

The negotiated strategies arising from QH Enterprise Agreements contextualise the QNU N/MUM Project 2011. The NaMIG priority projects and the QNU Career Structure Objectives and Policy on Advanced Practice Nursing, directly connect with this Project..

Members identified a number of themes that inform the structure and detail of this Project. These are

Span of Control,

Role Responsibilities,

Role Supports and Enablers, and

Role Preparation, Recruitment and Retention.

N/MUMs as well as Grade 7 nurses and midwives in advanced practice roles in clinical, education, and research streams (two cohorts) were selected for direct expert reference consultation. This Report provides an account of the current operating environment of QH; the extant research on the N/MUM role, and advanced practice; findings of the state-wide consultation conducted over 14 weeks (Aug-Oct 2011) with 610 Grade 7 QNU member nurses and midwives; and makes recommendations based on these findings.

The findings confirm the validity of N/MUMs' major concerns, in compressed role work (span and responsibilities); and the intensity of role demands without resources, including position authority, commensurate with the expectations of the role. Material support, prioritized by the N/MUMs in this study, are advanced clinical roles (including education and research); and business supports, particularly human resources and administration systems.

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These concerns are shared across the Grade 7 nurse and midwife cohorts to varying degrees of role stress. The findings across both participant cohorts, isolate barriers to role capacity and satisfaction in limited career and classification structure opportunities for recognition of advanced practice in the respective career streams. Related recruitment and retention challenges are found to persist in complicating stability and effectiveness in these clinical service leadership roles.

Consultation outcomes are substantially consistent with the findings in the literature.

The twenty (20) recommendations of this research report are validated through member consultation and the evidence-base collated from a comprehensive search of relevant literature. The recommendations direct a range of critical investments in structural and material role supports for N/MUMs in particular, and Grade 7 nurses and midwives generally, including strategic utilization of an updated QH Career and Classification structure.

The objectives of the QNU N/MUM Project 2011 have been substantially met, with the recommendations endorsed by the Council of the QNU. It is anticipated that the Report will add to the resources available to NaMIG, and to QNU members, in the shared interest-based EB8 negotiations 2011-2012.

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Recommendations

1 Nursing and Midwifery Governance

1.1 That Nursing and midwifery governance undergo a strategic re-build to enable leadership capability and role effectiveness, including opportunities to secure:-

- empowerment through structured nursing and midwifery governance and self-regulation;
- investment in nursing and midwifery's primary positioning for system and patient safety and quality;
- investment in nursing's health service leadership and reform capability- service models and pathways; expert co-ordination in partnerships and teams; and
- respect, recognition and reward for advancement in nursing and midwifery knowledge and practices (QH Career & Classification Structure).

1.2 That a professional career structure based on differentiated nursing and midwifery practice and multiple levels across streams, be affirmed and consolidated.

1.3 That operational authority be formalized in roles with significant resource accountabilities tied to role responsibilities, specifically the Business Planning Framework: a tool for nursing workload management, Version 4 (2008);

1.4 That professional career advancement in an updated QH Career Structure be applied in maximizing synergies and new opportunities in recruitment and retention strategies currently scoped by the lead strategic reference group of QH (NaMIG) in priority project work, comprising :

- Career and Classification Structure;
- Models of Nursing and Midwifery;
- Business Planning Framework;
- Working Arrangements.

2 Span of Control

2.1 That realistic spans of control be achieved for N/MUMs by identifying and applying measures to modify current over-wide spans, where role capacity is limited.

2.2 That evaluation of current role N/MUM role spans be based on best-practice measures, and

- adopt span indicators with proven sensitivity to the context of the N/MUMs' professionally grounded management practice;
- inform the selection of strategies for achieving appropriate modifications to the operational environment of the N/MUM; and
- be applied in recognition of N/MUM advanced management expertise in appropriately matched grades and bandings in the QH Career and Classification Structure.

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2.3 That a range of clinical, business, human resources, administrative, and material supports be implemented in effective modification of current over-wide spans of N/MUM roles, consistent with and prioritized in the Service Profile of the Business Planning undertaken by N/MUMs in collaboration with their teams, service-users, and line managers.

2.4 That formal role authority be established in the N/MUMs' position description, commensurate with the expected accountabilities for outcomes across the designated span of managerial and professional clinical control.

3 Role Responsibilities

3.1 That the tacit, expert, and professionally grounded role work of the N/MUM be recognised as advanced nursing and midwifery management practice, differentiated by role responsibilities, and formally valued by:

affirming the unique hybrid clinical leadership and managerial role of the advanced practice N/MUM;

implementing role span modifications to achieve effective balance in the N/MUM hybrid role work, in line with the N/MUM practice context;

agreement on role outcomes and revised position descriptors; and in

correcting persistent anomalies across the current QH Career and Classification Structure at Grade 7, that negatively impact on N/MUM, and related staff recruitment.

3.2 That appropriate recognition and strategic utilization of advanced practice nursing and midwifery in the QH Career and Classification Structure be effectively achieved for nursing and midwifery roles across all career structure streams, with specific reference to:

QNU Objectives of the Career Structure and Classification Structure (2011); and

QNU Policy on Career and Classification Structure recognition of Advanced Practice Nursing and Midwifery (QNU 2011).

4 Role Enablers and Role Supports

4.1 That recommendations related to role span and responsibilities be recognised and endorsed as key enablers of N/MUM clinical leadership and managerial role capacity.

4.2 That administrative assistants be introduced in light of the current operational context for QH N/MUMs, and with reference to the evaluation outcomes for N/MUMs in the New South Wales Health N/MUM capacity building program, *Take the Lead* (AIHI 2011).

4.3 That ancillary staff such as finance and human resources be reoriented to a support role for N/MUMs.

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4.4 That QH N/MUMs be supported in achieving the appropriate clinical infrastructure (clinical, education, and research) and in meeting the established standards and principles of nursing and midwifery professional practice frameworks, where the N/MUMs strategic, professional, and operational expertise is relied upon, and where new complexities and instabilities challenge the front-line N/MUM's role capacity and capability.

4.4 That formal, resourced peer network structures be established to enable N/MUM leadership capacity and capability, towards high resilient organizations.

5 Role Preparation, Recruitment & Retention

5.1 That recommendations related to role Span, Responsibilities and Enablers be embedded in consolidating role preparation, recruitment and retention strategies for N/MUMs, and where applicable, for Grade 7 Nurses and Midwives in advanced functional management, clinical, education, and research roles.

5.2 That evidence-based recruitment and retention strategies be incorporated in preparation, recruitment and retention of nurses and midwives at all levels of clinical leadership and managerial role development and advancement.

5.3 That access to role related education and training, orientation, mentoring framework and related offerings available through the work of the Nursing and Midwifery Office of Queensland (NMOQ, 2011) and others, be effectively resourced.

5.4 That alternate approaches to 'fix the N/MUM' be promoted and resourced, in particular:-

relationship-centred programs, peer mechanisms, and learning on the job;

managerial (training) programs sensitive to and modified for recognition of the professional expertise and practice context of the participants; and

demonstrated investments in material supports to rebuild confidence in the

attractiveness of the N/MUM role.

5.5 That an updated QH Career and Classification structure with improved opportunities for access to recognition for advanced practice, be established to ensure:-

stability and continuity in recruitment and in retention of clinical leaders in each of the four (4) QH Career Structure streams; and

access for nurses and midwives early in their careers of advanced practice.

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Acronyms

ABS	Australian Bureau of Statistics
AHPRA	Australian Health Professionals Registering Authority
AIHI	Australian Institute of Health Innovation
AIHW	Australian Institute of Health & Welfare
AO	Administration Officer
BPF	Business Planning Framework: a tool for nursing workload management, Version 4, 2008.
CN	Clinical Nurse
CNC	Clinical Nurse Consultant
CNS	Clinical Nurse Specialist
CSO	Clinical Support Officer
DON	Director of Nursing
EB	Enterprise Bargaining
ENAP	Enrolled Nurse Advanced Practice
FG	Focus Group
IPPC	Industrial and Professional Policy Committee of the QNU
LHHN	Local Health and Hospital Network
ND	Nursing Director
N/MUM	Nurse and Midwife Unit Manager
NaMIG	Nursing and Midwifery Implementation Group
NMOQ	Nursing and Midwifery Office, Queensland
NP	Nurse Practitioner
QH	Queensland Health
QNU	Queensland Nurses Union
S:#1	Survey Number 1 : Grade 7 Nurse and Midwife UNIT Managers
S:#2	Survey Number 2 : Grade 7 Nurses and Midwives (NOT N/MUMs)

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1 Introduction

1.1 The QNU N/MUM Project 2011

Conditions affecting nursing and midwifery workforce planning, recruitment and retention have been subject to decades of reviews and recommendations, and markedly in Queensland Health (QH), since the 1999 *Ministerial Taskforce – Nursing Recruitment and Retention*. The history of the QH Career Structure milestones, related workforce planning, and outcomes evaluations is summarized (Appendix 2).

For more than two decades, with selected achievements hard won, the planning work continues. This work intensifies, as pressures apply for keeping pace with changes, and in limiting unacceptable delays in delivering strategies that work, and in limiting the long-standing negative impact of under-estimating nurses' and midwives' concerns.

The concerns of nurses and midwives have been long-standing, and are also well known, having been validated over several QNU member campaigns, government, professional and industrial reviews (Appendix 2).

This report presents the findings of a research project established by the QNU Council to focus on the concerns of Nurse and Midwifery Unit Managers in particular, in context with the Grade 7 Classification of advanced nurse and midwife positions in the QH Career Structure.

The scope and purpose of this research, directed by the Council of the QNU, is

to assist the QNU to inform QH EB8 negotiations with respect to any changes required to the role, responsibility, and span of control of the N/MUM role and its inter-relationship with roles in other streams of the nursing and midwifery career structure (QNU Council July 2011).

Key deliverables are to:

Provide a summary of the key findings of recent relevant research and literature in relation to the NUM role and its inter-relationship with other roles within the career structure, commentary on key issues for consideration by the QNU and recommendations on the broad QNU position to be adopted for EB8 negotiations. This will be in the form of a final report to QNU Council.

Develop a framework for consultation with relevant members via focus groups to be conducted during the project on the key issues and potential strategies

The QNU Council's reference in directing the project to the central recognition mechanism, the Career Structure, is the core construct for the work. A problem statement, represented as a Position Picture was formulated to concentrate the conditions and concerns of the role of the N/MUM in the current Grade 7 classification of the Career Structure (Appendix 1). The themes of this Position Picture structure the project approach, content, findings, and recommendations. These are:

Span of Control,

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- Role Responsibilities,
- Role Enablers and Supports, and
- Role Preparation, Recruitment and Retention.

Key findings in reviews of the most recent literature in relation to the N/MUM role are presented in Section 3. Key findings of the most recent literature focusing trends in advanced practice roles not positioned as N/MUMs and critical analysis of relationships, are presented in Section 4.

A consultation framework recruiting QNU nurse/midwife member State-wide, was designed and implemented over a period of 14 weeks (Appendix 3). Two cohorts were identified in the Grade 7 classification of the QH Career Structure for Nurses and Midwives - Nurse and Midwife Unit Managers (N/MUMs) and Grade 7 Nurses and Midwives in a range of positions other than unit managers, including, functional managers, clinicians, educators, researchers, and project leads.

A total of 610 member consultations were conducted by means of electronic survey, postal mail survey, focus groups, and interview (Appendices 6 & 7). Results are presented in Section 5.

In line with the QNU Council's purpose and direction of the project, and in view of the scope of the research, the current QH Career and Classification Structure is consistently referenced throughout this report through to the findings and recommendations of the Report (Section 6).

The findings in this research confirm the importance of the Career Structure in grounding the concerns of the N/MUMs and other Grade 7 nurses/midwives in the themes of the Position Picture (Appendix 1) and found without reservation, in the outcomes of member consultation. The following background underscores the QNU Council's intentions with this project.

1.2 Career Structure

The Career Structure is a fundamental framework for the structuring and organizing of the nursing and midwifery workforce in QH. The career structure is a primary means of recognizing and translating the value of nursing and midwifery - professionally, organizationally, publicly and socially (Silver 1986).

Nurses and midwives are the most highly regarded of the professions (Morgan 2011). The votes for nurses were up one per cent from 2010, with ninety per cent of Australians aged 14 and over, rating nurses as the most ethical and honest profession. The defining qualities, unique talents, expert knowledge, and distinct purposes of nursing and midwifery are given expression, and made publicly accessible and accountable in the professional career and classification structures.

The twenty (20) year history of implementation and review of the Career Structure for nurses and midwives in Queensland public sector, confirms a relentless struggle in sustaining and advancing the structured recognition and valuing of nursing and midwifery (Appendix 2).

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This finding sits against a longer history of evidence to the present, where hospitals and health service organizations, continue to impose disproportionate responsibility for making services more affordable, onto nurses and midwives. The work of nurses and midwives is harnessed for health care efficiencies with systemic dilution of nursing and midwifery resources.

This is demonstrated in unresolved issues of work environment quality, related to the integrity of nursing and midwifery governance, excessive workloads, diluted skill mix, and structural limitations in access to career structure opportunities and positions (Hegney, Eley & Francis 2011; Chiaraella & Roydhouse 2011; Duffield et.al. 2007b). The work of nurses and midwives and the QNU throughout ongoing representations in building a strong career-focused workforce, has been important in promoting the value of nursing and midwifery. It has also been important in sustaining the ongoing contribution of nursing and midwifery to the achievements of the public health system in Queensland.

The QNU Career and Classification Structure Objectives (Barry, 2011) are to:

- Develop a career structure that properly reflects the current and future roles and responsibilities of nurses and midwives;
- Review the current career structure with principles that all streams (clinical, management, education, and research) are appropriately identified in the structure;
- Facilitate flexibility and recognition of innovative roles and responsibilities for nurses and midwives;
- Allow for more strategic utilization of the current classification structure (grading and banding) to foster new and emergent roles, for example, Enrolled Nurse (Advanced Practice),
- Recognise nursing and midwifery positions (advanced clinical practice levels) in additional bands at Grades 5 and 6;
- Review the current Grade 7 and 8 classification grade and bandings, to recognise clearly differentiated senior clinical leadership positions (management, clinical/including Nurse Practitioner, education, and research).

A key committee of members elected at QNU Annual Conference, the Industrial and Professional Policy Committee of QNU (IPPC), received full endorsement of the following resolution based on the research, consultation, and findings in the IPPC Report to Conference (Mitchell, 2011). This is an important QNU resolution, recommending :

- incorporation of Advanced Practice Nursing (APN) bands within nursing and midwifery career and classification structures;
- adoption of findings and principles of the IPPC Report to Conference (2011), informing EB8 negotiations;
- no cap on the number of APN positions;
- establishing personal upgrades where APN attainment is demonstrated;
- assessment of advanced practice to be peer review, professional judgment, and evidence based;

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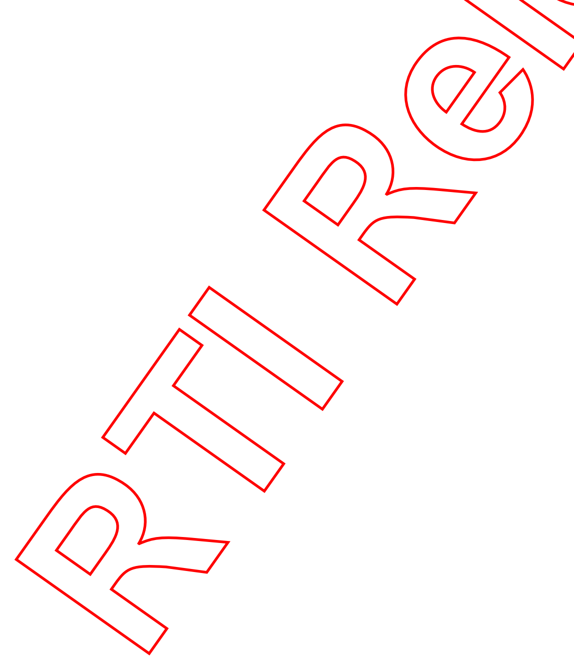
- advanced practice nursing (APN) recognition across all nursing and midwifery health and care sectors and practice environments;
- APN recognition across all four (4) Career Structure streams;
- APN investment for its capacity to expedite and guide responsiveness to creating new and innovative models of nursing and midwifery;.
- APN is informed and determined by a validated framework.

These formally endorsed QNU policy positions are the outcome of a history in the QH Nurses' and Midwives' Career Structure, of certain struggles in defending, sustaining, and advancing the best possible outcomes of a professional structure that secures workforce stability and the significant subsequent benefits in health care and service (History of the Present, Appendix 2).

These valuing efforts and campaigns have been critical in focusing recruitment, succession planning and retention of advanced clinicians, and nurse/midwife managers. The QNU N/MUM project 2011 is directed to these ends.

The following section introduces the key drivers in the operational environment of QH which influence the role work of the N/MUMs and other Grade 7 advanced practice nurses, in the context of the scope and objectives of this project.



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2 Background / Socio-political Context : Nurse/Midwife Unit Manager/ Grade 7 Roles, Queensland Public Health Sector

Summary 1. Key Drivers in Queensland Health Nursing & Midwifery Workforce Planning

Nurse/midwife shortages of up to 5500 by 2017 have been identified for Queensland.

The largest cohort of nurse/midwife registrants is the 50-54 age group (AHPRA 2011).

Queensland has the second lowest nursing rate in the nation (1160 per 100,000 with NSW, lowest rate, 1110) (AIHW 2011).

The N/MUM role has been agreed by QH for review, recognition and support since 1999.

Cycles of restructuring, re-engineering, and pressures for further cost containment continue to impact managers and clinicians.

Instabilities in management, workforce, and case-mix add to the complexity of nursing/midwifery workforce planning and risk for the reform agenda (Chiarella & Roydhouse 2011).

Significant QH initiatives last 5 years - organizational culture interventions; clinical governance; safety and quality regulatory and reporting infrastructure

System failures (clinical governance 2004; corporate governance/payroll 2010).

Health system reform agenda is set, with a shift in value priorities and goals in the work nurse managers are expected to carry out.

QH Strategic Plan (2011-2015) commits to "reshaping culture and employment experience."

***Take the Lead*: N/MUM role has been reviewed by NSW/Chief Nursing & Midwifery Office 2008-2011 :-**

Impetus from NSW Health patient survey data and Garling Report (2008) with funded recommendations;

similar focus adopted in QH NUM role review – role clarification, role support by way of training;

achievements in positive outcomes of training and employment of Clinical Support Officers (CSOs).

***Glueing It Together* (Duffield et.al. 2007b) evidence confirms lead role of N/MUM in system, staff and patient safety; staff retention.**

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QH NUM Review: **NUM role has been reviewed by QH/Nursing & Midwifery Office 2008-2011:-**

- role dissatisfiers identified and isolated to role preparation and training, core functions, administration workload, and succession planning;
- significant work achieved in compilation of training resources;
- 4 role dimensions catalogue N/MUM position descriptors; clinical leadership is emphasised; 6 principles to carry through to NaMIG & EB8;
- no recommendations made re career classification for advanced management practice or advanced clinical practice /support positions.

Report of the NaMIG Nursing Career & Classification Structure Group yet to be submitted with all (4) NaMIG Priority Project Reports, EB8 negotiations (2011-2012).

Midwives determine to seek a separate Career Structure (QNU 2011).

2.1 Introduction

The purpose of this section is to outline the operational context of the N/MUM and in part, the background for the QNU N/MUM Project 2011. The QNU is introduced as giving the authority and direction for the project. Key drivers are identified in workforce planning, system reform, specific role reviews, and current career structure reviews. Important connections are made for reference in subsequent sections. The focus and direction of the project objectives are situated. These will be realized further, in subsequent sections presenting findings from selected literature reviews and member consultation across the Grade 7 Classification of nurses and midwives, in the QH Career Structure.

2.1.1 Context of the QNU N/MUM Project 2011

The QNU represents all categories of workers that make up the nursing and midwifery workforce in Queensland. The Union has industrial, professional, political and social objectives providing direction and leadership for a high growth membership, currently at 45000 (www.qnu.org.au). Rank and file membership drive the agenda of the QNU through well established democratic structures and processes. The QNU is empowered by its capacity to lead and contribute to the health policy environment. The QNU is strengthened by member voice in shaping the political and social economy of nursing and midwifery for best health outcomes for Queenslanders.

The QNU's democratic structure is foundational in QNU accountabilities generated by its mission and objectives. Resolutions from Annual Conference for example, in relation to the Career Structure for Nurses and Midwives (Public Sector) are key references for this project. In addition, dedicated longitudinal research has been invested to secure direct inclusion of member views and aspirations in the organisation's strategic direction in *Your Work. Your Time. Your Life*. (Hegney, Eley, et.al. 2001, 2004, 2007, 2010).

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The QNU, QH and other key stakeholders conducted a Nursing and Midwifery Workforce Summit (April 2010) from which recommendations have been advanced in response to recruitment and retention challenges.

An important political punctuation in the history of QNU campaigning for the valuing of nursing and midwifery in Queensland health services, was the *Ministerial Taskforce : nursing recruitment and retention* (1999). From this point, an intense strategic effort can be tracked through substantial campaigns and enterprise bargaining negotiations to 2011 (Appendix 2).

The Enterprise Bargaining Agreement (The Agreement, EB 7, 2009) undertaken with an interest-based bargaining approach (Todhunter 2010), directed work in high priority areas. Each of these was generated, as in the 1999 *Ministerial Taskforce* by the need for strategic attention to recruitment and retention of nurses and midwives in Queensland.

The principal forum for consultation on The Agreement (2009), is the Nursing and Midwifery Midwives' Implementation Group (NaMIG). Workforce planning is addressed in the work of four strategic projects: (QNU EB7, Public Sector 2009)

Business Planning Framework (V4, 2008),

Classification and Career Structure,

Working Arrangements, and

Models of Nursing and Midwifery.

Each working group is to report to NaMIG, in preparation for interest based bargaining for the next enterprise agreement (EB8), where the current EB7 agreement expires in March 2012. The QNU member consultation outcomes of the QNU N/MUM Project 2011 (this report), reflect the complex and contiguous nature of the four (4) projects in matters of workforce challenges.

Over a protracted period, the QNU voice from these sources has directed and supported member campaigns, *Nurses. Worth looking after* (2002); *Nurses for You. For Life (*from 2008), and *Because We Care* (from 2009). Member concerns identified and re-confirmed throughout these campaigns, are taken into account in this project.

The QNU has integrated into its member organizational values statement, the professional values of nursing and midwifery. These have primacy in considering the role development, influences, impact and potential of senior clinical leadership roles in QH, for example, those across the Grade 7 classification of the QH Career Structure.

The core professional values of nursing and midwifery have been clarified and made explicit in the literature. These are: (Volp 2006)

Caring (nursing/midwifery as indispensable, complex, knowledgeable, human caring);

Professionalism (regulated codified practice; legislated authority and accountability);

Holism (nurses and midwives keeping the system human); and

Advocacy (nurses and midwives keeping the system safe; including ethical safety).

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These values as agreed beliefs about the intention and outcomes of nursing and midwifery are embedded in well established professional practice frameworks, standards, and codes which obligate nurses and midwives in the conduct of their conduct, first before organizational and employee identities. This understanding is important in the critical reading of the N/MUM project findings, and subsequent recommendations.

It is this professional orientation that underpins the N/MUMs' identity as 'linch-pin' to practice excellence (O'Rourke 2007). It is this professional grounding brought to the forefront of change initiatives that is evident in the N/MUMs' relentless efforts in keeping solutions patient-centred; and it is this expert knowledge and practice wisdom that need proper acknowledgement and valuing in the managerial practice context of the N/MUM. This is the meaning, not to be taken-for-granted, of the reference to N/MUMs as the 'glue' in the system (Duffield, 2008).

2.1.2 Workforce Planning

In exploring the nurse labour shortage in Victorian public hospitals Buchanan (2004) finds that it is more accurate to define this as a shortage of 'decent' jobs, that is, jobs that are not only well paid, but which offer attractive hours of work and offer satisfying opportunities for skilled workers to care for patients and their co-workers. "Exploiting the good will [of nurses] to maintain services has led to deepening disengagement with the system as evidenced by the deepening recruitment and retention problems."(Buchanan 2004, p.266)

The evidence for adequate numbers of appropriately qualified nurses/midwives in terms of (i) effects on quality and safety in health care, and (ii) economic and human costs, is fully detailed in *Ensuring quality, safe, and positive patient outcomes.Why Investing in Nursing Makes Sense* (ANF 2009). In this review, the ANF sets out the current concerns, evidence, and predictions for interrelated planning elements of nurse staffing, nursing workload, nursing skill-mix and work environment with ten recommendations (ANF 2009, pp.1-10).

Predictive modeling warns that the nursing and midwifery professions will face ongoing and serious shortage in coming years in work environments with increased patient acuity, high patient loads, perception of limited management support, and dissatisfaction among nurses (Lavoie-Tremblay et.al. 2011, Duffield 2009; O'Brien-Pallas, Duffield & Hayes 2006). An ageing nursing workforce with a generation of 'baby boomers' reaching retirement age is reflected in the largest cohort of registered nurses and midwives in the 50-54 age group (Australian Health Practitioner Regulation Agency 2011). Nurses will be retiring just at the time when an ageing population will require an increased workforce to care for them.

The nursing workforce is in crisis as there are less entrants to the workforce as a result of lower birth rates, wider choices of career, and nurses leaving the profession for less stressful, more satisfying jobs (Graham & Duffield 2010, p.44).

Monthly reporting on the health workforce has been in place by QH following the Forster Review (2005) recommendation that numbers of nurses (doctors and allied health practitioners) be increased. The target of 3,500 new clinical staff was met in 2010 (QH

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Workforce Informatics 2011). However, QH Workforce Analysis and Research Unit predicts a State-wide deficit of Registered Nurses in Queensland of up to 5000 by the year 2017.

This is inclusive of the "More Beds for Hospitals Strategy", which requires an additional 5550 extra full-time nurses. The QNU believes the shortage could be worse than expected, especially when QH continues to deny new graduates work in nursing (QNU 2011, p.9). The ageing health workforce means that over the next twenty years, around two-thirds of the currently employed registered nurses and midwives in Queensland will be reaching retirement age. Of interest to this project are QH advanced practice career positions for nurses and midwives. These are tabled below (QH, 2011c Workforce Informatics).

Table 1. Queensland Health Workforce Profile September 2011

Advanced Practice Position to Gr 8	2009	2011
Enrolled Nurse Advanced Practice	374	457
Clinical Nurse	5933	6987
Clinical Nurse - Midwife	377	446
Nurse Educator	344	375
Nurse Educator – Midwife	1	3
Nurse Researcher	65	58
Nurse Researcher – Midwife	0	0
Nurse/Midwife Unit Manager	835	907
Nurse/Midwife Manager	308	358
Clinical Nurse Consultant	940	1219
Clinical Nurse Consultant -Midwife	8	12
Other Nurse/Midwives Gr 7	58	62
Public Health Nurse	30	31
Nurse Practitioner Candidate	2	25
Nurse Practitioner - Midwife	1	1
Nurse Practitioner	48	107

SOURCE: QH Monthly Workforce Profile/Headcount, September 2011, pp.12-14

The dramatic increase in Nurse Practitioner positions and drop in researcher positions are noted along with very moderate increases in headcount despite demand drivers, such as population growth and historic under-employment of nurses per 100,000 population in Queensland (AIHW 2009). Currently nursing rates in Queensland are the second lowest in Australia at 1170 per 100,000 population, followed by the lowest rate of 1110 per 100,000 population in New South Wales (AIHW 2011, ABS Cat No.AUS 139). Australia wide, the largest staffing category in public hospitals is nurses who made up 45 per cent of the full-time equivalent staff numbers in 2009-2010.

The supply of nurses increased by 6.2% between 2005 and 2009, from 1,040 full time equivalent (FTE) nurses per 100,000 population to 1,105 FTE nurses based on a 38-hour week. This was mainly a result of both a 13.3% increase in the number of employed nurses, and a 0.9% increase in the average hours they worked over this period (AIHW 2010). QH has approximately 12 per cent of employed nurses/midwives positioned in

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clinical and/or administration management. This is consistent with national figures (AIHW 2009).

The QH Strategic Plan 2011-2015 forecasts the demand for medical, nursing and midwifery workforce to increase by about 50 per cent by 2024. In its strategic priority of a 'sustainable and high quality workforce', QH states, "we will continue to reshape the culture and employment experience in Queensland Health to meet the health service challenges of today and tomorrow." (QH 2011a, p.20).

The QNU launched its *Nurses For You For Life Campaign* (2008) appealing to government and health and aged care employers to address the employment of more nurses before nurse and midwifery shortages reach crisis levels in the next few years. The QNU continues to call for a comprehensive nursing and midwifery workforce plan for Queensland that is linked to a national plan. The QNU has supported the initiatives of the Health Skills Formation Strategy (Health and Community Services Workforce Council 2010) in improving sustainability of health workforce by ensuring strong links between industry, government, and the education and training sectors (QNU 2011, p.12).

Health Workforce Australia (HWA) established in 2010, is a national body partnering with jurisdictions in workforce planning, clinical training, innovation and reform, and international recruitment and retention. This body was formed in acknowledgement that the existing evidence base to guide major decision making in health workforce planning is sub-optimal (McGinty 2010, p.103).

Chiarella and Roydhouse (2011) confirm this in the most recent analysis of nursing and midwifery workforce planning. Their critique of current operational environments, pervaded by instabilities in three specific domains of workforce, management, and case-mix finds that a multi-pronged stabilization approach is fundamental in workforce planning (2011, p.97). The authors emphasise the impact of these instabilities on job satisfaction and retention and that simply increasing numbers of nurses and midwives is no solution to nursing shortages or skill mix.

In particular, workplace culture is worsened by the "trio of instabilities". Another important consideration for case=mix in Australian public hospitals for nurses, is the demand for advanced practice which affects nursing skills development, and skills mix (Chiarella & Roydhouse 2011, p.96). These instabilities present new and additional risks for the system reform agenda.

2.2 Queensland Health Reform

The context of system reform in QH is presented in foreshadowing the following sub-sections, on specific public sector N/MUM role reviews, Queensland and New South (QH: NMOQ 2011; NSW: CNMO 2008; AIHI 2011). Both reviews commenced in 2008, with journey points injected with system reform demand pressures.

How best to ensure decent health care for the population is a key challenge for every nation and now harder to achieve given the global economic downturn. For Australia, as a developed nation with universal coverage, the goals are how to maintain equitable access to care, public satisfaction and confidence in public health, quality and greater efficiency while controlling costs.

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The final report of the National Health and Hospitals Reform Commission (NHHRC) (2009, p.9) presents over 100 recommendations to transform the Australian health care system in response to reform demand:

> *Australia's health care system is in need of reform to meet a range of long-term challenges, including access to services, the growing burden of chronic disease, population ageing, costs and inefficiencies generated by blame and cost shifting, and the escalating costs of new health technologies.*

The report is shaped by a population health perspective (building healthier communities); and a consumer empowerment perspective which considers how individuals can take greater responsibility for their own health.

Restructuring into a single National Health and Hospitals Network as part of this national reform agenda, means for QH, the full establishment by July 2012, of 17 Local Health and Hospital Networks (LHHN) responsible for the day to day operation of public hospitals and delivery of public health services (QH, 2011a).

Sustainability has become the catch-cry in reform solution building. Frequently debate is polarized around arguments about whether the health system as a whole, or at least important components of it are in crisis, or unsustainable. The NHHRC (2009, p.10) confirms the public concern that '..our hospitals are under severe pressure, directly influencing their ability to provide safe, high quality, accessible and timely care to people."

Typically, system reform levers include national directives, institutional regulation, financial incentives, and local accountability such as those applied by the NHHRC (2009). In addition, intra-organisational levers, such as clinician and consumer engagement, individual motivation and behaviour for improvement and innovation have been stressed (Podger 2006).

Duckett (2007, s16) evaluates a new approach to clinical governance in QH which makes a priority of changing the culture in which clinical services are situated. The reforms are summarized in directing:

> *A culture which supports improvement in patient safety and quality, to have the right person, doing the right job, with the right skills, working in high performance teams, supported by effective organizational systems. (Duckett 2007, sS17).*

Many countries now have national healthcare quality improvement agencies which are using redesign techniques. Examples include the Institute of Healthcare Improvement (IHI) in the United States, the Modernisation Agency in the United Kingdom (NHS), and in Australia, the Australian Council for Safety and Quality in Healthcare and the Australian Institute of Health Innovation (AIHI). There is substantial international exchange of techniques between these bodies where ideas are adapted, tested, and reformulated (Dixon & Alakeson 2010).

The major effort in system reform in QH followed the eruption of a high profile scandal about safety of hospital care at Bundaberg Hospital (Van der Weydon 2005). QH was made subject to two external reviews which were highly critical of its approach to

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governance and organizational culture (Davies 2005; Forster 2005). As part of the solution of 'cultural transformation', attention to leadership and management training has been prioritized.

Hewison (2006, p.2) reviews the "huge emphasis on leadership development" in health service modernization. Hewison points out the purpose of middle management for nurses is taking responsibility for the managerial problem – as boundary spanners, mediators, and administrators, in the carriage of the organisation's overall task.

QH continues to promote leadership for cultural transformation and refers to its Healthcare Culture and Leadership Service Framework in a strategic priority (QH 20011a, p.20):

> *To identify and develop leadership at all levels with the personal qualities and professional capabilities to deliver high quality and safe services, and to inform the long-term direction for the delivery of those services.*

Nurse/midwife (N/M) managers are a cohesive source of leadership, support and stability for clinicians and others delivering care and service to patients in complex environments (Duffield et.al. 2007b). They are promoted as linchpins to practice excellence, who understand their role in creating more efficient operations, improving practice, building healthy and satisfying work environments, and leading effective teams centred on the patient (O'Rourke 2007).

With the reform agenda so clearly set, it is important to acknowledge how changes give rise to new relationships within the organization in which N/M managers practice; to new conceptualisations of the role and purpose of health organizations; and a shift in value priorities and goals in the work that N/M managers are expected to carry out

2.3 Health System Reform and Nurse/Midwife Managers

N/M managers are at the interface of the corporate agenda and professional practice, more directly than other middle level practising nurses/midwives. Newbold (2005) described the new health economics, or managerialism, as a rapidly developing discipline especially influencing health care practices, including that of nursing management. What it means for NUMs to function within multiple and competing discourses, such as that of medical, managerial and nursing /midwifery discourses has been explored by a number of nurse, midwife and other researchers (Pannowitz 2008; Duffield et.al. 2007a; Nowak & Bickley 2006; Orrock & Lawler 2006; Newbold 2005; Ogle 2004; Ceci 2001; Traynor 1996).

The Charge Nurse title was changed to Nurse/Midwife Unit Manager in 1991, when the first wave of system reform reshaped the Queensland Department of Health, to "Queensland Health" (QNU 1992). Wards and clinical units became cost centres in the adoption of New Public Management (NPM) across the public sector generally. While an evolving market approach under NPM (Hood 1991) was adopted in the public sector generally, in QH, a new *Health Services Act* 1991, 'decentralised' service districts, program structures, deficit management, public-private partnerships, and contracting out of services were introduced (QNU 1992). 'Enterprise' became the focus of government of organisational life.

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New Public Management and its alter-ego – managerialism, represent a marriage between economic theories (public choice, transaction cost, and principal-agent) and a variety of private sector management techniques that have been successively introduced into the public sector (Hood 1991, p.5). The former emphasises notions of user choice and transparency while the latter promotes the portability of professional managerial knowledge and the need to increase the freedom available to public service managers to generate results and improve organisational performance.

Initiatives reflecting the wholesale managerial mobilization of QH corporate culture have enmeshed nurse/midwife managers and clinicians in enacting strategic and operational objectives with an emphasis on new skills and competencies in the 'business' and the management of cultural transformation. Importantly, several iterations of enterprise-based managerialism have co-opted the new and urgent rhetoric of quality and safety of care and service, cultural transformation, and patient centredness (Garling 2008; Forster 2005; Institute of Medicine 2010, 2004, 2001).

The improvement initiatives are driven by construction and governance of conditions for high level efficiency. Intervention sites include organizational structure, human resources management and leadership technologies; process routines and work intensification; process mapping and standardization; medical technologies; information and communication technologies; and budget management. The work of nursing and midwifery has been increasingly managerialised in a palpable shift from patient-care to patient and service economics (Brunetto & Farr-Wharton 2007; Nowak & Binkley 2004; Traynor 1996).

This is captured in the New South Wales experience by Orrock and Lawler (2006):-

> *The technical rational approach to health care is underpinned by a shift from a culture of care to a culture of getting the numbers right; the norms and values of a 'reformed' health care sector were inimical to nursing which, despite a long history of political invisibility, and voicelessness in the discourse of public health care, have found themselves further marginalized, yet expected to be the primary implementers of the reform agenda (Orrock & Lawler 2006, p.68).*

Duffield and Lumby (1994, p. 557) announced similar concerns in the 1990's, for nurse managers in developing their role in the "current context of a dynamic health care system" while facing the lack of recognition and persistent devaluing of the role; dissonance between corporate and professional values; and the exclusion of "nursing's voice as part of common management discourse in this country". McMurray (2010) gave a more optimistic and perhaps idealized account in urging empowerment and enterprise in solidarity, and in leveraging both voice and value in the political economy of nursing and midwifery.

An instrument of managerial control as a pressured system demand, which has impacted significantly on organisational, professional and personal identities, is organizational restructuring. The cycles of restructure have relied on industrial and business models promising cost reduction and improved productivity.

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Exposed as a somewhat blunt instrument with overstated productivity effects, serial restructuring has resulted in increased organizational politics, significant dumping of hard decisions on staff, and polarized attitudes in whether patient care had improved (Braithwaite, Westbrook, Hindle et.al. 2006, p.10). Similar findings from service managers in QH were published by Moss (2008, p.40) who reflected disappointment that "the status quo remains largely unchallenged despite the significant reforms since Forster". The Institute of Medicine (USA) argued in its landmark publication *Crossing the Quality Chasm* (2001), that structural measures have not been shown to relate either to process quality or outcomes.

The risk for nursing has been its definition primarily as an operational level resource. This comes with an appreciation of the impact of organizational design on the enhancement or diminution of the status and influence of nursing/midwifery. Duffield, Kearin, Johnstone et.al. (2007a, p.44) review the impact on nurses of restructuring where the focus is more on increased efficiency and less on factors affecting the quality of care and the work life of nurses. A significant impact of current approaches to restructuring is the loss of, or changes to the nurse executive role with less direct representation of nurse and their issues at both institutional and policy levels.

Duffield, Roache, O'Brien-Pallas et.al. (2007b) assert that it is the reduction in the number of first-line and middle management positions in nursing that will prove to have the greatest impact on the nursing workforce in the long-term. The resulting re-defined roles with wider spans of control and less capacity for supervision, mentoring, and support for staff has led to dissatisfaction, isolation and frustration for clinical staff and new graduates. Less direct management support and clinical leadership for nursing staff have multiple and compounding negative effects for nurses, for outcomes of nursing, and for the organization. Importantly for the nurse managers, these redefined roles come with little additional support (Garling 2008).

It is clear that corporatist and managerialist reforms in health systems have significantly altered the terms of role development for N/M managers. The following sub-section presents findings of the most recent public sector reviews (NSW, Q'ld) of the nurse/midwife unit manager.

2.4 Nurse/Midwife Unit Manager Role Reviews

2.4.1 New South Wales – "take the lead"

'Take the lead' is a nursing/midwifery unit manager project originally established as a collaborative project between the Chief Nursing and Midwifery Office (NSW Health, CNMO) and the Health Service Improvement Branch (NSW Health). The impetus for the project was patient and carer feedback (NSW Health statewide Patient Survey in 2007), and anecdotal information about N/MUMs' experiences. The patient concerns related to attention to physical and environmental needs, continuity of care and smooth transition; and timely access to reliable health care (NSW Health 2011).

The project expected to achieve the following:-

clarity and standardization around the purpose and core functions of the role;

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- that N/MUMs have the appropriate capacity and capability in order to fulfill their role; and that
- N/MUMs are enabled and facilitate highly co-ordinated patient care, reflective of their role and patient and carer expectations (NSW Health 2011).

Phase 1 report of 'take the lead' attends to role preparation, and skills development designed for N/MUMs. A series of five (5) professional development modules was developed with organizational support for N/MUMs to complete. It is noted that by 2009 (post-Garling Report 2008), the course was no longer voluntary (AIHI 2011, p.25). The course modules are :

- Facilitating Critical Communication;
- Lean Thinking and Leadership;
- Financial Management of the Nursing/Midwifery Unit;
- Rostering for Patient Care; and
- Leadership – Making it Happen.

The other key achievement of 'take the lead' is a Conceptual Framework articulating the purpose and core functions of the N/MUM role developed in consultation with key stakeholders including the NSW Nurses Association and the NSW N/MUM Society (NSWH 2011). This was adopted by the QH NUM Project reference group (QH, 2011e).

Additional impetus for 'take the lead' was a dramatic injection of interest and funding by NSW Health following the recommendations of the *Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals* (The Garling Report, 2008). Garling's recommendations directed priority to review and redesign the role with measures to reduce the administrative load. The latter was pressed by Garling in recommending increased N/MUM presence in their units, and 'away from their desks' (AIHI 2011, p.83).

This exclusive focus on strengthening the N/MUM clinical role by reducing their administrative load led to the employment of some 500 clinical support officers (CSOs) reported as a positive outcome (AIHI 2011, p.25). The CSO role is designed to support clinical and managerial staff in acute hospital settings, including N/MUMs, nurses, midwives, medical and allied health personnel.

