Developing a Health Workforce Strategy For Queensland

Submission to the Workforce Strategy Branch Department of Health

August, 2016
Introduction

The Queensland Nurses’ Union (the QNU) thanks the Workforce Strategy Branch for providing this opportunity to comment on Developing a Health Workforce Strategy for Queensland Discussion Paper (the discussion paper). The QNU covers all categories of workers who make up the nursing workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 53,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU.

Our submission addresses the questions set out in the discussion paper recognising that some of this information may already have been provided during the course of discussions arising from enterprise bargaining (EB9) and the implementation of legislated minimum nurse/midwife-to-patient ratios.

Discussion questions

1. Which factors do you consider will have the most significant impact on the health workforce in the period to 2026?

Funding

The National Health Reform Agreement (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 system. In setting out the services the Commonwealth will fund, Schedule A to the Agreement (Council of Australian Governments, 2011) refers to hospital services, teaching and training functions, research funded by states in public hospitals and public health activities managed by states.

The QNU believes the ongoing contest around public hospital funding may be moderated by Activity Based Funding (ABF). Under this arrangement, the Commonwealth funds 45% of efficient growth of activity based services increasing to 50% from 1 July, 2017. Efficient growth consists of:
• The national efficient price for any changes in the volume of services provided (determined in Schedule B); and
• The growth in the national efficient price of providing the existing volume of services (Council of Australian Governments, 2011, p.13).

Under clause A36 of the National Health Reform Agreement, the Administrator\(^1\) will provide the Commonwealth and states with a formal forecast of the Commonwealth’s funding contribution for each ABF service category before the start of each financial year. The Administrator will also provide informal estimates of the Commonwealth’s funding contribution to states where requested, should a state provide estimated service volume information for all Local Hospital Networks within that state (Council of Australian Governments, 2011 p. 19). We are concerned to ensure that ABF methodology is sound and adequately takes into account the quality of care provided, not merely the ‘efficiency’ of the price struck.

Until there is a permanent resolution of ongoing disputes and blame shifting over health financing between the States and the Commonwealth, the ability to plan the health workforce effectively will continue to be hindered.

The ageing of the nurses and midwives, lack of a comprehensive, integrated workforce plan and lack of investment in the workforce are other key factors highlighted elsewhere in this submission.

2. Which health workforce characteristic or issue do you consider to be of most concern to future health service delivery?

The provision of safe, high quality care remains at the core of nursing and midwifery practice. Strategic directions for developing the nursing and midwifery workforce must consider that the profession is continually expanding and advancing in both education and practice.

Nursing research (Aiken et al., 2014; McHugh et al., 2013) shows that a higher percentage of bachelor-educated nurses in a health service correlates to lower mortality and morbidity rates.

\(^1\) Means the Administrator of the National Health Funding Pool, who is appointed in accordance with clause B24 of the Agreement and performs the functions set out in clauses B26-27. See the Agreement, p.67.
3. What do you consider are the top three priorities for the health workforce in Queensland?

To maintain and develop the nursing and midwifery workforce we suggest the following priorities:

- reasonable workloads;
- appropriate pay and conditions of employment; and
- a safe work environment where nurses and midwives can operate to their full scope of practice.

4. What are the key barriers and enablers in delivering on these priority areas?

Budget constraints and differing priorities within each Hospital and Health Service (HHS) will continue to produce inconsistent decisions and outcomes. The government’s wages policy must reflect the cost of living and allow for the delivery of productivity measures where these are achievable. The short-term view that the workforce is a cost rather than an investment is a key barrier to delivering on priority areas.

5. What are the main challenges with current clinical education and training in preparing the required future health workforce?

Individual nurses and midwives, and the community, have invested significantly in their educational preparation which has led to initial registration and the gaining of a license to practice. It has been estimated that the exit of every nurse who leaves the profession represents a loss of public funds of AUD$150,000 (conservatively) (ANMF, 2009).

