



australian
nursing federation

Submission to the Productivity Commission Issues Paper Early Childhood Development Workforce

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1. Introduction

The Australian Nursing Federation (ANF) was established in 1924. The ANF is the largest professional and industrial organisation in Australia for nurses, midwives and assistants in nursing (however titled) in Australia, with Branches in each state and territory.

The ANF's 200,000 members are employed in a wide range of settings in urban, regional, rural and remote locations, in both the Australian public and private health sectors. The core business of the ANF is the professional and industrial representation of our members and of the professions of nursing and midwifery.

The ANF participates in the development of policy relating to nurses, midwives and assistants in nursing on issues such as: practice, professionalism, regulation, health and aged care, community services, veterans' affairs, education, training, workforce, safety and quality, socio-economic welfare, occupational health and safety, industrial relations, social justice, human rights, immigration and migration, foreign affairs and law reform.

The ANF welcomes the opportunity to provide input into the Productivity Commission's study of the Early Childhood Development Workforce. The ANF has reviewed the Issues Paper and has specifically addressed the questions raised as they relate to Maternal, Child and Family Health (MC&FH) nursing.

2. Background to Nursing and midwifery workforce

Nurses and midwives together form the largest health professional group in Australia, providing health care to people throughout their lifespan, and across all geographical areas of Australia. Nurses and midwives comprise over 55% of the entire health workforce¹. There is a combined total of 272,741² registered and enrolled nurses actually employed in nursing in Australia, with 18,998 of these being midwives³. The depth and breadth of nursing and midwifery practice reaches into: people's homes, schools, general practice, local councils and communities, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional organisations.

Nurses and midwives, as members of self-regulated health professions, are autonomous providers of nursing and midwifery care as legislated under the *Health Practitioner Regulation National Law Bill 2009*⁴ and regulated in accordance with the Australian Health Practitioner Regulation Agency by the Nursing and Midwifery Board of Australia. This means that they have independent authority to act within their scope of practice and they are accountable for their own clinical decision-making and the outcomes of their actions when providing health care.

Primary health care nursing and midwifery roles include registered and enrolled nurses, midwives and nurse practitioners, working as: maternal and child health nurses, general practice nurses, community health nurses, school nurses, occupational health nurses, rural nurses, remote area nurses, women's health nurses, men's health nurses, sexual health nurses, and mental health nurses.

3. Maternal, Child and Family Health Nursing

MC&FH nurses are registered nurses, and in many instances midwives, with additional qualifications in maternal, child and family health and community health.

These nurses offer a range of services in their practice through individual consultations, home visits and group meetings. They provide health education to families to promote health and wellbeing and prevent illness; offer support and guidance to families while developing parenting skills; assess child growth, development and behaviour at key ages and stages; guide and inform families in relation to family health, breastfeeding, immunisations, nutrition, accident prevention and child behaviour; and provide access to information on child and family services.

A key distinction for MC&FH nurses is that the children for whom they provide services are generally well as compared to their colleagues in paediatric nursing. MC&FH nurses are primarily concerned with health promotion and illness prevention. Kruske and Barclay⁵ identify that MC&FH nurses “work autonomously and deliver holistic care, often without the need to refer to another service provider”, “working with families in a ‘wellness model’.” In this role the MC&FH nurse works with families to build self-esteem and the capacity to identify their own solutions to family problems

There are 4,686 identified nurses working in the area of family and child health⁶. The majority of these nurses are employed in New South Wales, Victoria and Queensland.

4. Early childhood development

What are some other examples of integrated and co-located services? What are the benefits and limitations of integrating and co-locating ECD services?

The Victorian Association of Maternal and Child Health Nurses has described, in their submission to the Productivity Commission, a model of service delivery which aims to replace the single nurse centres with centres which have more than one MC&FH nurse, and preferably include other Early Childhood Development services. The ANF supports this approach, which not only benefits the mother and child/ren through convenience of access to co-located services, but also reduces professional isolation by bringing the MC&FH nurse into an environment of increased human and material resources. This collegiate environment offers personal and professional development opportunities.