Progress of 'take the lead' has been reported in a major evaluation study by the University of New South Wales, Institute of Health Innovation (AIHI 2011). The evaluation findings are largely positive for the mandatory training program for N/MUMs and the employment of CSO's (AIHI 2011, pp.82-86).

Certain political weight came with the Garling Report (2008) in prioritizing the N/MUM role review. The report recognised the pivotal role of the N/MUM in the provision of highly co-ordinated and safe care at a unit level. This conclusion, however, had already been published in research into nursing in NSW Health, by Duffield, Roach, O'Brien-Pallas, et.al. (2007b) in *Glueing it Together: Nurses, Their Work Environment and Patient Safety.*

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The following findings are important in recognising (and valuing) the N/MUM role at the interstice of highly politicized system reform and role work pressure at the point of service delivery. Key findings by Duffield et.al. (2007b, pp.9-10) are:

Nursing unit managers must be provided with the necessary human resources (adequate nursing hours and an appropriate skill mix for the work of that particular ward or unit) as well as appropriate data and institutional support;

Work environment factors such as nurses' autonomy, control over their practice and good nursing leadership on the ward were statistically significant predictors of job satisfaction;

The work environment, including aspects such as nurse leadership, the presence of a nurse educator on the ward, adequate resources, nurse autonomy and nurses control over their own practice, are important for providing safe patient care;

Stability of the ward environment, whether by reducing nurse turnover or stabilizing nursing leadership and providing skilled human resources, improves patient outcomes;

The importance of nursing leadership at the ward level on job satisfaction, satisfaction with nursing and intention to leave, which ultimately impact on patient safety, cannot be over-stated.

2.4.2 Queensland – The NUM Role Review

Distinct similarities are recognizable in the QH NUM Role Review (2008-2011) and the orientation, process and outcomes of the NSW Health N/MUM project, "take the lead."(2008-2011). The key exceptions are the sharp political interest and subsequent funding of recommendations of 'take the lead' and the public catalyst of health service user expectations underpinning the project, in NSW Health.

Phase 1 of the NUM Role Review by the (then) Office of the Chief Nursing Officer commenced in 2008. NUM role dissatisfiers and the most significant stressors were identified. These were isolated to role preparation, core role functions, administration workload, and succession planning. In response to the findings, the NMOQ initiated the second phase of the NUM Project in July 2010, however, the NUM role only was considered 'in scope'.

The review found a role in crisis, low morale, with 98 per cent (n=154) of review participants stating they could not complete their work adequately; and 37 percent (n=154) stating they would like to leave the position (QH, OCNO 2008a, p.4).

The recommendation from the 2008 project that QH address inequity of work level standards of Grade 7 roles, was considered 'out of scope' for this phase , along with issues relating to disparity between Grade 7 roles, banding and remuneration (Clayton 2010b, pp.3-4).

The NaMIG received quarterly reports on the QH NUM Project which carried the theme, "Strengthening leadership capacity and capability for our nurse leaders." (Clayton, 2010b, p.1). As reflected in the 2010 Project Statement, the focus of Phase II was enabling the clinical leadership component of the NUM role by improving role preparation and training resources, and reviewing the administrative workload. The first *NUM Project Newsletter*,

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centred on refocusing clinical leadership, announced that “We need to get NUMs out of the office and leading their teams.” (Clayton 2010b).

Achievements noted by the NUM Project Reference Group include the following: (Clayton 2010a, p.2)

- Generic level statements and role descriptors, identifying the core functions of the NUM position established.
- Extraneous administrative duties and tasks undertaken by the NUM identified, with strategies explored to reduce the load.
- Existing training resources to support NUM role preparation reviewed.
- A standardized suite of training resources relevant to the NUM skill set, along with a standardized orientation package developed.

In May, 2011, the QH Nurse Unit Manager Succession Framework was revised Communications were widely disseminated regarding accessible and available NUM Training Resources (QH 2011e) for example, Leadership self-assessment tools, generic QH Manager and Supervisor Leadership Development Program, Emerging Clinical Leaders Program , module links to international innovation institutes, and Clinical Education Queensland (ClinEdQ) offerings.

The project outcomes are significant in terms of work completed in the Nurse Unit Manager Core Functions Framework (NMOQ, 2011) which catalogues role descriptors in the following 4 role dimensions:-

- Clinical Management and Co-ordination,
- Clinical Leadership,
- People Management, and
- Business Management.

While the 2010-2011 (Phase 2) QH NUM project has achieved important outcomes, the project scope was narrowed by the interpretation of findings from Phase 1. These were isolated in Phase 2, from Career and Classification issues, and no specific recommendations were made. These classification issues apply to all Grade 7 nurses and midwives and other grades and relate substantially to the supports the NUM requires in order to achieve the revised NUM Core Functions role descriptors.

Clinical infrastructure in role support from other career positions (education, clinical research), for example, was not included, nor were issues of differentiation in career structure classification for advanced nursing management practice or for differentiated bandings in the Grade 7 classification for nurses and midwives.

In completing the OCNO NUM Project Phase 2, six (6) principles have been advanced, in part related to other NaMIG Working Groups, for incorporation by the NaMIG in the negotiating period for EB8 (2011-2012). These are:

Principles

- Support the clinical leadership and governance role of the NUM.

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- Develop NUM leadership and management capabilities.
- Provide sufficient preparation, training and succession planning.
- Consider financial strategies which recognise the leadership and governance accountability of the role with a view to promoting retention of existing NUMs and attraction of future nursing leaders.
- Job-sharing arrangement to be supported for all NUMs.
- Implement quality frameworks and models of professional practice to support the role.

In furthering the interest of the project Phase 2, the NMOQ has commissioned a research team from Griffith University Gold Coast Campus in a task-time quantification study to further enable the NUM clinical leadership role component (NMOQ, 2011). Outcomes have yet to be reported.

The evidence of multiple reviews makes it clear that managing in today's clinical environments requires skilled nurse leaders who can both understand and manage this complexity to ensure a safe work environment for staff and positive outcomes for patients (Duffield et.al. 2007b, p.9).

The reviews and reports outlined in this sub-section provide an evidence audit trail supporting further investment in a strategic and operational support system for the N/MUM role.

2.4.3 NaMIG Nursing Career and Classification Structure Refinement and Enhancement Project

The Agreement (EB7, 2009) endorsed four priority areas of work to inform strategies for Queensland Health in achieving a sustainable nursing and midwifery workforce. This work along with the work of the other intersecting working groups (Business Planning Framework, Models of Nursing and Midwifery, and Working Arrangements) has been funded by QH as part of The Agreement (2009). Reference Group meetings commenced in November 2010 to oversee the project's progress and performance (QH 2011d, pp.1-3).

The QNU Career and Classification Structure Objectives (2011) and the QNU policy on recognition of advanced practice nursing in the development of bandings and classifications in the Career Structure (2011) are critical references in this NaMIG priority project.

The objective of this project is to review the classification structure for nurses and midwives and the current generic level statements and definitions. Key roles of midwives, enrolled nurses, nurse managers and other grade 7 descriptors, and nurse practitioners are focused (QH 2011d, p.2). This working group is yet to report to the NaMIG in 2011. Selected consultation with nurse and midwife educators has been undertaken with outcomes to be reported.

The QH Nurse Unit Manager Project (2008-2011) was generated in part, by this priority interest, however the work was undertaken by the Office of the Chief Nursing Officer (OCNO, and now NMOQ). The QNU was not formally involved in the first instance, or

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during the first phase. The second phase was completed in 2011, with summary outcomes noted in this report (above).

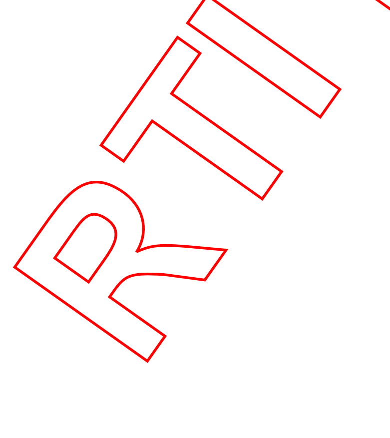
Midwives' Career Classification Structure

In August, following a meeting of midwives' representatives from across the state, a determination was made to pursue a separate career classification structure for midwives in Queensland. Definitions of midwifery roles in this structure will require clear articulation and differentiation from nursing positions, for example, Nurse Practitioner. Principles agreed are:

- Midwives must have a separate classification structure;
- Midwives must manage midwives;
- Midwives of all levels from novice to expert must have access to clinical work, and this must be articulated in a role description;
- Recognition of levels must be matched with appropriate remuneration (TQN 2011, p.29).

A considerable body of work has been undertaken in Queensland and New South Wales in response to the concerns raised from several sources, sharing similar concerns for the N/MUM role. It is planned for the reports of the respective NaMIG working groups to be incorporated into Enterprise Bargaining Agreement No 8 negotiations (EB8, 2011-2012). The QH/NMOQ NUM Role Review will be an important reference in this process.

This QNU N/MUM 2011 report, grounded in QNU nurse/midwife membership consultation across all classifications at Grade 7 of the QH Career and Classification structure, is expected to be an additional resource in the EB8 negotiations.



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3 Nurse/Midwife Unit Manager – Literature Review

3.1 Introduction

This section of the QNU N/MUM Project 2011 Report centres the Nurse/Midwife Manager in findings from nursing and related literature. The literature search focuses on issues identified by members in the original Position Picture (Appendix 1) and scoped by the objectives of the QNU N/MUM Research Project 2011, (Section 1).

It is understood that the key concerns identified in the Position Picture are contiguous and compounding in shaping the N/MUM role experience and effectiveness. These are:-

Span of Control

Role Responsibilities

Role Supports & Enablers

Role Preparation, Recruitment and Succession Planning

An overview of the literature is presented, followed by a series of research summaries pertinent to the respective Position Picture issues. Summary sections capturing key findings are inserted for each Position Picture issue.

The purpose of this section is to make immediately available a significant body of evidence, that will confirm and support the recommendations arising from the QNU N/MUM Project 2011 member consultation (Section 6).

Summary 2. Research Findings – N/MUM Role, Overview of the Literature

Hybrid role confirmed; multidimensional - professional (nursing practice and leadership) and corporate (policy and practice in administration and management of resources). The key concern for nurse managers is the integration and balancing of role dimensions.

Scope of Responsibilities – management balanced with clinical/clinical leadership; practice context determined by specific span of control indicators (complexity, stability, geography) (Murphy 2011).

Valued leadership traits – honesty, credibility, supportive presence, passion for nursing/midwifery; working collaboratively, flexibility, current clinical and trend knowledge; recognition of desire for clinical autonomy by those not in positional management.

Role work largely invisible/ expert knowledge under-recognised.

N/MUM leadership impact 'cannot be over-stated' (Duffield et.al. 2007b)

N/MUM leadership is key to:

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staff nurse satisfaction, and retention,

unit morale, and team effectiveness,

Clinical governance lead,

front line culture of safety & quality,

innovative practice models, reform measures,

professional culture,

quality of patient journey/experience,

ethical leadership and climate,

strategic service planning,

business management and unit productivity,

advocacy in skills mix and workload in business management, gatekeeper 'glue' that holds hospitals/health services together.

Challenges

Strengthening integrity of nursing & midwifery governance;

Clarity in role responsibilities with authority, appropriate recognition & reward;

Ensuring alignment of role preparation with professional nursing/midwifery intentions and outcomes;

Adequate support and resources to fully enact roles, clinical, business/administrative systems.

Achieving effective balance in role work.

3.2 Literature Review – Overview

The N/MUM role is subject to renewed interest in health system reform initiatives directed at nursing and midwifery work and workforce sustainability, and in meeting organisational goals of safe, efficient and effective service within pressured service environments (QH/OCNO 2008, 2011; Garling 2008). The literature pertaining to the N/MUM has expanded as a result in recent years.

The literature search by electronic data bases (*SCOPUS, Medline, Embase and PyschInfo*) has key sources stored in EndNote (Volp 2011). Search terms were inclusive of role title range, key terms in the scope of the project, references from primary sources, scholarship with application to QH practice, and lead authors in the discourse production (Australia and internationally). The reference list is expansive and represents primary sources only (Section 7). Selected literature not electronically accessible has been hand searched and referenced.

The nurse/midwife manger is defined as a nurse or midwife appointed as such, accountable at an advanced practice level for the coordination of clinical practice and the provision of human and material resources in a specific patient/client area or in

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supporting a division or systems or service (*Queensland Health Nurses and Midwives Award – State* 2011, p.56).

The term 'first-line manager' denotes the position representing the first level of management to whom non-managerial employees report (Hales 2005, p.473). The term is used interchangeably in the nursing literature with position titles, for example, nurse manager or nursing unit manager (Australia); head nurse, mid-level nurse manager (North America); and ward sister and modern matron (United Kingdom). Clinical nurse specialists, clinical educators, and clinical managers are roles that are increasingly differentiated from the nurse manager role.

Titles variously found in other Australian State and Territory jurisdictional nursing and midwifery career structures, include Nurse Co-Ordinator, Management Facilitator and Advanced Management Facilitator (Analysis of Current Australian Nursing Enterprise Agreements Appendix 3).

The discourse of nursing management can be identified from the 1950's in United States of America and more visible in journals and texts in Australia, from the 1960s. From the late 1970's, studies of nurse managers began to discuss the changes in the role from clinician to manager in decentralised nursing and organisational management structures (Adkins 1979; Powers 1984).

Throughout the 2000s, the work of the nurse as leader has expanded remarkably (Duffield et.al. 2010; Laschinger, Finegan & Wilk 2009; O'Brien-Pallas et.al. 2009; Carney 2009; Surakka 2008; Sellgren 2008; Duffield et.al. 2007b), and in particular, multidisciplinary health service team leadership (Sorensen, Delmar & Pedersen 2011; Sorensen, Iedema and Severinsson 2008).

The most published author on first line nurse managers in Australia, is nurse researcher, Professor Christine Duffield whose work dates from the late 1980's. Duffield remarked with prescience that, "It is at the interface of management and patient care that the changes within the health care industry and nursing will be felt most strongly"(Duffield 1989, p.997).

Allen (2004, p.279) reflects that the literature shows that the largely invisible work of nurse managers is highly skilled and essential to health service delivery. A major finding by Pannowitz (2008, p.87)in conducting a review of nurse manager literature (1990-2005) was the unacknowledged expertise of the nurse manager. This is an Australian study affirming that the status of nurses in management positions was in urgent need of being formally validated as expert.

In exploring the ways in which nurse managers traversed the nursing-management interface, Australian and international scholars have identified recurring and related themes in an increasingly compressed role. These are span of control and structured empowerment, role responsibilities, role supports and enablers, and role recruitment and succession planning (Australia: Duffield 1989-2011; Palliadelis 2008; Pannowitz 2008; Duffield & Franks 2001; Chiarella 2008; Ogle 2004; New Zealand: McCallin & Frankson 2010; Canada: Carney 2009; Laschinger & Finnegan 2008; Laschinger & Wong 2007; Thorpe & Loo 2003; UK: Read et.al. 2005; Hewison 2001; Traynor 1999; USA: Laschinger ,

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Laschinger et.al. 2006-2009; Douglas 2008; Patrick 2006; Finland: Sorensen et.al 2011; Sweden: Bondas 2009; Skytt et.al. 2008; Surakka, 2008; Lindholm 2001; Ingersoll, Cook, Fogel, et.al. 1999). These themes are those confirmed by QNU members in the M/NUM Position Picture (Appendix 1), and detailed in the following sub-sections.

The research, in its continuity over decades, and in drawing on the same, recurring themes, situates the role of the N/MUM and leader at front-line level, in demand for the right mix of resources and supports (Duffield et.al. 2007b; Chiarella & Roydhouse 2011). Without the appropriately placed supports, the role is experienced as unrealistic to the extent that it compromises the individual and the profession, and limits the organization.

The critical reading in the research overview, is that rather than isolating the N/MUM for 'fixing', the value and impact of the expert manager nurse or midwife has to be recognised, and the context (workload, resources and supports) in which the N/MUM is compressed needs to be 'fixed'.

3.3 Span of control and Structured Empowerment

Summary 3. What is known about N/MUM Span of Control

Spans have expanded under new organizational structures, instabilities, shifting boundaries, and cycles of reform initiatives loading the N/MUM role.

Raw span (# direct reports/size of budget) declared an inadequate measure with higher sensitivity indicators proven in:

nurse satisfaction with manager contact;

staff nurse perception of N/MUM empowerment;

multidisciplinary teamwork & effectiveness ; (Myer 2010)

Realistic spans achieved through modification of the N/MUM operational environment – first line clinical supports (advanced clinical, education, and research, admin.) where supervision quality, teamwork, nurse satisfaction and patient outcomes amongst other things, demonstrate improvement.

Concentration of managerial power with non-nursing corporate bureaucracy; fractured nursing/midwifery governance to lack of position power dominoes to undermine capacity to modify or manage N/MUMs role spans.

N/MUMs bear the responsibilities of business results and service quality without the resources, sufficient to achieve the results.

N/MUMs capacity in strategic and operational business management in response to their service demands, is limited without formal role authority.

Empowerment with appropriately bounded professional governance is key determinant in N/MUM role effectiveness in restructured healthcare settings

Span of control and role responsibilities are laces that tie the same shoe of effective empowerment for N/MUMs.

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Span of control is defined as the scope of responsibility (Myer 2008). This includes the number and experience, autonomy and stability of individuals for which the manager is responsible (direct reports); inherent risk in work complexity, for example, workforce, casemix and management instability (Chiarella & Roydhouse, 2011); geography of area being managed; budget size; assistance (clerical and clinical); number of non-direct reports, and percentage of non-supervisory work (projects, planning, and number of services) (Murphy 2011, p.15).

A shift from clinical to management activities has been acknowledged as first-line management functions such as training, supervision, and care delivery management have devolved to other roles (Duffield, Donoghue & Pelletier, 1996). Span as managerial scope, has significantly extended to finances, operations, and human resources, for one or multiple units.

Research on managerial span is limited by the failure to consider complexity of the N/MUM role and has yet to be considered in relation to the total workload of the nurse manager (Meyer 2010). Raw span or span by reporting structure as the number of direct reports is found to be inadequate a measure for span or responsibility scope (Murphy 2011; Meyer 2010).

Job enlargement, in particular expanded span of control and the impact on the effectiveness of the work of nurse managers has been well reported (Thorpe and Loo 2003; Jones & Cheek 2003; Doran, McCutcheon, et.al. 2004; Laschinger et.al. 2008; Stewart, 2009; Murphy 2011). Recent work confirms the direct links of nurse manager span of control to the safety of the nurse practice environment, safety climate, and nurse-sensitive indicators (Merrill, 2011).

Unworkable spans of control are identified as important role stressors for Canadian nurse managers in the study by Stewart (2009). Isolation was the most common theme identified by nurse managers, for example, limited contact with their colleagues, to eating alone at their desk while working, and little support and visibility of their senior administrators (2009, p.57). Increased responsibility, role complexity and lack of trust (organizational climate of distrust) were the next most significant themes ranked as stressors by nurse managers in this study (Stewart 2009, pp.60-62).

Additional work is generated for nurse managers as multidisciplinary team leaders and team gatekeepers at clinical unit/service level. Boundary spanning both direct and non-direct reports including different professions and unit 'people traffic' is time and relationship-intensive work. The higher the number of non-direct reports working in areas assigned to the nurse manager, the lower the level of team work under that manager (Meyer 2010, p.109). The professional and role boundaries inherent in multidisciplinary teams create boundary work which involves the integration of interdependent work processes and managing intergroup relationships to achieve integrated, patient-centred care (Meyer 2010, p.37).

Antecedent factors identified in the literature, are service restructuring, and downsizing of middle management positions, Allen (2001, p.165) notes nurses' willingness to blur the boundaries of their formal jurisdiction, that is, nurses do whatever is necessary to meet patients' needs; to fill the gaps in hospital labour. This willingness is readily exploited.

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Nurses' place in the division of labour is essentially that of doing in a responsible way, whatever necessary things are in danger of not being done at all (Hughes 1984, p.308). Many elements of the role remain invisible to those outside of the occupation.

A recent review in determining optimal span of control for acute care hospital nurse managers finds little evidence of structures grounded in theory, but rather influenced most notably by cost constraints (Murphy 2011, p.2). Murphy finds that designing an effective operating structure can lead to long-term cost containment while providing improved outcomes for staff, patients, and the organization.

Nurse satisfaction with manager contact and effective multidisciplinary teamwork are the two most highly sensitive indicators of manageable spans for nurse managers (Myer 2010, pp.34-36). Relationships with staff are moderated by span of control. Meyer's focus in examining span of control was the nurse manager's capacity to supervise and support staff. Nurse managers' span of control must be modified to allow them to develop and use leadership skill necessary for empowering their staff to practice to the full scope of their professional role (Myer 2010; Lucas, Laschinger & Wong 2008; Lee & Cummings 2008). The evidence is that supervision quality, coaching, teamwork, nurse satisfaction and patient outcomes can be improved with modification of first-line management span of control.

Research has also shown that the beneficial influence of positive leadership is conditional on the number of staff reporting directly to the nurse manager (McCutcheon et.al. 2009), so that no matter how strong the leadership style, nurse managers with overly wide spans were unable to positively influence nurse job satisfaction and empowerment respectively. Compressed work hours in combination with wide spans of control lead to lower supervision satisfaction by direct report staff (Meyer, O'Brien-Pallas, Doran et.al. 2011). Operational hours which affect the manager's daily span, should be factored into the design of front-line management positions (Meyer et.al. 2011, p.611).

Numbers of nurse managers are important as well as ensuring that nurse managers have reasonable spans of control that allow them sufficient contact with nurses in the setting and the time to complete their duties (Murphy 2011; Lucas, Laschinger & Wong 2008).

The findings in this sampling of the literature, confirm the need to reconsider the key indicators in establishing appropriate spans of control for N/MUMs.

The evidence supports considered modification of N/MUMs role spans, rather than perpetuating the risks of currently unmanageable spans. In modification of the operational environment, in relation to achieving best possible outcomes from manageable role spans, Paliadelis (2008) exposes the working world of the N/MUM as responsibility without power. The next sub-section details this critical connection further.

3.3.1 Structured Empowerment – N/MUM position power

Kanter's (1993) refined definition of power is most often referenced in the nursing literature, as a theoretical framework in critical scholarship around professional governance of nursing and midwifery. An example is Palliadelis (2008) in work on positional power and the nurse manager. The definition explains effective power as the ability to mobilize resources and achieve goals, through access to empowering structures

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in the work setting: the resources, information, and support nurses require to do their job and the opportunities they have to learn and grow in their work (Kanter 1993, p.66). This application of power underpins the following discussion on structured empowerment and the N/MUM.

For nurse managers, the experience of empowerment has been reported as verbal or espoused with little influence at organizational level (Sorensen et.al. 2011; Pannowitz 2008; Palliadelis 2008; Patrick & Laschinger 2006). Not being involved in decision-making is experienced as devaluing (McClure & Hinshaw 2002) and described by Pannowitz (2008, p.42) in the nurse manager as 'marginalised expert'.

Health systems now subject to new governance structures, systems of care and organisational models have radically changed in regard to nursing leadership and management structures. The changes for N/MUMs have meant widening spans of control, increasing workloads and position accountabilities, without commensurate position authority to achieve role demands, or even to modify the limiting conditions that undermine their effectiveness.

Matrix structures are multiple command structures and have developed since the late 1970's as divisional, product or service line structures. They were initiated in part, to counter the history and experience of a rigid single command configuration and reporting structure. This was deemed inadequate to cope with the sheer complexity of health organizations and that 'managing staff' and that 'being micro-managed' did not work for professional knowledge workers, such as nurses/midwives.

Key words in this literature are fluidity, flexibility and porous boundaries (Rolfe 2007, p.676) with the N/MUM subject to wider spans of control, and involved at multiple levels of communication, reporting, and accountability.

Restructuring of this kind, was designed to match culture transformation interventions and initiatives for empowering staff collaborative individualism. The new social architecture was based on equitable power manifested in shared decision-making, effective leadership, and interpersonal constructs of mutual respect, trust and authenticity toward the shared goals (Brown et.al. 2000, p.427).

Hurley (2007) in studies of the NHS, finds that nursing leadership must be challenged to move nurses toward collaborative individualism within emerging neo-corporate bureaucratic structures and matrix team structures. Contradictions are discussed regarding trust and respect versus checking and veto controls, and workload support when new initiatives are taken on by the collaborative individual. Matrix management structures require the individual to achieve a level of competence with the concept of having two (2) "bosses". The new models were also cast as a rejection of the hierarchical and authoritarian structures of nursing's past (Hurley 2007, p.750).

Notably, since the middle 1980's, nurses have been identified as ideal service line and matrix managers due to their clinical background, strong communication skills, ability to lead multidisciplinary teams, and advocacy (Bruhn & Howes 1986, p.18). Indeed, nurses and midwives are positioning for service leadership in shared governance of interdisciplinary teams (Hoying & Allen 2011, p.252). N/MUM expertise is acknowledged

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in this regard and in part, is re-badged in the reforms of clinician engagement (QH, 2011a; Fulop & Day 2010).

In health organization restructuring and subsequent enlargement of nurse manager span of control, shared governance empowerment structures emerged as 'new look' models to contain increased management costs during the 1980's (Porter-O'Grady 1992). Shared governance in the Magnet hospital application, is defined as empowering structures that legitimize health care professionals' decision making control over their practice, while extending their influence to administrative areas previously controlled by managers (Hess 2011, p.235). Shared governance structures provide formal mechanisms that ensure nurses' right, responsibility, and power to make decisions (Kramer, Maguire, Brewer, et.al. 2008). They are alternate models of concentrating nursing decision influence.

Such empowerment models have been impelled further following the Institute of Medicine's 2004 Report, *Keeping Patients Safe: Transforming the Work Environment of Nurses*. This report focused the essential role of nursing in patient safety, while pointing to disempowered first line managers and negative working conditions for nurses, as major threats to patient safety (Page,2004).

The evaluation of shared governance in advancing nurse and nurse manager engagement, role effectiveness, and the link to patient safety, has been convincingly positive on accounts from models in place (USA: Barden, Griffin, Donahue et.al. 2011; Kramer, Maguire, Brewer et.al. 2008; Armstrong & Laschinger 2006). Lewis and Urmston (2000) consider the model's application in the UK, National Health Service in light of managerial practice and attitudes, that mitigate against empowerment.

The Princess Alexandra Hospital (QH, Brisbane) is the only Magnet accredited hospital in Queensland. The Magnet organizational structure and decision-making models, in particular, have been validated in terms of success factors in positive clinical outcomes, patient, staff, and service satisfaction (Porter-O'Grady 2003, p.252). The following sub-section details Australian research fore-grounding professional governance as a critical determinant in positioning for N/MUM role success.

3.3.2 Nursing and Midwifery Governance:

It is evident that there are different influences in identity formation for nurses whose roles and responsibilities are increasingly managerialised in relation to new forms of structured power relations in health service organizations. Professional governance of nursing and midwifery has been significantly distorted and diminished as a result (Chiarella & McInnes 2010; Orrock & Lawler 2006).

Nursing and midwifery governance is tightly connected to control of staffing budgets, which are considerable and highly contested in the current state of New Public Sector Management (Bloom, 2000). This implies for boundary setting in terms of professional and managerial controls and accountabilities, reporting structures and communication.

An important consequence of the program management model introduced in the 1990's was the loss of a senior executive with sole responsibility for nursing affairs in the organization (Chiarella & Roydhouse 2011; Chiarella & McInnes 2010; Orrock & Lawler 2006).

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This was a move to alternative budget holding business structures, leaving senior nurses with much reduced operational line responsibility for nursing services. As nursing executives took on added responsibilities beyond nursing service, some no longer had operational line responsibility for nursing services. While the opportunity for expanding influence was taken, the move diminished influence on nursing personnel at lower levels of the organization depriving nursing of disciplinary leadership representation at policy level in the organization. As a result, nursing work organisation suffers, threatening the quality of care (Chiarella et.al. 2010; Laschinger et.al. 2008; Duffield et.al. 2007b; Wong & Cummings 2007).

Nursing governance in New South Wales is a case in point with developments shadowed in Queensland Health (Appendix 2). By 1995, nurses in New South Wales had 'lost the fight to retain or regain the nursing budgets, and much of their line management control of nursing' (Chiarella & McInnes 2010, p.14). Health service restructures have marginalized senior nursing management roles, dramatically reduced nursing middle management roles, and "left clinical nurses at the ward level being relatively isolated, leading to dissatisfaction and frustration" (Duffield, Kieran, Johnston et.al. 2007, p.5).

The authority relations are multiple and competing, the goals are unclear, and priorities equivocal between different reporting entities (Chiarella & McInness 2010, p.18). This has major implications for N/MUM engagement in professional governance, and for their reporting and communication activities.

Concerns related to under-bounded governance structures for nursing and midwifery concern not only safety and morale in nursing practice, but also the effectiveness of clinical innovation, demonstrated by way of examples (Chiarella and McInness 2010, p.19) in the work of Chiarella (Models of Care Project, NSW Health 2006).

Orrock and Lawler (2006, p.68) track the demise of nursing governance in New South Wales where senior nurses found themselves further marginalised, yet were expected to be the "primary implementers of the reform agenda". The authors argue that the current nursing crisis is the consequence, in part of marginalized nurse leaders, as well as a fundamental misunderstanding of nursing's value base and contribution to health care service provision. Where hospitals have a powerful nursing executive and unit-based decision-making along with support for professional practice, they are more likely to provide superior care (Armstrong & Laschinger 2006, p.124).

There is solid evidence that N/MUM empowerment is essential. When nurse managers empower their staff, they increase staff nurses' commitment to the organisation and reduce job stress and nurse turnover (Laschinger et.al. 2001; McClure & Hinshaw, 2002; OBrien-Pallas et.al. 2005; Heid 2010). Not only is nurse manager empowerment a strong predictor for patient safety, but importantly, being perceived as having effective power affects others. Staff nurse effectiveness including job satisfaction is related to nurses' perception of their nurse managers' empowerment (Howle 2001; Patrick & Laschinger 2006).

Budget control concentrates empowerment and professional governance concerns for N/MUMs. Scope of practice for N/MUMs includes key accountabilities as fiscal gatekeepers in management of human, material, and financial resources at front-line

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service level. The effects of N/MUMs clinical knowledge and management skills on productivity, particularly in the current climate of aggressive financial and productivity goal setting is acknowledged (Hewson 2010).

Budget control is a key locus in perceptions of decision-influence for N/MUMs and the tensions around resources enough to do what the job requires (Hewison 2010; Paliadelis 2008). A key concern for all N/MUMs is the extent to which they are given the authority to take corrective action and to make final budget-related decisions in budget planning, and managing cost drivers and productivity performance.

The business responsibilities generated by structures that normalize managerial controls subject the N/MUM to constant surveillance, including micro-management, and performance auditing. Review of business practices as part of the N/MUM role responsibilities is currently being addressed by the joint strategic reference group, NaMIG (2011), in relation to the Working Group on the Business Planning Framework Version 4 (2008).

Developed by the QNU and incorporated for mandated application into QH/QNU Awards and Enterprise Agreements from 2003, this framework is an important tool for linking resources to the service or demand profile of the service (QNU 2009a, p.3). Revised in 2009, with inclusion of enforceable minimum requirements, the tool continues to be inconsistently applied and a source of certain dissatisfaction for N/MUMs (NaMIG Working Group, EB7 2009).

It is the **service profile** with which the N/MUM engages in expert planning and evaluation of skill mix, workload measures, and budget outcomes. Increasingly, relations with corporatized Human Resources and Business Management managers generate additional relationship work in priority accountabilities, for example, workloads management, and stabilizing the unit based workforce.

It is emphasized that further revision of the BPF (QH/NaMIG 2011) is linked to other priority NaMIG Working Groups, such as Models of Nursing and Midwifery, Working Arrangements, and Career and Classification Structure. For example, in innovative models of nursing and midwifery, a properly scoped and authorised budget is essential (Hewison 2010).

N/MUM authority in unit-based resources management continues to be contested within the whole of the service operational environment, governance and related power relations.

Lee and Cummings (2008) evaluate the findings of their systematic review of nurse manager job satisfaction with recommendations for modifications to the N/MUM operating environment, namely spans of control, and in particular, developing strategies for empowerment. Evidence demonstrates that the N/MUM and other senior nurses, do not have enough power to influence the effectiveness of their organization.

Much of the nursing literature evaluating restructuring, reform and impacts on professional governance refer to changing and deteriorating conditions for nurse managers. In this context, the plethora of publications exhorting empowerment techniques could be anticipated

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Structured empowerment and appropriately bounded professional governance as key determinants in N/MUM role effectiveness in restructured healthcare settings is the central finding in this sampling of the literature. The following sub-section identifies the research on what concerns the N/MUM in relation to their role responsibilities. Here the loops of span of control and role responsibilities intersect with the determinant of empowerment.

3.4 Role Responsibilities – *Between a rock and a hard place…*

Summary 4. What is known about N/MUM Role Responsibilities

The operational environment for N/MUMs has changed in significant ways (instabilities in casemix, workforce, management, cycles of reform initiatives) to increase level and intensity of role responsibilities.

Challenges of being responsible for expected results without the resources to achieve these; and by being pressured, uninformed, and under-resourced them (Paliadelis 2008)

Role work expert and complex; under-recognised.

Contested space in role ambiguity exposed for Grade 7 nurses & midwives, demanding intra-professional negotiation in the delineation of practice context-sensitive role responsibilities.

Role overlap between CNCs, educators, and N/MUMs is complicated by the level of authority assigned to different roles.

Negotiation professionally, organisationally, and industrially is the key in scope of practice matters of role ambiguity, and role overlap.

Approached differently, N/MUM role ambiguity is a strategic advantage in role value where work is appropriately resourced.

Negotiating patient 'distance-closeness' underpins the N/MUM work of navigating the hybrid role of the nurse as clinician and manager. Hybrid role confirmed.

The clinical identity of the nurse manager is the primary value in affirming the hybrid clinical leader-manager N/MUM role.

Formalisation of organizational power within the N/MUM role is a priority in clarification of position statements and responsibility descriptors.

N/MUM influence on staff retention, practice environment quality, and patient satisfaction is solidly established and cannot be over-stated in current crisis climate.

N/MUMs are key drivers in safety culture and in building high-reliability health care organizations.

This sub-section takes from the literature, current issues in the N/MUM role responsibilities. Themes in role work are presented, followed by referenced detail to

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'linch-pin' responsibilities in operational effectiveness. These are staff retention, and safe practice environment.

Nurses generally and nurse managers in particular, engage in complex activities because their structural location in the healthcare division of labour requires them to articulate a number of fundamental dilemmas of healthcare work. These include the requirement to reconcile the needs of individuals with the needs of the many; to balance the need for quality with the need for cost-effectiveness and efficiency; to mediate between standardization and individualization; to articulate specialist with generalist skills; to manage professional aspirations for clear jurisdictional boundaries with the everyday need for an integrated service; to negotiate between patients and families; and to reconfigure infinite needs to match finite resources (Allen 2004, pp.279-80).

N/MUM sets of role responsibilities are outlined in the following table.

Table 2. Generic level position descriptions

Nurse/Midwife Unit Manager	• Has ability to lead a nursing team in a multidisciplinary environment utilizing the principles of contemporary human, material and financial resource management; • Demonstrates sound knowledge of contemporary nursing practice and theory; • Participates directly or indirectly in the delivery of clinical care to individuals/groups; • Ensures clinical practice is evidence based to facilitate positive patient outcomes; and • Has sound knowledge and the ability to apply relevant legislation, guidelines and standards.
Nurse /Midwife Manager	• Provides nursing expertise in a specialist area of nursing management (e.g Patient Flow, Informatics, After Hours Nurse Management; • Demonstrates sound knowledge of contemporary nursing practice and theory; • Integrates the principles of contemporary human, material and financial resources management into service delivery; and • Has sound knowledge and the ability to apply relevant legislation, guidelines and standards.

SOURCE: Queensland Health Nurses and Midwives Award – State 2011, p.56

The breadth of responsibilities for the N/MUM extends beyond direct patient care, to the management and leadership of staff, and organizational resource management. When this work is considered with increased patient acuity, nursing shortages, organizational business pressures, expansive performance measurement culture, then questions about the scope of the role arise. Difficultly in recruiting to the role and increasing turnover and burnout of nurse managers, suggest that the role is problematic (McCallin & Frankson 2010; Shirey et.al. 2008; Laschinger & Fingegan 2008; Palliadelis 2008).

The normalization of clinical units as units of business, decision marginalisation, and a contested space of role ambiguity and workload stress compounds the complexity of the nurse manager's role responsibilities (QH/OCNO 2008). Approaches to these trends in the N/MUM role have been tested in projects for role clarification and resourcing N/MUM training and development (QH NMOQ, NSW Health CNMO 2011).

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Where the administrative load or 'paperwork' has been politicized, administration officers have been appointed to support front line teams (Garling 2008). Attention to a more strategic utilization of clinical career structure supports, such as advanced practice nurses/midwives in practice, education, and research, has been less fore-grounded as N/MUM role remedies in these projects (NSW & Qld).

In researching the working world of the nurse manager, Paliadelis (2008, p.256) concludes the implications are for stakeholders around the need to develop a more realistic role description that clearly identifies the scope and power of the N/MUM position. Nurse managers are challenged by being responsible for expected results without the resources to achieve these; and by being pressured, uninformed, and under-resourced. Paliadelis calls for the formalization of organizational power within the N/MUM role (2008, p.262).

The changing operational environment for N/MUMs is a critical focus in role clarification and development. The concept of role development is understood as an emergent process which can be influenced by pre-defined role expectations, by changing organizational requirements, by individual needs, and by ongoing interaction among actors in a particular role set (Miller, Joseph et.al. 2000, p.196). The N/MUM role clarification process must be responsive to variety of contingencies in the organizational environment.

Features of this changing organizational environment which directly impacts the role responsibilities of the nurse manager, are identified (Chiarella & Roydhouse 2011; Chiarella 2007, s109; Myer, 2010; McCallin & Frankson 2010; Duffield 2007; Orrock & Lawler 2006) as:

Significantly greater numbers of staff in the workplace who require education and support.

Much-needed increases in undergraduates, trainee enrolled nurses, enrolled nurses, and new graduates; depletion in senior/more experienced clinicians at the bedside.

Greater numbers of highly specialized staff across the workforce.

Introduction of new roles, such as Nurse Practitioner, and other specialist advanced-practice roles

Changes in the allocation and ownership of work.

Focus on multidisciplinary workforce development and approach to problem solving; changes to care delivery patterns, such as clinical streaming, outreach and in-reach programs; increase complexity compression and task loading for nurse managers.

Geographical and structural shifts in the nature and location of teams.

Generation of boundary-spanning work for managers integrating interdependent work processes (Myer 2010, p.37); increase in number of non-direct reports and responsibilities for team outcomes/effectiveness.

Three related instabilities: (Chiarella & Roydhouse 2011)

Unstable casemix,

Unstable workforce, and

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Unstable management.

Highly diverse casemix means nurses see a diverse range of patients and a significant turnover of patients (churn); is a source of variation for nursing intensity and staffing needs; workforce instability (casualisation, skill loss, lack of role clarity (senior nursing roles), role overlap; management instability and lack of consultation, decision inclusion and transparency (Chiarella 2011, p.p.95-98).

Fractured nursing and midwifery governance

Budget control vs accountability

Concentration of managerial power with non-nursing professional corporate bureaucracy; limited decision influence; disempowering organizational and communication structures; marginalisation of expertise down the line; need for alternate models for positioning nursing and midwifery influence (Orrock & Lawler 2006; Chiarella 2011).

Identified as key agents in the reform program of QH with significant investment in leadership skills training, N/MUMs are expected to combine their professional and managerial experience to better negotiate the inherent uncertainty and conflict identified in the QH, OCNO (2008) NUM role review. The N/MUM role reviewed in NSW Health (AIHI 2011) has been co-opted in a more politically sensitive set of recommendations (Garling 2008). The NSW N/MUMs have been directly authorised in the reform agenda of 'patient-centredness', as a reinvestment in community confidence in the public health system, and made subject to mandatory skills training.

Lack of role clarity or role ambiguity, has been reported in the literature since 1996 (Oroviogiocoechea) and linked to the nurse managers' lack of empowerment in the role. The increasing span of control is understood to have a domino effect resulting in increasing stress, decreasing job satisfaction (Silvetti et.al. 2000) and burnout (emotional exhaustion, lack of accomplishment, and depersonalization) (Jamal & Baba, 2000).

The subject positioning between a 'rock and a hard place' is a recurring theme in N/MUM role work research. Pannowitz (2008, p.313) finds that the complexity of integrating expert nursing knowledge and the management/leadership practices means that nurse managers are constantly 'different in the moment', and constantly adjusting their priorities and responses, 'in the moment'. This requires high levels of ethical maturity, emotional intelligence, self-knowledge, and clarity in professional nursing/midwifery values.

This role work is time-consuming relationship activity. Miller, Joseph et.al. (2000, p.204) find that N/MUMs adapt with relatively complex and fluid behavioural routines at individual level, while meeting the organizational goals for the position. Various role predispositions were found to be competing and conflicting across human and bureaucratic dimensions with the highest tension between 'nurturing mother' inclined to defend staff from pressures exerted from the top; and the 'rational producer' inclined to defend upper management's views against pressures from the staff (Viitanen et.al. 2007, p.121).

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Self work and relational maneuvering work are reflected and reported as concerns of systemic role ambiguity or multiple roles within the role, and the consequent stress indicators. It is important to value this 'role work' for the N/MUM is uniquely and strategically placed as they are, and to do what is possible to reduce the stress. Key recommendations in this regard, focus system support for the role, rather than over-reliance on 'fixing' the N/MUM. If approached differently, role ambiguity can be reframed as a strategic advantage.