Of paramount importance to the retention of the nursing and midwifery workforce are workplace environments which enable nurses and midwives to work to their full scope of practice facilitated by safe staffing levels and skills mix appropriate for meeting care needs. In essence, good leadership, good management, shared governance models and balance between productivity and quality will attract and retain nurses and midwives in the workforce.

Significant health care expenditure is wasted when graduates of nursing and midwifery programs, experienced nurses and midwives, and those re-entering the workforce after a period of absence, are not supported in their workplace and decide to leave. This is regrettable not just for the individual health professional, but also for the community. It represents a waste of significant financial and time investment, and more critically, a further reduction in the numbers of qualified nurses or midwives to deliver optimal health outcomes.
The QNU maintains there needs to be on-going and regular dialogue between those undertaking health workforce planning, education planners and professional associations, so that each sector is able to prepare for future workforce and population health needs. Multi-disciplinary education and training will help to break down the barriers between health professionals.

We contend further analysis of future health workforce requirements must take into account educational programs, capabilities, health and aged care reforms, new models of care and innovation.

6. What do you consider are the critical success factors in an effective clinical education and training system?

**Clinical Placements**

Clinical experience is a critical component of undergraduate education for students of nursing and midwifery. Theoretical concepts from the sciences and from the perspective of nursing theorists need to be supplemented in the learning experience with practical application.

The QNU contends adequate clinical education must be provided to students so they can acquire the clinical experience necessary to meet the competency standards. Staffing levels and skills mix in health and aged care settings providing clinical placement for students must be adequate to optimise the learning experience.

Clinical placements for enrolled and registered nurse education, either undergraduate or post graduate, require:
- active and positive collaboration between the health and education sectors;
- and sufficient resources to assist education providers; and
- facilities in which clinical education delivers a quality learning experience.

We encourage education providers and health service providers to continue to explore new and innovative areas for clinical placements. This not only exposes new nurses and midwives to a greater breadth of practice areas but also persuades employers to provide positions during the transition to practice period following graduation.

We consider the most critical feature of clinical learning for all health disciplines is its quality. In particular, when nursing and midwifery students experience well managed, clinical placements in a positive learning environment, they are more likely to want to stay in the health workforce.
Continuing Professional Development

Under the National Registration and Accreditation Scheme that came into effect in 2010, all nurses and midwives must meet Continuing Professional Development (CPD) requirements in order to maintain their registration. These requirements are to participate in at least 20 hours of CPD per year for continuation on the register. This has been a worthwhile initiative in keeping nurses up to date through ongoing learning and development.

However, even though CPD is now a compulsory registration requirement and the QNU and Queensland Health negotiated to include this leave for this purpose in EB6, an impediment to its uptake is the inability for many nurses and midwives to have their position backfilled whilst doing so. Again, policy interventions aimed at attracting and developing the nursing and midwifery workforce can only operate to full effect if they are properly resourced.

7. In which area do you consider the workforce can make the greatest impact?

It is important to provide incentives for hard-to-staff positions, roles or locations – whether the targeted nurses and midwives are re-entrants, new entrants, transfers or continuing in existing positions. However, it is replenishing the total pool of qualified nurses that should be given priority as the large cohort aged around 50-55 moves into retirement. The Department should consider transition to retirement strategies including ‘reasonable adjustment’ work practices to enable older nurses and midwives to continue to work as mentors. It should also be a priority to improve the general attractiveness of nursing and midwifery as a career to ensure adequacy in quantity and quality of new recruits over the coming decade.

Employment of student nurses is a strategy that may keep nurses and midwives in the profession longer and we welcome the government’s commitment to this purpose over the coming years. This arrangement aims to build a conduit so that there is fluid movement of students from the beginning to graduation.

A workforce strategy that addresses the cross-generational issues in nursing will improve recruitment and retention of nurses and midwives in Queensland Health. This would not be in lieu of clinical placement or clinical hours required to fulfil the requirements of the course but provide an opportunity for the student to experience the workplace to which they might be recruited on completion of their course.