Role success depends on the N/MUM's negotiation of the dual identities of clinical leader and manager. The **hybrid role** of the N/MUM necessarily represents a navigation between closeness and distance to the patients and the staff (Sorensen, Delmar & Pedersen 2011). Where clinician OR management roles were assumed, negotiation was absent, leading to reactive, adaptive and isolated practices. The hybrid role was associated with dialectical negotiation of roles leading to stable and proactive nurse manager practice (Sorensen et.al. 2011, p.421).

The stronger and more effective identity in the hybrid role was found to be professional/clinical leadership rather than a managerial identity. The clinical identity of the nurse manager is primary in the hybrid role, summarized as:

Table 3. Managerial roles

Clinical focus predominant	Hybrid Role (negotiated balance)	Managerial focus predominant
Strong nursing identity; weak management identity, negotiation between clinical and management absent; unstable, reactive, and adaptive practices.	Practices that variously accent nursing and management work; strong nursing identity integrated with strong management identity leading to stable and proactive practices; professional identity works to stimulate mutual respect and positive outcomes inter-professionally.	Weak nursing identity; strong management identity, negotiation between nursing and management roles absent; management practices that stimulate professional isolation, short-term adaptive behaviours; and harmful alliance formation.

SOURCE: Sorensen et.al. 2011, p.428

N/MUMs report a need to reduce ambiguity (for themselves and for others) to enhance their own job effectiveness. The review of the nurse manager role by QH (2008, p.29) noted 'the consensus to refocus the role on clinical leadership and provide support for the administrative work'. Garling (2008) took a similar stance.

Role ambiguity ought not be confused with role overload (nurse manager doing everything without enough time or resources to do it). Sorensen et.al. (2011) model an approach to role ambiguity that reframes ambiguity as a strategic advantage, for example, in affirming and privileging clinical leadership over managerial identity formation.

It is precisely because the role is **both**, balanced to meet the service context, that it is unique, strategic, and operationally critical. More importantly, for the N/MUM manager, is that the role is embedded in the identity of the nurse or midwife, and the values of nursing/midwifery for its profound sensitivity to and influence on key operations, such as staffing, resources and patient outcomes.

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Rather than being a problem for serial review and re-work, Miller, Joseph and Apker (2009, p.210) take ambiguity advantage in developing new nursing management and coordination roles. These are opportunities for advancing quality care and cost containment in complex times and in complex organizational environments. Case in point is the role of Modern Matron (NHS, UK) as a manipulation of N/MUM role ambiguity (Hewison 2001, p.257).

The revised nurse manager role entitled 'modern matron' has been initiated to establish a 'strong clinical leader with clear authority at ward level' (DoH 2000, p.86). Modern matrons fit the model of 'hybrid' management, that is, a new type of management in which non-medical health care professionals engage in aspects of generic management, in this case quality improvement and consumer complaints, combining this with their clinical management responsibilities (Savage & Scott 2004). A key role descriptor is the provision of 'visible, accessible and authoritative presence in ward settings to whom patients and their families can turn for assistance, advice, and support" (Wildman& Hewison 2009, p.1657).

Role overlap with clinical nurse consultants was identified early in the Australian career structure development (Duffield 1989; Duffield, Pelletier, et.al. 1994). It is now observed that the scope of nursing and midwifery practice is being distorted with a need for unambiguous boundaries within nursing and health practitioner roles; and in reconfiguration of nursing teams (Eagar, Cowan, Gregory, et.al. 2010).

Negotiation has allowed nurses to redefine appropriate nurse-patient proximity, promote patient safety and find innovative ways of working in nursing and cross-professional teams (Schluter, Seaton & Chaboyer 2011). Negotiation professionally, organisationally, and industrially is the key in scope of practice matters of role ambiguity, and role overlap.

Role overlap has been reported between clinical nurse and midwifery consultants and nurse and midwifery practitioners, and clinical nurse and midwifery consultants and M/MUMs (Chiarella, Harford & Lau 2007). Chiarella (2011, p.97) reports lack of role clarity as a factor in workforce instability particularly for senior clinical nursing roles. Role overlap was also identified between consultants and educators, further complicated by the level of authority assigned to different roles. The N/MUM views their role as similar to that of the clinical nurse and midwifery consultant (Chiarella et.al. 2007).

The literature on role responsibilities has illuminated the inherent challenges and recent responses to the ubiquity of clarity versus strategic ambiguity of the N/MUM role.

N/MUMs are identified as a linchpin to practice excellence (O'Rourke 2007, p.44). In the forefront of change initiatives and relentless in keeping solutions patient centred, the N/MUMs are point-of-care leaders. Particular 'linch-pin' responsibilities are universally referenced in position responsibility descriptors. These are detailed in the following sub-section as staff retention, and safe practice environment.

3.4.1 Staff Retention

Nursing's ability to sustain an adequate, quality workforce continues to be challenged with evidence that strategies so far have been partial and limited (Chiarella et.al. 2010; McGillis-Hall 2007; O'Brien-Pallas, Duffield and Hayes 2006). New approaches are needed

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that speak to the fundamental concerns voiced by nurses about values dissonance, role stress, and perceptions that nursing is not properly understood and valued (Ceci & McIntyre 2001).

Nurses and midwives who believe they provide and can provide good patient care are satisfied with their careers. Chiarella declares that nurses leave the profession because: (1) they feel undervalued, and (2), they are unable to deliver the care they feel they should (2007, p, 109). Related factors are lack of career opportunities (Hegney, Eley & Francis 2011; Hegney, Plank & Parker 2005; Friedrich 2001); and values dissonance (Takase, 2010; Takase, Maude & Manias 2007; Nowak and Blinkley 2005; Verplanken 2004). Nurses who are satisfied with their career choice "live out their core values and engage in interdependence' while nurses value most 'making a conscious difference' to patients'/relatives' lives (Perry 2005, p.41).

A key finding of the first large study exploring the work environment at the ward level in public hospitals in New South Wales is that "the importance of the role of nursing leadership at the ward level to job satisfaction, satisfaction with nursing, and intention to leave, cannot be overstated." (Duffield, Roche, O'Brien-Pallas, et.al. 2009, p.11). The quality of the nursing workplace is a key factor in achieving optimal workplace outcomes and in retaining nurses. Nursing workforce planning research and findings localized to QH are introduced in Section 2, this Report.

A healthy work environment is one in which staff can accomplish professional and organizational goals and experience work satisfaction and fulfillment. Nurse satisfaction is in turn, a key indicator for health services because of its positive association with patient satisfaction (McGillis Hall 2003) as well as its negative associations with nurses' intentions to leave and nurse turnover (Duffield et. al. 2007b).

Negative effects on outcomes for patients, nurses and health systems including economic costs of avoidable nurse turnover have been identified (O'Brien-Pallas, Griffin, Shamian, et.al. 2006). This is particularly so for new graduates found to have a significantly higher rate of turnover in the first year of practice to over 60 per cent (Lavoie-Tremblay, et.al. 2911, p.39)

In understanding the exit rates of Generations Y and X nurses, contributing factors are lack of participation in decision practices, inability to provide quality care, and inadequate supervision (Lavoie-Tremblay, et.al. 2011, p.43). This is important in light of the nurse managers' role in providing resources for clinical supervision for an increasing number of graduates requiring that support (Chiarella 2007).

That N/MUMs influence nurses' job satisfaction and retention is well established (Duffield, Roche, Blay et.al. 2010; Armstrong & Laschinger 2006; Laschinger, Finegan & Wilk 2009; Kramer et.al. 2007; Duffield 2007). The N/MUM who is perceived to be a good leader, is visible, consults with staff, provides praise and recognition, and is flexible with work schedules, distinguishes the positive and negative wards (Duffield et.al. 2010, p.23). Nurse manager visibility and responsiveness are found to be important contributors to the job satisfaction and perceived empowerment of clinical nurses (Upenieks 2002).

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Communication and relationship with line N/MUMs are significant predictors of nurse job satisfaction (Cowden, Cummings & McGrath 2011; Duffield et.al. 2009; Cummings et.al. 2008; Hall 2007). Leadership or management style (McCutcheon et.al., 2009; Duffield et.al., 2009) as well as communication including performance feedback (Laschinger & Finegan 2005) are variables in this relationship.

The nine (9) highest ranked supportive role behaviors cited by staff nurse respondents (Kramer, Maguire et.al. 2007, p.325) most preferred in their line manager, are that the N/MUM is: approachable and safe, cares, "walks the talk," motivates development of self-confidence, gives genuine feedback, provides adequate and competent staffing, "watches our back," promotes group cohesion and teamwork, and resolves conflicts constructively. McNeese-Smith (1997, p.49) adds being passionate about nursing and reliable follow-through with identified problems as empowering N/MUM behaviours..

O'Brien-Pallas, Duffield and Hayes (2006, p.262) find disparity between perceptions of nurse executives and those of nurses who have left the profession. They suggest that nurse executives ensure support for nursing unit managers who are more likely to understand methods of retaining nurses at the clinical interface.

Increasing casualisation of the nursing workforce poses challenges to matching skills and workforce needs (Chiarella 2011, p.96). Kuokkanen and Katajisto (2003, p.214) found in their Finnish study, that short-term contracts significantly impeded nurses' empowerment where nurses felt insecure and uncommitted to the health organization. Continuity of staff and retention of higher skilled registered nurses is increasingly important for patient outcomes (Duffield 2007). Dissatisfaction with work environment; lack of recognition or professional status; and lack of career opportunities are key factors for senior clinical nurses (Friedrich 2001).

The literature expounds a solid body of evidence linking N/MUM influence on nursing and midwifery workforce retention, quality of working life, job satisfaction, productivity, and subsequent implications for patient and organizational outcomes.

Given the criticality of safe practice environment, it is worth surfacing the relevant literature in focusing N/MUM role responsibilities in the next sub-section.

3.4.2 Safe Practice Environment

Nursing scholars and clinicians alike have long sought to prove what is known in practice: that nurses have an indispensable role in keeping hospitalized patients safe and achieving positive outcomes. Patients are hospitalized primarily to receive the benefits of 24-hour nursing. Despite increasing evidence that the number and skill mix of nurses are critical to patient outcomes, it seems that the ability of nurses to successfully provide this care is more at risk than ever (Groves 2011, p.5).

While nurses "pick up" the work of others, and work not done by others, there is no one to pick up the work that nurses themselves are unable to get done with diluted resources. Krichhbaum, Peden-McAlpine, Diemert, et.al. (2011) enlarge on the experience of nurses in role complexity compression and the need to remedy organisational, administrative, and cultural problems that fuel this complexity.

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Significant patient safety research work followed with the IOM seminal report *Keeping Patients Safe*.: *Transforming the Work Environment of Nurses* (Page, 2004). This report addresses the need for a long term commitment to creating a culture of safety and connected nursing workforce issues and work environment factors to patient safety.

Nurse managers are targeted as key drivers in this safety culture work and in building high-reliability health care organizations (Kerfoot 2006).

Seminal research by Aiken, Clarke, Sloane et.al. (2001) across five countries, identified the major contributing factors for nursing workforce shortages, including work dissatisfaction, nursing ageing demographics, low levels of loyalty to the hospital by newly qualified nurses, poor work design and workforce management. The safe and healthy practice environment 'movement' advanced in part, because of this evidence.

Links between effective nursing leadership and patient outcomes have been explored and positively confirmed (Aiken, Clarke, Sloane et.al. 2008; IOM 2004). In a systematic review of the literature by Wong and Cummings (2007, p.517), four (4) key patient outcome areas sensitive to clinical leadership were described in patient satisfaction, patient mortality and patient safety; adverse events; and complications. Positive relationships between nursing leadership and 30-day patient mortality have also been confirmed (Cummings, Midodzi, Wong, et.al. 2010).

N/MUMs create safe practice through staff engagement and commitment (Carr & Clarke, 2010; Mackoff and Triolo 2008; McNeese-Smith 1997); empowerment of staff nurses (Purdy, Spence Laschinger, Finegan et.al. 2010, p.901); in generating passion for nursing/midwifery (Rivera, Fitzpatrick, & Boyle 2011); in promoting innovation and innovation, clinical governance and professional practice change (Balding 2005; McMurray & Williams 2004; Manojlovich 2005a); through leading evidence-based practice and improved staff nurse performance (Germain & Cummings 2010; Weston 2009).

Implications of nursing workforce issues, for example, the quality of nursing (staffing levels, workloads, skill mix, management and resources support) and workplace culture for patient safety, have been widely published, detailed, including costs and often cited as key references (Duffield et.al. 2007b; Needleman, Buerhaus, Mattake et.al 2002; Aiken, Clarke, Sloane, et.al. 2002).

There is evidence of positive work environments being safer for nurses (Clarke, Sloane, & Aiken, 2002). The empowerment of nurses to practice according to professional standards most directly creates a culture of patient safety (Manojlovich & Laschinger 2007; Armstrong & Laschinger 2006).

Patients' reports of satisfaction are higher in hospitals where nurses practice in better work environments and with more favourable patient-to-nurse ratios (Kutney-Lee, McHugh, Sloane et.al 2009, p.669).

There is strong evidence that organizational culture, defined authority and accountability for quality and safety improvement have a significant role in ensuring a safe system (IOM 2004). The N/MUM's ability and role capacity to lead has a major effect on work climate (Sellgren et.al. 2008). Organisational culture is defined as the way people customarily

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behave towards each other; it is something that is perceived and felt; and it knits a collection of individuals into an integrated entity called an organisation (Mintzberg 1983, p.264). It is often captured in the every-day expression of 'how things are done around here' and perhaps more importantly, the way things are understood, judged, and valued.

Jones and Cheek (2004:127) on the role of nurse managers in managing nursing and practice environments, conclude that how managers respond to the various forms of conflict in the nursing workplace, and whether they are perceived to value nurses and nursing, will be yardsticks used by practising nurses that colour their view of whether to remain in nursing.

Pillay (2010, p.545) identifies ethical competencies ranked highly as one of the most valuable skill sets for optimizing a safe practice culture. Together, hospital ethical climate, patient load, and control over practice together explain variance in professional turnover intentions with hospital ethical climate as the most important in explaining nurses' positional and professional turnover intentions (Hart 2005, p.173). The N/MUM's role responsibilities in ethical stewardship are given increasing attention (Bondas 2009).

Casali and Day (2010) underline the importance of value congruence in building and sustaining a healthy organizational culture confirmed by evidence in the Bundaberg Hospital Inquiry. The Queensland Health Systems Review final report (Forster 2005, p.56) noted an unhealthy organizational culture described as "tribalism", "tokenistic consultation", and a "'culture of power and control". It is noted that this Inquiry was precipitated by the actions of a NUM (Toni Hoffman) at the hospital in a celebrated heroic example of ethical stewardship (Davies 2005).

N/MUMs' experience of the role is highly positive, rewarding and effective when the role is well supported, when the manager is empowered to do their job, and where the manager is able to 'negotiate' the span and content of the job. They love their jobs because of their passion for patient care, care for staff, and passion for nursing/midwifery. They are highly skilled in self and relationship work required to integrate the best of their expertise in clinical and management 'linch-pin' leadership.

N/MUM role responsibilities presented in this literature review are focused on role work, and specific linch-pin dimensions in staff retention, and safe practice environment. The next sub-section presents a sampling of the literature that follows on from findings in role span responsibilities, in what supports are known to enable the N/MUM role.

3.5 Role Supports / Role Enablers

Summary 5. What is known about N/MUM role supports and enablers

Empowerment is the most significant predictor of role satisfaction for N/MUMs and advanced clinicians in making a difference for staff, and for patients.

Role supports are synonymous with empowerment strategies that specifically enable the capacity of N/MUMs to do their job.

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- **N/MUM role supports and enablers positively influence patient health-related outcomes, team effectiveness and N/MUM job satisfaction**
- **Administrative support positively impacts on the N/MUM role with limitations noted in evaluation studies (AIHI, NSW)**
- **Staff resources support, such as clinical facilitators and clinical nurse specialists, is associated with more nurses surviving the first year on the unit, and senior clinical nurse retention.**
- **In addition to workforce stability, the clinical supports for the N/MUM achieve significant modification of span of control, and responsibilities load for the N/MUM.**
- **Negotiation in scope of practice and authority delineations is key to the effectiveness of teams of advanced clinician (educators and researchers) and N/MUMs at unit/service level.**
- **A strong political survival skill for N/MUMs is identified in support networking with professional colleagues.**
- **Evidence supports benefits in building high resilient organizations, in appropriately resourced shared governance peer mechanisms for N/MUMs.**

It is not surprising that selected nurse manager role research identifies key role supports and enablers which are at the same time, pivotal to positively influencing patient health-related outcomes (role effectiveness) and nurse manager job satisfaction (Lee & Cummings 2008; Thorpe & Loo 2003). Shirey's studies in nurse manager stress and coping (2006, 2008) identify stressors related to constant change in the work environment combined with a continuing trend in expanded scope of control and administrative responsibilities.

Capacity to do the job is important for role encumbents' job satisfaction in addition to attracting future leaders to the N/MUM positions. Role supports are identified as empowerment strategies, designed to enable the N/MUMs' capacity to do their job. Empowerment is the most significant predictor of role satisfaction for N/MUMs (Patrick & Laschinger 2006).

Specific studies in nurse manager burnout re-state the importance of creating environments that prevent nurse manager burnout and that foster positive health for these nurses in their work (Laschinger &Finegan 2008). Recurrent themes in systematic literature reviews (Lee & Cummings 2008, p.768) reference the need to modify span of control and workload, increase organizational support from supervisors and advanced clinical practitioners, and to empower nurse managers to participate in decision making.

The amount and types of work performed by nurse managers Is partially dependent on the work performed by others with administration role functions and clinical functions (Duffield, Donoghue & Pelletier 1996; Kramer, Maguire, Brewer et.al. 2007). Support roles are used to allow for broader managerial spans with the observation that for N/MUMs, support of staff resources, such as clinical facilitators and clinical nurse specialists, was associated with more nurses surviving the first year on the unit (McCutcheon 2004).

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Meyer (2010, p.108) found a positive association between clinical support processes and team work. This is consistent with the work of Duffield et.al. (2007) finding that specialised nursing support (clinical teachers, clinical leader roles) is associated with fewer interventions left undone or delayed, and fewer adverse events on units. Case manager roles have been positively associated with enhanced medical and team collaboration; satisfaction with nursing, care outcomes, inter-professional resources, and team work (Gittell 2002). Higher retention of senior clinical staff is found with clinical supports (McCutchen 2004).

The line managers of the N/MUM are an important element in the support equation. Laschinger, Wong, Ritchie et.al. (2008, p.91) finds that transformational leadership style of senior nurses gave the middle managers higher level of perceptions of empowerment and decision latitude, less intention to leave, more organisational support, support for professional practice and more role satisfaction.

A role enabler of importance is nurse manager tenure or length of service in the role. Stability of first line management is related to lower nurse turnover in hospitals (Doran, McCutcheon, Evans et.al. 2004; Duffield 2009).

3.5.1 Administrative Supports

Patrick and Laschinger (2006, p.16) describe perceived organizational support as generalized beliefs by the nurse manager that management values their contributions and actually cares about their wellbeing. The messages of de-valuing and the 'absence of care' have been identified in Australian nurse manager studies (Pannowitz 2008; Ogle, 2004). Effective leadership at the point-of-care needs support (O'Rourke, 2007).

Paliadelis and Cruickshank (2008) studied the nurse manager in New South Wales to find increasing managerial and administrative responsibilities indicated the need for clerical and peer support (2005, p.6). The AIHI (2011) has published an evaluation of the appointment of some 500 clinical support officers (CSOs) in NSW Health. The support has been welcomed by N/MUMs although some limitations are noted, given the CSOs are shared across interdisciplinary teams based in clinical units. Of the N/MUMs surveyed across the State, 79 per cent indicated that CSO's had reduced the N/MUM time on administrative tasks (AIHI 2011, p.71)

The most recent research on the impact on the workload of nurse unit managers with the introduction of administrative assistants is from the UK (NHS) (Locke, Leach, & Kitsell et.al. 2011). There was overwhelming support for the introduction of administration assistants by the nurse managers participating in the year-long trial. Nurse managers were able to provide greater support to ward teams, and could spend more time with patients (Locke et.al. 2011, p.177. Findings indicate the support increases ward productivity. Other researchers find the administration support enables the nurse manager to know the patients and their needs, and improves manager job satisfaction (Gooding 2003; Kramer et.al. 2007; RCN 2009).

3.5.2 Clinical Supports

Ogle (2004) advocates the creation of further designation clinical positions of authority such as clinical nurse consultants and advanced practice nurses. Ogle also suggests that

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these clinical positions should be of equal or higher prestige than nurse management positions - where valuing the work of the occupation above that of the work of management and the subsequent intra-occupational relations is important (Ogle 2004, p221).

The point about Grade 7 nurses and midwives' role overlap due to insufficient delineation in authority, and the need for intra-professional scope of practice negotiation, has been made in Role Responsibilities, 3.4.4. Intra-professional negotiation (Eager et.al. 2010) is modeled in well established and underutilized unit/ service based triumvirate structures of N/MUM and advanced clinical practitioners (educators, researchers, and clinicians) (Chiarella, Hardford & Lau 2007).

Ogle concludes that as long as management work is viewed as a superior occupation to that of the work of nurses, nurses will be managed, and nurse mangers and leaders will be marginalized (2004, p.290). In regard to valuing clinicians and the support they provide in clinical units managed by N/MUMs, Ogle recommends that the interpersonal relationships between nurses and nurse managers be centered rather than marginalized to the realms of unimportance.

A strong political survival skill for nurse managers is identified in support networking with professional colleagues and in avoiding additional vulnerability through isolation (Pannowitz 2008, p.314; Paliadelis et.al. 2007). In understanding how New South Wales public sector nurse managers 'manage' their role, Paliadelis, Cruickshank, and Sheridan (2007, p.830) found that nurses did not feel supported by the wider organization, however, they gained support from within their own nurse manager ranks. The researchers recommend the investment in more effective support mechanisms for nurse managers.

Formal peer support groups are identified as success factors for nurse manager retention (Buckles 2010); leading to enhanced manager partnerships across medical-surgical units for consistency and reliability in practice; contributing to high resilient organizations (Kerfoot 2006); and providing excellent training and development for nursing leadership roles (Beglinger, Hauge, Krause, et.al. 2011)..

The literature identifies what nurse managers find disempowering, which leads to role instability, dissatisfaction, turnover and failure to recruit to the role. Improving the role satisfaction of middle level nurse managers by increasing access to empowerment structures and organizational support must become a priority for health care organizations to ensure quality work environments are created for the recruitment and retention of tomorrow's nursing leaders (Patrick & Laschinger 2006, p.21).

The following sub-section tracks selected literature in trends in N/MUM role preparation, recruitment and succession planning.

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3.6 Role Preparation, Recruitment & Succession Planning

Summary 6. What is known about N/MUM role preparation. recruitment and retention

Inadequate role preparation compounds role confusion, role stress, and undermines effectiveness in the key N/MUM position.

Role preparation programs need to be tailored to individual managers' needs, flexible and sensitive to the context of the manager's professional practice.

Leadership and management training is recommended before appointment to the role. Generic management programs are limited by de-legitimising local N/MUM expert professional knowledge and skills.

Alternate approaches to 'study and fix the person' are required.

N/MUM training based on relationship-centred programs where human caring becomes an enterprise value, are proven effective.

Peer processes, such as mentoring, networked action research, and shared problem solving are proven effective in N/MUM role preparation.

Unstable management impacts on workforce, morale and operational outcomes.

Best practice strategies identified in the literature need to be invested in ensuring stability and continuity in the N/MUM workforce.

Nurse manager retention is multi-factorial with strong relationships found between leadership behaviour, job satisfaction and organizational health.

Interventions to build and sustain cultures of N/MUM engagement are known as most effective for retention and in building a solid N/MUM recruitment pool.

The literature is explicit in identifying proven strategies to secure improved recruitment and retention of N/MUMs.

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The findings in this subsection demonstrate the range of strategies, proven in moderating the increasingly loaded operational demands on the N/MUM role, and in positioning the role for best possible outcomes.

With significant changes in the role over the last two decades in particular (Duffield et.al. 2009; Surakka 2008), nurse managers today are expected to have the advanced leadership skills and competence to manage people, organizational resources, and change (Sellgren et.al. 2008). The challenges are intense, as these nurses take on expanded roles and responsibilities without in some cases, adequate training, education, resources or support. Many nurses promoted to these roles commonly with no formal management preparation, an inherent under-confidence, and in some cases a tangible reluctance to manage (Fairbairn & Platt 2008, p.853; Currie, 2006).

Palliadelis (NSW, 2006) found tensions for nurse managers in the integrated role duality, were compounded by their lack of preparation and support for managerial work. McCallin

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& Frankson (2010) identify key themes of role ambiguity and overload with business management deficit in their exploratory study of charge nurse managers in New Zealand.

Effective management and leadership training before appointment to the role is recommended (Azaare & Gross 2011; McCallin & Frankson 2010).

Work by Duffield and Franks (2002, p.182) in evaluating how well nurse managers are prepared for health service management compared with other professional groups, assert that "nurse managers have skills attained through their academic studies and experience that cause them to be as capable as (if not in some cases better than) health service administrators". This work reflects Duffield's alert to the competition and potential replacement of nurses as middle managers, by generic service managers.

Reference is made to Dean (1990) who pointed out that what distinguishes nurses in health services management from their non-nurse counterparts is their unique understanding of the art and science of nursing and an acute appreciation of the many aspects of clinical care and service (Dean cited in Duffield 2002, p.183).

The most recent developments in nurse manager preparation link to national and international patient safety and system reform agendas (Fennimore & Wolf 2011). This includes nurse manager impact in high performing cultures, safety and quality culture building; leading teams of professionals and others; and expressed in personal development programs towards 'transformational' leadership practice and outcomes.

Increased attention to the role preparation for N/MUMs led to range of work-based learning programs in QH particularly post Forster Review (2005) as part of transforming organizational culture. The QH nurse manager role review noted rapid system change and that processes in place should enable the nurse manager to realise more efficient and effective work practices and that without the right training and mentoring, "nurse managers will view the changes with suspicion and scepticism" (QH/OCNO 2008, p.30).

Organisations are interested in middle management effectiveness given the impact this has on employee commitment to the organisation, thereby reducing turnover amongst other counterproductive behaviours (Duffield et.al. 2009; Brunetto and Farr-Wharton, 2007).

Specific attention has been given to role transitioning, human resources management (performance management, staff development, payroll management), budget management, information management, communication and conflict management, and 'managing upwards' (McCallin & Frankson, 2011; Sullivan et.al.,2003; Duffield & Franks, 2001).

More recently, formal development programs have been developed including management toolkits, such as orientation and tailored leadership competencies, skill development programs, web-based learning, and opportunities for stretch assignments (QH/NMOQ 2011; AIHI 2011). Peer support, formal networking and colleague relationships are critical in role development, recruitment and retention (Buckles, 2010; Kerfoot 2006).

Transformational competencies are those including developing (the self) emotional intelligence (Goleman 1998) competencies in developing a learning culture (Ward &

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McCormack 2000); 1990's. transformational leadership with its emphasis on participative management, worker autonomy, job design theory and research (Kramer et.al. 2007).

Critical thinking skills and disposition to use those skills are identified as an antecedent in establishing work flows and creatively solving problems that support professional practice. Nurse executives and those responsible for initial and ongoing maturation of N/MUMs need to encourage the development and use of critical thinking dispositions (Zori, Nosek & Musil 2010). In this regard, practice development (Ward & McCormack 2000) is championed as a means of personal and professional growth in creative work. Chiarella celebrates the NSW Health innovations in "Models of Care" (Chiarella 2007) in shared learnings in the state-wide roadshow, and where nurse managers see their work as a source of energy and excitement (Chiarella 2006).

Fulop and Day (2010, p.344) suggest that approaches to the preparation of 'hybrid' clinician-managers focused on the leader as being "study and fix the person", "give them a position or title", and "make them responsible for results". A significant amount of nursing management literature is leader-focussed, with preparation designed to 'fix the person'. Fulop and Day argue for different approaches to role preparation in this regard, which is more relevant to the daily experiences of the clinician managers, specifically relational-focused approaches.

Approaches to N/MUM role preparation are contested on the grounds that 'generic' management training is limited, and undervalues and often delegitimizes the professional management expertise of the N/MUM (Ogle 2004; Pannowitz 2008). The N/MUM constitutes diverse identities in a complex context of nursing and management practice. This raises questions in the current thinking about role preparation particularly by scholars through post-modern and feminist ethnographies of nurse managers (Pannowitz 2008; Sambrook 2006; Ogle 2004; Glass & Davis 1998).

Pannowitz (2008, p.242) finds that the taken-for-granted personal skills and knowledge of nurse managers are inadequately acknowledged as the critical hinge in a public hospital system that makes good patient care possible and which fosters retention of nurses in the workforce. The interconnected personal, professional, and corporate functions of the nurse manager's role are intertwined and enacted within a dominant cultural context that subjugates nursing and nursing knowledge (Pannowitz 2008, p.242).

The meaning of role preparation for nurses, focusing on skills and attitudes 'making up' the nurse manager are based on limited and constraining meanings of what it is to be a nurse manager. This affects the self-management practices of the N/MUMs. The tacit knowledge of nurse managers has not been made sufficiently explicit in the knowledge-creating and knowledge-validation 'science' of the generic training that nurse managers are made subject to. The transfer of this tacit knowledge is better managed through peer processes, such as mentoring, networked action research, and shared problem solving (Skytt et.al. 2001; Pannowitz 2008; Ogle 2004).

Bondas (2009, p.353) finds nurse manager education is directed by leader-centred competencies, and where the nursing (direct and indirect) becomes an ambiguous part 'beside' leadership and management.

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3.6.1 Alternate Approaches

Role preparation needs to focus on clinical leadership described by Bondas (2009) as "Preparing the Air for Nursing Care" based on creating the direction and content of nursing and concern about nursing. This work is critical in creating the nursing (ethical) caring culture in health services (Bondas 2009, p.361).

Alternate approaches to generic management training, reinvest in professional foundations, where human caring is an embedded. For example, management and leadership training based on relationship-centred care programs where human caring becomes an enterprise value, has been described (Moore 2000; Gilmartin 2001).

Role preparation that provides opportunities for N/MUMs to champion the inscription of nursing/ midwifery values and standards as distinct but not opposed to instrumental economic values (Moore 2000) is preferred. Chiarella's work on building an ethos of collegial generosity in inter-nurse models of practice adds to the scholarship on positive, healthy and professionally collegiate workplace culture (Chiarella 2007).

Traynor observes how managers were keen for nurses to learn the new language and techniques of management (1996, p.327). He found that the experiential/subjective narrative by nurses was cast as untrustworthy and discredited alongside formal, numerical information. The nurse managers' reports on workloads and staffing, for example, were considered gender-equivalent of 'nagging'.

Another managerialist strategy reported by Traynor was 'the invisible nurse', that is, where nurse managers were made ineffectual in an organization, by keeping them so busy that they were too exhausted to think or participate (1996, p.341). Nursing discourse becomes a secondary world view.

Reedy and Learmonth (2000:160) suggest that the competency-based management training designed for nurse managers operates to 'deform' them by making them more compliant with official managerial values that are at odds with those traditional in nursing where nursing knowledge is subjugated in the privileging of management knowledge (Ready & Learmonth, 2000:161).

Evaluations suggest that the managerial assumptions on which many programs are based result in 'resistance from participants' who are nurses (Currie 1998:123. There is room for more critical approaches beyond conventional and problematic conceptions of knowledge relating to management. Some participants are directed by their managers to do these programs which do not necessarily represent development for more experienced nurse managers. Participants found the trainers 'talking across' their professional identities with attempts to 'engineer culture' by normative controls of management development rubbed against the nurses (Currie 1998, p.197).

The key message is that sensitivity to the context of the management development is important (Currie 1998, p.198; Sambrook 2007). The current thinking is that more individualized management capability training programs are indicated where the most effective form of development is connected directly to managers' experiences in the workplace (Skytt et.al. 2011; Jumaa 2005).

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3.6.2 Leadership Training

The literature reveals considerable interest in the creation of a stable work environment for nurses and centering the accountability for that stability with the N/MUM leadership responsibility. The lead work is in transformational leadership and related competencies, promoted as an advance on transactional styles (Laschinger et.al. 2008). The transformational N/MUM is a more effective boundary spanner by virtue of their leadership behaviours, and is shown to impact on job satisfaction, retention, organisation commitment, group cohesion, and a range of other positive outcomes related to empowerment of self and others (Kouzes & Posner 2002).

Iterations of 'transformation' training have marketed new technologies of working on the N/MUM 'self'. For example, N/MUMs are made subject to 'transfusion techniques' as dramatic and evangelical experiences aimed to impact the 'whole person' rather than specific training needs. These are high impact techniques for the integration of managers into their roles, and the values and practices of the organization. They include 'scripted' interpersonal communication patterns (Studer 2004).

The aim of the Studer "Hardwiring Excellence" workshops is to engage line managers emotionally and psychologicaly as well as behaviourally and attitudinally (Grundy 2011). The Studer promise is transformation of the self as a strategy in transforming organizations. This approach is modeled in N/MUM training based on psychological inventories and emotional intelligence skills training (Ausmed 2011; Smith-Trudeau 2009).

Renewed investment in management training is directed to 'upgrading people capability' with courses that focus productivity, such as performance and process management. Innovation, change management and risk management continue to be most popular subjects in government executive and management training (Trounson 2008, p.47) Lunchtime e-learning offerings 'putting concepts into action' include topics such as "In the Leadership Mode", and "Making a difference to frontline healthcare using Lean problem-solving techniques" and the like, are readily available and accessible to QH N/MUMs (QH 2011e).

Leadership training has become a high visible, highly invested corporate strategy designed and promoted to enable the capability of N/MUMs in their role. In the case of N/MUMs in New South Wales Health, this training is mandatory (AIHI 2011). Evaluation of this training has been largely positive.

3.6.3 Recruitment and Succession Planning

From Charge Nurse to Nurse Unit Manager (QH 1991) was a change of significant bearing not only in title indicating management authority, but also in recruitment practices, job content and expected outcomes. Previously, the most experienced clinical nurse was most likely to succeed as nurse in charge of a clinical unit. With implementation of the Career Structure for Nurses in Queensland (QH 1991) promotion was oriented to those with management competencies and qualifications and a component of 'hands-on' clinical function was relinquished.

Similar transitions occurred as the career structure was implemented nationally. Duffield and Lumby (2004, p.556) report that role confusion resulted for many in this transition,

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exacerbated by the potential for conflict arising from differences in values held by nurse managers and those of the organizations which employed them. This role confusion continues to be similarly reported for the nurse manager in Queensland public hospitals (QH, OCNO 2008).

There is evidence that transition from a clinical nurse to nurse manager is 'traumatic' (Duffield & Franks 2001, p.89) with continuing exodus of nurse managers and lack of enticement into the role. The profession needs to promote succession planning to reduce some longstanding problems (McCallin & Frankson 2010, p.319). Nurse managers report low morale and difficulty recruiting to the role (OCNO 2008, p.4). This is a strong index of the organisation's value for the role and how effective investments have been in ensuring role continuity and stability.

MacKoff and Triolo (2008) recommend building a model of nurse manager engagement in contrast to a retention model in improving the short tenure of nurse managers, noting that 'engagement' is the key to understanding why nurse managers stay. In this work, interventions to build and sustain cultures of engagement are outlined.

Succession management has been described as an organized way of identifying and developing talented individuals within organizations and giving them the opportunity to advance and achieve promotion (Johnson & Borkowski 2000, cited in Duffield 2002). Effective succession planning works to enhance the quality of leadership and the pool of talent needed to meet present and future needs.

One of the reasons for nurse manager shortage, is the recruitment pool of clinicians (Allan 2001; Reedy and Learmonth 2000;) and that nurses may move into middle management 'reluctantly' (Currie 2006, p.50). It is important to recruit nurses into leadership roles earlier in their careers given the next ten year baby boomer retirement projections (Brown 2010).

Where the role lacks support, nurses will reject leadership positions (Brown 2010; Hoskins 2009). High numbers of acting positions and churn in nurse management positions (exiting the role, deployment to project work, for example) leads to unstable management which impacts on workforce and operational outcomes (Duffield 2007; Chiarella 2011). Instability in unit leadership leads to low morale, which is a major organizational concern and costly in terms of staff and patient outcomes (Day 2007, p.31).

Factors influencing staff nurses' rejection of nursing leadership positions including middle management roles are reported: (Hoskins 2009, p.110)

Inadequate support from the organization;

perception of workload being too high and unreasonable;

role has too much stress and responsibility to be attractive;

perception of job insecurity (related to management positions being non-union contracted, Hoskins 2010, p.99);

compensation not incentive enough for the hours needed to be worked.

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Factors known to be important for nurse managers when they are considering leaving or staying in their current position are (ranked) (Brown 2010, p.80):-

- Job satisfaction;
- Empowerment;
- Work-life balance;
- Leadership practice of senior management; and
- Ability to ensure quality of care.

These findings are consistent in research by others (Skytt et.al. 2007, Parsons & Stonestreet 2003). Effective administration systems have been identified as important in nurse manager retention (Parsons, Cornett, & Jenkins 2006).

Recommendations based on the findings of the nurse manager stress, coping and work complexity study (Shirey, McDaniell, Ebright, et.al. 2010, p.90) identify role design, span of control, co-manager modeling, succession planning, work-life balance, support structures and systems, and education as key in sustaining nurse manager engagement and effectiveness in the role.

It is evident that N/MUM retention is multi-factorial with strong relationships found between leadership behaviour, job satisfaction and organizational health. Work-life balance can only be attained if the organisation's culture supports reasonable expectations in terms of workload from the senior management level down to front-line managers. Span of control review is critical in this regard.

Organisational support including supportive nursing leadership goes to respect (Laschinger et.al. 2006) demonstrated for example, by providing the resources, such as personnel and time, to deal with workload. The perception of excessive workload was highly correlated with each of the factors that led to nurse manager role rejection.

The factors were found to be consistent with an expansive literature review by Brown (2010) and consistent with the findings throughout the nurse manager literature review in this report.

Changes that need to happen before recruitment and retention of nurse managers will improve have been widely identified (Brown 2010; Hoskins 2009; Lee & Cummings 2008; Kramer, McGuire, Brewer, et.al. 2007; Thrall 2006):

- greater support from upper management;
- empowering philosophy from upper management;
- increased mentoring and orientation for the role;
- additional education and skill development (context specific);
- effective administration systems (staffing/HR, information, resources);
- addressing spans of control and workload.

Pannowitz (2008) found high level commitment to nursing values, expressed in passion for nursing, held the nurse managers in their stressful jobs. This was enhanced further

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when the nurse managers' and their senior nurses' values, resonated. The resonance factor is an important consideration in securing greater support from upper management, specifically nurse executives (Brown 2010). In a similar vein, nurse managers reported that they would not take on a nurse manager role unless they felt their goals were congruent with the organizational goals (Hoskins, 2009, p.106).

Mentoring is widely supported as a practice of nursing leadership and for enhancement of nurse-nurse relationships (Brown 2010; Nelson, Godrey & Purdy 2004). Borbasi, Jones and Gaston (2004, p.173) identify the mentor role as someone who 'passes on useful information and acts as a coach, allowing a individual to learn risk-taking behaviours, communication skills, political skills, and specific skills related to the profession'. It can include information about training programs, fellowships, networks, and career protection.

Work shadowing, progressive work experiences, implementing a nurse management 'internship', and fellowship programs are similar strategies described in the literature (Hopkins 2006; Borbasi et.al. 2004).

Given first line N/MUMs are described as 'glue' that holds the hospital' (Parsons & Stonestreet 2003, p.120), investment in continuity and stability of the N/MUM workforce is critical. The N/MUM recruitment and retention literature is explicit in nominating successful strategies to achieve this.

3.7 Conclusion

The most significant investment a health service executive can make in an organization and to the delivery of quality patient care is in N/MUM role success. The unique position and contribution of the N/MUM and the expert role work inherent in N/MUM role responsibilities have been affirmed in published research findings. Proven strategies have been demonstrated in moderating the N/MUMs' operating environment in practical and proven strategies, to optimize the influence and impact of this leadership role.

This work supports the outcomes of the QNU member consultation (Section 5) and underpins recommendations in this Report in response to the consultation. The next Section of the Report, collates findings of a selected literature search on current trends in advanced clinical practice relevant to Grade 7 nurses and midwives in the *clinical stream* of the QH Career Structure.

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4 Advanced Practice (Clinical, Education, Research)

Summary 7. What is known from the Review of Advanced Clinical Practice

Career structure is key to professional governance for nurses and midwives.

Career and classification structures formalize ownership and authority for nurses and midwives to sustain and grow practice and practitioners.

Career structure is formal recognition and valuing of nursing and midwifery knowledge, experience, and contribution to health service.

Access to dedicated career path progression is linked to nurse/midwife role satisfaction, and sustainable workforce retention.

With the exception of marked achievement in Nurse Practitioner and selected Clinical Consultant roles, the clinical career structure is underutilized.

The renaissance in clinical leadership is acknowledged for its importance in driving health system reform.

More work needs to be done to grow and sustain clinical leaders in formative Clinical Nurse/Midwife (CN/M)career structure classifications,

Barriers and enablers to wider recognition and utilization of advanced practice in nursing and midwifery have been identified.

Impact and outcomes of advanced and extended clinical practice by nurses and midwives are identified as positive and significant.

Recurring themes identify career structure as a strategic response to recruitment and retention challenges, extended to practice and role development, and innovative service models.