Regional and remote areas also experience workforce issues specific to their location. Adequate housing in regional and remote areas is a major concern in attracting and retaining a health care workforce. Housing affordability is a critical issue that is affecting the provision of such services in these areas and elsewhere in the state.
Maternity Care

The development of the National Maternity Services Plan has provided an opportunity for consideration of this important area of health. According to the plan’s five year vision:

Maternity care will be woman-centred, reflecting the needs of each woman within a safe and sustainable quality system. All Australian women will have access to high-quality, evidence-based, culturally competent maternity care in a range of settings close to where they live. Provision of such maternity care will contribute to closing the gap between the health outcomes of Aboriginal and Torres Strait Islander people and non-Indigenous Australians. Appropriately trained and qualified maternity health professionals will be available to provide continuous maternity care to all women (Australian Health Minister’s Conference, 2011).

A series of barriers in implementing the National Maternity Services Plan has resulted in significant delays in the benefits this model offers women. One of these is the lack of universal hospital admitting rights for private practice midwives with Medicare eligibility which impedes midwives in all states other than Queensland. Additionally items numbers and rebates achieved are limited. A significant number of ‘bed’ days are spent in maternity care yet there is not the opportunity for a reorientation toward primary maternity care. This is despite being a contemporary, evidence-based option.

Midwives in rural areas are not being fully utilised for contemporary midwifery care and across all regions are not recognised as primary health practitioners. They are being directed toward nursing duties, particularly in rural areas, when a reorientation of services could provide much better options for both women and midwives.

We also note there are limited opportunities for student midwives, often external university students enrolled in universities throughout Australia who are working in rural hospitals to see contemporary midwifery- caseload, private practice and midwifery group practice. As a result, evidence based midwifery practices in rural and remote areas have become isolated. Maternity clients in these areas may experience fragmented nursing care that is often poorly resourced.

The QNU seeks funding specifically set aside for midwives who work in these areas who provide vital services but are isolated from mainstream practice. These funds must provide ongoing professional development for midwives to deal with women requiring complex care.
8. What do you believe to be the key enablers to transforming the workforce to deliver the health services that Queenslanders require?

**Workforce planning**

Since 2008, the QNU has been campaigning to compel governments and health and aged care employers to address the employment of more nurses and midwives before staffing shortages reach crisis levels in the next few years. The QNU has consistently advocated for a nursing and midwifery workforce plan for Queensland that is linked to a national plan. The solutions need to be both state and national given the overlap in educational preparation. A nursing workforce plan must be situated within an overall health workforce plan. In our view, responsibility for developing the plan in consultation with key stakeholders lies with the Office of the Chief Nursing and Midwifery Officer (OCNMO).

The QNU remains extremely concerned about the lack of integration of workforce planning across the HHSs and the absence of appropriate nursing and midwifery input into workforce planning processes. Unfortunately it remains the case that duplication of effort occurs alongside inadequate consultation about workforce strategies affecting nursing and midwifery when these are being driven by areas outside OCNMO. The Department must address these issues urgently.

The Department of Health’s data (2016, pp. 8-9) predicts -

**Registered Nurses**

**Potential undersupply:** A potential undersupply of between 1,350 and 4,090 registered nurses (RNs) is projected by 2025.

**Retirement:** Approximately 39% of RNs have indicated that they would retire by 2025.

**Expanded utilisation of existing workforce:** Utilisation of the nursing workforce may be enhanced by scope of practice strategies to optimise and expand nursing service delivery.

**Enrolled Nurses (ENs)**

**Potential oversupply (with caveats):** Despite a projected high level of retirements, a significant oversupply of enrolled nurses (ENs) by 2025 is projected due to high enrolment numbers to date. New research suggests a significant reduction in the number of enrolments in EN training in Queensland after 2014. If this trend continues, it will have a considerable impact on graduating EN supply after 2017.

**Rural and remote service delivery:** Strategies to attract ENs to regional, rural and remote areas would help to address the potential maldistribution of this workforce as the majority of ENs are graduating from the southeast corner of Queensland.
**Midwives**

**Stable supply, with caveats:** While graduate supply of Queensland midwives is in balance to meet future demand to 2024, the increase in midwifery-only qualified graduates produces challenges to supply labour to the rural and remote sector which has relied on dual qualified registered nursing and midwifery workforce.