4.1 Introduction

The QH career structure is a grading structure that facilitates career progression for nurses and midwives, and where differentiation of pay by defining different levels of clinical and professional practice is acknowledged, and formalized. The purpose of this section, in reviewing selected literature in advanced nursing and midwifery practice, is to facilitate recognition of the significance and value of an updated, contemporary career structure for the nurses and midwives of Queensland.

This section will affirm advanced and expert practice is a foundational classification principle in the structuring of career progression for practitioners in each of the current four (4) structured streams of clinical, management, education, and research.

As significant development has been achieved at the higher end of the Nurse/Midwife Practitioner role (QH Career Structure, Classification Grade 8), the progressive

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classifications for lower grades from RN/Midwife Grade 5, have been advocated less, with advanced practice less recognised and less utilized. A cap on current career progression was identified by QNU members as the most common barrier to career advancement (Hegney, Eley & Francis 2011). The current iteration of the Queensland Health Career Structure for nurses and midwives needs attention in the classification of advanced practice at all formative levels. This is unambiguously supported by current research in

- clinical leadership;
- role preparation and retention of senior nurses and midwives; and
- productivity and effectiveness of investing the full value potential of nursing and midwifery in health service reform.

This Section is referenced to the objectives of the N/MUM Project 2011 in exploring the QH Career Structure Grade 7 roles, and the QNU Industrial and Professional Policy Committee Resolution (July 2011). These are aggregated from annual conference resolutions of QNU membership, and are further established in QNU Policy, *Nursing and Midwifery Workforce Planning* (2010) the QNU *Career Structure Objectives* (2011.

The intent of this resolution is to provide developmental opportunities from the current Registered Nurse (RN Grade 5) and Clinical Nurse (CN Grade 6) level through graduated levels of advanced practice to Clinical Nurse Consultant, Nurse/Midwife Clinical Service or Clinical Practice Co-ordinator/other like terms, and Nurse Practitioner Candidate currently within the Grade 7 RN classification band (QH Nursing and Midwifery Classification Structure HR:B7, 2008).

4.2 Clinical Leadership - Renaissance

Nurses and midwives are at the crossroads of today's health care requirements and the various responses to those requirements. They have been vested with new organizational responsibilities that demand an expertise that constitutes the basis of advanced nursing and midwifery practice (Perron & Holmes 2006). It is important to realize that at every level of an organization and regardless of whether nurses are in clinical, education, research or management streams, they have the potential to influence and direct patient care by exemplary leadership and excellence in clinical practice (Davidson et.al. 2007, p.186).

Clinical leadership has been established as a core component of the Grade 7 N/MUM role and is applied in recognising advanced nursing and midwifery management expertise and role value.. Clinical leadership has been fore-grounded and expanded in N/MUM role reviews in Queensland (NMOQ, 2011) and New South Wales (*Take the Lead*, 2011). The relationships between nurse/midwife structural empowerment, nurse /midwife manager leadership and staff nurse/midwife clinical leadership, are thoroughly demonstrated (Patrick, Laschinger, Wong et.al. 2011).

Clinical leadership is synonymous with advanced practice and is undergoing a "renaissance" (Cook 2001, p.38). This is in large part due to the studies acknowledging the critical link of leadership at the point of care in driving seminal changes required to achieve quality and safety across health care settings (Kohn, Corrigan, & Donaldson,

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1999/IOM to IOM 2010). Facilitating this leadership at the point of care has been extensively explored (RCN 2011; Davidson et.al. 2010; Heid 2010; Garling 2008; Forster 2005; Mark, Sayler & Wan 2003; Aiken, Clarke, and Cheung et.al. 2003; Cook 2001).

The relationship between of point of care nurse decision making, patient outcomes, organizational efficiencies and the quality of health care in decentralized institutions is well understood and published (Chiarella et.al. 2007; Duffield et.al. 2007; Aiken et al. 2000, Curtain 2000, Needleman et al. 2002).

Health care practice settings desire and require graduates who are professionally ethical and accountable, are effective clinicians; who work well in teams and in relationships with other health professionals; and who are prepared to continue learning and use critical thinking skills to solve problems. The clinical nurse/midwife leader across a number of advanced practice roles, acts as lateral integrator of care, patient advocate over the many components of the continuum, and information manager to the multiple disciplines involved in care (Tornabeni, Stanhope & Wiggins 2006).

This role development demands expertise, responsibility and accountability to improve clinical outcomes for patients and to promote the professionalism of nursing and midwifery. Clinical leaders are identified as the nurse /midwife "directly involved in providing clinical care and who continuously improves care through influencing others" (Cook 2001, p.39). A distinct type of clinical leadership of staff nurses is highlighted and differentiated from positional leadership by Heid (2010).

Attributes of the Clinical Leader have been variously reported for purposes of recruitment, development, and selection of nurses/midwives for clinical leadership roles. These include excellent interpersonal skills; love of the profession; commitment; integrity; problem solving and negotiation skills; team motivation; staff development and empowerment; initiative; creativity; and introspection (Picker-Rotem, Schneider, Wassersug et.al. 2008, p. 917). Others attest the value of clinical leadership training (Stanhope & Turner 2006) and more specifically, team leadership training (Cook 2010).

Clinical Leadership Development programs, for example, those offered by the Clinical Excellence Commission state-wide and sponsored by the Chief Nurse (NSW Health, 2009) list modules in Practice Development, Self Governance, Team Governance, Strategies for Creating a Learning Culture, and Management of Clinical Processes and Governance as s producing highly positive outcomes for nurse/midwife participants. Cook's review (2010) finds a common theme in UK, USA and Australian nursing literature of the importance of clinical leadership and its positive direct impact on quality, safety, and effectiveness in outcomes of patient care.

The expansion and development of professional practice and skills are focused on the needs of the patient and the community based on sound evidence, in enhancing clinical credibility and in the exercise of professional autonomy. This is derived from the fundamental philosophies of nursing and midwifery, discrete to those disciplines, and which complement and facilitate the skills of other health care professionals. Clinical leaders are emboldened by their philosophies, demonstrated in their capacity to work across boundaries and to lead with the flexibility needed to face the challenges of the century (Nutt & Hungerford 2010; Lockhart 2005).

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Clinical leadership underpins all levels of the career structure and is integral to the intentions and outcomes of nursing and midwifery, in responsive role development and role value. In an Australian nursing review, Davidson et.al. (2006, p.180) affirm that "systematic and strategic initiatives are required to nurture and develop clinical leaders". The critical connection of a dedicated path of career progression to clinician job satisfaction is reinforced in the clinical leadership literature.

4.3 Advanced Practice and Career Structure - From satisfaction to retention

Expert clinical practice remains the foundation of nursing professionally and philosophically, and is the currency with which nurses negotiate and engage with other health professionals, express the theoretical foundations of nursing science, and deliver care to our communities (Davidson et al. 2003). Advanced and expert practice is the key to self-governing professional practice for nurses and midwives.

Perron and Holmes (2006, p.38) emphasise the shift in the legitimacy of advanced practice as part of the nursing and midwifery professional project, now entrusted with a clearly consolidated authority and power to take on a greater role within the political and policy sphere of health care. The protracted politicization and ultimate success of the Nurse Practitioner role in Australia, is case in point (Chiarella et.al. 2007). Advanced and extended practice roles provide important career structure opportunities that allow nurse to retain significant patient contact (Duffield 2007; RCN 2005; Silver 1985) and enable ownership and authority over nursing/midwifery practice (Kramer et.al.2008).

The career structure as a professional governance framework, becomes a critical instrument in the sustainability of the nursing and midwifery professions and in workforce recruitment and retention. The high multiple costs of the impact of nurse turnover on patient, nurse and system outcomes have been systematically reviewed and widely reported (O'Brien-Pallas, Griffin, Shamian, et.al. 2006; Duffield & O'Brien Pallas 2003). Where reliability in the supply of nurses and midwives is a concern, the development of advanced practice roles is a way to increase recruitment and retention rates by enhancing career prospects in the professions (MacDonald-Rencz & Bard 2010).

Nurses and midwives are less likely to leave their professions where they experience satisfaction with career development, role autonomy, and recognition for the value of their expertise (Chiarella, Hardford & Lau 2007; Takase, Maude, and Manias 2006; Buchan 1999). This is reported as increasingly relevant in career structure recruitment strategies for generation X and Y nursing workforce (Brewer et.al. 2010). Clinically proficient, mature nurses are known to seek out work environments that foster professional practice, which includes shared decision-making and attractive career pathways (Laschinger et.al. 2007).

Dissatisfaction with career progression and professional development opportunities have been tracked in longitudinal studies of Queensland nurses in *Your Work. Your Time. Your Life.* (Hegney, Eley & Francis 2011). A career structure that acknowledges and rewards the advancement of clinical practice and leadership is an important facilitator in retention

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(Mullen 2011; Chiarella et.al. 2007). The message from the literature for expert clinical nurses is to grow them, and hold them (Spivak, Smith & Logsdon 2011).

A universal theme in clinical leadership literature, is the early identification of nurses and midwives with the abilities and qualities and preparation for leadership through clear career structures (Cook 2001, p.40). This includes 'associate' leadership roles in discrete functional areas such as management, education, and research. Other role terms likened to the associate role development are cited as 'link', 'portfolio', or 'resource' nurse (Heals 2008). For Queensland nurses and midwives, this leadership role is currently formalized at Clinical Nurse (RN/RM Grade 5) classification.

Irrespective of title, these roles are examples of advanced practice in improving practice and facilitating change, dissemination of current and evidence-based knowledge, improving communication between clinicians and specialties (Byron, Moriarty, & O'Hara 2007). The associate roles are important for continuity in the ward/unit leadership team across all days of the week and most times of the day (DoH, SA 2006, p.4). The associate roles provide development and a well prepared recruitment pool for more advanced leadership roles.

Duffield et.al. (2006) explored the use of skilled nursing personnel in public hospitals in New South Wales, comparing registered nurses and clinical nurse specialists (CNS). Findings reflected a trend for the CNS to be engaged in more managerial activities than direct clinical nursing with the authors questioning if this was the best use of an expert clinician. The study identified concerns about nursing work left undone (by nurses), and nurses doing work better done by others, such as clerical staff (2006, p.40).

The Grade 6 and 7 clinical roles currently are experiencing significant work intensification, compounded by difficulties in securing sufficient quarantined time 'off line' to complete their role responsibilities (Byron et.al. 2007). It is important that unpaid time is not relied upon for CNS and others, to achieve their role. The CNs in acute hospital settings are pivotal in leading practice standards at the bedside, coaching and skills development, and leading others in practice development (DiCenso 2010).

In rural settings, the graduate may be the only registered nurses on duty and in charge, requiring practice of leadership and some management tasks as an integral part of their role. These clinical nurses tend to advance as expert generalists. Bushy (2002) illustrates the need for effective clinical leadership for rural nurses being 'expected to wear many hats" while being 'effective team players" (2002, p.109).

In the context of nursing and midwifery workforce shortage, there is at the same time, an increased demand for nurses and midwives with enhanced skills who can manage a more diverse, complex and acutely ill patient population than ever before (Duffield, Gardner, Chang, et.al. 2009). Advanced practice nurses are critical for the future, provide cost-effective care and are highly regarded by patients/clients (Duffield et.al. 2009, p.55).

Public policy response to health workforce planning in light of whole of health-workforce shortage and these complex demands on health service delivery requiring inter-professional collaboration and role boundary spanning can be tracked across decades of inquiries, reports and workforce planning documents. Strategic focus for nursing and

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midwifery is captured, for example, in the *National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015* (Commonwealth of Australia 2011); Royal College of Nursing research reports (2004-2010); Duffield, Gardner, Chang et.al. 2009; Chiarella et.al. 2007; *Liberating the Talents* (NHS, UK 2002 in Ewens 2003), *The Patient Profession* (Commonwealth of Australia, 2002).

The current Queensland Health Clinical Workforce Policy directs the development and maintenance of a skilled, sustainable and flexible clinical workforce, that is responsive to changing service delivery models and meets health care needs of Queenslanders." (QH-POL-333, 2011). Specifically, current interest in advanced and extended nurse/midwife clinician role development is related to national health reform agenda and agreements (COAG, 2011). Intentions to improve role satisfaction, recruitment and retention of nurses and midwives are explicit in all strategic orientations and domains of national and state clinical workforce planning. The range of expected nurse/midwife workforce expectations summarized from policy documents includes, to:

- influence and carry sweeping reforms of health care;
- work across boundaries within flattened management hierarchies;
- improve quality of care within clinical Microsystems;
- improve recruitment and retention of nursing/midwifery workforce;
- co-ordinate care for patients in increasingly complex health care systems; and
- intervene to prevent patient harm from medical errors.

Benefits and health policy implications for extending and advancing practice for nurses and midwives are identified (Baernholdt & Cottingham 2011, p.77):

- reduction of health care costs, particularly in the context of national health care system;
- improvements in existing patient safety and quality of care indicators and development of new indicators such as care coordination;
- increased nurse satisfaction and retention; and
- consolidation of scope of practice and education of all advanced practice nurses.

Advanced practice engages nurses and midwives in the political arena, and prepares them to analyse existing health policies and develop strategies to influence them (Hamric et.al. 2000). The interest in achieving maximum job satisfaction for nurse and midwife clinicians through the provision of a strong clinical career path and thus optimum retention of expert clinical nursing and midwifery personnel in the health workforce is well established (Chiarella et.al. 2007, p.10). From satisfaction to retention is a recurring theme in formalizing recognition of advanced practice in professional nursing and midwifery career structures.

4.4 Advanced Practice - Role Development

Advanced practice is specialized practice grounded in knowledge that comes from diverse theoretical foundations, experience, and research. It necessitates multidisciplinary partnerships with health system stakeholders as well as substantial autonomy and

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accountability. It requires the integration of specialization and the expansion of nursing and midwifery roles (Chiarella et.al. 2007; Gardner et.al. 2007). Clinical specialists lead, drive, and support quality improvement, and increase service productivity and effectiveness (Mullen et.al. 2011, p.280).

The path in the legitimizing and recognition of expert clinical knowledge tracks the breakthroughs over the past twenty (20) years, providing an impetus for viewing optimistically, the future of clinical nursing and midwifery practice. These are the transfer of nurse/midwife training from the traditional hospital-based to university education; advances in the education status for nurses/midwives practicing in the clinical setting, scope of nursing practice regulation, and legislative change. (Pannowitz 2008, p.91). Scope of Practice frameworks (Nursing and Midwifery) have been published by the newly established Nursing and Midwifery Board of Australia (NMBA 2010).

Chiarella reports that the first Practice Improvement Roadshow Report "is a testimony to the impact nurses and midwives can have on clinical care delivery and redesign - the result of 20 years of university education for nurses." (Chiarella 2005, p.ii). Gardner et.al. (2007) conclude that to ensure longevity of advanced practice roles, there is need for commitment from governments to provide adequate funding and resources to support the roles, robust evaluation processes grounded in approved standards of practice, and comprehensive corporate and clinical governance strategies in relation to the position.

Chiarella (2004, p.16) attests that the multiple reform agendas do not operate on a level playing field and that nurses compare as less powerful in asserting their occupational claims than other groups. The issue is larger than handing over a number of what might be considered lower-order tasks (or picking up lower-order tasks of others) as it goes directly to nursing's capacity as a profession to name its work unambiguously, and to control that work sufficiently to meet its accountabilities according to its professional mandate.

Australian States and Territories vary in titles adopted for nurses and midwives recognised in advanced practice roles and the formative levels from which this recognition begins. Examples include clinical nurses (CNs/CMs), clinical nurse specialists (CNS/CMS), Clinical Nurse Consultants (CNC/CMCs), Nurse/Midwife Practitioners (N/MPs), Care Co-Ordinators/Service Co-Ordinators, Advanced Clinical Facilitators (Appendix 4). These career structure roles are yet to be to be fully utilized and integrated into the health system to the full potential, across the continuum of health care. This is despite the substantial body of research evidence demonstrating their safety, effectiveness, efficiency, and responsiveness in meeting the complex needs of various system stakeholders, including patients, communities and service delivery teams (Chiarella et.al.2007).

These are roles that align with current and emerging population health and system needs, and roles that are designed to meet criteria developed through broader national and international frameworks. Advanced practice in functional support roles for direct clinical care providers are also recognised in Australian nursing and midwifery career structuring, and include for example, Clinical Facilitator, Advanced Clinical Facilitator, Clinical Teacher, Clinical Educator, Advanced Clinical Educator, Researcher and Advanced Researcher,

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Nursing Advanced Practice Director – where the function of the role is teaching and/or research and/or formal management of advanced practice and practitioners.

Sayers and DiGiacomo (2010) examine the role of the hospital-based nurse educator identifying the need for role clarity, a defined career pathway and support for professional education and development. Hospital based nurse-educators are recognised as experts in the educational process, facilitators of learning, mentors and inspirational clinical leaders for nurse clinicians and health staff (Conway & Elwin 2007). Clinical leadership, education support for nurses and midwives, and the advancement of research coalesce to produce synergies leading to better outcomes, and enhanced patient experiences (McDonald-Rencz & Bard 2010). The necessary condition of intra-professional **negotiation** to realize functional role clarity and success in role outcomes has been fore-grounded by (Eager, Cowin, Gregory et.al. 2011).

The concepts of role specialization and role expansion have been widely discussed in relation to advanced practice (Hardy & Snaith 2006). Clear articulation of scope of practice where lack of clear role definition, boundaries and expectations can cause role ambiguity (Eager et.al. 2010; Nutt & Hungerford 2010; Duffield, Gardner, Chang et.al. 2009, Gardner et.al. 2007). Developments have been positive in role clarification of advanced practice roles, for example, Gardner et.al. (2007) report the differentiation in the breadth of knowledge and skills of the advanced practice nurse, in contrast with the more in-depth, and focused clinical application demonstrated by nurse practitioners.

A defining feature of advanced practice is the central competency of direct clinical practice (Hanson & Hamric 2003). However, the core components are shared across articulated practice, consultation, collaboration, education, research and leadership. Advanced practice roles are situated in specific practice areas defined in terms of a population, setting, disease or medical sub-specialty, type of care, complex problem or particular 'patient journey' (DiCenso et.al. 2010). Competency standards for the advanced registered nurse are catalogued within three (3) domains of conceptualising practice, adapting practice, and leading practice (ANF 2005, p.12-14). QH has published a comprehensive governance framework including role statements, practice scope and outcomes for the Nurse and Midwife Practitioner (QH, N&MO 2011).

Table 4. Queensland Health Current Employment of Advanced Practice Nurses and Midwives

Position	Number
Enrolled Nurse Advanced Practice	457
Clinical Nurse	6,987
Clinical Nurse - Midwife	446
Nurse Educator	375
Nurse Educator – Midwife	3
Nurse Researcher	58
Midwife Researcher	0
Clinical Nurse Consultant	1,219
Clinical Nurse Consultant -Midwife	12
Nurse Practitioner Candidate	25

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Position	Number
Nurse Practitioner - Midwife	1
Nurse Practitioner	108

SOURCE: QH Monthly Workforce Profile/Headcount, September 2011,pp.13-14

Priority enablers for advanced practice roles are leadership support (Reay et.al. 2003), full funding and remuneration to match responsibilities and inter-professional collaboration (DiCenso et.al. 2010; Chiarella et.al. 2007; MacDonald et.al. 2005). A key challenge is organizational understanding of the roles (Mullen 2011).

There is no shortage of research affirming the positive impact of advanced and extended nursing and midwifery practice. Findings on the Clinical Nurse Consultant (CNC) role demonstrate the role as complex and diverse, with scope and purpose of the CNC role being **underutilized,** in relation to leadership where they can challenge existing practice and guide future directions in care delivery (Bloomer & Cross 2010). In their Victorian Study, Bloomer and Cross (2010, p.68) find that CNCs are underutilized as nurse leaders, and lacked support systems to enable their role to meet the workplace demands, to challenge existing practice, and to guide future directions in care delivery. The authors note the need for strategies to address the issues of power/powerlessness and leadership, along with improvement in support systems available to CNCS to support role success, satisfaction, and retention.

Specified practice domains of the CNC role are clinical service and consultancy, clinical leadership, research, education, and clinical services planning and management (Bloomer & Cross 2010, p.62).

Roles demonstrate effectiveness in improving health services at the point of access, continuity and coordination of care, and support for patients and carers. Advanced clinical roles are about direct clinical practice and most efficient use of nursing resources (Chiarella et.al. 2005).

The CNC role in New South Wales emphasizing activities in the clinical, research, education

and professional domains, is well designed to prepare nurses for this important clinical leadership role (Davidson 2007, p.185). In a report on the evaluation of Nurse/Midwife Practitioner and Clinical Nurse/Midwife Consultant Roles (Chiarella et.al. 2007) recommendations were made for clarification of a comprehensive and coherent **clinical career path** for senior clinical nurses and midwives, workforce planning, and workplace infrastructure directed at keeping clinical expertise and leadership at the clinical interface (Chiarella et.al. 2007, p.9). Career paths were reviewed and complemented a Work Value Case at the time, conducted by the New South Wales Nurses Association in relation to clinical career structure.

There is an expansive account in the literature of the development and role effectiveness of the Nurse Practitioner (NP) (DiCenso et.al. 2010; Chiarella et.al. 2007; ANF 2005). The NP demonstrates professional efficacy, enhanced by an extended range of autonomy that includes legislated privileges. NP practice is dynamic, involving the application of high

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level clinical knowledge and skills in a wide range of contexts (Carryer, Gardner, Dunn et.al. 2007, p.1818).

The significance of advanced practice nursing research is made explicit in work generated in innovative models of nursing and midwifery in health service delivery. An overriding consideration to ensure optimal health care delivery to patients in the future is a systematic research agenda to determine and evaluate appropriate and effective models of care.

The QH/QNU (EB7) project, Models of Nursing and Midwifery has given attention to an ageing workforce and a projected undersupply of nurses and midwives by 2017 in the project "to utilize and develop all levels of the nursing and midwifery workforce" (NMOQ 2011, p.1). Consistent with the NSW Health work in practice development, the Queensland project is about positioning nursing and midwifery for the future and generated by strategic responses to recruitment and retention challenges.

The QH and QNU Nursing and Midwifery Implementation Group (NaMIG) has formulated recommendations for Models of Nursing and Midwifery in contributing to the Nurses and Midwives Enterprise Agreement process (QH/QNU NaMIG, 2007-2011). These are principled guidelines for enabling clinical leadership in service delivery models that reflect, for example, increased autonomy and accountability in a diversity of practice contexts, and with a diversity of professional roles and skill mix. Models are demonstrated in chronic disease management; primary care options; integrated hospital and community; patient flow initiatives; interdisciplinary team leadership; partnership management; and nurse and midwife-led services.

In New South Wales Health, Duffield and Lau (2006) highlight innovative practices by nurses and midwives across the State. Nurse and midwife- led health services are celebrated in evaluations, as significant indicators for roles in direct expert clinical care, access to direct comprehensive care, support of systems, professional leadership, education, and research (Gardner et.al. 2007). Midwifery led services, including free-standing birth centres have been significant developments out of Australian maternity services reviews (Newnham 2010). Formal recognition of funding-eligible midwives has meant new possibilities for a modernized career structure for midwives.

Innovative practice modeling is underpinned by practice development. This is understood as a systematic process with the intended outcome of improving the patients' experience, by helping nurses and teams to develop the knowledge and skills to enable them to transform the culture and context of care (Boomer & McCormack 2010; Chiarella 2007). Chiarella (2007) advocates practice development and an ethos of collegial generosity to embed innovation and creativity in advancing responsive, and effective models of nursing and midwifery. This philosophy continues to affirm the links between advanced nursing and midwifery practice, role flexibility and development in career structure progression, and workforce retention.

The *Models of Care* work in New South Wales Health (Chiarella 2006-2010) has been translated into *Ways of Working* (WoW) to assist nurses in organizing their clinical work. It is a project introduced into NSW Health (NaMO 2010) directing support for nurses in order to grow the workforce of the future by improving the work environment and

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organization, collaboration, and communication (NSW Department of Health 2010). Guidelines are included for the implementation of Clinical Nurse Manager role within clinical units. This demonstrates the flexibility of the career structure in responsiveness to identified needs, in this case, in **retention** of nurses in New South Wales.

4.5 Conclusion

The findings of the literature review on advanced nursing and midwifery practice reflect recurring themes linked to strategic interest and responses to nurse and midwife recruitment and retention challenges. The literature affirms the re-valuing and investment benefits of clinical leadership, the connection between advanced practice, dedicated career path progression, job satisfaction and nurse/midwife retention, and the benefits of structured advanced practice role development.

This section wraps a substantial evidence base around the QNU Career and Classification Structure Objectives (2011) and the QNU Policy on advanced practice nursing (2011) identified in Section 1.

Increasingly, professional groups are working together to develop innovative models of care that can address current and emerging healthcare gaps and in sustaining nursing and midwifery workforce retention. Improved health service productivity through integration of advanced practice clinicians is dependent on successful role development and implementation. This is where clarity and consistency in career structure positions are important in realizing the full contribution of advanced nursing and midwifery practice in sustainable, accessible, quality health care.

Clinical practice is the key to self-governing, professional practice, and must be positioned to meet the demands in the current context of health service reform. This underscores the importance of emphasizing and formally recognising expert nursing and midwifery at all levels, and in all streams of the career structure.

The next Section details outcomes of the QNU Grade 7 member consultation rounds.

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5 QNU Member Consultation

5.1 Introduction

This section will outline the QNU N/MUM Project 2011 Consultation Framework and approach designed to meet the QNU N/MUM Project 2011 Objectives. This is followed by the findings. These are presented in coloured summaries for immediate accessibility, and supported by discussion in further detail in subsequent sub-sections.

5.2 Consultation Framework

The problem statement, represented as a Position Picture (Appendix 1) was generated for testing known and published concerns of Grade 7 QNU member nurses and midwives and others, in relation to role and career structure matters in the public sector, Queensland. The confirmed elements of the Position Picture are:

- Span of Control,
- Role Responsibilities,
- Role Enablers and Supports,
- Role Preparation, Recruitment and Retention.

The Position Picture was confirmed by:

- Summary review of the QNU evaluations of the nurses' and midwives' Career Structure (public sector) Queensland, 1991-2011 (Appendix 2),
- Review of the work reported at QNU annual conferences by the Industrial and Professional Policy Committee (QNU: IPPC, 2011), and
- Focus groups conducted over the period of the QNU Annual Conference (July 2011).

5.2.1 Consultation Methodology

Questions emerged from the Position Picture which directed the consultation approach. Surveys in addition to focus groups were identified as best method match.

Survey was determined as the preferred method to accommodate member voice across the state with selected focus groups in metropolitan and regional sites. Two surveys were designed and piloted over three weeks with approximately forty (40) members, with amendments made (August 2011). The questions prepared for consultation by survey and focus group emerged directly from the Position Picture (Question Grid, Appendix 5).

Electronic survey number 1 (e-Survey #1) selected for Grade 7 Nurse and Midwife Unit Managers (Appendix 6).

Electronic survey number 2 (e-Survey #2) selected for Grade 7 nurses and midwives (not unit or service managers), such as Clinical Nurse/Midwife Consultants, Clinical Coordinators, Clinical Leads/Project Management, After Hours and Functional Nurse/Midwife Managers, Nurse/Midwife Educators, Clinical Facilitators and Nurse/Midwife Researchers (Appendix 7).

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Survey management was facilitated by *survey-monkey* software with hard copies generated for postal mail-out. Surveys returned by this method were included in the electronic data base held at QNU office.

Member sampling was directed accordingly to nurses at Grade 7 level and clinical nurses with experience in the Grade 7 roles.

The QNU membership data base was sourced for direct e-mail and direct postal mail for those members identified in the data base by position title across Grade 7. Snowballing contact occurred thereafter with additional distribution via QNU organizers across regions and cities of Queensland. Survey responses indicate a wide coverage of Grade 7 membership including metropolitan, regional, rural and remote.

Data collection continued to accommodate maximum member voice before closure of the e-mail communication and completion of selected focus groups, October 15, 2011.

The following tables present the QNU Nurse/Midwife Member respondents reflected by category of the Grade 7 Employees, Queensland Health September Monthly Workforce Profile) The distribution of respondents in the Grade 7 cohort for e-Survey #2, is reflected directly in the cohort distribution of employees recorded by QH. This invests in data reliability in terms of member voice, for example, educators, clinical nurse consultants, and nurse managers (not M/NUMs) as representative in close to identical proportion with QH employed numbers.

A total of 330 completed e-surveys were received, and 280 consultations by focus group participation were achieved making total participation in consultation rounds of 610 Grade 7 nurses and midwives. The triangulation of methods further invested data reliability in terms of being able to cross-check data from multiple member sources.

Table 5. Results Grade 7 Registered Nurse and Midwife Employees

Grade 7		Grade 7	
Nurse Unit Managers	852.10	Clinical Nurse Consultants	1089.07
Nurse Educators	349.86	Nurse Manager	317.57
Nurse Practitioner Candidates	11.26	Nurse Researcher	64.67
Other Grade 7s	20.61	Public Health	26.00
Total NUMs	**852**		
Grade 7s (not NUMs)	**1929**		
All Grade 7 RNs Total	**2781**		

SOURCE: Queensland Health September 2011 (Monthly Workforce Profile)

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Figure 1. Queensland Health 2010 Grade 7 RNs

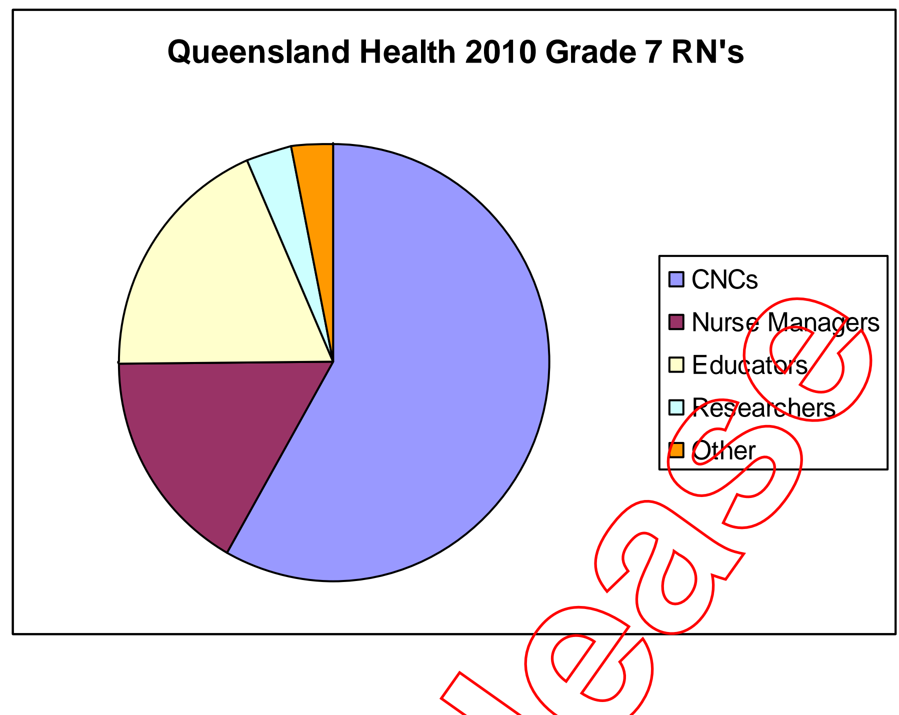

Table 6. Results Grade 7 Registered Nurse and Midwife QNU Member Respondents, QNU e-Surveys 1 & 2

Grade 7 Respondents e-Survey			
Nurse Unit Managers	138	Clinical Nurse Consultants	101
Nurse Educators	39	Nurse Manager	36
Nurse Practitioner Candidates	2	Nurse Researcher	7
Other Grade 7s (Caseload Midwives, Project Officers)	6	Public Health	2
Total NUMs	**138**		
Grade 7s (not NUMs)	**192**	***All Grade 7 RNs Total***	**330**

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Figure 2. e-Survey #2 Grade 7 RNs

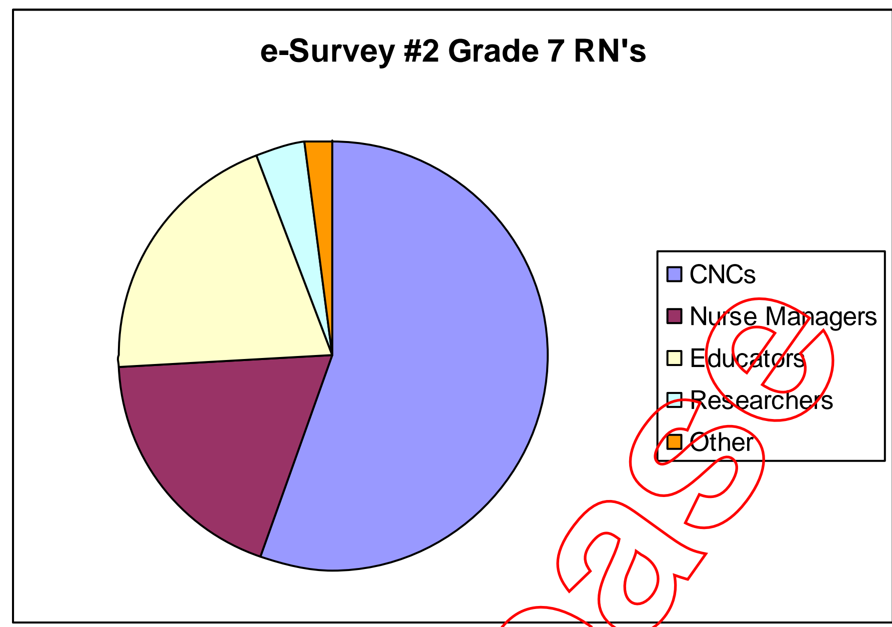

Table 7. Results: Grade 7 QNU member Nurses and Midwives, Consultation Method

Consultations		Surveys (e-survey)		Total Consults
Focus Groups				
- QNU Conference x3 sessions (July)	58	- Nurse Unit Managers	138	
- Midwives (July)	18	- Grade 7 RNs/Clinical/Res/	192	
- Toowoomba (Aug) x2 sessions	38	Education/Others		
- Rockhampton (Sept)	13	(Sept-Oct)		
- Townsville (Sept)	34			
- Nambour (Sept)	13			
- QNU Organisers/Others	12			
- Council (QN/ANF)	18			
- PAH (Sept)	24			
- RBH (Sept)	36			
- Postals + e-mail consults	16			
Total	***280***		***330***	610

5.2.2 Tests for Reliability of Findings

Efforts were made to ensure data were free as far as possible, from author bias and that confirmability and replicability of the study by others remained a possibility. The decision trail regarding question generation, response coding and the making of connections between codes, is transparent and readily auditable. Focus group transcriptions were undertaken and confirmed by the second facilitator (QNU Officials).

QNU member-respondent checking will be undertaken selectively through draft publications, and member e-mail reporting.

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Various means of data checking have been applied to ensure the findings make sense to the respondents and to those who read this work. Internal validity and authenticity have been considered. Project Steering Committee members and other QNU officials/professional officers were shown the codes and the audit trail. It is anticipated that as the report is discussed further at QNU Council and other member groups, that the account subsuming all the respondents' views will be further tested and critiqued.

The understandability and usefulness of the study have been evaluated by the Project Steering Committee and will be further confirmed by QNU Council and member-respondents.

Data have been treated with sufficient rigor to be considered transferable to other contexts. The respondent sample is clearly identified, along with the career structure roles, settings and coded responses. It will be possible for the readers of the findings to assess transferability to other contexts of career structure development for nurses. This may have relevance for other Australian State and Territory Branches of the Australian Nursing Federation (ANF)

Limitations

The study limits are delineated in the statement of project scope and objectives. The time frame of (14 weeks) compressed some activities, however, the consultation framework has been evaluated as effective in meeting the objectives of the project.

Ethical Considerations

No member-respondent is identifiable on questionnaire data sought and received. No respondent identified themselves on surveys submitted. Focus group members are identifiable. All e-mail respondents in direct contact with the author are identifiable. However, no individual is identifiable in the reported data. Members were assured that their feedback would be integrated into the report without means of personal identification. Data have been stored and secured at QNU office, with copies held and secured by the author.

Treatment of Data

Activities of survey distribution, collection and management of individual member needs, and focus groups were undertaken over twelve weeks (August-October 2011).

Data treatment commenced from 10 October 2011. This applied to survey responses by means of electronic *survey-monkey* software, which included all completed hard-copy responses received; and transcribed focus group summary information.

Data were categorized to match question codes nominated from the survey structure and generated from the original Position Picture.

A number of respondents completed information at each question that did not entirely match the code for that question. Question categories or codes interconnected. Cross-referencing to a number of codes was done to ensure analysis according to the respective coded question themes. A number of N/MUMs completed e-Survey 2 and a number of Grade 7 members (not N/NUMs) completed e-Survey 1. Data were cleaned accordingly prior to analysis. Vivo coding (using the actual words of respondents) was used in the report of findings.

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The following sub-section presents an aggregated Summary of Findings for immediate reference.

5.3 Summary of Findings

Summary 8. Shared Findings : All Grade 7 Nurse and Midwife Respondents

Each of the following statements is shared across the two cohorts of Grade 7 Nurse and Midwife Respondents. Grade 7 Nurse and Midwife Respondents:

support advanced practice roles across all career structure streams as key drivers to nursing and midwifery recruitment, retention, and leadership succession planning;

are concerned for future workforce sustainability given the recruitment and retention challenges caused by inadequate career advancement opportunity (numbers of positions available, insufficient classification grades) at Grade 7 , and for nurses earlier in their careers, at Grade 5 and Grade 6;

support advanced practice roles across all career structure streams particularly for CNs in the 'gap' between Grade 6 and Grade 7;

support recognition of differentiated levels of advanced skill across all career streams, for example, Grade 7 Unit Managers, Educators, Researchers, and Clinicians;

identify concerns with accountability at unit level, where one or more Grade 7 nurses are assigned, and where workloads between Grade 7's are variable;

identify serious concerns regarding structured empowerment capacity of their line managers and themselves, in meeting their position responsibilities;

identify concerns with parity considerations for purposes of role recruitment and retention; recognition, career structure classification (grading and banding), and remuneration of Gr 7 roles across each of the four (4) career streams, in relation to :

levels of role span (complexity and responsibilities), for example, clinical, human and financial resources management;

recognition of knowledge/expertise required in the role, for example, advanced practice as manager, clinician, educator, and researcher;

practice context, for example, isolated or sole practitioner, level of professional/other supports, and level of practice autonomy; and

anomalies that still exist.

identify concerns with insufficient clarity in role responsibility and authority;

prioritise clinical supports by way of well developed clinical infrastructure over administration officer (AO), emphasizing that AOs are insufficient if the only support for N/MUM;

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confirm the need for business systems supports with wide support for adequate human resources in recruitment, and workforce stability;

confirm that reasonable work hours flexibility is essential for work-life balance in light of respective role workloads and responsibilities;

identify importance of line management visibility, support, recognition, and inclusive leadership style;

confirm that structured role preparation and in particular mentoring, for all streams of Gr 7 role succession planning are essential, and that role preparation is currently under-resourced.

Summary 9. Findings : Grade 7 Nurse/Midwife Unit Managers Report

Grade 7 Nurse/Midwife Unit Managers report:

significant levels of job dissatisfaction related to too- wide span of control, expanding and compressed workloads, insufficient valuing of the position reflected in inadequate role support;

position descriptions that are too generic and lacking role differentiation;

significant levels of structural disempowerment and diluted authorization related to budget management, specifically, the Business Planning Framework for Nursing and Midwifery Workloads Management;

significant level of concern for inadequate nursing and midwifery governance, structurally and functionally within their organization and which impacts negatively on the effectiveness of their organizational role;

serious deficits in managerial role support as: dedicated administration officer, and business support, particularly human resources and recruitment support;

serious deficits in clinical role support as: day-to-day unit clinical leadership presence and support for clinician practice and development; research and service improvement;

capacity to influence models of nursing and midwifery realized where clinical infrastructure is adequate (CNCs, Researcher); where models are cost neutral; and success where senior management support is direct and consistent;

support without reservation, for recognition of advanced clinical practice in direct patient care and in clinical leadership role succession planning;

high level satisfaction where hours are flexible and work-life balance is manageable;

consistent and unreasonable amounts of unpaid overtime;

most important role enablers are early mentoring, support from line managers, empowered line managers, authority commensurate with N/MUM role responsibilities, appropriate clinical and managerial supports;

structured /resourced peer support as key to survival and development;

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most important role preparation is in programs and courses that incorporate and value their professional expertise and relate to their professional practice context.

Summary 10.Comparative Findings : Grade 7 Nurses/Midwives and N/MUMs

Grade 7 nurses and midwives compared with Gr 7 Nurse/Midwife Nurse Managers

are more satisfied with their span of control and empowerment structure than are midwife/nurse managers;

are more satisfied with their perceived level of autonomy and capacity to get things done (role empowerment);

experience more variability in reporting relationships, with more often having more than one higher report;

report less professional isolation than do N/MUMs although all Grade 7 nurses identify structured peer support as important;

have more perceived capacity to influence models of care and practice;

are more satisfied than N/MUMs with the reality match of their position descriptions while sharing with N/MUMs concerns that scope, complexity, expertise, role change, role overlap, differentiation, and authority of their respective roles are not adequately reflected;

experience less manifest lack of recognition, understanding of their roles and excessive role expectations by senior management as a key dissatisfier;

are equally equivocal about the value of an Administrative Assistant for the NUM [than N/MUMs) reflected in statements that clinical support including acting N/MUM roles would be more beneficial. Where AO's are supported for N/MUMs , Grade 7 nurses consider that AO support is important in contributing to their role effectiveness as well;

experience significantly more satisfaction with work hours flexibility;

report role attractors as autonomy, capacity to influence outcomes, and flexible hours;

record shorter role tenure in 10-20 year period than N/MUMs' tenure in that period; and marginally higher (4%) levels of equivocation in staying in role, than N/MUMs.

5.4 Results - Detailed Report With Discussion

This sub-section presents more detailed tables catalogued in line with each of the Position Picture themes (Appendix 1):

Span of Control,

Role Responsibilities,

Role Supports and Enablers,

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Role Preparation, Recruitment and Retention.

A general description of the QNU Member Nurse/Midwife respondents introduces the results tables.

5.4.1 General Description of QNU Member Nurse/Midwife Respondents

Role tenure of Grade 7 Nurses and Midwives is predominantly five (5) years or less with longer tenure ten (10) years or more, for N/MUMs. Intention to stay in the role for N/MUMs is influenced by retirement planning (stay), looking for promotion and studying for nurse practitioner advancement (no intention to stay in current role). Equivocation in intention to stay is similar (less than 10 per cent) across the two cohorts.

Diversity of practice contexts identifying the remarkable range of specialization is tabled.

Table 8. Results Description of Nurse and Midwife Respondents

	Time in Current Role	N/MUMs n = 138	Grade 7 n = 192 RNs /Clinical/Education/ Research/Others	Total
	0-3 years	36%	45%	
	3-5 years	26.5%	26.8%	71.8%
	5-10 years	18%	14.6%	
	10-20 years	13%	11.6%	
	20+ years	6.5%	2%	18.2%
Acting in Current Role		**7.5%**	**8.8%**	100%
Intention to Stay in Current Role		Yes: 82% No or Equivocal: 18%	Yes: 78% No or Equivocal: 22%	100%
Looking for Promotion		6%	6.25%	

Figure 3. e-Survey#1 Nurse/Midwife Unit Managers time in current role

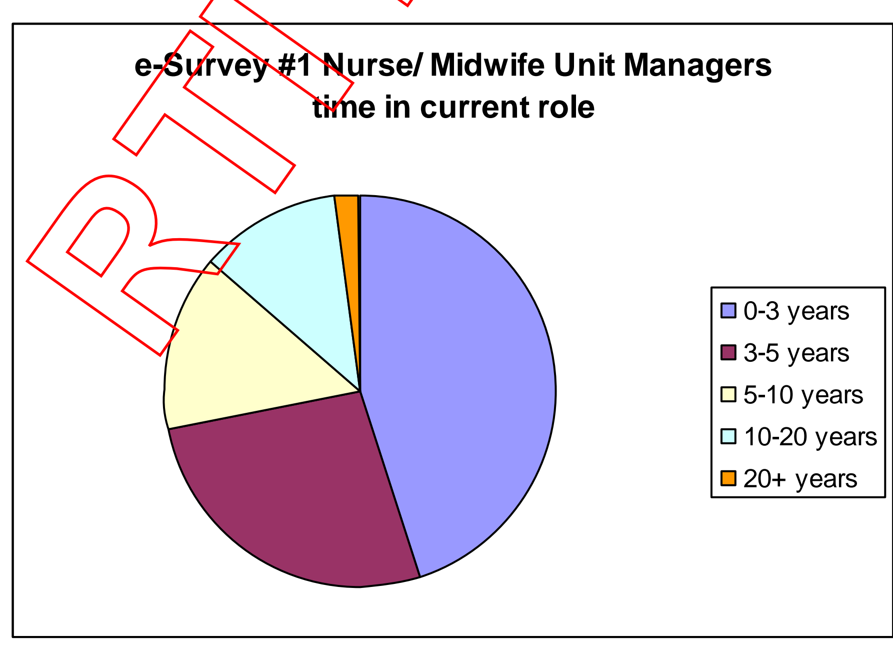

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Figure 4. e-Survey#2 Grade 7 RN's time in current role

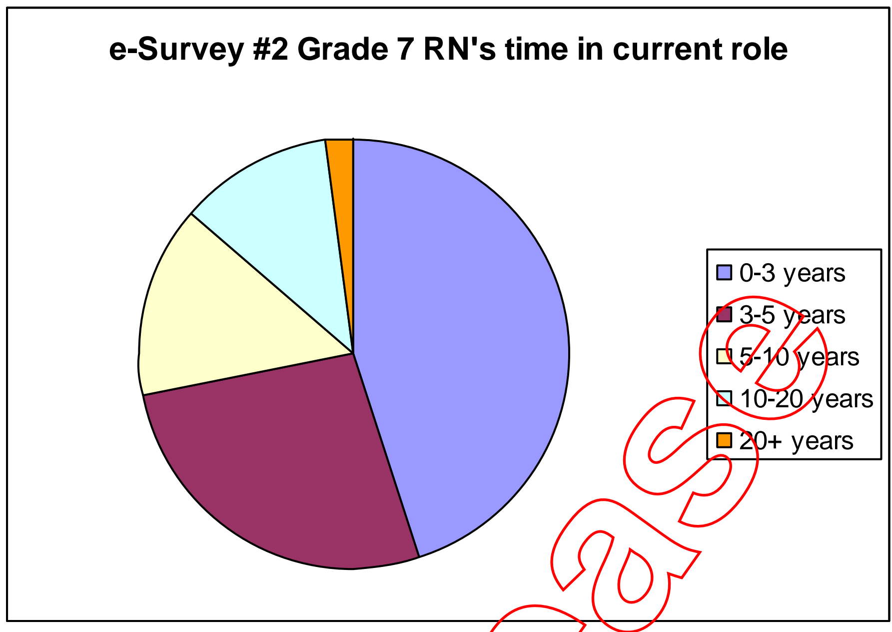

Figure 5. Intention to Stay in Current Role

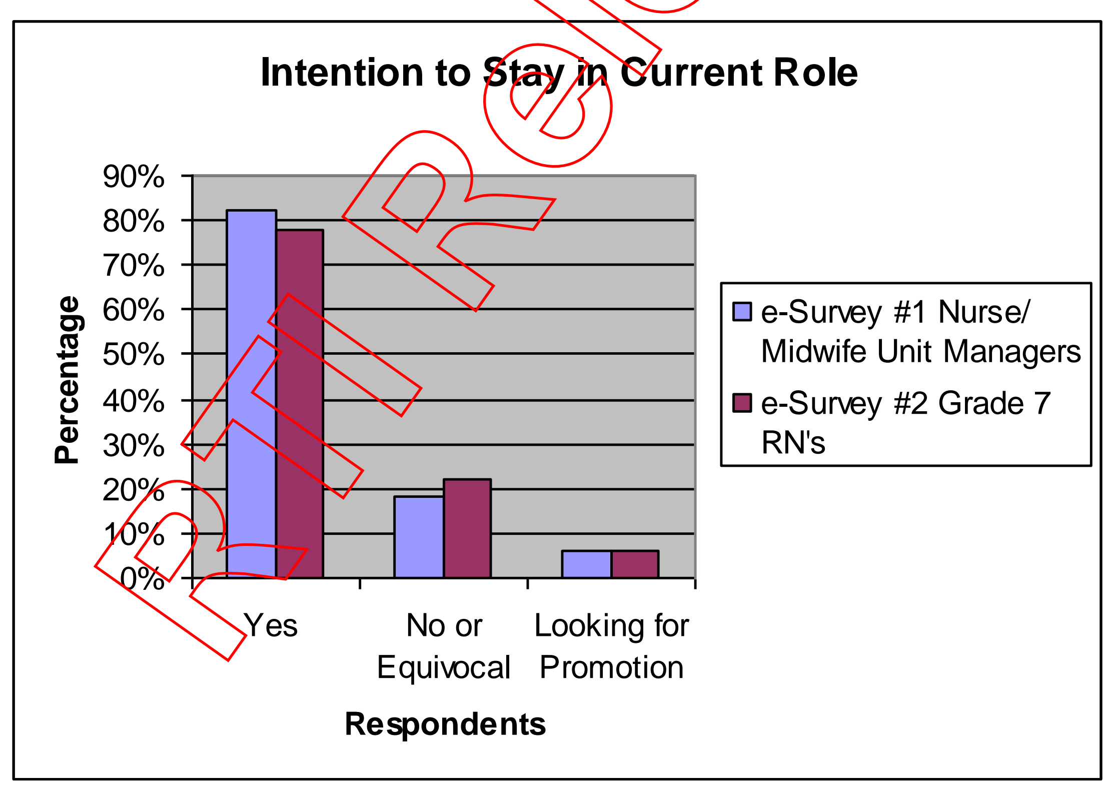

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Table 9. Results - Range of Practice Contexts – Grade 7 Nurse & Midwives (n=192)

Nurse Managers (36) (Not N/MUMs)	Research & Education	Clinical Nurse Consultants (104)
Equipment; Resources; Beds; Human Resources; ' Workforce, Products; Operations; Quality; Policies; Informatics/ BPF; Safety & Quality; Clinical Service Improvement; Community Health; Patient Flow; Duty Manager; After Hours; Consumer Engagement & Complaints Management; Project Officer; Projects & Policy.	Nurse Researchers (7) N/M Research; NM Clinical Research; Nurse Researcher Evidence Based Practice. Nurse Educators (39) Staff Development; Intensive Care; Emergency Care; Midwifery.	Public Health; Caseload Midwifery; Orthopaedic Co-Ordinator; Peri-Operative; Cardiac Rehabilitation; School Based Youth Health; Mental Health; Mental Health for Children in Foster Care; Gastro-Enterology; Trauma Care; Emergency Response; Rehab. & Manual Handling; Paediatric Emergency; Bone Marrow Transplant; Forensic Liaison; Women's Health; Mental Health Intervention; Pharmacy; Resuscitation Co-Ordinator,; Diabetes Educator; Bowel Cancer Screening; Early Detection and Screening for Breast Cancer; Intensive Care; Tuberculosis Control; Paediatrics; Sexual Health; Emergency; Wound Management; Team Leader HP5 Mental Health; Child & Family Health; Cardiology; Rural Facility; Contact Tracing; Haemophilia; Rehabilitation; Cancer Care; Infection Control, Heart Failure. Nurse Practitioner x1 (Women's Health) Clinical Nurses x2 (Midwives) Caseload Midwives x2 Practice Nurse x1

Table 10. Results : Range of Practice Contexts – N/MUMs (n=138)

Nurse Unit Managers (138) Metropolitan, Regional, & Rural (State-wide)
Endocrinology; Surgical Services; Peri-Operative; Renal; Aged Care; Rehabilitation; Intensive Care; Orthopaedics; Medical; Mental Health; Central Sterilising; Palliative Care; Community Health; Geriatric Rehab; Acute Adult Mental Health; Maternity; Women's Surgical; Hameodialysis; Cardiac Cath Lab; Acute Care; Midwifery & Child Health; Spinal Injuries; Alcohol & Drugs; Endoscopy; Acute Respiratory; Oncology; Sub Acute; Day Surgery/Pre-Admissions; Ortho & Trauma; General Surgical; Emergency Department; Short Stay; Chronic Dialysis; Antenatal Clinic; Ambulatory Oncology; Birthing Services; Respiratory & Sleep; Medical Imaging; Neonatal; Indigenous & Nutrition Services; Ophthalmology; Dual Disability; Cardiology; Cardiac Specialist Clinics; Midwifery Group Practice; Neonatal Intensive Care; Cardiothoracic Unit; Neonatal Discharge; Older Person Mental Health; Dementia Specific Unit; Short Stay Surgical; Chronic Disease Team; Clinical Measurements; Recovery; Chronic Disease and Primary Health; Urology; Radiation Oncology; Outpatients; Palliative Care; Adult and Disability Team.

5.4.2 Nurse/Midwife UNIT Managers: Span of Control

The findings in Span of Control for N/MUMs are significant and in part, roll into role responsibilities. The findings situate evidence of role expansion, role compression, and significantly, that the role has become unmanageable.

All but 3 respondents (n=138) are dissatisfied with role span and in particular, the balance between clinical and managerial spans and related responsibilities. The (3) only respondents reporting satisfaction with a balanced role, gave the reason for satisfaction

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as clinical support, specifically, clinical nurse consultants. All other respondents report an increasing and predominant component of the role being managerial. This leads to expressed concerns about limited investment in clinical leadership, and in particular, 'time on the floor'.

There is no evidence of realistic role spans across this cohort. N/MUMs identify a range of factors in their operational environment that have widened their span and over which they have little influence to resist or modify. Restructuring with changes to matrix models has meant a widening span for N/MUMs in communication, reporting, and co-ordination work. The impost on N/MUM role of the QH payroll system failure is seriously negative with ALL N/MUMs commenting on the weight of this issue.

N/MUMs consider their position authority status as one of 'disempowerment' to a level that impacts negatively on their capacity to do their job. Responses related to the Business Planning Framework for Nursing and Midwifery Workloads Management (BPF) sharpen the evidence in this regard. Of all N/MUM respondents, 98 per cent state the BPF is not working for them or their teams. Disempowerment concerns also relate to disempowered senior nurses (line managers), and concentration of organizational power away from professional lines to managerial lines, such as the business managers.

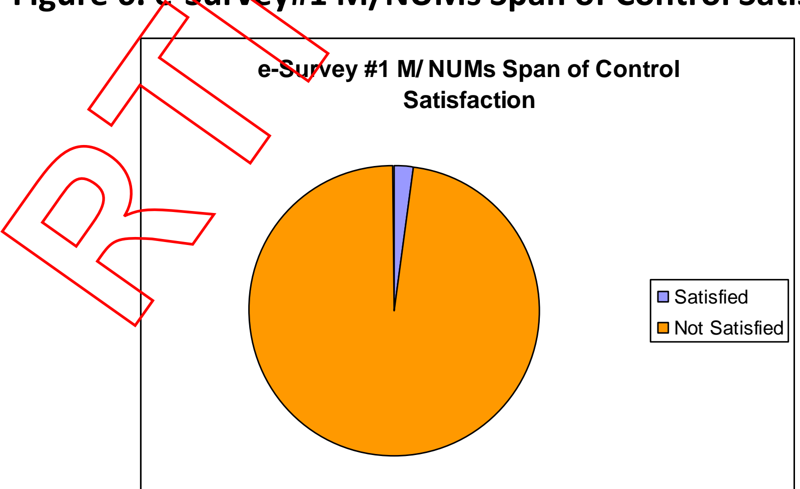
Concerns about differentiation of role spans are captured in **Table (14)** in role retention and recruitment where the N/MUM Career Structure recommendations are detailed.

The findings in span of control for N/MUMs are entirely consistent with the findings in the literature review, Section 3.3, Summary 3.

5.4.3 N/MUMs' Span of Control

Key Theme: Satisfaction with role span/ balance – clinical and managerial in success of the role; Clinical Leadership Capacity in Current Role

Figure 6. e-Survey#1 M/NUMs Span of Control Satisfaction



Discussion

3 satisfied out of a sample of 138:

> *"Fairly well balanced" (S1:#3767)*

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"I have a CNC working beside me and it works well." (S1:#1095);

"I fortunately have excellent CNs" (S1:#5792)

Not satisfied:

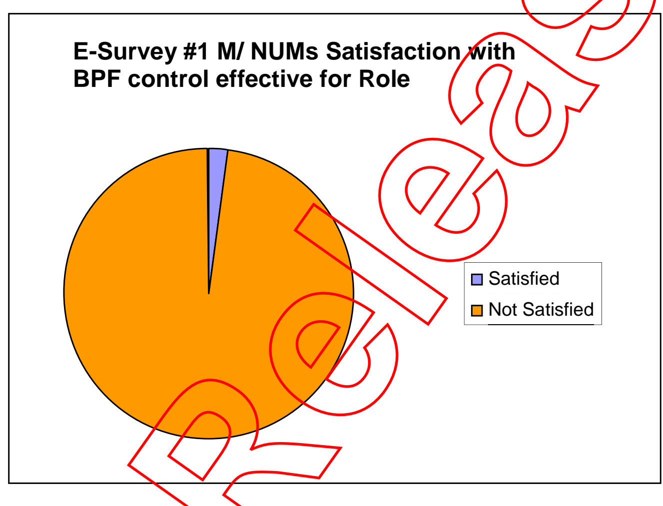
"No time for clinical. Payroll consumes many hours." (S1:#1649)

"Most days no lunch break and no overtime is approved.. we have no CNC, no clinical facilitators, and do both business and clinical.." (S1:#9807).

Key Theme: Accountability & Authority in BPF

"Exercise in futility…" (S1:#6072)

Figure 7. e-Survey#1 M/NUMs Satisfaction with BPF control effective for role



NOTE: 3 BPF works; n=138

"BPF.. isn't happening." (S1:6976)

"There is constant pressure to achieve more with less." (S1:#7728)

Key Theme: Professional Communication (matrix) effectiveness and role span

"I have good professional communication." (S1:#1281)

"This is difficult as we have NPs and CNCs all vying for roles and no one takes accountability except NUM." (S1:#5507)

Examples of Members' Statements – Span of Control

"95% management 5% clinical – this is a complete reversal of 5 years ago." (S1:#3842)

"110% admin/payroll and HR." (S1:#6072)

"20% clinical..very difficult to meet expectations of the role. Too much time required in the office and away from the clinical area." (S1:#0980)

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"The CN team now compensate for the decreased visibility of the NUM on the floor" (S1:#0302); "Without a CNC, I would find the role exceedingly difficult." (S1:#4060

"The clinical role is unfortunately disappearing..80% management." (S1:#2834)

"Poor balance..only achieve goals by working at home and unpaid extra hours." (S1:#4534)

"Crisis management does not achieve measurable outcomes." (S1:#6072)

"Clinical, 5%..very difficult to be setting service standards when not able to go out and see..what's going on."(S1:#9452)

"..Am constantly covering shortfalls in the roster." (S1:#5004)

"My job is nearly all management..very lucky to have experienced team, otherwise the clinical side..would suffer considerably." (S1:#5673)

"I have achieved positive outcomes in my area..only because of my personal sacrifice in my work-life balance.." (S1:#3315)

"Clinical is always my focus..which means everything else gets done at the end of the day." (S1:#9513)

"I have concerns that the current demands on the NUM role.difficult to maintain clinical expertise and knowledge of current best practice." (S1:#9513)

"..the role does not need changing, it just requires more support." (S1:#3524)

".. the role has changed incredibly over the past five years.. I need 2 CNCs to do now what needs to be done for my team and... patients..(FG)

"80-90% admin. Officer...clinical role is a poor second cousin." (S1:#2615)

"Need time to spend with clinicians..also need clinical time to maintain own skills. No time at present..yet the staff expect it." (S1:#6652)

"Payroll issues has meant more time required in management rather than clinical leadership." (S1:#5792)

"My role is totally business management. I rely on my CNs and Clinical Facilitator to look after clinical practice, and I only get involved when there is a safety or performance issue." (S1:#8220)

"20% clinical leadership and that is only achieved via unpaid overtime." (S1:#0414)

"You always feel as if you haven't completed anything. Jobs feel half done. It is unsatisfying and unrewarding." (S1:#4664)

"The only way I have any clinical leadership time is by offloading management on my own time." (S1:#1805)

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"I do 50:50..work on the floor most mornings until 12pm. Office work after lunch." (S1:#9332)..The fact that I spend so much time on the floor with both patients and staff ensures that the decisions I am making are necessary and backed by fact and observation." (S1:#9332)

"Staff payroll problems have made my job impossible and I'm supposed to send them to HR..but no resources to backfill the hours and hours.."(FG)

"Would be nice to have service profile acknowledged as the tool it was intended to be and not something that is an exercise in futility." (S1:#6072)

"BPF is a document we complete. It has no impact on reality and resource allocation." (S1:#7666) ; "Authority is overridden.. I feel there is quote a lot of micro-managing going on." (S1:#1704)

"I am not staffed according to the BPF..I am told there not the funding for it."(S1:#3315)

"We have no say in the BPF..we are just told the number and told to work within that." (S1:#7913)

'I feel it is a paper exercise and not worthwhile management tool..and I am a BPF trainer!" (S1:#3930) "My ND and DON don't have any power either." (FG)

"..has been taken away and managed by the Business Manager and the ND – very frustrating." (S1:#4976)

"What is needed for the service is overridden by financial constraints. "Doesn't matter what data I collect, it isn't reflective of workloads." (S1:#3704)

"There is no real BPF that depicts midwifery anyway."(S1:#6652)

"..it doesn't equate to patient and staff safety – notional staff ratios are not considered." (S1:#3454)

"There is perceived authority..however, this is very different in practice." (S1:#3612)

"NUMs not involved in developing the BPF" (S1:#5212)

"I find myself reporting to the Acting ND's,Acting EO." (S1:#9807)

"I'm reporting now to a business manager..who tells me what equipment I can have." (FG)

"Intra-unit communication works well. Hospital system..very one way (trickle down) which limits.."(S1:#4042)

"Higher management does not listen to nurse managers, but doctors, I feel very degraded in this and think 'why bother' (S1:#7950)
"ND and EDON difficult to contact them due to their minders.. and very little visual appearance." (S1:#1704)

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"We're not allowed to meet as a NUM group." (FG)

5.4.4 Nurse/Midwife Unit Managers - Role Responsibilities

The N/MUM's provide solid evidence of role change by way of expansion and compression of responsibilities in recent years in particular, and related to specific developments in their operating environment. Of all N/MUM respondents (n=132). 92 per cent stated in various expressions, that their current position description was not a realistic match with their role responsibilities. There is evidence of a high reliance on unpaid overtime in an attempt to keep up with the expanding boundaries of the role. Key response themes are ambiguity and unrealistic expectations without resources commensurate with meeting those expectations.

As in the Position Category, Span of Control, N/MUM's stated they were not in a position (empowerment) in relation to their expansive and expanding role responsibilities. A recurrent theme is the lack of power to modify the limitations and stressors in their operating environment, for example, the number of audits, cycles of finance reporting, BPF re-writes, recruitment paperwork, and the extraordinary imposte of payroll matters. 92 per cent of N/MUMs stated that their position description did not match the reality of their role responsibilities.

Capacity for innovation was one area of limited capacity due to overload in managerial responsibilities. 85 per cent of N/MUMs confirmed that they were unable to drive innovation in this regard, with the exception of models that were cost-neutral, or where support from nursing executive was substantial and consistent.

Budget pressure and the demand to 'do more with less' were recurrent themes expressed by N/MUMs. Most cited frustrations in the role were lack of time, unpaid overtime, and lack of resources (86 per cent), consistent unpaid overtime and refusal of overtime claims, micro-management and little valuing and recognition for what is achieved (14 per cent). Where all of the cited frustrations are indices of poor valuing of the role, 100 per cent of respondents identify inadequate valuing of the N/MUM role. Suggested solutions to known frustrations were directed to specific role supports.

The findings in role responsibilities for N/MUMs are entirely consistent with the findings in the literature review, Section 3.4, Summary 4**.**

Results: Role Responsibilities

Current Position Description/Capacity to Meet Current Role Expectations

"Not sure where the NUM role is meant to stop.." (S1:#1571)

"Responsibility overload.. The "Minister for Everything" without the authority." (S1:#2688)

"I work extended hours (unpaid) to ensure that my expected outcomes are met." (S1:#5988)

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Figure 8. Responsibilities match with position description

NOTE: n=132 92% No match

"You do whatever to keep things going..the patient flow..filling the gaps yourself..and then wait, a week or so..and then it comes – the Mexican wave slap!" (FG)

Examples of members' statements

"Unclear, blurred roles and responsibilities.." (S1:#3612)

"Increase in complexity, every new thing to be implemented by QH or the district goes to NUM to do without any increase in support.." (S1:#9452);

"Very busy team with multidisciplinary management role and by my choice very active clinical role. Expectations on my role are unrealistic" (S1:#9513)

"Overall..descriptive but really inadequate for reality." (S1:#1805)

"NUM stands for numerous useless meetings." (S1:#2061);

"In no way does it reflect the amount of admin. work attached to the role." (S1:#5776);

"Generic and does not translate into the workload nor the knowledge required." (S1:#7672)

"Generic and ambiguous." (S1:#4593) "Broad sweeping statements with little relevance to daily accountabilities." (S1:#0302)

"OK if it was adhered to by the next level of management, having discussed the frustration of disempowerment." (S1:#4976)

"Hopelessly inadequate and not realistic of the true work load and expectations." (S1:#3315)

"A good summary of the position." (S1:#7672); "Accurately describes the role." (S1:#5792)

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"Vague..doesn't reflect the intensity or the demanding nature of the job." (S1:#2983).

"It is a simplistic PD and there is no way I can manage both the clinical and managerial component of it." (S1:#8220);

Models of Care & Capacity for Innovation

Figure 9. Capacity for innovation

NOTE: 86% No; 14% Yes, supported or supported where cost neutral; n=132..

"Highly supported and encouraged as long as they are cost neutral." (S1:#0325);

"..no time to be innovative when in catch-up mode all the time." (S1:#9452)

Examples of members' statements

"There are no constraints other than time and supports to introduce change. Too weary to introduce anything new with current work requirements." (S1:#2446);

"EVERYTHING is dictated by what the finance department supports." (S1:#7728)

"Less floor time…every time corporate come up with a new idea, NUM has to maintain the initiative.' (S1:#7913);"Limited by skill mix and staffing levels." (S1:#3524)

"If I had a CNC, I'd be able to do a lot more." (FG); "Good capacity for this largely due to executive support..can be stifled by budget issues." (S1:#7538)

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"Capacity to be innovative has increased over the past 2 years. The decision-making and ability to question and bring about change comes with experience in the role and a fully recruited workforce." (S1:#0980)';

"I would love to instigate innovative models on my ward, improve standards of care etc. but I barely have time to breathe." (S1:#0122) "Certainly have the ability..but lack of time." (S1:#2713)" "I am able to alter the model of care as long as it is within the BPF." (S1:#5694)

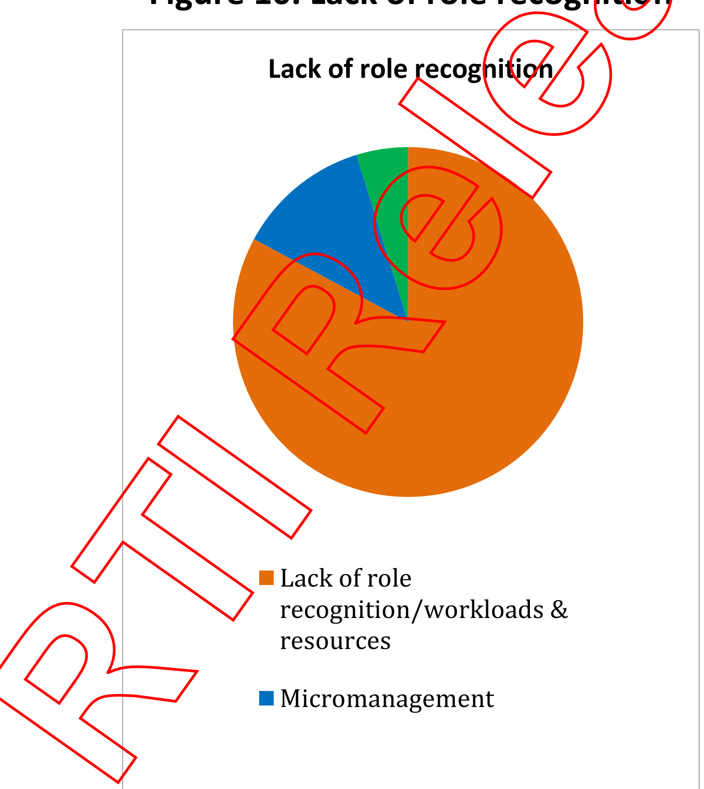
Frustrations Current Role

"No autonomy or authority to buy even a pack of pens yet expected to sign responsibility for our over-spend each month." (S1:#9807)

Most cited frustrations in current role

Workload, Lack of time, Lack of clinical resources, unpaid overtime 86%;Micromanagement 8%;Other Lack of respect and recognition for role, N/MUM knowledge & value; 6%) n=130

Figure 10. Lack of role recognition



"The role has just got bigger with more and more dumped on the NUM." (S1:#8460)

"Nothing is ever taken away but NUMs are expected to do more and more." (S1:#7728)

"..the payroll system is doing our heads in on a daily basis." (S1:#3842):

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Examples of members' statements

"Paper work ever-expanding.." (S1:#9542)' "Payroll issues." (S1:#3930)' "Wasting time on inefficient processes with the pay debacle." (S1:#6436)' "Unsustainable workloads." (S1:#2061)

"Lack of clinical resources..; (S1:#1364); "Lack of clinical leadership time." (S1:#5694)

"Working unpaid…little recognition." (S1:#0122); "Long hours..being rapped on the knuckles for not keeping to budget..balancing clinical and admin." (S1:#0122); "Unpaid overtime." (S1:#5988)

"Role overload..has always been too large for the role." (S1:#0410); "Work dumping by other disciplines." (S1:#3524)

"Workloads are insurmountable." (S1:#6652)' "Not being able to take a full lunch break." (S1:#7174)

"Task dumping."(S1:#0302); "Little time for NUMs to network with each other." (S1:#1704): "Constant allocation of new tasks to NUMs from various silos within QH.." (S1:#2061); "

"Expectations to cover shifts." (S1:#5004)

"Inability to support staff adequately. (S1:#0414)

"Management lack of understanding of the NUM role." (S1:#3315); "Lack of understanding of my role." (S1:#5004); "Lack of acknowledgement from executive of work well done." (S1:#0302); "DON barking about budget when they don't understand.." (S1:#6515)

"Workloads with no real, dedicated person with the authority to advocate for the NUM.:" (S1:#3315);

"Business management expectations." (S1:#0980); "No pathway planned for my role but lots for every other level." (S1:#0325)

"Real action in relation to workloads - not just another investigation which acknowledges an already long identified problem.." (S1:#3315);

"Dread Thursday afternoons when pay slips arrive in the unit.." (S1:#8779); "Micro-management." (S1:#3612); "Since 2008, I feel the degree of micro-management has increased..I feel I have lost any sense of autonomy." (S1:#3930);

"Professional isolation." (S1:#0519);

"Role surveillance without support..role is undervalued by the organization." (S1:#0325)

"Auditing, and being constantly audited by dieticians, infection control…" (S1:#5446)

Suggested Solutions to Frustrations…

"..Be allowed to manage as employed to do." (S1:#7756)

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"..get payroll sorted ASAP." (S1:#7756)

"AO assistance with payroll." (S1:#0122); "More support from HRM." (S1:#2834); "On-site processing of payroll." (S1:#1649)

"Again, an AO would be invaluable." (S1:#7756)' "More AO and Associate NUM positions." (S1:#4060)

"Respectful communication between nursing executive and the NUM team." (S1:#0302); "Inclusive communication." (S1:#2688);

"Being acknowledged for our experience." (S1:#2688)

"Educator or Clinical Facilitator to support new staff." (S1:#1704).

"Gr 7 Clinical and HR Manager, and Gr7 Education and support." (S1:#9050)

"Clinical support, clinical facilitators/admin. Support...and grading of NUMs." (S1:#7124)

"More solution finding other than NUMs doing all the tasks." (S1:#2713)

"Career path for CNs stuck at Grade 6." (S1:#8220)

"Personal assistant." (S1:#2061) "The right assistance." (S1:#3347)

5.4.5 Nurse/Midwife Unit Managers - Role Enablers, Role Supports– Discussion

78 per cent of N/MUMs (n=130) support administrative assistance (Administration Officer) unconditionally, with 42 per cent of this cohort emphasizing that this support only, is insufficient. A number of N/MUMs (12 per cent) were not convinced an Administration Officer would be a useful role enabler, and stated preference for clinical support, and included an associate N/MUM role support. 30 percent of N/MUMs (n=130) emphasise human resources support. This finding reflects the view made explicit by the N/MUMs throughout the themes, that the number of appointed clinical facilitators, educators, researchers and CNCs relative to perceived need, is deficient.

82 per cent of all respondent N/MUMs referenced varying degrees of emphasis, both clinical and administrative supports required to better enable the role. These included clinical support as first preference role support, including clinical teacher, clinical nurse consultant, clinical nurses and nurse researchers; followed by administrative support, including business, human resources, recruitment, information system support, and administrative officer support.

Having formal and resourced networking opportunities with their peer group, was identified as an enabler in selected focus groups.

The findings in role enablers and role supports for N/MUMs are consistent with the findings in the literature review, Section 3.5, Summary 5.

Results: N/MUM Role Enablers and Supports

Nurse Managers : n= 130

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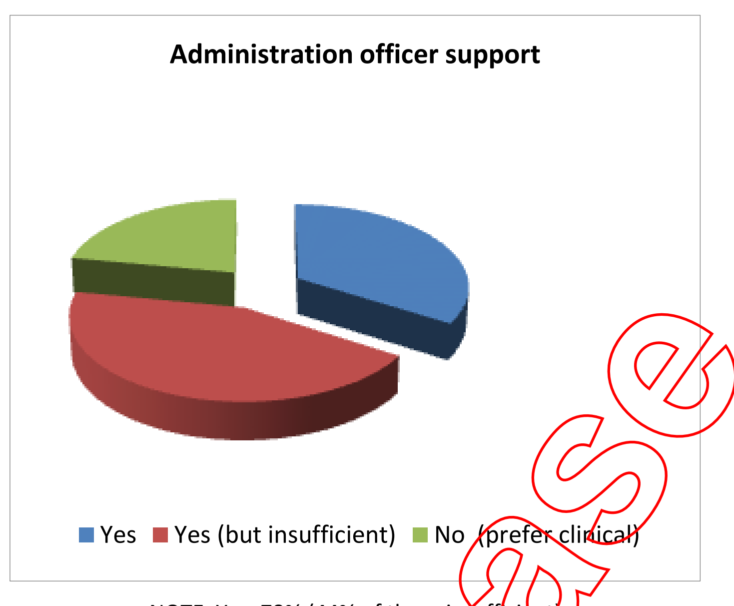
Figure 11. Administration officer support



NOTE: Yes, 78% (44% of these insufficient)
and 22 % NO..prefer clinical n=130

"Although an AO would assist with some tasks, it would not be sufficient to enhance my effectiveness. Succession planning with CNs and developing them to be able to step into the NUM role better enhances the NUM position." (S1:#1843)

"AO support would be good but not as effective as a CNC." (S1:#5022)

"The unit should have a CNC and a NUM." (S1:#6436);

"Definitely need a CNC or an educator." (S1:#3930);

"I would just like to see someone from People and Culture and have more help instead of them sending everything back to me.." (FG)

"A good CN with leadership and management skills is better [than anything]." (S1:#7913)

"AO, no..the clinical facilitator would add so much more value for staff and patients." (S1:#3930).

"The biggest impact would be to have a CNC role.."(S1:#3612)

"Off line time for CNs.."(S1:#5212)

Preferred Enablers & Supports

"Protected time to take on clinical/team engagement strategies." (S1:#4827); " "A mentorship program." (S1:#3056)

"Empower the NUM to be the leader of the work unit." (S1:#4976)

"More researchers would enhance the role and assist with promotion of research and evidence-based practice environment." (S1:#1303)

"I would support an educator in..the effectiveness of my role. (S1:#5792)'

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"An educator to help with clinical development, not just mandatory study days." (S1:#3613)

"Even though these [CNC] positions are at level, there must be a single point of accountability for decision-making and leadership, and this must stay with the NUM." (S1:#0302); "An assistant NUM role where CNs are given time to learn and assist the NUM would be great.."(S1:#9452)'

"CNC and CNs who are able to act up." (S1:#9091); "CN Teacher already in role but not being paid as such. (S1:#5446)

"Admin support would be huge support – paper work detracts a great deal from what I really want and need to undertake as a NUM." (S1:#4976);

"AO..absolutely not sufficient." (S1:#3454);;

"I need more business, HR, and admin support." (S1:#7913);

"What I need is someone to help me with the admin/business work so that clinical care is not compromised." (S1:#0122);

"Being able to meet regularly with peer group to share information and catch up with what's going on would help us as a group." (FG)

"The best thing to help would be to have less staff to look after and less administrative and reporting requirements." (S1:#6652);

"We need better admin. systems that work for us, instead of generating more workload." (FG)

5.4.6 Nurse/Midwife Unit Managers: Role Preparation, Recruitment & Succession Planning

The majority of N/MUMs intend staying in the role, however, their reasons in many instances are conditional, and reflect the range of role satisfiers and dissatifiers. N/MUM tenure is highest in the 10-20 year period **(Table 3).**

Participants in two non-metropolitan focus groups stated, they could not go through another leadership workshop. The M/NUMs believed they were already 'hardwired' for leadership and that the more important issue for them was material support. N/MUM interest in training is that related to their professional practice context and which values their tacit expert knowledge **(**N/MUM comments were positive in relation to training, understood and known as available, which is consistent with the achievements reported by NMOQ (2011). The concerns noted in N/MUM training were more about accessibility, due to limitations around workload and backfilling. With succession planning, no N/MUMs cited the existence of the QH Succession Planning Framework, but made comments about resource limitations in providing structured succession planning. The N/MUM's firmly support succession planning with mentoring, buddying, and on the job training.

A recurring theme in succession management is the difficulty in recruiting Clinical Nurses to act in the N/MUM role. In particular, N/MUMs report that where they and their role work are stressed, observed by CNs to be unsupported and perceived as underpaid in

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comparison to CN on shift work, and where they are known to be structurally disempowered, it becomes an additional stress to recruit and to plan leave.

Role attractors for N/MUM recruitment and retention are identified more by what would make the role attractive for future recruits, than the attractions currently on offer. The N/MUMs cited passion for the patients, passion for their staff, having excellent CNs and/or CNC’s, and excellent executive support, as best measures of current attractors where these exist. N/MUMs recorded important attractors as positive work-life balance, authority and resources commensurate with the responsibilities of the role, and a demonstrated capacity to actually do the job so that others might encouraged rather than discouraged by the role.

Hours flexibility is a distinctly high satisfier for N/MUMs although a significant number of N/MUMs report working unpaid overtime in order to sustain 4 day weeks or 9 day fortnights.

N/MUM comments on career and classification structure related to recruitment and succession planning are significant for correlation with findings in scope of practice, and span of responsibilities. N/MUMs support additional opportunities for career advancement for nurses interested in management, clinical, research, and education streams, earlier in their career. In particular, there is support for CN advancement to higher levels of recognition (career structure banding) in Grade 6 to Grade 7.

This section gives voice to the anomalies in differentiation of role responsibilities across the current Grade 7 classification in the QH career structure. N/MUMs express concerns regarding span factors, such as size of budget and number of direct reports as a source of dissatisfaction in differentiation across the N/MUM Grade 7 (and Grade 8) classification grades and bandings, and negotiated role authority. This correlates directly with findings in span and in role responsibilities.

The findings in role enablers and role supports for N/MUMs are entirely consistent with the findings in the literature review, Section 3.6, Summary 6**.**

Results : N/MUM Role Preparation, Recruitment and Retention : Work Life Balance

Nurse/Midwife Unit Managers: n=133

Role Flexibility & Work Life Balance

Satisfaction with flexibility in current role

52% flexibility and high level satisfaction/48% limited flexibility and high level dissatisfaction

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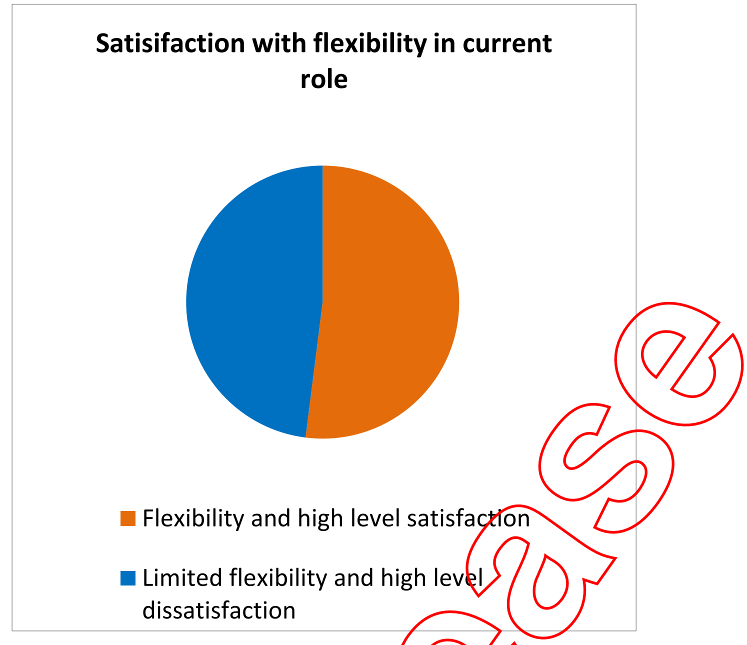
Figure 12. Satisfaction with flexibility in current role



"9 day fortnights have been negotiated. This has been the single most positive impact on my worklife balance." (S1:#0302)

"I am able to work part-time as NUM – 4 day week and this is positive for my worklife balance, However, I continue to do a large amount of unpaid and unrecognised overtime both at work and at home." (S1:#5694)

"I work 0.8 for worklife balance." (S1:#9513)

Examples of members' statements

"I rarely take my ADO's as no one can be offline.." (S1:#9452);

"We have less flexibility than anybody..have more now that I have remote computer access but don't know what worklife balance is." (S1:#6652);

"I work 10-12 hour days to achieve my current responsibilities..and have little worklife balance." (S1:#4976)'

"No flexibility – and as we are getting closer to retirement would be nice to consider sharing the position with the upcoming NUM for training and support." (S1:#2834);

"Work hours are aligned with meetings and business management..and not with need for clinical leadership and support so I work beyond the 8 hours to support staff."