**Retirement:** Risk of significant experience loss due to attrition from retirement of an ageing midwifery workforce.

We have some concern this data does not identify shortages in speciality areas such a mental health and paediatric nursing or the maldistribution of the workforce. The Department of Health also failed to include data on Nurse Practitioners (NPs). NPs are in a vital and expanding role that also require workforce modelling. We cover the role of the NP and advanced practice nursing in more detail under question 10.

We agree with the Department of Health (2016, p. 9) that a strategy which is heavily reliant on migrant overseas nurses to supplement the workforce may not be a sustainable option. We must continue to educate and support our own local nurses and midwives as the first and most ethical priority.

We also strongly oppose any moves to cut costs in the nursing workforce by substituting the nursing role with lesser skilled practitioners, particularly in light of the findings of the Mid Staffordshire report in the UK where unlicensed ‘nurses’ were incapable of delivering a proper standard of basic nursing care. Serious adverse outcomes resulted from a chronic shortage of nurses that was exacerbated by the need to meet financial targets (Francis, 2013). The excess of ENs identified in the discussion paper cannot be a substitute for RNs. There will be opportunities to maximize the contribution of these nurses through the development of nurse and midwife-led models of care.

It is the view of the QNU that nurses and midwives should work in a collaborative service model that allows independent decision-making and use of their knowledge within a multidisciplinary team that recognises and respects each professional domain. This requires proper measurement of nurses’ and midwives’ input into collaborative models of care. Nurse Practitioner-led and other advanced practice models in primary care and productivity improvements such as criteria-led discharge in hospitals will be essential to save costs and minimise the burden on hospital services.

The QNU continues to oppose the employment of Physician Assistants. In our view, there is no need to introduce another layer of unregulated health workers in any setting including rural and remote areas. We cannot understand why there is a need for these positions when there is already a fully functioning, regulated medical and nursing workforce that
consists of doctors, nurse practitioners, registered nurses, registered midwives, enrolled nurses and assistants in nursing.

**Technology**

The QNU supports the full role out of the National Broadband Network and the many possibilities that this will offer healthcare. We also point out that technology cannot supplant the skilled observations of nurses and midwives.

9. What do you consider are the main target areas for ensuring workforce sustainability for the health sector?

**Safe Workloads**

In determining service priorities, HHS must take into account the effect of any changes on workloads. Nursing and midwifery workloads are dynamic. They depend upon a wide range of factors, mostly relevant to acuity, case-mix and throughput, which can change by the hour, and certainly from shift to shift. It is a lawful requirement for registered nurses to exercise professional judgment when considering workload and skill mix. Nurses and midwives themselves must determine acceptable, safe workloads not budget constraints.

A focus on cost saving and efficiency measures holds limited regard for the level of knowledge and skill required for quality of care, complexity of care, professional delegation, and scope of practice for nurses and midwives. Yet these are the factors that safeguard patients and preserve a credible health system.

The introduction of legislated minimum nurse/midwife-to-patient ratios will contribute to enhance organisational productivity, hospital efficiency and continuity of patient care by increasing staff satisfaction, decreasing attrition rates, reducing patient readmission and adverse events, limiting service variation and improving equality across the healthcare sectors.

Ratios are vital as they form the ‘floor’ in the delivery of safe, high quality nursing and midwifery care while the BPF remains the mechanism for staff to reach above the ‘floor’ staffing levels to match the individual demand of their clinical service. Effective implementation of minimum ratios will alleviate many of the long-term workload and patient safety concerns held by nurses and midwives employed in HHS.
We will continue to monitor and enforce the implementation of ratios in HHS so that this significant public health initiative delivers safe, quality patient care and fair workloads for nurses and midwives.

10. What is working well now to facilitate the sustainability of the health workforce?

**Advanced Practice Nursing**

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 (Duffield & Gardner, 2014).