(S1:#0414); "Flexibility has been denied me a number of times.."(S1:#9332); "I am micro-managed to some degree and have difficulties accessing 9 day fortnight.."(S1:#7756)

"Am working a lot of extra hours without overtime or TOIL.I do this just to manage.." (S1:#3347)'

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"No flexibility..would like to work a 9 day fortnight plus work at home.." (S1:#5708)

"I have it pretty good on the whole..working4x10 hour days and have done for many years." (S1:#5446)

"I work a 9 day fortnight..which is great."(S1:#498; S1:#0122); 'I work long days – 10 hours but a 9 day fortnight..and I'm loving it." (S1:#3842);

(S1:#6983); "II work 4x9.5 hour shifts.."

Results : Training and Succession Planning for the Nurse/Midwife Unit Manager Role

Nurse/Midwife Unit Managers: n=129

"I was well trained. But of more help than that would have been a dedicated HR officer who would be available to assist and not be a token in an ivory tower somewhere.." (S1:#6652)

"Training is available if you look.." (S1:#3524)

"Enough.. not another leadership workshop..please." (FG)

"Managing upwards – no one trains you on how to manage past your line manager." (S1:#2688)

"Management training, no..nurses want to be nurses. NUMs want to be nurses who affect change. Pure management does not allow for this." (S1:#5708)

"My own peer network." (S1:#6652)

"More off line time for training and education in higher strategic planning to support the ND.." (S1:#5507);

"On the job mentoring would have been good." (S1:#9452)'

"Buddying with a NUM.." (S1:#7124)'

"Should be formal succession planning involving mentoring and internship." (S1:#8839)

"Business management, cost centre management, rostering, BPF, dealing with difficult conversations, leadership days, mentoring, clinical up-skilling, resilience, recruitment.." (S1:#3612).

"Team building strategies." (S1:#3613)' "Formal HR and financial training are essential but again, there needs to be a supportive environment to practice these skills.

"More financial education." (S1:#6983)

Workplace culture is running leadership courses which is free for QH staff – all 6 topics are fantastic." (S1:#6515)"Orientation to key operational stakeholders..much of the frustration of the role is not knowing who does what in the organization." (S1:#0302)

Results: N/MUM Career Structure Recommendations & Recruitment/Retention

Nurse/Midwife Unit Managers n=129

"..Needs to be another level which recognises the NUM positions with complex management responsibilities."..at the moment I get the same

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grade and pay as those totally free of such responsibilities as staff and cost centre management." (S1:#5673);

" 'I believe my current role is at a Nursing Director level not a NUM.."(S1:#4534);

'I think a level in between the Gr 6 and 7 similar to the old NO3 to allow graduation into a 7 role." (S1:#2801)

"Yes, having worked in Vic Health with ANUM roles, I believe having a structure that facilitates advancing roles..is key to moving forward for QH." (S1:#7174)'

"Would be good to have a fourth pay increment at Gr 6..we have difficulty filling Clinical Facilitator roles.." (S1:#4060);

"NUM payments should be increased from 3 to 6 pay points to encourage NUMs to stay in the role." (S1:#5402);

"Need a grade between NUM and that of Service Director." (S1:#7950)

.."We should all be CMC's with a much smaller band of control. (S1:#6652 MUM)

"Near impossible to recruit when CNs lose money and my pay is the same as CNC when I have huge responsibilities.." (FG)

"As Grade 7 I am equal to all others although my department is 3 times bigger."(S1:#5507)

Role Preparation, Recruitment & Succession Planning

"Am considering getting my position re-evaluated..however, my line manager does not support this.."(S1:#7950); "There is significant role confusion and inequities I expectations of the NUM role across service lines." (S1:#0980); "..NUMs role in staffing and budget need better resourcing." (S1:#0414)

"It is imperative to have an Associate NUM role to sustain longevity of NUM role." (S1:#3612); "Associate NUM role to ensure ward goals are being worked to." (S1:#9452); 'I would like to see an Associate NUM role..this is paramount..also CN advanced practice." (S1:#4976)

"Advanced practice nursing is a great step forward. NUM etc. have a very important role, and tend to undervalue themselves and other staff do not understand the difficulty of the role." (S1:#1633)

".. CNC aside a NUM role would improve patient care immensely." (S1:#0122)

"Keep in mind the accountability structure if you have all Gr 7's someone has to take ownership and accountability.." (S1:#5507)

"..Needs to be another level which recognises the NUM positions with complex management responsibilities."..at the moment I get the same

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grade and pay as those totally free of such responsibilities as staff and cost centre management." (S1:#5673);

"Different paypoints based on team size, ability to perform the admin part of the roles with a clinical facilitator. (S1:#4827); "

There should definitely be delineation between NUM with 40FTE and CNC with no staff reporting to them." (S1:#3767);

"Need to revaluate the entire career and pay structure in regard to the NUM role." (S1:#8839); 'I think a level in between the Gr 6 and 7 similar to the old NO3 to allow graduation into a 7 role." (S1:#2801)

Results: Making the N/MUM Role More Attractive

Nurse/Midwife Unit Managers: n=138

"Respect for what we have to offer.." (S1:#4976)

"Having more Grade 7s to support all roles of staff, medical and nursing.." (S1:#7174)

"If staff could see that the current occupant is supported, not working long hours, not stressed, and able to model an attractive job." (S1:#2834)

"Recommendations for improving the role need to become reality, for example, real authority behind the role." (S1:#3315)

"More authority to make decisions without the committee mentality for basic operational decisions – less interference from other services in role accountabilities.." (S1:#0302)

"Stay CLINICAL – it earns you more money, less responsibility, far less stress and you can blame the NUM for everything that you hate about your workplace." (S1:#3454)

"Recruitment to the role is a nightmare.." *(S1:4664)*

"I think the issue with succession planning is the level of responsibility..puts staff off. Having to be the one who sorts all the problems is not an attractive job prospect." (S1:#7538)

"Knowing clearly the structure – differentiating a business role with a clinical leader role." (S1:#3612); "On the job off-line training." (S1:#2615); "Fair and equitable workloads." (S1:#4534)

"Acknowledge the importance of this role. This has to be reflected by appropriate remuneration." (S1:#2446)

"Being fully resourced for mandatory training and professional development." (S1:#3056)

"A new payroll system." *(S1:#3842)*

"A complete revision of the role..no one wants to do it."(S1:#7728); "Clarity of the role." (S1:#5022)

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“Regular mentoring and feedback.” (S1:#4827)’ “Mentoring and access to supervision.” (S1:#2801)

“Reverse the position where most of my staff don’t want to do it [the role] because the pay is worse than theirs, and they see how much work the role has with little or no flexibility.” (S1:#6652)

‘More authority without being micromanaged..” (S1:#2801); “More time to spend being a clinical leaders and not just an administrator.” (S1:#4664)

“More worklife balance.” (S1:#7124)

“Hard to sell unless good supports in place.” (S1:#3347)

5.5 Grade 7 Nurses & Midwives

This next sub section carries through with results reporting for the Grade 7 Registered Nurses, comprising Clinicians, Educators, Researches, functional managers and others who are not unit managers.

Clinical Nurse Consultants, Nurse Managers, Educators, Researchers, Other

The elements of the Project Position Picture (Appendix 1) are applied in structuring the results reporting for this cohort of 192 Grade 7 nurse/midwife respondents in roles not that of clinical unit/service management. The sample of clinical nurse consultants, educators, functional service managers, researchers, and others is identified (5.2.1) and closely reflects the distribution of these roles in employed numbers reported by Queensland Health (October 2010). The responses are found to be reasonably consistent across all Grade 7 groups in this respondent cohort.

Where remarkable, differences will be reported in the following discussion. Shared and comparative findings with N/MUMs have been summarized in this Section 5.3, Summary 8 and Summary 10.

5.5.1 Grade 7 Nurses and Midwives - Span, Responsibilities, Enablers, Recruitment and Retention

Questions in e-Survey 2 in this Position Picture element are directed to role balance and effectiveness in meeting the expected outcomes of the Gr 7 RN role across the range of practice contexts and functional roles.

Clinical and management role balance is tested where clinical includes research, education/teaching, clinical leadership, policy development; research and practice improvement; and clinical service delivery; and where management includes managerial/administrative role components, such as data collection, performance score cards, and other reporting, in addition to clinical service co-ordination.

Preference is stated by respondents for greater clinical role content [rather than managerial], than they currently experience. Excluding functional service managers, such as informatics, products, patient flow, 72 per cent of the Grade 7 clinicians (educators and researchers), identify 80 per cent or more as clinical; 24 per cent as 60 per cent or more; and 16 per cent as 50 per cent or more for clinical. Where indicated, this group of

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clinicians stated a preference for higher levels of investment in clinical responsibilities and in exercising clinical leadership. This Grade 7 cohort identify higher levels of satisfaction with their role span, content, position descriptions, and capacity to influence innovation, than do N/MUMs.

Isolation in matrix structures in voiced, in addition to confusion created in multiple reporting lines, some at level with the NUM, others within a matrix (sideways) reporting structure. Being left out of decision loops and being subject to limitations due to the N/MUMs being too busy, are cited as professional communication limits on their role.

This cohort cite key dissatisfiers as those factors in their practice environment that devalue their expertise, and actual and potential contribution, for example, limitations in the career structure and classification structure where their advanced practice and role responsibilities are not sufficiently recognised or differentiated for grading and banding; poor understanding of the role by other clinicians and management; workload of N/MUMs (which create barriers to N/MUM role capacity); role overlap; unnecessary micromanagement; unstable management, lack of (number) positions, notably clinical nurse consultant and nurse researchers, and being used for backfill in staff deficits.

The Grade 7 Nurses and Midwives and N/MUM cohorts are equally equivocal about the role of administration officers (AO) for enabling the N/MUM role. Both cohorts are explicit in their conditional support, stating that while AOs are supported, clinical supports are prioritized where these supports are currently missing and missed. Grade 7 Nurses and midwives recommend clinical facilitators and teachers, clinical nurse consultants, associate N/MUMs and in a fewer number of responses, nurse researchers.

Role attractors for this cohort are autonomy in decision making and clinical practice; clinical leadership capacity; influencing direct patient care outcomes; influencing, inspiring, and teaching new and developing nurses, midwives, and other clinicians. Grade 7 Nurses and Midwives, (not N/MUMs) are significantly more satisfied with their role flexibility, working hours and capacity to self-determine their work role balance. The following tables capture the results, supported by a response sampling.

Role preparation for this cohort is centred on support for skills development opportunities and for further education, for example, Masters and PhD in specialty areas. “Off line” time is cited as insufficient in being able to manage portfolios, such as quality improvement, innovation planning, mentoring developing clinicians, and supporting the N/MUMs.

Recruitment strategies focus resource support to enable less experienced staff develop in advanced practice, education, and research. Strategies of structured mentoring, and quarantined time for junior staff are identified.

The predominant responses related to recruitment into senior advanced practice roles across each of the career streams, are emphatically related to better utilization of the career structure with both numbers of advanced practice positions available (utilized within the current structure), and modification to the current classifications in order to access more appropriate recognition grades and bandings within grades.

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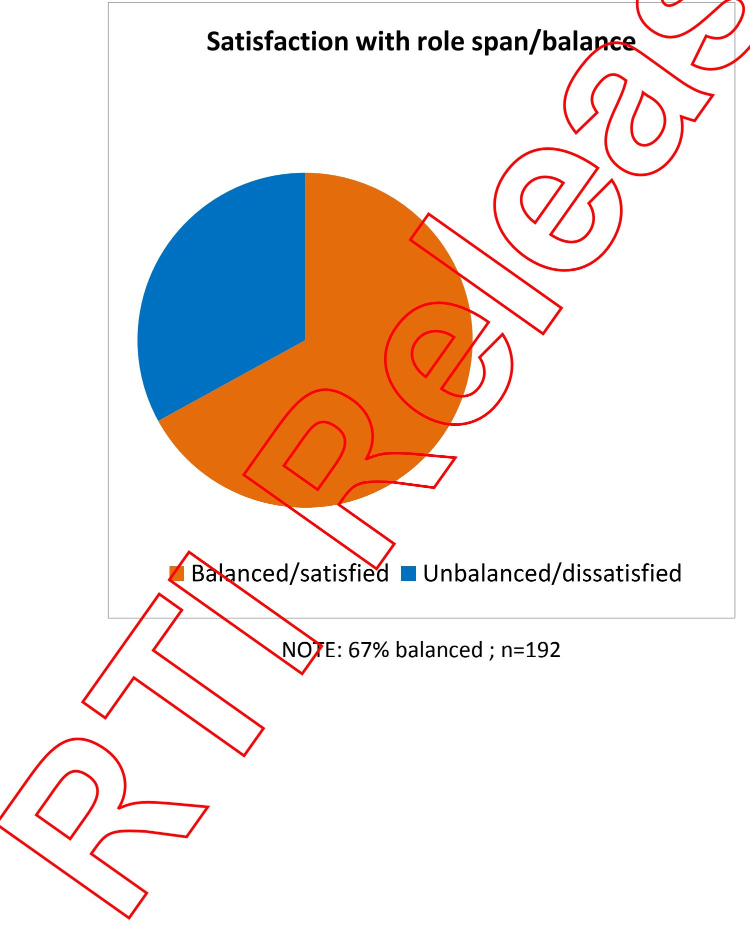
The Grade 7 Nurses and Midwives, not N/MUMs widely expressed empathy for the N/MUMs in relative terms, and compared to the advanced clinical roles where they valued for themselves, higher levels of autonomy and role flexibility. Twelve (12) respondents in this cohort had been N/MUMs in the past. The nurses and midwives (not N/MUMs) recommended associate N/MUM positions, and also commented on the need for recognition of advanced management practice in career classification grading.

The following tables sample the data collated from the Grade 7 Nurses' and Midwives' responses in relation to the Position Picture themes (Appendix 1).

Results : Grade 7 Nurses & Midwives (not N/MUMs) - All Position Picture Elements

Figure 13. Satisfaction with role span/ balance – clinical and managerial in success of the respective Grade 7 role



NOTE: 67% balanced ; n=192

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Figure 14. Clinical Leadership Capacity in Current Role

Current influence on models of care / innovation

Can influence | Very limited influence

NOTE: 72% can influence; n=189

"High capacity to influence models of care and practice." (S2:#4758)

"Difficulty engaging NUMs because of their busy workload." (S2:#6722)

Professional Relationship Matrix – and role effectiveness

"I have three line managers." (S2:#6524 Educator)

Statements: Clinical Nurse Consultants, Nurse Managers, Educators, Researchers, Other

"I feel capable of managing the balance to meet expected outcomes." (S2:#1552, Educator); "The balance is fine, however, little time for management..this is done after hours." (S2:#4117);

"90% clinical leadership and I am lucky to have NUM experience to draw on to facilitate my input at the unit level." (S2:#9667);

"Matches well as I work alongside the NUM." (S2:#5857);

"A lot of management and coordination and expert advice and consultation."(S2:#9094);

"Not balanced..we are deplete of Clinical Facilitators..too many promises but no outcomes re support." (S2:#4663 Educator)

"Balance is not that good and I don't think anyone really cares as long as there are no complaints from consumers and no PRIMEs." (S2:#1608);

"No balance. Kept out of the loop, no idea what is happening organizationally." (S2:#0933);

"I am able to adjust the balance according to service demands." (S2:#7756)

"Works well in balance of support, advisory role." (S2:#8348)

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"As an educator supporting 6 NUMs and 6 Clinical Facilitators, clinical support is 90% of my role." (S2:#3788);

"The Nurse Educator has huge capacity to facilitate the innovative models however, frequently left out of these decisions." (S2:#8589)

"Significant capacity [for clinical leadership] as State wide approach to nursing education and services mapping (cancer care). (S2:#2463); "

"Have a facilitator attached under my position as support for innovation." (S2:#1745);

"NUM overstepping boundaries into education, thus makes it hard to implement strategies based on educational theories/best practice." (S2:#3609)

"I have great capacity for having impact on nursing practice by being an advocate for review of practice based on evidence." (S2:#3615)

"NUM enables by investing energy in creating a good team culture which promotes flexibility and creativity." (S2:#8448); "I have full support, including budget..no constraints." (S2:#3443)

"Enabled through input into current networks but may be limited if LHHN do not place value [on models]" (S2:#9667);

"Great support of management team to be creative in role." (S2#5036)

"People willing to listen when I present the evidence to back things up but the NUM is sooo busy with the day to day stuff, it's hard to get things happening or sustaining initiatives." (S2:#6562)

"Innovation is sporadic – lack of multidisciplinary control, unable to secure new resources.." (S2:#5092);

"As virtually a sole practitioner, I have the skills and experience to implement models that reflect the need of the client." (S2:#4557)

"Team meetings and peer supports."(S2:#6414)' "I am uninformed and out of the loop in my position" (S2:#6304);

"Having an HP for team leader, we report to a DON who's work load is increased significantly." (S2:#4458);

"My line manager is over 100k away..it is just not working - never has." (S2:#0393)

"No formal structure in place." (S2:#5462)' "I meet with educators on a professional level but do not meet any other Gr 7s other than at a staff forum." (S2:#9411)

"My clinical Leadership (education) role is minimized by having to support divisional management activity (meetings) across the board." (S2:#3788)

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"Depends on area and leader/manager style." (S2:#5887); "Poor balance – budget restricts training for novice specialty nurses to be safe clinicians vs organizational meetings and data entry for reporting..without admin. support." (S2:#3561 Educator);

"Limitations in having so many reporting lines for the one role." (S2:#7389)'

"A lot of us have only peer support." (S2#9643 Public Health CNC)

"As CNC I report professionally to our NUM who is at the same level..and to our Medical Service Director." (S2#6607)

"Matrix structure not working..huge issues for nursing professionalism." (S2:#6981)

"There are many skilled clinicians who do not get support from peers in their units, and can be disabling for advancing clinicians..NUMs can and do see CNCs and Nurse Practitioners as 'outsiders'..has to be a service group structure that outlines roles and reporting lines.." (S2:#9240)

Figure 15. Responsibility match with position description

NOTE: Satisfied with reality match 18 % Dissatisfied 72 per cent; n=190.
(depth, scope, complexity, authority and expertise of the role not reflected)

Dissatisfiers

"Nowhere to go from here..career structure..no recognition of advanced practice." (S2:#9643)

"Lack of recognition for area of expertise." (S2:#1126)

"..the e-mail culture."(S2:#4319)

"People acting in positions..no continuity in decision making." (S2:#4984)

"Roster, budget, and skill mix constraints.." (S2:#3561)

"Lack of nurse researcher positions." (S2:#1069)

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Clinical Nurse Consultants, Nurse Managers, Educators, Researchers, Other

> *"Need to push for more CNC positions – they are in the structure, but underutilized as a cost containment strategy..could provide for clinical progression and improve patient outcomes." (S2:#3678);*
>
> *"I would not achieve my role if I did not work outside of hours..all clinical paid and non-clinical not paid." (S2:#7100)*
>
> *"At same level as the NUM..CNs feel they receive conflicting direction. There needs to be one person who is responsible to alleviate any confusion." (S2:#0950),*
>
> *"Mine is clinical leadership while giving direct patient care." (S2:#9733)*
>
> *"Team work across professional disciplines is paltry and given lip service at best." (S2:#8128)*
>
> *"The position allows for autonomy and innovation.." (S2:#0933)*
>
> *"We are expected to have portfolios to continue development, but no time to fulfill this.." (S2:#3967)*
>
> *"Poor understanding of my role by my managers." (S2:#0393)*
>
> *"Not being recognised/acknowledged/understood by other health disciplines." (S2:#7755)*
>
> *"HP team leader not listening as far as a nursing perspective." (S2:#4458)*
>
> *"Trying to find backfill for our specialized positions." (S2:#5774)*
>
> *"Enthusing an exhausted workforce." (S2:#3788)*
>
> *"Staff too busy to communicate changes and needs." (S2:#9400)*
>
> *"Difficulty getting staff off line to attend education or complete on-line education." (S2:#6916)*
>
> *"Transactional leadership styles." (S2:#9591)*
>
> *"Difficulty in selling the vision." (S2:#5887)*
>
> *"Bullying not being taken seriously." (S2:#3338)*
>
> *"Wokload of leaders which creates barriers to enable them to make decisions.." (S2:#1901)*
>
> *"Unnecessary micro-management." (S2:#1126)*

Role Supports/ Role Enablers (for N/MUM role)

> *"More benefit [than AO] from a supportive NO6."(S2:30221)'*
>
> *"A deputy or assistant NUM is what is required." (S2:#4319)*
>
> *"Time to support CNs who are succession managing into education." (S2:#8677)*

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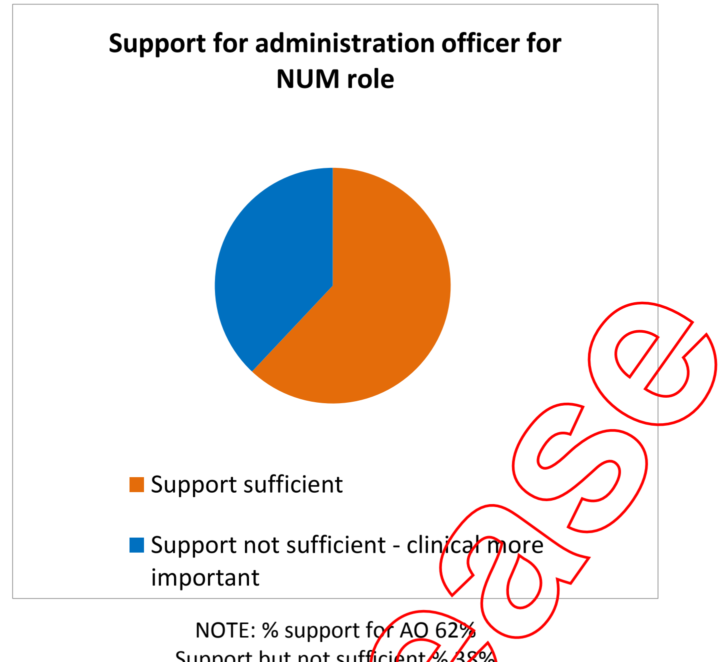
Figure 16. Support for administration officer for NUM role



NOTE: % support for AO 62%
Support but not sufficient % 38%
(Clinical support more important) n=181

'AO would enhance effectiveness of any Gr 7 role." (S2:#1745)

"An associate manager somewhere between NG6 and NG7." (S2:#4748)

"My Nursing Director is brilliant. It all comes down to the leadership style above you." (S2:#6557)

"The CNCs provide valuable resources and support, particularly out of hours for all staff (medical, nsg, allied health) and clientele." (S2:#1939)

Clinical & Education Support (For M/NUM role)

(99.4% support) n=180

Statements: Clinical Nurse Consultants, Nurse Managers, Educators, Researchers, Other

"Have an excellent supportive DON, which is helpful." (S2:#6802)

"Need multilevel support, not just AO." (S2:#7756); "..an associate NUM to enhance succession planning."(S2:#6850);

"Position with nursing background would be more helpful." (S2:#6087);' "NO2 to work as high level support to NUM." (S2:#1916); "A CN – Human Resources." (S2:#9221) "A good HR team doing good work with recruitment and retention.."(S2:#9529); "A nurse researcher." (S2:#6562);"

The ENAP position has further possibilities clinically." (S2:#3788)'

The role of the Nurse Practitioner will also increase a clinical management resource for the NUM." (S2:#2875)

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“Need for additional support for staff, especially the NUM role.” (S2:#1938); “Better understanding of roles.” (S2:#8843); “Having dedicated education time for wards.” S2:#6722).

“Allow me to the job I’m able to do without the kms of red tape.” (S2:#3215)

“Involve clinicians in decision-making.” (S2:#1552)

“...is an important part of the structure in providing good direction for strong professional development. It also promotes a healthy positive working environment where nurses feel supported in their roles.” (S2:#9529)

“No [to CNC]..theNUM/CNC model failed dismally. Educator attached to each unit would be significant improvement. (S2:#8128);

“Clinical support yes, but not an educator. I would rather a CNC that can provide hands on assistance to staff.” (S2:#5456);

“There’s a huge gap between the CNs and the NUM – we need a CNC.” (S2:#3686);

“I think an educator solely for midwifery would be a huge advantage.” (S2:#4932)’

“CNCs..Not just for service delivery, but also for succession planning.” (S2:#9591)

“Structured off-line time.” (S2:#9221)

“Only if clear definition of roles..this was not done when I was a CNC and it created conflict with NUM leading to major job dissatisfaction..” (S2:#4748);

They [NUMs] very much control the amount of input I have into the education of the clinical staff. (S2:#6524);

“The wards that I work with that have both NUM and CNC appear to meet KPIs more easily than those with just NUM position.” (S2:#0493)

“We have a CNC – would be lost and stressed without one.” (S2:#9411);

“..only if clear definition of roles..” (S2:#4748)

“Would much prefer to have more staff who actually do work. I think we have enough project people working on things that never see the light of day.” (S2:#9894);

“..permanent clinical facilitator role to support the NUM on the floor. (S2:#5036)

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Role Preparation, Recruitment & Succession Planning

Role Attractors

"In my role, I do not have to manage people, the hours are very attractive, and the workload is significantly smaller than that of a NUM." (S2:#4526)

"Empowerment..but slowly being eroded." (S2:#5857)' "

Closeness to the patient.."(S2:#4458)' "Capacity to get things done and build a team."(S2:#0933);

"Teaching and autonomy." (S2:#6722) "

"Direct focus on the patient while doing research." (S2:#0712)

Working Arrangements

"Fine apart from the fact that I have to e-mail my manager on my arrival and departure. (S2:#8840);"

Very flexible so I can plan my day as I see fit." (S2:#4458)

"I have a very good line manager who supports flexibility." (S2:#6802)

Career Structure / Recruitment & Succession

"..need to keep it simple. Patients need care and clinicians need support." (S2:#6557)

"Introduction of positions such as Associate NUM and clinical facilitators somewhere between NO6 and NO7" (S2:#1938)

"There should be consideration of advanced practice for Gr 7 managers."(S2:#9146);

".. There is definitely a gap between level 6 and level 7 positions which means succession planning is difficult." (S2:#8809)

Statements: Clinical Nurse Consultants, Nurse Managers, Educators, Researchers, Other

"Capacity to get things done..to contribute to patient safety; better workplace culture..direct focus on the patient, research and teaching." (S2:#4117);

"Project work, autonomy..".(S2:#1916); "Professionally developing staff in

knowledge, skills and attitude." (S2:#3609);

"Change agent capacity." (S2:#8448);

"Working in an area where lives are being saved through early detection of cancer." (S2:#0754);

"Direct focus on research, research and quality." (S2:#8128); "To make a difference to nursing practice.." (S2:#3788); "Closeness to direct care." (S2:#4932); "I have clinical work, a senior role in the tem and time permitting, looking at professional issues."(S2:#3680)'

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“Improving outcomes, enabling staff to achieve better work satisfaction.”(S2:#0202)’ Doing creative work.” (S2:#3338);;

“Make rural and remote nursing more attractive.” (S2:#6524)

“Autonomy and no management of staff.” (S2:#4319); “Lots of autonomy and power of expert knowledge.” (S2:#8299); “Autonomy in day-to-day practice without unit management responsibility.” (S2:#6973);

“9 day fortnight - good balance.” (S2:#4117);

“ Am a shift worker and hard to swap shifts.” (S2:#1666);

“Management trying to give us more choice.” (S2:#1942);

“Well balanced hours.”(S2:#5462); “Work 4 days a week.” (S2:#6544);; “Excellent as I have flexible hours to meet my work and family needs.” (S2:#9829);

“I do shift work and generally no problem being able to work my preferences.” (S2:#4932);

“Part-time and very flexible.” (S2:#6557)

“Need to treasure these (clinical) positions as normally promotion means moving away from patient care.” (S2:#0598);

Clinical grade that recognises advanced skills – CNC has hit the ceiling after 3 years unless becomes an NP.”(S2:#1721);

“There is very limited scope for Nurse Educator to go into ND role..” (S2:#9667);

“Need higher levels for educators Grade 7” (S2:#0933); “A CN advanced practice, and not just a change of name for those in current positions.” (S2:#7647)

“Too few stepping up positions available without NO3.” (S2:#0379)

“Merit in CN advanced practice for succession planning to CNC role.” (S2:#6073)

“Infection control practitioners at ND level given the scope and responsibility of their work in a large facility.” (S2:#9064);

Need gazetted Clinical Facilitator role.” (S2:#0498)

“CN advanced practice research needed.” (S2:#0980)d

“More levels within NG7 that reflect the advanced practice requirements of the position.” (S2:#9542)

“CN positions to support the Nurse Research Role and increase research capacity.” (S2:#1069)

“Succession pathways for junior staff – assist with workload while gaining experience.” (S2:#5940)

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"Agree on what is achievable." (S2:#4663)

"Lack of part-time options to study at higher levels, PhD." (S2:#0379)

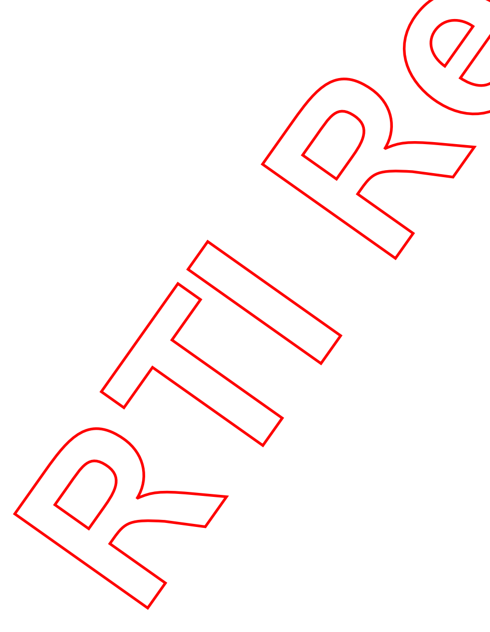
5.6 Conclusion

Findings of the Grade 7 Nurses and Midwives consultation rounds by means of e-survey, focus groups and selected interviews, have been presented. The purpose has been to identify and present for further evaluation, the relativities and comparisons in findings across the Grade 7 of the current QH Career and Classification Structure.

Results have been made immediately accessible by reporting findings in Summaries (8-10), and in Section 5.4, where the results demonstrate the value of having garnered the collective QNU Grade 7 member voice in this work. The knowledge and understanding gained from the responses are important in evaluating the relative concerns of nurses and midwives in the study, and how this most current information can be applied specifically in the negotiating work of the NaMIG.

The findings for this cohort of Grade 7 Nurses and Midwives are entirely consistent with the literature search on advanced practice, Section 4.

The next Section, as the final section of the QNU N/MUM Project (2011) Report, lists conclusions reached, and recommendations formulated, based on Grade 7 member consultation and selected research, presented in the previous Sections of the Report.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6 Conclusions & Recommendations

6.1 The Project

The purpose of the QNU N/MUM Project 2011 is to assist the QNU to develop a position to inform QH EB 8 negotiations with respect to any changes that are required to the role, responsibility and span of control of the NUM role and its inter-relationship with roles in other streams of the nursing career structure. In line with the objectives,

- current problems related to the span of control, role and responsibilities of the Nurse Unit Manager (NUM) employed in the public sector have been identified, along with the changes that may be required to support and enhance the role and succession planning for this pivotal position; and,
- consideration to the inter-relationship between the NUM role and roles at the same level in the Clinical, Research and Education streams has been given, and recommendations to ensure the integrity of each of the streams is maintained have been made.

A Position Picture (Appendix 1) was confirmed through preliminary member consultation and other validations, and consistently applied in structuring the body of study.

A QNU nurse/midwife member consultation framework was designed and implemented over a period of 14 weeks. Two cohorts were identified in the Grade 7 classification of the QH Career Structure for Nurses and Midwives – Nurse and Midwife Unit Managers (N/MUMs) and Grade 7 Nurses and Midwives in a range of positions other than unit managers, including, functional managers, clinicians, educators, researchers, project leads. A total of 610 member consultations were achieved by means of electronic survey, postal mail survey, focus groups, and interview.

The literature review provides a valuable resource of evidence to affirm and direct current and future strategies to address some protracted and unresolved issues, and some newly emergent issues around role complexities and operational environment instabilities.

This report contains twenty (20) recommendations collated from QNU member voice and validated by specific and important findings in extant role research. These recommendations are endorsed by QNU Council, and will be taken forward in shared interests, working with QH to achieve best possible outcomes for nurses and midwives, for the organization, QH, and for the communities they serve.

The project has achieved the objectives and more. The facilitation of member voice has been important in creating the critical space for identifying and clarifying possibilities in relation to updating the QH Career Structure for Nurses and Midwives in the face of protracted recruitment and retention challenges.

The following declaration captures a substantial theme of career structure experience in that major breakthroughs have been achieved when the expert knowledge of nurses and midwives who are managers and who are clinicians, is understood, valued, and rewarded.

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> *If the nursing profession is to be successful in attracting new recruits who will stay at the bedside, if it is to be able to change the working conditions and pay scales that now discourage a long-term retention, and if it is to fashion a new image, it must move from the focus on virtue to one on knowledge (Nelson & Gordon 2006, p.29).*

It is anticipated that this Project will promote further understanding, valuing, and reward for nurses and midwives whose roles are grounded in professional foundations and expert knowledge applied in the work of Queensland Health. The following recommendations are made to that end.

6.2 Recommendations

1 Nursing and Midwifery Governance

1.1 That Nursing and midwifery governance undergo a strategic re-build to enable leadership capability and role effectiveness, including opportunities to secure:-

- empowerment through structured nursing and midwifery governance and self-regulation;
- investment in nursing and midwifery's primary positioning for system and patient safety and quality;
- investment in nursing's health service leadership and reform capability- service models and pathways; expert co-ordination in partnerships and teams; and
- respect, recognition and reward for advancement in nursing and midwifery knowledge and practices (QH Career & Classification Structure).

1.2 That a professional career structure based on differentiated nursing and midwifery practice and multiple levels across streams, be affirmed and consolidated.

1.3 That operational authority be formalized in roles with significant resource accountabilities tied to role responsibilities, specifically the Business Planning Framework: a tool for nursing workload management, Version 4 (2008);

1.4 That professional career advancement in an updated QH Career Structure be applied in maximizing synergies and new opportunities in recruitment and retention strategies currently scoped by the lead strategic reference group of QH (NaMIG) in priority project work, comprising :

- Career and Classification Structure;
- Models of Nursing and Midwifery;
- Business Planning Framework;
- Working Arrangements.

2 Span of Control

2.1 That realistic spans of control be achieved for N/MUMs by identifying and applying measures to modify current over-wide spans, where role capacity is limited.

2.2 That evaluation of current role N/MUM role spans be based on best-practice measures, and

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- adopt span indicators with proven sensitivity to the context of the N/MUMs' professionally grounded management practice;
- inform the selection of strategies for achieving appropriate modifications to the operational environment of the N/MUM; and
- be applied in recognition of N/MUM advanced management expertise in appropriately matched grades and bandings in the QH Career and Classification Structure.

2.3 That a range of clinical, business, human resources, administrative, and material supports be implemented in effective modification of current over-wide spans of N/MUM roles, consistent with and prioritized in the Service Profile of the Business Planning undertaken by N/MUMs in collaboration with their teams, service-users, and line managers.

2.4 That formal role authority be established in the N/MUMs' position description, commensurate with the expected accountabilities for outcomes across the designated span of managerial and professional clinical control.

3 Role Responsibilities

3.1 That the tacit, expert, and professionally grounded role work of the N/MUM be recognised as advanced nursing and midwifery management practice, differentiated by role responsibilities, and formally valued by:

- affirming the unique hybrid clinical leadership and managerial role of the advanced practice N/MUM;
- implementing role span modifications to achieve effective balance in the N/MUM hybrid role work, in line with the N/MUM practice context;
- agreement on role outcomes and revised position descriptors; and in
- correcting persistent anomalies across the current QH Career and Classification Structure at Grade 7, that negatively impact on N/MUM, and related staff recruitment.

3.2 That appropriate recognition and strategic utilization of advanced practice nursing and midwifery in the QH Career and Classification Structure be effectively achieved for nursing and midwifery roles across all career structure streams, with specific reference to:

- QNU Objectives of the Career Structure and Classification Structure (2011); and
- QNU Policy on Career and Classification Structure recognition of Advanced Practice Nursing and Midwifery (QNU 2011).

4 Role Enablers and Role Supports

4.1 That recommendations related to role span and responsibilities be recognised and endorsed as key enablers of N/MUM clinical leadership and managerial role capacity.

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4.2 That administrative assistants be introduced in light of the current operational context for QH N/MUMs, and with reference to the evaluation outcomes for N/MUMs in the New South Wales Health N/MUM capacity building program, *Take the Lead* (AIHI 2011).

4.3 That ancillary staff such as finance and human resources be reoriented to a support role for N/MUMs.

4.4 That QH N/MUMs be supported in achieving the appropriate clinical infrastructure (clinical, education, and research) and in meeting the established standards and principles of nursing and midwifery professional practice frameworks, where the N/MUMs strategic, professional, and operational expertise is relied upon, and where new complexities and instabilities challenge the front-line N/MUM's role capacity and capability.

4.4 That formal, resourced peer network structures be established to enable N/MUM leadership capacity and capability, towards high resilient organizations.

5 Role Preparation, Recruitment & Retention

5.1 That recommendations related to role Span, Responsibilities and Enablers be embedded in consolidating role preparation, recruitment and retention strategies for N/MUMs, and where applicable, for Grade 7 Nurses and Midwives in advanced functional management, clinical, education, and research roles.

5.2 That evidence-based recruitment and retention strategies be incorporated in preparation, recruitment and retention of nurses and midwives at all levels of clinical leadership and managerial role development and advancement.

5.3 That access to role related education and training, orientation, mentoring framework and related offerings available through the work of the Nursing and Midwifery Office of Queensland (NMOQ, 2011) and others, be effectively resourced.

5.4 That alternate approaches to 'fix the N/MUM' be promoted and resourced, in particular:-

relationship-centred programs, peer mechanisms, and learning on the job;

managerial (training) programs sensitive to and modified for recognition of the professional expertise and practice context of the participants; and

demonstrated investments in material supports to rebuild confidence in the

attractiveness of the N/MUM role.

5.5 That an updated QH Career and Classification structure with improved opportunities for access to recognition for advanced practice, be established to ensure:-

stability and continuity in recruitment and in retention of clinical leaders in each of the four (4) QH Career Structure streams; and

access for nurses and midwives early in their careers of advanced practice.

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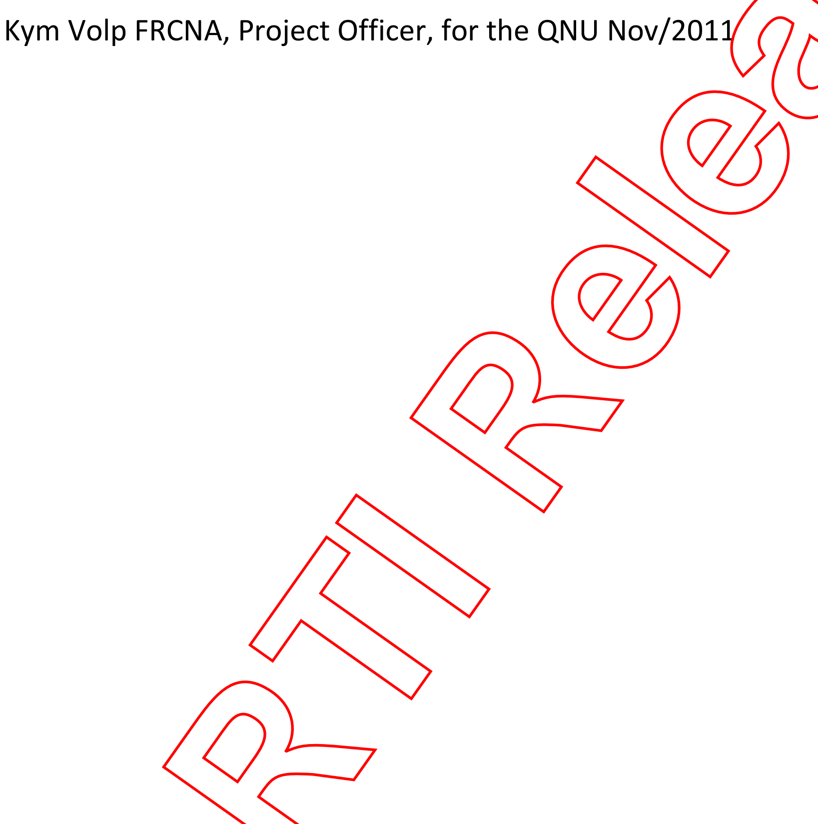
6.3 Conclusion

The QNU N/MUM Research Project 2011 has substantially achieved the objectives set by the QNU Council in formalizing the most accurate and current view of nurse and midwife members, currently classified in Grade 7, QH Career and Classification Structure.

The Project Report provides twenty (20) recommendations collated from QNU member voice and corroborated by specific and important findings in extant role research. These recommendations are endorsed by the QNU Council, and will be taken forward in shared interests, in working with QH to achieve best possible outcomes for nurses and midwives, for the organization, QH, and for the communities we serve.

> *If nursing is to find full expression within mainstream healthcare, nurses must set the stage for a full exploration of their difference, their defining qualities, their unique talents, and their distinct purposes, and their revolutionary spirit. (Northrup, Tschanz, Mackaroff, et.al. 2004, p.55).*

Kym Volp FRCNA, Project Officer, for the QNU Nov/2011



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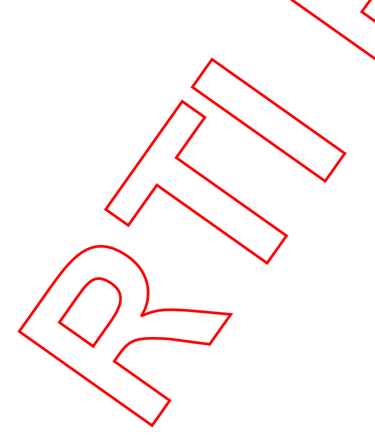
**All references used in text; for further readings, contact author at* kym.v@bigpond.com



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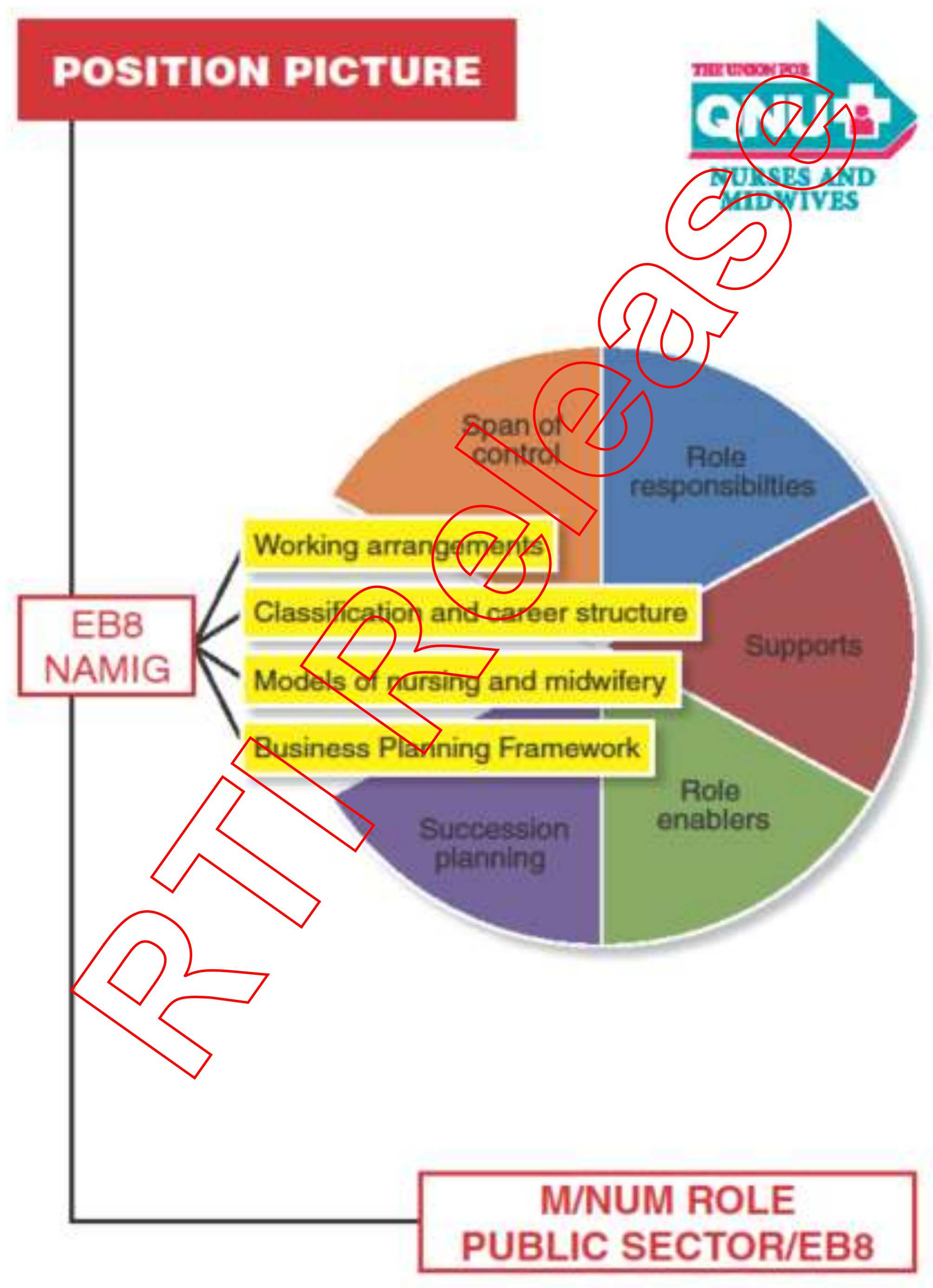
8 Appendices

8.1 Appendix 1: QNU N/MUM Project (2011) Problem Statement – Position Picture



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8.2 Appendix 2: A History of the Present QH/QNU Career Structure

The following summary identifies milestones in the history of the Career Structure for Nurses and Midwives in Queensland. The history is important in understanding the present concerns of members in relation to gaps to be corrected and enhancements yet to realized.

The career structure is a key strategy in recruitment and retention of nurses and midwives and is foundational to professional self-determination, growth, and sustainability of the professions.

A structured path of recognition of advanced practice in management, clinical, education, and research streams create important possibilities for nurses and midwives, for health service leadership and reform, and for the communities we serve.

From the outset, through implementation, and review, QNU reports "threats to the career structure' in consecutive Annual Reports, across changes in State and Federal governments, subjecting the career structure to trade-offs, cost cutting, inadequate filling of positions, increased workloads, role compression, underutilization of career roles, industrially disputed translation phases, and contested campaigns including strike action (QNU Annual Reports 1983-2010).

Implementation 1990-1991

The first definition of career structure is noted (Silver 1986, p.44) as "an organizational framework designed to provide career advancement and remuneration for demonstrated competence, experience and educational preparation in different roles and at different levels within the discipline of nursing."

The core of the professional project that the career structure symbolized, was a reclaiming of accountability, and authority over the practice of nursing by clinicians. This announced a shift in power/knowledge away from traditional hierarchical nursing (supervisory) management to the bed-side nursing practitioner.

Career Structure Implementation Objectives (QNU Annual Report 1991, p.3)

Establish a career path for clinical practitioners as well as nurse managers and educators.

Improve the standards of patient/client care by introducing an advanced clinical role.

Promote devolution of authority and legitimate power.

Decentralise decision-making.

Reduce spans of control.

Provide for differentiation between levels of nursing competence.

Increase accountability at each level of practice.

Provide role and remuneration equity between practitioners of the same level in different functional roles and fields of practice.

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The terms 'Charge Nurse", "Nursing Supervisor", and "Night Supervisor" were replaced with the title, Nurse Unit Manager and Nurse Manager. Terms such as Educator with Diploma, Senior Nurse Educator, Deputy Director of Nursing, no longer applied.

The traditional Charge Nurse role was subjected to task analysis and redefinition resulted in two new roles, the Nurse Manager and Clinical Nurse Consultant. The title of Clinical Nurse Consultant was carefully considered. The title reflects a position where the expert practitioner practices direct care, coordinates care and acts as a role model, patient and staff educator, action researcher, and change agent (Silver 1986, p.46).

Problems with the 'charge nurse' role reported by Silver as having a 20 year record in the literature from the 1960's with a role under review ever since.

The five-level structure represented a pure streaming framework with specific position titles referenced to clinical, management, education, and research in RN levels 3 and 4 and within a traditional nursing hierarchical organizational structure (Silver 1985, p.45). The primary incentive for the structure was the need to retain competent , experienced nurses at the nurse-client interface. The career structure at that time, and since, has been an assertion of the primacy of practice in nursing as a profession, and central to nursing's, purpose and outcomes.

Evaluation: 1993

The first evaluation of the Nurses' Career Structure in Queensland public sector was reported in 1993, "The 1993 Joint Co-Operative Review of the Career Structure for Nurses" as part of the Goss Labor Government ALP Policy Commitment (1992). The reference was a statement of support for 'the integrity of the career structure and its continued viability" (QNU 1993, p.1). The formal review broke down due to political influences, and in a climate of proposed cuts to non-clinical career structure positions.

However, 2 new positions emerged in Nursing Practice Co-Ordinator, and an Assistant Director of Nursing composite position (Clinical/Management).

By 1994, the new role of Nursing Practice Co-Ordinator has been established out of the 1994 Career Structure negotiations. The role provides a strengthening of nursing's position in devolved management structures where clinical and management decision-making are based at the unit level. What the role does not do, however, is remove the need for both nurse managers and clinical nurse consultants. Different circumstances will require varying combinations of all of these roles (TQN 1997, p.13).

Evaluation : 1996

QNU Annual Conference Review of the Career Structure (QNU 1996) stressed the need for Level 3 (Nurse Manager) pay rate increase to reflect increased role responsibilities and to address long-standing anomaly in recruitment from RN pool on penalty pay. The remuneration anomaly identified with Professional Officer Grade 4 rates of pay c.f. Level 3 Nurses pay rate in case of Integrated Mental Health Services for Team Leader positions (QNU Career Structure Review 1996, p.8)

By 1997, predictions of the major impact on future career structure as management structures and budget pressures prevailed (TQN 1997, p.13). It was not enough to bring in

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the Nursing Practice Co-Ordinator role, as there was still a need for management, clinical, and educator support (TQN 1997b, p.13).

The Report on the Career Structure (1996) points to a very real commitment by nurses to the structure, however, clear issue still remain with the implementation and function of nurses in the structure (QNU Annual Report 1997-98, p.7).

The Career Structure (Members' Feedback Report, QNU 1996, pp.11-13)

- Provides a clearly defined Career Path for Registered Nurses
- Note improvement in the advocacy provided for and by nurses
- Opportunity exists for increased professional autonomy
- Nurses have been encouraged to undertake further education.
- Incentives are provided to nurses to remain in the profession and to gain access to promotional positions.
- Accountability for nursing practice (at all levels) has improved.
- Is resilient and adaptable. It provides various career opportunities and promotes mobility
- Provides recognition in the multifaceted nature of nursing work
- Facilitates nursing leadership and allows for role models to be provided.

Evaluation : 1999-2004

Problems with delineation and understanding of various roles, and issues of workloads negating role capacity were stressed (QNU 1996, pp.17-23). In 1999, the issues persisted in career structure and role responsibilities, (QNU 1999, pp.8-13) taken up by then Health Minister, Hon W. Edmond, to establish the *Ministerial Taskforce – Nursing Recruitment and Retention.* Concerns were catalogued as:-

- Level 2 nurse are not able to fulfill their role due to excessive workload demands.
- The general lack of Level 2 positions results in nurses leaving the public sector because of limited promotional opportunities, while shortages of nurses in rural and remote facilities and specialty areas result in other people being promoted to Level 23 without having the commensurate skill or experience.
- Enrolled Nurses are not seen as part of the career structure and the advanced skills or qualifications of ENs are not recognised, thus devaluing these positions.
- Lack of recognition of the role of the Assistant-in-Nursing; further AINs are not seen as a vehicle for progression to Enrolled or Registered Nurse.
- Directors of Nursing are being appointed to joint Director of Nursing/Executive Officer positions, without regard to the additional responsibilities that such appointments create.
- Director of Nursing Community positions have been reduced across the State with no provision for alternative community nursing leadership positions. Nursing practice in the community sector has been under constant attack over the last few years.

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3, 4 and 5 Issue: From August 1999 to June 2003 out of a recommendation (Ministerial Taskforce 1999) for a review of the nursing career structure (QH) to redress anomalies in the nurse manager classification through to ongoing negotiation by QH through the new taskforce, a Peak Nursing Body recommended as part of the Section 170MX Award (2003, clause 13, p.8). This was essentially about a pay rise for nurse managers. QH as employer held fast on no offer of pay rise for nurse managers from October 2001 until the case went to arbitration (AIRC) in October 2002, and the 170MX decision handed down in June 2003.

The new structure reflected a protracted endeavour by ANF nurse manager members to have a classification that properly matched roles and responsibilities with remuneration. The new Nursing Officer (NO4) structure provided more scope for position assessment where any roles were to undergo development, expansion, or other change in organisational restructuring (Mole 2003 Affadavit:15).

Evaluation : 2004

2004 Annual Conference Resolution (IPPC Evaluation) *Role combination to NPC

"The implementation of a salary spined structure for nurses in 2003 did not address the following:

The anomaly specifically between clinical nurses Nursing Officer (NO2A) and Nursing Officer (NO3) positions (Nurse Unit Manager, Clinical Nurse Consultant, Nurse Manager, Nurse Researcher, and Nurse Educator).

Recruitment to positions remains difficult and backfilling for emergent or planned leave is increasingly difficult to do.

Inability to match roles and responsibilities with appropriate remuneration (i.e. currently there is no scope for NUM, CNC, NM, Nurse Educator and Nurse Researcher to be remunerated other than at NO3 or NO4). One of the agreed principles of a new career structure was flexibility and ability to remunerate based on roles and responsibilities.

Emerging and innovative nursing roles, and recognition of current nurses positions. The current structure needs to reflect at the very least, the role of: Nurse Practitioner, Advanced Clinical Nurse Positions, and inclusion of Enrolled Nurse and Assistant in Nursing Positions.

The net loss of nursing positions in the current structure, has been at Assistant Director of Nursing and Director of Nursing levels.

Evaluation : 2008-2011

By 2008, QH had established the Nurse Manager Role Review Project Phase I, in relation to the key priority working party, *Nursing Classification and Career Structure Project* (EB7). By 2010, Phase 2 of the QH NUM Role Review was funded to:

Objectives :

Establish work level statements and role descriptors identifying the core functions of the NUM position within Queensland Health.

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Identify duties and tasks NUMs currently undertake which sit outside the central role of the NUM and explore strategies to refocus the role on clinical leadership.

Review existing training resources to support preparation for the NUM role.

Identify a suite of training resources relevant to the NUM skill set, to inform performance appraisal and development and professional development activities.

Identify key components for orientation and succession planning for the NUM role

An Orientation Checklist has been developed, and a Core Functions Framework was published (28 Jan 2011) identified the following:

Clinical Management & Coordination

Clinical Leadership

People Management

Business Management

The following chronology identifies key milestones in the history of the present Career Structure for Nurses and Midwives in Queensland public sector.

Table 11. Key Findings from Career Structure Implementation & Evaluation 1982-2011 (30 years)

Year	Historical Context	Progress
1983	First QNU Council, January 1982	"..Union statements on a Clinical Career Structure for nurses will be produced for consideration by members." (QNU Annual Report 1983, p.6)
1983	Wage Case	
1984	Campaign "Valuing Nurses"	"..disappointing.. where certain groups of membership, e.g **Charge Nurses** in particular, would continue to be disadvantaged."(QNU Annual Report 1984, p.10)
1987-88	Principal objective of QNU – new career structure for nurses.. better conditions and skill formation linked to Award Restructuring." 10 months QNU Wage Case	Claims for wages/career structure opposed by government (Minister Austin to Ahern then Harvey) ; 2nd Tier/4% wage increase and trade-offs// Ahern Govt April 1988: Public Service Management & Employment Act new business-like, decentralized public administration (QNU Annual Report 1988, p.9).
1988	QNU Research Officer – project on interstate structures	
1989	**Proposed 7-leve Structure from AIN to DON**	Federal Funding for Award Restructuring Project Team – development of new career structure (structural efficiency principle)
2 Dec 1989	Labor State Government ALP Nursing Policy	

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Year	Historical Context	Progress
1990	**5-level Structure**	AIRC Aug 1990; then QIRC decision **6 Dec 1990** for new 5-level Clinical Career Structure for Qld Public Sector Nurses (QNU Annual Report 1993, p.9) QIRC: Dec. 1990 July-Sep (1990), Intense campaigning *Career Structure; Professional Rates of Pay; Workloads Management*.
1991	Abolition of Chief Nursing Office	
1992	Goss Labor Govt. Career Structure Review commitment	***From 1992, QNU Annual Reports note continuum of defending integrity and sustainability of the Career Structure***
1993	**1st Evaluation**	Negotiating environment – economic recession; pressure on c/structure positions in new management structures /regionalisation(QNU Annual Report 1992-93, p.5)
1994 Oct.	**Joint QNU/HQ Review of Career Structure Commenced (broke down)** **- Nursing Practice Co-ordinator** **- ADON (Composite: clinical/management)**	Attempts to trade-off positions for 38 hour week; cabinet statement to abolish 220 positions and save $8m – industrial actions; to first EBA November 1994.
1995		No agreed number of nurses for each classification; and no direction on use of funds saved with relieving nurses of nonprofessional clerical work (QNU Annual Report 1995, p.2)
1996	Career Structure Dispute to AIRC: Unresolved Increase in non-nurse managers, nurses reporting to non-nurse managers. Protection of c/structure paramount.	"Highly trained and experienced nursing leaders will manage nurses. Nurses will manage m=nurses" (QNU Annual Report, 1996, p.6.)..
1997	QNU Annual Conference: C/Structure Evaluation with members, Report Dec. – into EBII negotiations "Fair Workloads & Fair Wages" Sept 1997	
1998	IR changes (State/Fed Awards) to 20 conditions; erosion of c/structure;	"..to strengthen the career structure." (p.11); rise and rise of economic models of health care (1998, p.2); pressure to downgrade nursing career structure (1998, p.4).
2000	Hon W.Edmond (Health Minister)	L3 and L4 RNs new pay rates; QNU Submission: ***Valuing Nursing.; 6 months intense negotiation; work begins on Review of L3, 4, & 5 roles. Concern with growth of Nurse Practice Coordinator Role and loss of delineation of L3 career streams.****
2001	EB3 : rectification of 'anomalies'59 recommendations/*Ministerial Taskforce – Recruitment & Retention*	

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Year	Historical Context	Progress
2002	**Evaluation** New pay point for L3; upgrade for L4; x2 more Exec. DONs; work on NP role; more work on Taskforce reckies (42, 43). **Business Panning Framework**	**Nurses. Worth Looking After.** Disappointed ENs and L3 RNs; QH denying workforce shortage; NO Classification (salary spine structure); Translation NO3-NO7 based on scoring tool; BPF; Quals Allowance; Peak Nursing Body (later Nursing & Midwifery Implementation Group, NaMIG).
2003	AIRC EB 5 : to **Nurses (QH) Section 170MX Award 2003 at 1.4 New Career Structure for Registered Nurses (6 June 2003)**	
2004		2004 QNU IPPC: Recommendation to role combination to Nursing Practice Coordinator.
2006	Grievances lodged, L3, 4, 5 (NO1-NO9) Translation Grievances continue EB5 expiry Oct 2006	
2007 1 July		>470 individual grievances AIRC Hearings – 126 heard; BPF and unmanageable workloads continue. Your Rights at Work
2008/ Oct	First in Interest Based Bargaining EB6 Professional Development Package	
2008	**Evaluation** 5 Priority Areas to 4 priority projects 2009 – **Nursing & Midwifery Workforce Planning** QH Nurse Manager Role Review Phase 1; 2010-2011 Phase 2. NIBBIG; Revised BPF Version 4	Working Parties – 5 Priority Areas out of EB6 Models of Nursing & Midwifery Nursing Education & Development Framework Career & Classification Structure Working Arrangements Business Planning Framework Nurses. For You. For Life / Because We Care
2009-2010		To report to NaMIG 2011 Review of generic level statements & definitions to support contemporary models of nursing and midwifery; emphasis on key roles such as enrolled nurses, midwives, nurse practitioners, nurse unit managers. ..Career Structure Review
2011	**Evaluation** **Priority Project:** **Nursing & Midwifery Career & Classification Structure** EB7 : NIBBIG – 5 priority areas continue Expires Mar 2012 *Queensland Health Nurses & Midwives Award – State 2011* QNU Nurse & Midwife Unit Manager Research Project	QNU Council: Career Structure Objectives (2011/Feb) QNU IPPC: Policy Advanced Practice Nursing (2011/July)

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8.3 Appendix 3: QNU N/MUM Project 2011

Table 12. Consultation Framework

Consultation	Contextual Reliability	Scope	Approach	Resources
Span of Control Role Responsibilities Supports Role Enhancement Succession Planning Classification/ Career Structure ↕	*Members* NUMs MUMs CNs CNCs Educators Researchers Other	Metro Regional Rural Remote	Focus Groups Teleconferencing Q/aire – random/ targeted sampling e-mail/ reply-paid postal	Time Budget
	Lead Stakeholders DONs Rural DON&FMs NDs	Selected sites Selected oppositional sources	Focus Groups Teleconferencing Interview	Time Budget
NUM POSITION EB 8	QNU Organisers Branch Delegates /MODs Councillors	Internal Organisation Branch Network	Focus Group Teleconferencing	Time Budget

Connections ←→

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8.4 Appendix 4: Analysis of Current Australian Enterprise Agreements (Nurses & Midwives, Public Sector)

8.4.1 Tasmania

State EBA

Nurses and Midwives Heads of Agreement 2010 (Read in conjunctions with Nurses (Tas Public Sector) Award 2005 & Nurses (Tas Public Sector) EB 2007. To be replaced no later than 31 Mar 2013. *Interest Based Bargaining for 2010 outcomes

Intended Consequences

Joint Consultative Committee to:

- undertake specified Career Structure Reviews – NUM role review 2011
- including community nurses in Statewide and Mental Health Service
- resolving implementation issues
- complete Award modernization

Safe Staffing and Outcomes of Care Committee (new)

Reduction of shifts to 6 hours by mutual agreement

Reduction of shift overlap in rostering

$150 PD per annum

Preceptor Allowance for Gr2&3

$30K sabbatical for Gr 8 & 9

Multidisciplinary allowance for Community /MHealth T/Ls

EN Quals Allowance (Adv.Dip)

Career Structure

NEW Career Structure – progress including acceleration, & pay point maintenance (Grade 4) subject to ***Formal Capability Assessment***; all Gr 4s assessment every 2 years.

New Name: Clinical Co-ordinator (Gr 5)

Nursing Co-Director (at Directorate level)

Gr 7 NUMs into 7a & 7b (differentiated on role responsibilities)

Intro of **AIN/AIM role**/ 7 day week/ 2 shifts/day; trial for 6 months x4 hospitals

2 points in Gr 7 – based on bed numbers/FTE/scope of role/services provided.

Grade 8 for NPs, Senior Nurse Managers and State-wide clinicians e.g. IC/Director of Clinical Practice;

Gr9: Executive DON

Classification

Wage Increase 9.25 per cent

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9 Grades from AIN to EDON (Total 38 pay points)

Gr 1: AIN

Gr 2: EN

Gr 3: RN (8 pay points)

Gr 4: from year 8 in Gr 3

Grade 4 for CNs

Grades 5-7 – merit appointment/promotion

(Subject to work value review; AIN trials)

8.4.2 South Australia

State EBA

Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2010 – *to June 2013*

Intended Consequences

continual improvement

attract and retain staff

work value changes

contribution to productivity and efficiency

replace Excelcare with Cinical Practice Support system

70% RN skill mix

staffing tool for Comm/& M.Health

Night Duty standard length is 10 hours

portfolio management time for CNs

NUM's – No ADO's or o/time

3 days paid PD

Training & Development Forums for each worksite

Capability Development Framework (workforce/gaps/ Training)

d/making tree for shift to shift staffing (Clinical Services Co Ordinator)

Includes AIN/AIMs

quals allowance in place RNS & ENs

Career Structure

NEW C/Structure in 2007 Agreement.

Modified post translation

Quals allowance for ENs

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Clinical Service Co-Ordinators (L3 & L4)

Associate CSCs

Education Facilitator (L3)

Management Facilitator (L3)

Progression on anniversary date

Classification

Wages 5 per cent; plus revised career /salary structure.

NEW: Advanced Skills EN x3 pay points

RN **L1** : 10 pay points

CN/CM **L2 :** 10 increments

Associate CSC (CN): 5 pay points

CSC/Clincial Practice Consultant/ Education, Facilitator/Management, Facilitator **L3**: 3 pay points

(Same titles with "Advanced" + NP **L4**: 3 pay points)

N/Mid Director **L5:** 3 pay points

Program//Divisional Directors **L5.1**

Advanced Directors **L5.2**

DON **L6 :** 7 pay points

8.4.3 New South Wales

State EBA

Public Health System Nurses' and Midwives (State) Award 2011

Intended Consequences

differential payment clause (17(xi) for Nurse T/L's cf. HP's

Registration Pending Clause 28. (payment from date of applicat'n)

Reasonable Workload Committees

Specific Commitments Cl 58 – efficiency & productivity initiatives (a)-(m).

Scope for Promotional Positions – based on Bed #

Career Structure

EN Special Grade (no meds /but Advanced Cert)

Clinical Educator (ward based, day-to-day)

NEW (2009)

CNS/CMS Grades 1 & 2

CNS/CMS Grade 1 is a personal grading (distinguished from RN Year 8)

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In Charge Allowance

Quals Allowance

CNS/CMS Grade 2 – appointment based; extended autonomy, specialist practice, case management and leadership

NEW (2009)

Nurse/Midwife Educator Grades, 1, 2, & 3

CNC's Grades 1-3

Nurse/Midwife Manager

Nursing/Midwifery Unit Manager

Grading Committee (2 Union/2 Employer Reps) for N/M Manager Position Gradings – pay point movement subject to satisfactory performance

Classification

Less than 150 beds – a Deputy DON

Moe than 150 beds – Deputy DON, ADONs

RN/Midwife – 8 pay points

CNS Grade 1 – 1 pay point

CNS Grade 2 – 2 paypoints

Nurse/Mid. Educator

Grades 1-3 (2 pay points each)

Nursing/Mid. Unit Manager – 3 p.points

CNC/ CMC – 2 paypoints

Nurse/Midwife Practitioners – 4 paypoints

Nurse/Midwife Managers

9 Grades/ each 2 pay points.

8.4.4 Western Australia

State EBA

Registered Nurses, Midwives and Enrolled Mental Health Nurses – Australian Nursing Federation – WA Health Industrial Agreement 2010

Intended Consequences

highly specified workloads management clause

Career Structure

Skill indicators identified for each pay point for) progression (EN Mental Health)

Career Streaming explicit from SRN Level 2 to 10

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Nurse Practitioners at SRN Level 3 and above

Incremental progression subject to satisfactory performance appraisal.

Classification

RN L1

RN L2 – to perform in stream of clinical, management, research or staff development

Senior Registered Nurse

SRN Levels 1

SRN L 2: Clinical, or Education

SRN L3: TLeader/ multidisciplines; expanded role clinical, management.

SRN L4: clinical resource, expanded practice, change management.

SRN L5: clinical, management, research or teaching emphases in scope of role.

SRN L6: as above (career streamed) consultancy; divisional level.

SRN L7: as above (career streamed) Facility manager, DON, HSM;

SRN L8, 9, 10 Leadership, Advisory, DONs.

8.4.5 ACT

State EBA

ACT Public Sector Nursing and Midwifery Agreement 1010-1022

Intended Consequences

Appointment (career positions) ***on basis of 'stream'*** with exceptions only for 'composite' roles on size/complexity/nature of service

From Level 3 to Level 4 Assistant Directors

New work level standards being developed (for consistency & parity across all classifications measured against agreed work level standards) **

Quals allowances

Responsibility/In Charge Allowance: $20.34

Career Structure

Personal Classification at Level 2 or promotional advancement

At Level 3: CN/CM Consultant Nurse/Mid Educator; Nurse Manager or Nurse Coordinator or Clinical Nurse Coordinator **

At Level 4: Assistant Director Nsg/Mid – Clinical, Management, or Research, or Education or Clinical/Management/Education (composite)

Classification

AINS (2 pay points)

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ENs Level 1(4 pay points_ & Level 2 (1 pay points)

RN/EM

Level 1 (8 pay points)

Level 2 (25% both personal & established positions) 4 paypoints

Level 2 (75%in community)

Level 3, Gr 1 – 3 pay points

-Level 3, Gr 2 (1 pay point)

Level 4 (4 grades: 1 pay point each)

Level 4 Gr 2 (NP) 1 pay point

Level 5 – DON/and/or Midwifery – 6 Grades

8.4.6 Victoria

State EBA

Nurses (Victorian) Public Health Sector Multiple Business Agreement 2007-2011

Intended Consequences

Career Structure streams explicit for management & clinical

RN-CNS-CNC

Clinical Support Nurse (teaching/clinical facilitation; supernumerary with no case load)

CNCs – 3 Grades (5, 6, & 7)

Gr 5 Supervisor (Rural Hospitals)

Quals Allowance Div 1 & Div 2

Ratios specified

Career Structure

Division 1 RNs- start Grade 2, through to Grade 7

CNS – classified by criteria met

No Lift Coordinators

Associate NUM and

NUM roles

Clinical Consultant

A, B, C, D, and E

Nurse Practitioner

Deputy DON for > 30 beds

Grade 5 to Grade 7 – based on bed numbers

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Classification

RN Div 2 - 8 pay points **(EN)**

RN Grade 2 Div 1 (RNs) – 10 pay points

CNs – single rate

Division 1

RN Grade 3A – 2 pay points RN Grade 3B – 2 pay points

ANUM: 2 pay points

RN Grade 4A – 2 pay points (CNC)

RN Grade 4B – 2 pay points (Teacher)

NUM: 3 pay points

RN Grade 5 (CNC): 5 pay points (number of beds)

RN Grade 6: 6 pay points (number of beds)

RN Grade 7: 11 pay points (number of beds)

RN Group C- Div 5 – 6 pay points

RN Group D –Div 5 – 5 pay points

8.4.7 Northern Territory

State EBA

Northern Territory Public Sector Nurses' 2008-2011 Union Collective Agreement

Intended Consequences

Nurses 1-8

No specific nomenclature (eg. NUM/CNS) – just numbers

Quals Allowance

PD Allowance

Exemplary Practice Allowance 6-13%

Career Structure

Nurse 5 - Nursing Resource Consultants

Classification

Nurse 1: EN 5 pay points

Nurse 1: EN Advanced Practice : 1 pay point

Nurse 2 RN : 8 pay points

Nurse 3 RN: 3 pay points

Nurse 4 RN: 3 pay points

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Nurse 5 RN: 2 pay points

Nurse 6 RN: 3 pay points

Nurse 7 RN 1: pay point

Nurse 8 RN: 1 pay point

8.4.8 Queensland

State EBA

Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009

Relevant Schedules (6 & 7) in Nurses (Queensland Public Hospitals) Award 2004

Intended Consequences

Explicit Career Structure – 4 streams from NO 7

CNC

Nurse Manager

Nurse Educator

Nurse Researcher

ADONs

Clinical

Management

Education/Staff Development

Research

Director of Nursing

Career Structure

CN – 25 % RN workforce

CN – appointment only

ND's in Directorate Structure

Classification

Grade 1 : AIN to Advanced AIN- 6 pay points

Grade 2 : Undergrad Student Nurses/Midwives : 2 pay points

Grade 3 : ENS – 5 pay points

Grade 4: ENAP- 2 pay points

Grade 5 RN: 7 pay points

Grade 6 : Clinical Nurse/ Clinical Midwife 4 pay points

Grade 7: CNC/ NUM/NM/N. Educator/Nurse Researcher/Public Health Nurse/NP Candidate – 3 pay points

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Grade 8 – NP

Grade 9 – ADON/ND 3 Bands/ 2/1/1/ pay points

Grade 10: DON 4 bands/ 3/2/1/1/ pay points

Grade 11: DDON / 4 bands/ 2,2,2,2 pay points

Grade 12: EDON 1 pay point

Table 13. Summary of Findings – Inter-State EBAs (2010-2011)

RN pay points	X10 (SA); x8 (other Branches); x7 Qld
CN pay points	X4 Qld; x4 (CNS, NSW); x4 WA; x10 (SA)
Career Structure Streams	Explicit from CN; most explicit SA, and NSW From CNs practice directed to management, advanced clinical, education, or research. CNs- up 'Engaged in Research' positions (NSW) Managerialised at Nursing Director Role. Q'ld - Nursing Director Education, Research; SA - Clinical Practice Director (SA)
New Roles	Management Facilitator ; Education Facilitator (SA); Clinical Services Co-ordinator ; Assist. Clinical Services Co-Ordinator (SA) ; Clinical Co-ordinator (Tas)
Midwifery Models of Care	All agreements
Role Review	NUM Role Review (NSW, Queensland) Tasmania & SA (2011-2012)
Career Progression	CN- up to merit based promotional appointed positions based on Formal Capability Assessment (Tas); anniversary progression on satisfactory performance appraisal (SA, NSW, WA) otherwise; CNS Grad 1 (NSW) Personal Grading
Health Practitioner Role	Allowance to align with Community/Mental Health T/Leader viz Health/Allied Health Practitioner pay points (Tas & NSW)
Nurse Manager *(Changing nomenclature)* *Advanced Practice (Management) *Advanced Practice (Education)	X2 Grades (Tas) 7a &7b ; Management Facilitator & *Advanced* Management Facilitator (SA) Clinical Services Coordinator (SA); Clinical Coordinator (Tas) for CNs streaming into management; *Advanced* Clinical Services Co-ordinator (SA) *Advanced* Education Facilitator (SA) *Advanced* Director (Service/Division or Stream, SA)
*Advanced Practice (Clinical)	CN, CNS,.. CNC, CPC (Clinical Practice Consultant SA) to *Advanced* Clinical Practice Consultant to Clinical Practice Director (with sessional arrangements) (SA only example of Director level in advanced clinical practice)
Nomenclature – not standardized across jurisdictions	Management roles – NUM, Facilitator, Clinical Services Coordinator, Advanced Clinical Services Coordinator, Advanced Management Facilitator, Director, Advanced Director. Clinical roles – Clinical Nurse, Clinical Nurse Consultant, Clinical Nurse Specialist, Clinical Practice Coordinator; Advanced Clinical Practice Consultant, Clinical Practice

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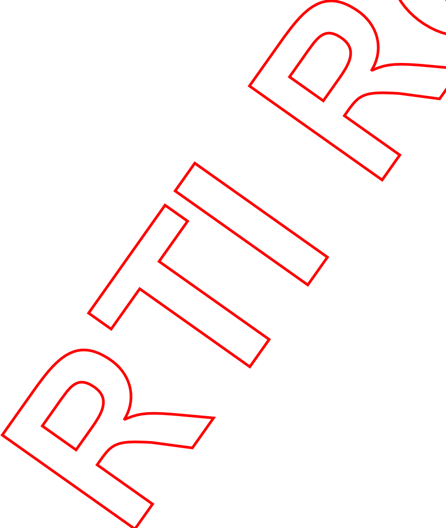
	Director.
Reference to skill mix, workloads management +/- ratios, models of care	All States & Territory agreements

Table 14. NSW and SA State EBAs

State EBA 2011	Nurse Unit Manager /Nurse Manager	Advanced Practice Clinician
New South Wales	NUM Levels 1 to 3 Coordination of Patient services Unit Management Nursing Staff Management	
South Australia	Nurse /Midwife Clinical Service Coordinator; Advanced Clinical Service Cordinator; Nurse/Midwife Management Facilitator; Advanced Nurses/Midwife Management Facilitator. *-accept accountability for the outcomes of nursing/midwifery practices and/or multidisciplinary outcomes in the specific practice setting; for addressing inconsistencies between practice and policy; and for developing team performance and a positive work culture in the interest of patient/client outcomes*	Clinical Nurse/Midwife; Associate Clinical Service Coordinator to Nurse/Midwife Clinical Practice Consultant. *- accept accountability for the outcomes of nursing/midwifery practices for the specific client group and for addressing inconsistencies between practice and policy.* Advanced Nurse/Midwife Clinical Practice Consultant/NP – *autonomous clinical decision makers, independent and collaborative.*



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8.5 Appendix 5: QNU N/MUM Research Project 2011: Survey & Focus Group Question Grid

Table 15. e-Survey & Focus Group Question Grid

QNU Member Position Picture Nurse & Midwifery Manager/Unit Manager	Question Grid (1) M/NUM Survey	Question Grid (2) Grade 7/CNC/other Survey
Biographical Details	Biographical Details	Biographical Details
	Questions (1, 2, 3, 4, 5)	Questions (1, 2, 3, 4, 5)
Span of Control & Empowerment	Question (9)	Question (9)
	Question (10)	Question (10)
	Question (11)	Question (23)
	Question (28)	Question (24)
	Question (29)	Question (25)
	Question (30)	
Role Responsibilities	Question (7)	Question (7)
	Question (8)	Question (8)
	Question (12)	Question (11)
	Question (21)	Question (17)
	Question (22)	Question (18)
	Question (25)	
	Question (26)	
Role Supports & Enablers	Question (13)	Question (12)
	Question (14)	Question (13)
	Question (15)	Question (14)
	Question (16)	
Role Preparation, Role Recruitment & Succession Planning	Question (6)	Question (6)
	Question (17)	Question (15)
	Question (18)	Question (16)
	Question (19)	Question (19)
	Question (20)	Question (20)
	Question (23)	Question (21)
	Question (24)	Question (22)
	Question (27)	
	Total : 30 Questions	**Total : 25 Questions**

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8.6 Appendix 6: QNU N/MUM Research Project 2011 e-Survey #1

NURSE/MIDWIFE NURSE MANAGER PROJECT

1. What position do you currently hold?

2. How long have you been in current role?

3. Note if you're acting in the role

4. What is the service you manage and/or provide in your role ?

5. What was your previous position?

6. Do you intend on staying in your current role? Comment as you may wish.

7. How would you describe your [written] position description?

8. Has your job changed since the classification structure came in EB6 (2008)? If changed, add a comment on how

- Span of control
- Complexity
- Uncertainty
- Task dumping
- Skills, knowledge required
- Models of care/nursing/midwifery
- Role compression
- Role overload
- Role scrutiny/performance surveillance
- Other

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NURSE/MIDWIFE NURSE MANAGER PROJECT

9. N/MUMs: The QH Role Review 2008:2 states "NUMs are experiencing role stress in relation to increasing demands on their role...particularly, administrative duties, moving NUMs further away from their clinical leadership role. NUMs cite insufficient training and preparation for the role as impacting upon intent to remain in the position." What's your comment on your current investment in the clinical practice/clinical leadership/co-ordination content of the role versus the business management content of the role?
(Say, on balance, percentages making up a total of 100 per cent.)

10. How does this 'balance' match the viability/success of achieving the expected outcomes of your role, in your particular service context?

11. Your service profile is a key workforce management tool. How does accountability/authority and ownership of the BPF work for you, in your role as N/MUM ?
Comment as you wish.

12. Comment on your capacity to modify/innovate models of care /nursing/midwifery in your practice context.

- **Organisational constraints**
- **Nursing sub-culture constraints**
- **Limited networking access/knowledge**
- **No constraints**
- **Other**

13. Do you/ would you support a clinical leadership role (Clinical Facilitator/ CNC/Educator) in supporting the effectiveness of your role as N/MUM ?
Comment as you wish.

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NURSE/MIDWIFE NURSE MANAGER PROJECT

14. If you had clinical leadership support, would you identify more, and invest more in the business /HR/service management /professional leadership content of your role in order to be [more] effective as N/MUM?

15. Do you consider that an administrative assistant (AO) or otherwise named, clinical support officer (CSO) as the ONLY additional support, would be sufficient in enhancing the effectiveness of your role as N/MUM ? Comment as you wish.

16. Do you consider any other mechanism of support to be useful in enabling the effectiveness of your role as N/MUM ?
Comment as you may wish.

17. Describe your work arrangements in relation to flexibility and work-life balance/other.

18. Do you advise any improvements to the career structure and/or the Nursing Officer (Gr) Classification, in, for example:

- **Being able to accommodate new (advanced practice) roles? E.g. Associate NUM role at CN/Advanced Practice (Gr 6), Clinical Nurse Facilitator (CN/Advanced Practice (Gr 5-6), Advanced Practice Midwifery and so on**

- **Being able to accommodate levels of role differentiation eg. M/NUM/ CNC ... and progression points with roles M/NUM /CNC .../other**

- **Other (comment as you wish)**

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NURSE/MIDWIFE NURSE MANAGER PROJECT

19. Given your current experience/understanding of the role of N/MUM, what training would you have benefitted from in taking on the N/MUM role?

20. What education/training/ preparation would you recommend for others considering the role ?

21. What frustrations do you experience most (Top 3)?

1
2
3

22. And what do you see as possible solutions to your Top 3 frustrations?

1
2
3

23. Do you think recruitment to your role/succession planning would be easier if your role was clearly identified in management and professional leadership (as differentiated say, from clinical leadership in the CNC role)?
Comment as you may wish.