As a result of their national survey on advanced practice nursing, Duffield and Gardner (2014) called for nurses and midwives to have autonomy over their service and to conceptualise, categorise and promulgate a rational framework that delineates levels of practice. This in turn will inform education providers to prepare a nursing and midwifery workforce for the future and enable policy makers and health service managers to fully understand the service potential for matching clinical nursing service with the clinical need of patients.

**Nurse Practitioners (NPs)**

In the contemporary health setting the NP is a highly skilled nursing role, generating immediate, sustainable capacity in health care modelling and delivery. The NP role has continued to grow as has the research on advanced practice nursing.

The NP role originated in the USA, and has been adopted in a number of OECD countries such as the UK, Canada, NZ and Australia. A NP is an experienced registered nurse, educated to function autonomously and collaboratively in an expanded clinical role. We do not suggest that PAs and NPs are in competition with each other. NPs have their own distinct role and scope of practice.

NPs train within a nursing model and must first be an experienced registered nurse and complete a Masters degree. Some of the tasks that NPs perform are beyond the usual scope of nursing practice include detailed health assessment and diagnosis, ordering diagnostic investigations, referring patients to other health care professionals, prescribing medications and other treatments/therapies.

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2 The latest Nursing and Midwifery Board Australia (NMBA, 2015) statistics indicate there are 342 NPs in Queensland.
Rural and Isolated Practice Endorsed Nurses (RIPEN)

RIPEN registered nurses are authorised, educated and competent to practice. The RIPEN registered nurse provides emergency and primary healthcare to an advanced and expanded clinical scope of practice to patients in rural and remote (isolated) areas. This may occur in isolation or in a collaborative environment with other health professionals. RIPEN registered nurses can work in rural hospitals, mining sites, indigenous communities, tourist resorts, remote pastoral stations where onsite access to medical practitioners and/or nurse practitioners is by visit only or not available at all and to rural and remote area emergency sites (Nursing and Midwifery Board Australia, 2010).

Queensland is Australia's most geographically decentralised state with regional centres located throughout as well as many isolated communities. The RIPEN nurse is particularly effective in this environment. These geographic and demographic factors are largely the reason why Queensland has the most RIPEN nurses in the country. In December, 2015, there were 809 registered with the Australian Health Practitioner Registration Authority (Nursing and Midwifery Board Australia, 2015) and around 160 additional registered nurses enrolled in the Cunningham Centre (Queensland Health) accredited RIPEN course that leads to endorsement.

Registered nurses seeking endorsement for scheduled medicines (rural and isolated practice) undertake an approved program through an approved National Board Education Provider. There currently are two approved programs of study in Queensland; the Rural and Isolated Practice (Scheduled Medicines) Registered Nurse course and Postgraduate Certificate Advanced Practice (Rural and Remote).

The program course of study modules’ elements reflect the combined breadth of advanced practice and generalist nursing practice required to undertake the full scope of practice required for rural and remote nursing, including:

- Advanced clinical assessment and diagnostic skills;
- Practice boundary awareness in the context of location, capability, referral, escalation of care and patient follow up;
- Legislative context of practice and the application of the Drug Therapy Protocol (DTP) application to rural and isolated practice;
- Safe medication practice, including Pharmacology pharmacokinetics and pharmacodynamics; and
- Health Management Protocol (HMP) used through the Primary Clinical Care Manual (PCCM) are very broad and include for example:
  - Assessment and transport;
  - Emergency;
In Queensland, the RIPEN model/endorsement is in effect already a type of supplementary prescribing right as it is an agreed formula in the DTP within the registered nurse scope of practice. This allows the RIPEN registered nurse to assess the patient, formulate a diagnosis and initiate medicine treatment.

Completion of this course confers a RIPEN scheduled medicines endorsement which qualifies the registered nurse to obtain, supply and administer schedule 2, 3, 4 and 8 medicines for nursing practice in a rural and isolated practice area. The course is open to registered nurses employed in a Queensland rural hospital or isolated practice setting as defined by the Health Drugs and Poisons Regulation 1996.3

Aboriginal and Torres Strait Islander Health Workers

The QNU has consistently supported a career pathway for Aboriginal and Torres Strait Islander Health workers that includes articulation into a nursing program. This is an obvious benefit to the individual and their communities as it provides a way forward to equity of access to health service in rural and remote areas and a meaningful career path.

Industrial Relations Framework

The discussion paper makes passing reference to the industrial relations framework that will enable service delivery, safe workloads, conditions necessary to quality of care, improved nurse-sensitive indicators and improved retention and longevity. The discussion paper states (p. 19):

The complexity of the industrial relations and employment regulatory environment has been identified as creating barriers to achieving a dynamic, flexible, and motivated workforce. Similarly, the limitations of health legislation and regulations has been identified in some cases as an impediment to innovation and the introduction of new and more effective practices, such as expanded scope of practice. Current funding models have also been shown to impede health workforce innovation and opportunities for reform.

3 The Medicines, Poisons and Therapeutics Goods Bill 2016 is expected to be introduced into Parliament later this year. An accompanying indicative Regulation is presently being drafted to replace the Health Drugs and Poisons Regulation 1996.
Human resource practices will increasingly need to focus on productivity-based incentive schemes which ensure alignment of workforce capacity and capability with the areas of health service need.

The regulatory environment is the mechanism for providing pay, conditions of employment and protections for the health workforce. Many of the identified measures will need to be implemented through consultative mechanisms enabled by industrial instruments. Importantly, the discussion paper fails to identify significant activities that have facilitated productivity enhancements such as the Interest Based Problem Solving (IBPS) approach adopted since 2006 to the negotiation and implementation of the enterprise agreement covering nurses and midwives employed by the Department of Health.

It has been the experience of the QNU that co-operative workplace relations through Interest Based Bargaining (IBB) and an Interest Based Problem Solving (IBPS) approach to workplace change and implementation of enterprise agreements facilitate effective improvements in strategies to recruit and retain a nursing workforce. IBB and IBPS build on the ‘integrative’ bargaining concept. It is distinguished by a focus on the parties’ interests rather than their positions or the outcomes they seek. The parties acknowledge that they can have shared, conflicting or different interests, but work in partnership to achieve durable outcomes.

A co-operative approach such as IBB/IBPS is an essential ingredient in improving the quality and delivery of health services. Difficult enterprise bargaining negotiations in the public sector do little to improve community perceptions or gain support for the government or unions. Through the negotiation and implementation of four enterprise agreements, the QNU and QH have demonstrated the potential value for IBB/IBPS in addressing contemporary organisational and workforce issues. This scheme has delivered benefits for both parties.

11. How important is building a well workforce to enabling health workforce efficiency, effectiveness, and sustainability?

The precursor to building a ‘well workforce’ is a safe workplace. High levels of workplace violence and heavy workloads do not enable efficiency, effectiveness and sustainability.

As a first step, we recommend the Department demonstrates its commitment to safe workplaces by implementing the recommendations of the Occupational Violence Prevention Taskforce Report (Queensland Health, 2016).
12. How important is planning for employee wellness a strategic priority?

The Department of Health through the HHS can enable employee wellness through workplace cultures that recognise and value their employees. Providing access to industrial entitlements such as carer’s leave, domestic violence leave and flexible rostering arrangements can assist an essentially female nursing and midwifery workforce to balance their work/life commitments.

13. What experience do you have with new and redesigned health care roles or teams?

The QNU has extensive experience in the design and implementation of nursing and midwifery roles across successive governments. We are most concerned there may be duplication of effort here when OCNMO and the QNU are currently engaged in complex planning and development of the nursing and midwifery classification and career structure. The previous LNP regime imposed unnecessary restrictions on nursing and midwifery career development. We will vigorously oppose any moves to yet again ‘redesign’ these roles under the guise of ‘productivity’ or any other such banner.

14. What do you consider is the greatest challenge in redesigning the health workforce and how should this be approached?

In the first instance we need further information on why and how the workforce is being ‘redesigned’. As the union representing more than 53,000 nurses and midwives we would expect to be consulted at the outset if there are any plans to do this.
References