24. What do you consider would make your role more attractive to potential management /business /service nurse leaders?

25. What motivates you most or what gives you the greatest satisfaction, in your current role?

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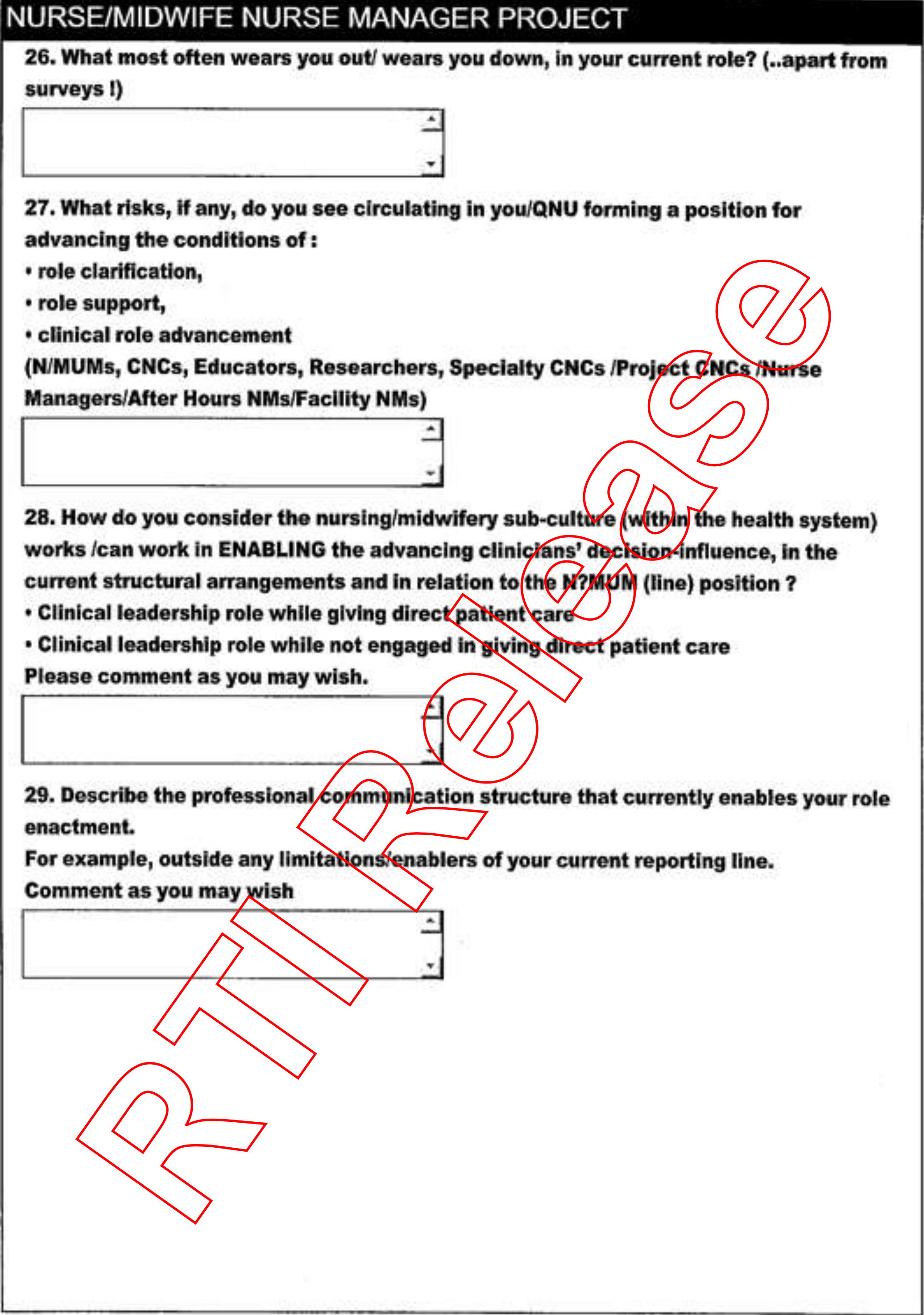

NURSE/MIDWIFE NURSE MANAGER PROJECT

26. What most often wears you out/ wears you down, in your current role? (..apart from surveys !)

27. What risks, if any, do you see circulating in you/QNU forming a position for advancing the conditions of :
- **role clarification,**
- **role support,**
- **clinical role advancement**

(N/MUMs, CNCs, Educators, Researchers, Specialty CNCs /Project CNCs /Nurse Managers/After Hours NMs/Facility NMs)

28. How do you consider the nursing/midwifery sub-culture (within the health system) works /can work in ENABLING the advancing clinicians' decision-influence, in the current structural arrangements and in relation to the N?MUM (line) position ?
- **Clinical leadership role while giving direct patient care**
- **Clinical leadership role while not engaged in giving direct patient care**

Please comment as you may wish.

29. Describe the professional communication structure that currently enables your role enactment.
For example, outside any limitations/enablers of your current reporting line.
Comment as you may wish

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NURSE/MIDWIFE NURSE MANAGER PROJECT

30. How would you advise the enabling of a clinical nurse leader role (Gr 5 through to Gr 7-8 : facilitator, clinical consultant) i.e. a clinical stream career position for nurse/midwife with the strong clinical knowledge, leadership skills, ability to coordinate, manage and evaluate care for groups of patients across the continuum of care, and the ability to think at a system level....to improve outcomes while they remain direct care providers.

- **In the career /classification structure**
- **Within the current structural/line relationships**
- **Connection with models of care**
- **Other**

Page 6

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8.7 Appendix 7: QNU N/MUM Research Project 2011 e-Survey #2

NO GR7 Project Officers, Quality Coordinators, Clinical Facilitators,

1. What position do you currently hold?

2. How long have you been in current role?

3. Note if you're acting in the role

4. What is the service you manage and/or provide in your role?

5. What was your previous position?

6. Do you intend on staying in your current role? Comment as you may wish.

7. How would you describe your [written] position description?

8. Has your job changed since the classification structure came in EB6 (2008)?
If changed, add a comment on how

- **Span of control**
- **Complexity**
- **Uncertainty**
- **Task dumping**
- **Skills, knowledge required**
- **Models of care/nursing/midwifery**
- **Role compression**
- **Role overload**
- **Role scrutiny/performance surveillance**
- **Other**

Page 1

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NO GR7 Project Officers, Quality Coordinators, Clinical Facilitators,

9. How does your role balance out between clinical leadership /co-ordination versus management (if you have business/service management in your role)?
(Say, on balance, percentages making up a total of 100 per cent.)
Comment as you may wish.

10. How does this 'balance' match the viability/success of achieving the expected outcomes of your role, in your particular service /practice context?

11. Comment on your capacity to modify/innovate models of care /nursing/midwifery in your practice context
Constraints & Enablers

12. Do you/would you support a clinical leadership role (Clinical Facilitator/CNC/Educator) in supporting the effectiveness of the N/MUM role ?
Comment as you may wish.

13. Do you consider that an administrative assistant (AO) or otherwise named, Clinical Support Office (CSO) as the ONLY additional support, would be sufficient in enhancing the effectiveness of the N/MUMrole?

14. Do you consider any other mechanism of support to be useful in enabling the effectiveness of the role of N/MUM ?
Comment as you may wish.

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NO GR7 Project Officers, Quality Coordinators, Clinical Facilitators,

15. What aspects of your role are attractive in your view, or that attracted you, compared with your understanding of the role of the M/NUM ?

- **Autonomy/decision discretion**
- **Empowerment /capacity to get things done**
- **Professional support**
- **Closeness to the patient**
- **Direct focus on the patient, research work, teaching work project work**
- **Other**

16. Describe your work arrangements in relation to flexibility and work-life balance/other.

17. What frustrations do you experience (Top 3)?

1
2
3

18. What do you see as possible solutions to your Top 3 frustrations?

1
2
3

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NO GR7 Project Officers, Quality Coordinators, Clinical Facilitators,

19. Do you advise any improvements to the career structure and/or the Nursing Officer (Gr) Classification, in, for example:

- **Being able to accommodate new (advanced practice) roles?**

Eg. Associate NUM role at CN/Advanced Practice (Gr 6); Clinical Nurse Facilitator (CN/Advanced Practice (Gr 5-6) Advanced Practice Midwifery..And so on...

- **Being able to accommodate levels of role differentiation?**

(N/MUM/ CNC / Researcher/ Educator/ AH Nurse Manager/ Facility Manager...) and progression points with roles (Clinical Facilitator to Educator or to CNC..and so on.

- **Enhancing Recruitment/relief**

Other (comment as you wish)

20. What motivates you most or what gives you the greatest satisfaction, in your current role?

21. What most often wears you out/ wears you down, in your current role?

22. What risks, if any, do you see circulating in you/QNU forming a position for advancing the conditions of:

(N/MUMs, CNCs, Educators, Researchers, Specialty CNCs /Project CNCs /Nurse Managers/After Hours NMs/Facility NMs)

- **Role Clarification**
- **Role Support**
- **Clinical Role Advancement**

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NO GR7 Project Officers, Quality Coordinators, Clinical Facilitators,

23. How do you consider the nursing/midwifery sub-culture (within the health system) works /can work in ENABLING the advancing clinicians' decision-influence, in the current structural arrangement and in relation to the N?MUM (line) position ?

- **Clinical leadership role while giving direct patient care**
- **Clinical leadership role while not engaged in giving direct patient care**

Please comment as you may wish.

24. Describe the professional communication structure that currently enables your role enactment (across the Gr 5-8 for Gr 7's who are not N/MUMs).
For example, outside any limitations/enablers of your current reporting line.
Comment as you may wish.

25. How would you advise the enabling of a clinical nurse leader role (Gr 5 through to Gr 7-8 : facilitator, clinical consultant) i.e. a clinical stream career position for nurse/midwife with the strong clinical knowledge, leadership skills, ability to coordinate, manage and evaluate care for groups of patients across the continuum of care, and the ability to think at a system level....to improve outcomes while they remain direct care providers.

- **In the career /classification structure**
- **Within the current structural/line relationships**
- **Connection with models of care**
- **Other**

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Natalia Rosenblatt

From:	s73 Irrelevant Information @qnu.org.au>
Sent:	Tuesday, 3 November 2015 7:08 PM
To:	s73 Irrelevant Information @fwc.gov.au)
Cc:	Dave Waters; Frances Hughes
Subject:	QNU CC Overview ver 0.2 BM.docx
Attachments:	QNU CC Overview ver 0.2 BM.docx; ANSWER 4 NURSING_FINAL REPORT_ 20141110_MA.pdf

Dear s73 Irrelevant Information

QNU have put together a draft overview document that we believe may be of assistance in guiding the phone planning session for the workshop that will be held tomorrow afternoon. This is the attached word document. (Unfortunately I could not get the watermark "Without Prejudice First Draft" on every page - for some reason it is only on the cover sheet. I will ask my PA to remedy this.)

For the sake of completeness I have also attached the significant report by Gardiner and Duffield that is referenced in the document. We have identified other useful pre-reading reference materials that we have summarised in the attached word document and can discuss further tomorrow.

Can you please provide these documents to DP Booth and DP Bloomfield?

Thanks a lot.

Warmest Regards,

s73 Irrelevant Information

 This message contains privileged and confidential information and is only for the use of the intended addressee. If you are not the intended recipient of this message you are hereby notified that you must not disseminate, copy or take any action in reliance on it. Any views expressed in this message are those of the individual sender, except where the sender specifically states them to be the view of the Queensland Nurses' Union. If you have received this message in error please notify the Queensland Nurses Union immediately on 07 3840 1444. Whilst we have virus scanning software devices on our computers we do not represent that this communication (including any files attached) is free from computer viruses or other faults or defects. We will not be liable to you or to any other person for loss and damage (including direct, consequential or economic loss or damage) however caused and whether by negligence or otherwise which may result directly or indirectly from the receipt or use of this communication or any files attached to this communication. It is the responsibility of the person opening any files attached to this communication to scan those files for computer viruses.

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Nursing and Midwifery Career and Classification Structure

Workshop Background Document and

Statement of Interests

Queensland Nurses' Union

November 2015

DOH-DL 15/16-032 RTI Document 729

Introduction

The refinement and enhancement of Queensland Health's (QH) nursing and midwifery career and classification structure has been one of the key agreements within both the *Nurses and Midwives (Queensland Health) Certified Agreement (EB7*) and the *Nurses and Midwives (Queensland Health) Certified Agreement (EB8*).

The primary purpose of reviewing the career and classification structure is to build a workforce that is capable of successfully implementing contemporary models of nursing and midwifery that fully utilise, develop and value nurses and midwives in all categories and in all stages of their career.

This document outlines relevant information to support discussions between QH and the Queensland Nurses' Union (QNU) regarding the status/outcomes of the EB7 and EB8 refinement and enhancement initiatives and to provide points for considerations in future planning.

A brief literature review has also been included to establish the link between the evidence and the QNU's statement of interests prepared for the EB9 negotiations.

Background

The career and classification structure has featured prominently in both EB7 and EB8. While there have been many efforts to review, plan and implement improvements in the structure the realisation of developing an innovative and responsive career and classification structure for nurses and midwives has not been fully achieved.

Tables 1 and 2 outline the purposes, actions and progress updates of the nursing and midwifery career and classification structure refinement and enhancement initiatives as per EB7 and EB8.

There were a number of reports produced during the EB7 Nursing and Midwifery Career and Classification Refinement and Enhancement project, including:

- Draft desktop review of nurse grade (NG) 1-4 (2011, which reviewed the generic level statements (GLS) of NG1-4, identified issues in relation to contemporary models of care as well as potential system enablers.
- Draft career and classification structure issues identification (2011), which identified and categorised issues relating to the career and classification structure such as role ambiguity, aligning role function with models of care and structural barriers and enablers.
- Nursing career and classification structure issues register, which identified individualised issues from NG1-12.
- Draft final career and classification project report (2011), which summarised issues/ anomalies of the structure and offered a number of solutions regarding workload and remuneration, business practices, naming conventions, advanced practice roles, career pathway development, delegation, rural and remote issues and industrial frameworks.

Many of the reports from this project remain in draft form and have not been endorsed by the Nursing and Midwifery Implementation Group (NaMIG). The lack of endorsement has resulted in very few recommendations being actioned.

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The intention to advance the refinement and enhancement of the career and classification structure beyond what was achieved in EB7 was confirmed in the EB8 agreement however, there has been limited success in fully achieving the initiatives below:

- A review of the existing classification and career structure focusing on the generic level statements and definitions to support contemporary models of nursing and midwifery.
- Provide a classification and career structure that offers a choice of accessible and rewarding career paths for nurses and midwives incorporating consistent professional standards and principles.
- Implement innovative and responsive approaches to succession planning and management.
- Develop agree standardised role description to promote role recognition and the image of nursing and midwifery.
- Maintain and extend a joint central evaluation process for all unresolved nursing and midwifery classification evaluations.

Table 1 EB7 Refinement and enhancement initiatives

Purpose and Actions	Status
• Develop innovative and responsive approaches to fully utilise, develop and value nurses and midwives in all categories and levels and at all stages of their career.	Partially achieved
• A review of the existing classification and career structure focusing on the generic level statements and definitions to support contemporary models of nursing and midwifery. There will be a focus on optimising the utilisation of roles within the structure with a particular emphasis on key roles such as enrolled nurses (EN), midwives, nurse practitioners (NP) and Nurse Unit Managers (NUM). The work undertaken in these areas will inform the career structure review.	Partially achieved

Table 2 EB8 Refinement and enhancement initiatives

Purpose and Actions	Status
• Provide a classification and career structure that offers a choice of accessible and rewarding career paths for nurses and midwives incorporating consistent professional standards and principles.	Partially achieved
• Implement innovative and responsive approaches to fully utilise, develop and value nurses and midwives in all categories and levels and at all stages of their career through effective succession planning and management.	Partially achieved
• Arising from the career and classification structure project from EB7, further work will be undertaken to develop agreed standardised role descriptions to promote role recognition and the image of nursing and midwifery. The Human Resource (HR) policy B7 will be varied to maintain and extend a joint central evaluation process for all unresolved nursing and midwifery classification evaluations. This process will consist of a peer panel including Directors of Nursing, QNU Professional Officers and HR representatives. The panel will make recommendations to Hospital and Health Service (HHS), or delegated authority on nursing/midwifery classifications.	Partially achieved
• It is recognised the nurses occupying the roles of team leaders in Integrated Mental Health and Community Health will receive relevant HHS wage rates and conditions while being required to retain their registration to practice as a nurse. Specific recognition will be given by notation in the nursing and midwifery classification at Schedule 1 of this agreement.	Achieved

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Literature

There are a number of research studies that have the potential to assist in further refining and enhancing the career and classification structure to meet the requirements of new and emerging models of care, which include:

- Report of the Australian Nursing/Midwifery Workforce Survey (2014)
- Magnet Model - five components to achieve excellence in nursing practice (multiple sources and dates)
- Comparison of role and professional development needs of nurse executives working in metropolitan, provincial, rural or remote settings in Queensland (2002)

A summary of the evidence sources and their 'value-add' to career and classification discussion are listed below.

Report of the Australian Nursing/Midwifery Workforce Survey (Gardner & Duffield 2014)

Professor Gardiner and Professor Duffield undertook the Australian nursing/midwifery workforce survey to profile the clinical nursing workforce from Nurse Grade (NG) 5 to NG8. The study provides results for two broad aims:

1. To map nursing and midwifery titles across Australian jurisdictions according to patterns of clinical practice.
2. To establish an operational framework for differentiating and describing advanced practice nursing for the Australian health service context and future development of the nursing profession.

Relevant background information includes:

- The study uses a validated Advanced Practice Role Delineation (APRD) tool developed from the Strong Model of Advanced Practice.
- The APRD has five domains – direct care, support of systems, education, research and professional leadership.
- It was an Australia-wide study support by Australian Nursing and Midwifery Federation (ANMF).
- The study recruited a total of = 6,939 participants.

The findings from this study include:

- Advanced practice nursing in Australia is characterised by the practice profile of the Clinical Nurse Consultant (CNC).
- The NP is delineated from the advanced practice nursing (APN) by significantly higher scores in the direct care domain.
- Other levels are delineated as having mean domain scores at a determined metric below those of the APN e.g. managers, clinical nurses, registered nurses
- Provide an evidence base that Australian nursing workforce can be conceptualised and structured into four bands:
    1. Nurse Practitioner
    2. Advanced Practice Nurse

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3. Domain Specified Nurse
4. Registered Nurse

- Mapping of all nursing titles (66) across the eight Australian jurisdictions produced seven cluster groups. Each cluster was identified as having a pattern of position titles from all states and territories:
    1. NP cluster is uniform across all states and territories.
    2. APN cluster is primarily CNC.
    3. Educator titles in various forms – homogenous group and had a high mean score in the education domain.
    4. Manager Type 1 clinical type managers across various titles – low in direct care but show high levels in support and systems and moderately high levels in education, research and professional domains
    5. Manager Type 2 smaller manager group similar to type 1 but characterised by lower mean scores across all domains – there is a very low nursing profile in this group.
    6. Clinical Nurse (CN) cluster is highly heterogeneous group made up of 12 different titles – characterised by moderately high score across the first three domains but low in research and professional leadership domain scores.
    7. Registered Nurse (RN) cluster represents all RN titles and shows a similar pattern of scores across domains as the CN, except at a lower level.

The chart and table below has been copied directly from the report (p.32) and demonstrates the 'footprint' of the seven clusters over the five domains.

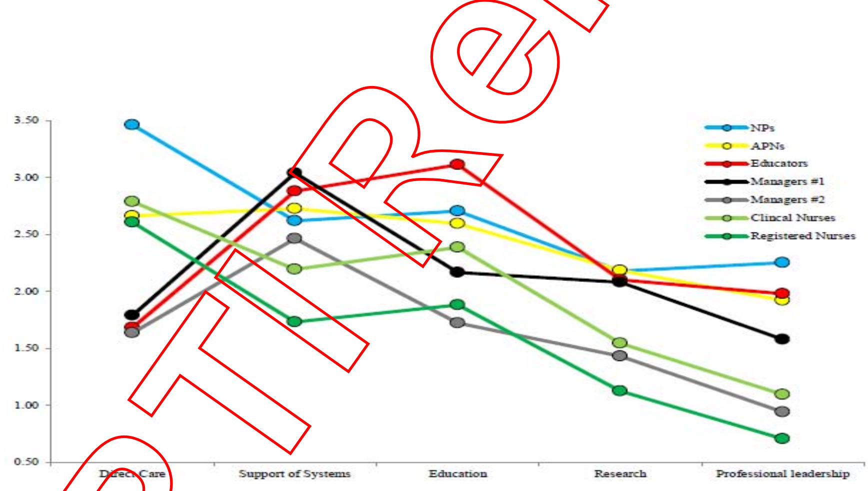

Figure 10: Domain means for all mapping clusters

Table 19. Cluster Domain Means and ANOVA Results

	Clusters							
	Nurse Practitioners	Advanced Practice Nurses	Educators	Managers #1	Managers #2	Clinical Nurses	Registered Nurses	F*
Number of Participants	263	580	284	390	43	1344	2758	
Direct Care	3.46	2.66	1.68	1.79	1.64	2.79	2.61	48.99
Support of Systems	2.62	2.73	2.88	3.04	2.46	2.19	1.73	27.11
Education	2.70	2.59	3.11	2.17	1.72	2.39	1.88	48.61
Research	2.18	2.18	2.10	2.08	1.43	1.55	1.13	28.28
Professional Leadership	2.25	1.92	1.98	1.58	0.94	1.10	0.71	32.09

*p<0.001

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Conclusions from the study include two main findings:

- Delineation of nursing levels of practice above and below the APN practice profile provide an instrument to identify four primary bands of clinical nursing activity levels.
- Mapping of the diverse state and territory based nursing position titles into seven coherent groups. These seven cluster and their descriptions bring clarity and structure to the nursing position titles across Australia.

Career and classification workshop:

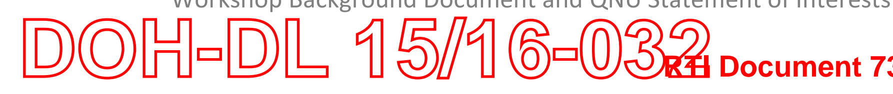
- Consider the opportunities for applying Gardner and Duffield's four bands and seven clusters to progress discussions regarding the career and classification structure as they apply to NG5-8.
- Apply Gardner and Duffield's study findings and APN delineation tool to determine advanced practice nurses in consideration of the alignment with the CNC role.
- Consider using the five APRD (direct care, support of systems, education, research and professional leadership) and the associated assessment tool to develop an assessment framework for NG5-8 positions for the purposes of classifying or reclassifying positions by evaluation panels. These domains would replace the ones being currently used (clinical, management, education and research) to better support emerging and/or advanced positions requiring classification such as nurse navigators and project based nurses.
- Consider using the five APRD domains (direct care, support of systems, education, research and professional leadership) as a framework to develop succession planning frameworks for Nurse Unit Mangers and other nursing leadership roles.
- Consider using the five APRD domains (direct care, support of systems, education, research and professional leadership) in conjunction with other relevant research to develop an evidence base for enhancing the career and classification structure for NG 9-12.
- Consider the requirements of developing an evidence base to support a midwifery career and classification structure.

Magnet Model - five components to achieve excellence in nursing practice (multiple sources & dates) [1, 2, 3, 4, 5, 6]

Magnet hospitals are successful in attracting and retaining nurses and are associated with better patient outcomes such as lower mortality and less adverse outcomes.

The Magnet model is renowned for achieving excellence in nursing practice and is based on five components:

1. ***Transformational leadership*** – nursing leaders at all levels must demonstrate advocacy and support on behalf of staff and patients to transform values, beliefs and behaviours. The Chief Nursing Officer (Nursing Executives) must be strategically positioned within the organisation to effectively influence other executive stakeholders including the Board.
2. ***Structural empowerment*** – nurses are involved in shared governance and decision-making structures and processes to establish standards of practice and address opportunities for improvements. Nurse leaders service on decision-making bodies that address excellence in patient care and the safe, efficient and effective operation of the organisation. There must by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multi-directional information and decision making from the frontline nurse through to the nurse executive.

3. ***Exemplary professional practice*** – evidenced by effective and efficient care services, interpersonal collaboration and high quality patient outcomes. Achievement of exemplary practice is grounded in a culture of safety, quality monitoring and quality improvement.
4. ***New knowledge, innovation and improvements*** – integrated evidence-based practice and research into clinical and operational processes. Nurses are educated about evidence-based practice and research, enabling them to appropriately explore the safest and best practices for their patients and practice environment and to generate new knowledge.
5. ***Empirical outcomes*** –the empirical measurement of quality outcomes related to nursing leadership and clinical practice in Magnet recognised organisations is imperative. Outcomes are categorised in terms of clinical outcomes related to nursing, workforce outcomes, patient and consumer outcomes and organisational outcomes.

Numerous studies highlight the leadership characteristics of nursing executives are integral to achieving clinical quality and patient care outcomes through the creation of structures and processes supporting nurse empowerment and evidenced practice. The credentialing processes for Magnet place considerable emphasis on the nursing executive role as a transformational leader, one who develops a strong vision and philosophy , communicates expectations effectively, develops others and leads the organisation to meet strategic priorities.

The nurse executive's effectiveness as a change agent is dependent upon effective, transformational leadership practices, such as creating a shared vision, inspiring others and empowering others to lead.

Career and classification workshop:

- Consider applying the component of the Magnet model in conjunction with the five APRD domains (direct care, support of systems, education, research and professional leadership) to develop an evidence base for enhancing the career and classification structure for NG 9-12.

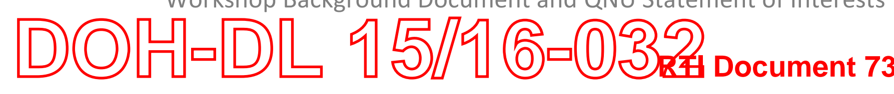
Comparison of role and professional development needs of nurse executives working in metropolitan, provincial, rural or remote settings in Queensland (2002)

This research profiles nurse executive's roles, career opportunities and professional development needs across metropolitan provincial, rural and remote settings in Queensland.

While the study was conducted in 2002, comparisons can still be drawn between the findings from this research and the nursing career and classification structure issues register which identified the individualised issues noted for NG9-12 in 2011.

The key findings of this study included:

- The role of nurse executives had expanded and diversified with multiple role responsibilities increasing with distance from the metropolitan areas.
- Metropolitan executives were able to utilise more career enhancing opportunities than any other group.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- Financial management, human resource management and information technologies were identified by nurse executives from all areas as professional development priorities, with other professional development needs varying according to location.
- Nurse executives lacked supervision, mentorship and attendance at career enhancing activities, which made it difficult for them to keep pace with other health service executives.

This study made a number of recommendations, including:

- Improving the quality of supervision for nurse executives especially in remote areas.
- Expand, refine and evaluate the mentorship program for nurse executives.
- Include postgraduate business and management education in preparation of future nurse executives.
- Design professional development programs to address the specific roles and needs of nurse executives in al geographical areas.
- Provide financial, logistical and management support to improve access for nurse executives outside the metropolitan area to professional development and career enhancing opportunities.

Career and classification workshop:

- Consider applying the findings from the Queensland nurse executive study in conjunction with the component of the Magnet model and the five APRD domains (direct care, support of systems, education, research and professional leadership) to develop an evidence base for enhancing the career and classification structure and succession planning framework for NG 9-12.

QNU statement of interests

The career and classification structure is critical to the maintaining and developing a strong, safe and effective health system.

An integral part of the career and classification system is the recognition of nursing and midwifery specialisation and skills in the delivery of safe, high quality care - on every level.

Based on the partial achievements in refining and enhancing the QH career and classification structure in EB7 and EB8 (outlined in Table 1 and 2) to date, and in respect of the ongoing needs to contemporise the structure as per the literature above, the following interests are proposed:

- improve the recognition of the contribution of ENs, through improved policies and a renewed commitment to the advancement of ENs to Enrolled Nurse Advanced Practice (ENAP) positions;
- incorporate the Nurse Navigator role in the classification structure using an evidence-based approach to improve consistency;
- establish an equitable and consistent approach to the classification of NG 9-12 positions and review the industrial entitlements applicable to senior classifications including allowances and leave provisions ;
- focus on the development and successful implementation of strategies, both local and state-wide, to support and develop NUMs and MUMs;

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- provide support for midwifery led models of care through the further enhancement of industrial structures such as the development of an evidence based specific classification structure for midwives working in such models;
- establish and maintain a consistent process to ensure wage relativities between nursing and midwifery and like positions in other professional streams; and
- review and continue to monitor the number and percentage of nurses and midwives in non-base grade positions, such as Nurse/Midwife Grade 6 and Nurse/Midwife Grade 6/7A positions.

To pursue these interests and in summary of the considerations made, the following recommendations are proposed:

- The GLS is contemporary and all sources referencing the GLS descriptors are up to date (e.g. HR Policy B7).
- Baseline data is gathered regarding the number and location of NG3, NG4, NG6, NG6/7A, NP positions to develop an evidenced 'profile of demand and supply' for our discussions.
- Consider the opportunities for applying Gardner & Duffield's four bands and seven clusters to progress discussions about the career and classification structure as they apply to NG5-8.
- Use Gardner & Duffield's research and APN delineation tool to determine advanced practice nurses - consider the report findings that APN aligns with CNC role.
- Consider using the 5 APRD (direct care, support of systems, education, research and professional leadership) and the associated assessment tool to develop a framework for NG5-8 positions for the purposes of classifying or reclassifying positions by evaluation panels or workforce planners. These domains would replace the current ones being used (clinical, management, education and research). This action will support emerging and/or emerging positions to be classified such as the Nurse Navigators.
- Consider using the 5 APRD domains (direct care, support of systems, education, research and professional leadership) as a framework to develop succession planning frameworks for NUMs and MUMs and any other nursing leadership roles.
- Consider the requirements of developing an evidence base to support a midwifery career and classification structure.
- Consider applying the findings from the Queensland nurse executive study in conjunction with the component of the Magnet model and the five APRD domains (direct care, support of systems, education, research and professional leadership) to develop an evidence base for enhancing the career and classification structure and succession planning framework for NG 9-12.

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[1] American Nurses' Association, “Magnet Model,” American Nurses' Association , 2015.

[2] A. Stimpfel, J. Rosen and M. McHugh, “Understanding the role of the professional practice environment on quality of care in magnet and non-magnet hospitals,” *Journal of Nursing Administration,* vol. 44, no. 1, pp. 10-16, 2014.

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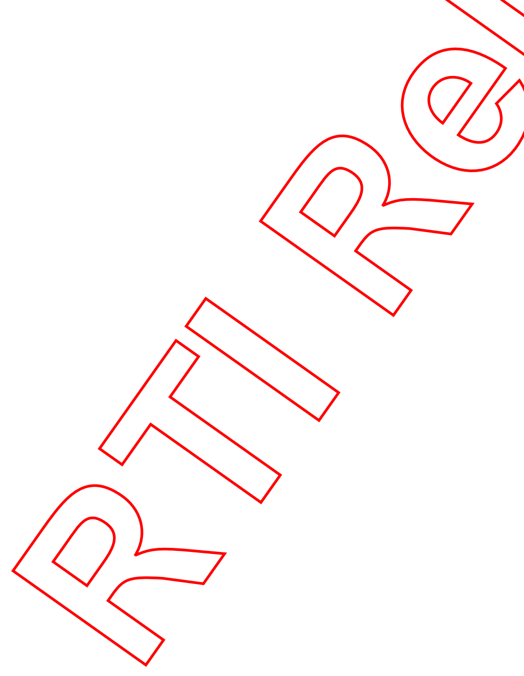

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Natalia Rosenblatt

From: Bethany Halpin
Sent: Tuesday, 29 September 2015 3:01 PM
To: s73 Irrelevant Information
Subject: RE: NaMIG communiqué
Attachments: Key messages NaMIG Communique September (2).doc

Hi s73 Irrelevant Information,

Please see attached a copy of Andrews's minutes from the out of session meeting.

Please include in the update and progress.

Thanks so much for changing the look and feel.

Many thanks
Bethany

Bethany Halpin
Principal Communications Advisor (Monday, Tuesday and Wednesday)
Office of the Chief Nursing and Midwifery Officer
Clinical Excellence Division
Department of Health | Queensland Government
Level 14, 147 - 163 Charlotte Street
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GPO Box 48
BRISBANE QLD 4001

Release

From: s73 Irrelevant Information@qnu.org.au]
Sent: Tuesday, 29 September 2015 8:56 AM
To: Bethany Halpin
Subject: FW: NaMIG communiqué

Hi Bethany

I am sorry it seems like we still need to finalise the content for the NaMIG newsletter.

Beth advised that Andrew Stevens took the agreed outcomes from the NaMIG meeting held last week and he would be best placed to provide us with content so we can finalise the first edition of the NaMIG newsletter. Andrew last Friday advised you and Natalie have the content he updated.

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If you wouldn't mind please sending it over when you're happy with it so we can add it in to the update, that would be great.

In addition, we have revised the draft design in light of your feedback last week – it is now attached for your review.

I am looking forward to having that discussion re. governance with you so hopefully we can be clearer on whose doing what going forward. Let me know when you're ready.

Thanks Bethany.

Regards

s73 Irrelevant Information
s73 Irrelevant Information
Director, Communications and Campaigning
Queensland Nurses' Union
Phone: 07 3840 1444
Web: www.qnu.org.au

QNU
NURSES AND MIDWIVES

From: Andrew Stevens [mailto:Andrew.Stevens@health.qld.gov.au]
Sent: Friday, 25 September 2015 9:27 AM
To: s73 Irrelevant Information
Subject: RE: NaMIG communiqué

Hi s73 Irrelevant Information
I have amended Update #1 (added in the EB9 planning outcomes)and sent it on to OCNO yesterday for the Chief Nurse to settle.

I'll let Natalie and Bethany know that you are looking for it (they were aiming to have it over to you by c.o.b. yesterday, so it can't be too far away.)

Kind regards
Andrew

From: s73 Irrelevant Information@qnu.org.au]
Sent: Thursday, 24 September 2015 5:41 PM
To: Andrew Stevens
Subject: RE: NaMIG communiqué

Hi Andrew

Beth said you took the minutes from the NaMIG sub-committee meeting on Monday.

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Were there some agreed messages/outcomes we can put in the joint NaMIG communique?

We would like to add in the content to update #1 (which is yet to be sent) and then send it to OCNMO for review before we send out.

Regards

s73 Irrelevant Information
s73 Irrelevant Information

Director, Communications and Campaigning
Queensland Nurses' Union
Phone: 07 3840 1444
Web: www.qnu.org.au

RATIOS: SAVE LIVES
www.ratiossavelives.com.au

THE UNION FOR QNU NURSES AND MIDWIVES

From: s73 Irrelevant Information
Sent: Wednesday, 9 September 2015 11:02 AM
To: 'Andrew Stevens'
Cc: Sharon Durham; Natalie Spearing; Bethany Halpin
Subject: RE: NaMIG communiqué

Dear Andrew

I can confirm the QNU is happy with the updated wording of the NaMIG joint communiqué and we would like to proceed with publishing as soon as possible.

Bethany – I will give you a call shortly to discuss design/layout.

Regards

s73 Irrelevant Information
s73 Irrelevant Information

Director, Communications and Campaigning
Queensland Nurses' Union
Phone: 07 3840 1444
Web: www.qnu.org.au

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www.ratiossavelives.com.au

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From: Andrew Stevens [mailto:Andrew.Stevens@health.qld.gov.au]
Sent: Monday, 7 September 2015 2:30 PM
To: s73 Irrelevant Information
Cc: Sharon Durham; Natalie Spearing; Bethany Halpin
Subject: NaMIG communiqué

Hello s73 Irrelevant Information

Please find attached QH's proposed wording for the NaMIG joint communiqué. Beth's suggested amendments have been incorporated.
The only change by QH of any note was in the wording of the paragraph clarifying the joint communication protocol for NaMIG. (last para on first page)
I understand Bethany from OCNMO will be in touch regarding the design/layout of the document.

Kind regards
Andrew

Andrew Stevens
A/Senior Advisor
Employee Arrangements | Human Resource Services
Department of Health | Queensland Government
GPO Box 48 Brisbane, Qld, 4001 | 147-163 Charlotte Street, Brisbane, Qld, 4000
t. 07 3405 5796 e. andrew.stevens@health.qld.gov.au | www.health.qld.gov.au

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Joint Communique *(to be co-badged QH and QNU)*

The Nurses and Midwives Implementation Group (NaMIG) held an extended meeting on 25 August 2015 to consider the significant work agenda arising from recent government initiatives relating to nursing and midwifery.

In addition a NaMIG sub-group meeting was held 21 September to agree on a range of process and procedural matters relating to the commencement of EB9 negotiation.

Key Messages EB9:

- In accordance with Clause 9 of the *Nurses and Midwives (Queensland Health) Certified Agreement (EB8) 2012*, negotiations for a replacement agreement are due to commence in October 2015.
- The parties have agreed to again use a facilitated interest based bargaining (IBB) approach for the negotiation of EB9.
- In order to meet the required timeframes, it has been agreed that negotiations will commence on the 19th of October 2015 with a two day preparatory training/planning session and that single day negotiations will continue on a weekly basis from the 4th November 2015, until the 23rd December 2015.
- The final makeup of the negotiation team is currently being finalised and will include:
    - The State Secretary of the QNU and additional Representatives
    - The Chief Nurse and Representatives from OCNMO?
    - Executive Directors of Nursing
    - A HHS Chief Executive
    - The Chief Human Resources Officer and representatives from the Employment Arrangement's Nursing team.
- Given the tight timeframe for these negations, it has been agreed that separate NaMIG meetings will not be scheduled during the negotiations.

Key messages NaMIG:

- NaMIG is considering the future composition of the group, in light of its role in the oversight of the roll out of the Government's Nursing and Midwifery Commitments. The August meeting was longer than usual due to the participation of, and a presentation from representatives working on the nursing commitments.
- It is anticipated NaMIG will continue to include representatives from the QNU, Department of Health IR team, Office of the Chief Nursing and Midwifery Officer, Professional Nursing and Midwifery leads, and Executive sponsors, in addition to HHS CE representation and expert representatives it may be necessary to co-opt.

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- The current Terms of Reference for NaMIG and the Nursing and Midwifery Consultative Forums (NaMCF) are being reviewed prior to the next NaMIG meeting and will include details of the new membership of NaMIG once finalised.

- NaMIG is undertaking an exercise to map the key groups that impact on nursing and midwifery, including existing governance arrangements and inter-relationships of those groups. This will be considered further at the next NaMIG meeting.

- The parties agreed that NaMIG, however it may be titled in the future, continues to be the peak body for industrial and professional issues for Queensland's public sector nurses and midwives. The vital importance of local NaMCFs was also acknowledged and further particular attention will be paid to strategies to improve the functioning of these forums.

- A major work program for the group will be consultation about and progression of the government's policy commitments in relation to nursing and midwifery, including nurse: patient ratios and associated work relating to the Business Planning Framework (BPF), nurse navigators, graduate nurse initiatives and the Child Health Nurse initiative (coordinated by Children's Health Queensland HHS).

- It was agreed NaMIG will establish a protocol to jointly communicate the outcomes of NaMIG meetings, commencing with the issue of this Joint Communique. It was agreed that particular attention needs to be paid to improving communications so that nurses and midwives and other key stakeholders are provided with timely and accurate information on current initiatives.

- The group acknowledged the significant work that has been undertaken in the working groups that are assisting with the government's nursing commitments and thanked those involved for the work undertaken to date.

- Joint intensive QH-QNU work is also ongoing in relation to modernisation of the *Qld Health Nurses and Midwives Award – State 2012*, in the lead-up to commencement of EB9 negotiations later in the year.

- IT capability and research capacity will be a standing agenda item at future meetings. This is especially important given the commitment to ensure the implementation of the initiatives is underpinned by evidence and to publicly report outcomes.

- NaMIG will seek to receive regular reports from a Child Health initiative that is being undertaken within Children's Health Qld HHS.

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Natalia Rosenblatt

From: CNO_ESO
Sent: Monday, 26 October 2015 11:10 AM
To: s73 Irrelevant Information Andrew Stevens
Subject: RE: re OCNMO BPF positions

Good Morning s73 Irrelevant Information

I have been advised that this process is now being done by Andrew Stevens and will come back through NAMIG.

Dr Hughes has suggested that you contact Andrew Stevens if you require any further information.

Thanks
Dianne

Dianne Rogan
ESO to Chief Nursing and Midwifery Officer
Office of the Chief Nursing and Midwifery Officer
Clinical Excellence Division | Department of Health | Queensland Government
Level 14, 147-163 Charlotte Street, Brisbane Qld 4000
(07)3836 0527
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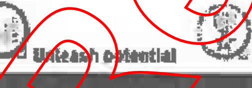

Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

From: s73 Irrelevant Information @qnu.org.au]
Sent: Thursday, 15 October 2015 11:23 AM
To: Andrew Stevens
Cc: CNO_ESO
Subject: RE: re OCNMO BPF positions

Hello Andrew,
It is my understanding that the CNMO has sent the documentation for classification/grading of the BPF positions into the relevant process in QH IR department.
At last advice – Frances was awaiting their response prior to forwarding to QNU.
Perhaps Diane you might follow this up with Frances?
Kind regards,
s73 Irrelevant Information

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s73 Irrelevant Information
RN, B.App.Sc. (NURS), MNRS.
Professional Officer
Queensland Nurses' Union
Phone: 07 3840 1444
Direct: 07 3840 1407 or s.73 Irrelevant Information
Web: www.qnu.org.au

From: Andrew Stevens [mailto:Andrew.Stevens@health.qld.gov.au]
Sent: Thursday, 15 October 2015 10:36 AM
To: s73 Irrelevant Information
Cc: Sharon Durham
Subject: RE: re OCNMO BPF positions

Hi s73 Irrelevant Information

I understand a role description is being developed, however I am not aware what level/grading the Chief Nurse has allocated to the role.

Our understanding, as per Schedule 2 to the B7 Policy (attached) is that there is only a need for a panel if the QNU disagrees with the proposed level allocated to a role.

I would recommend we wait and see what level the CNMO proposes the role be established at. If you agree with the proposed level, there would be no need for a panel?

Kind regards
Andrew

Andrew Stevens
A/Senior Advisor
Employee Arrangements I Human Resource Services
Department of Health I Queensland Government
GPO Box 48 Brisbane, Qld, 4001 | 147-163 Charlotte Street, Brisbane, Qld, 4000
t. 07 3405 5796 e. andrew.stevens@health.qld.gov.au I www.health.qld.gov.au

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From: s73 Irrelevant Information @qnu.org.au]
Sent: Wednesday, 14 October 2015 3:29 PM
To: Andrew Stevens
Subject: re OCNMO BPF positions

Hi Andrew ,

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I understand that the positions descriptions for BPF/Ratios positions in the OCNMO were developed recently. QNU is enquiring about the convening of a grading panel for these positions.
I await your advice,
Kind regards,

s73 Irrelevant Information

s73 Irrelevant Information
RN, B.App.Sc. (NURS), MNRS.
Professional Officer
Queensland Nurses' Union
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Direct: 07 3840 1407 or s73 Irrelevant Information
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