The ANF Recommends:

That the model for Early Childhood Development services include a minimum staffing level of two maternal, child and family health (MC&FH) nurses.

An additional benefit is the closer affiliation of health care services with education and other developmental services. Integration of such services better acknowledges the multi-variant aspects of a person's development including physical, emotional, psycho-social, spiritual, and cultural. Nurses bring an holistic approach to their care of an individual and recognise that all these aspects must be considered in the healthy development of a child.

5. The early childhood development workforce

5.1 Child health and family support workforces

What characteristics describe the child health and family support workforces – in terms of demographics, wages and salaries, working conditions, employment status, staff turnover, unfilled vacancies, and job satisfaction?

Characteristics which describe the maternal and child health nursing workforce are summarised below:

- **Age:** the MC&FH nurse workforce is ageing. The average age is 46.2 years which is slightly higher than for all nurses and midwives (44.1 years)⁷. In some States the average age for MC&FH nurses is considerably higher than for nurses/midwives working in other sectors. For example, Queensland has seen, with their ageing M&CH nursing workforce, a high number of staff retirements within the last 5 years and this trend looks set to continue (albeit with a slightly higher retirement age due to the impact of the Global Financial Crisis). The higher than average age range for MC&FH nurses is probably reflective of the work experience and educational preparation requirements for the role, as many nurses enter this field after considerable experience in other areas.

In Victoria, verbal information gained by the ANF (Vic Branch) from the Municipal Association Victoria Workforce Initiative shows that (as at June 2010) of the approximately 960 Maternal and Child Health nurses employed across Victoria, 33% were aged 56 years and over, of which 14% were aged 60 years and over.

- **Gender:** perhaps not surprisingly, as it is the case for the nursing and midwifery workforce at large, the MC&FH nurse workforce is predominantly female. The gender balance in the nursing and midwifery workforce currently sits at 90.6% female and 9.4% male².
- **Salaries:** vary according to the State/Territory Nurses Award for the public sector under which M&CH nurses are paid. In Victoria there is variation across the State due to the fact that wages are determined by enterprise agreement negotiations with each local council – the employers of MC&FH nurses. The ANF holds a strong view that there should be wage parity amongst MC&FH nurses within each jurisdiction.
- **Working conditions:** variable in relation to location ranging from multi-nurse metropolitan sites in identifiable child health clinics to working in isolation in rural and remote areas where the service may be offered from a Country Women's Association (CWA) or community hall, a pre-school or a primary school, a small room attached to the regional hospital, or a single nurse health clinic; or provided by a home-visiting service.

MC&FH nurses have largely predictable and stable rostering arrangements when compared to their acute sector nursing and midwifery colleagues. The requirement for them to work 'shift work' is minimal.

- *Employment status:* may be on a part/full time basis or in a casual capacity. There is a trend in some States of an increase in part time employment which increases the need for more MC&FH nurses to cover the work requirements.
- *Staff turnover:* amongst MC&FH nurse staff, turnover is low. There is an indication that economic factors such as, effects of the Global Financial Crisis, and on-going economic instability in rural areas brought about by adverse climatic conditions, have meant lowered vacancy rates and staff turnover. Nursing is a primarily female occupation, reflected in the MC&FH nursing workforce, and these women have often become the major source of family income when their partner has lost employment.

The main cause of attrition amongst MC&FH nurses appears to be due to retirement relating to ageing.

- *Job satisfaction:* MC&FH nurse members of the ANF report that the complexity and variety of their work with mothers and their child/ren contributes to a high level of job satisfaction. Additional factors are:
 - the high level of autonomy enjoyed in MC&FH nursing;
 - a desire to work in the community and engage with mothers and families throughout the child's early development.
- *Qualifications:* MC&FH nurses are registered nurses and in many cases are registered midwives (in Victoria this is a mandatory requirement under the Maternal and Child Health Service Program Standards – M&CHSPS); may have post registration qualifications in mental health, counselling, family planning, breastfeeding, health promotion and immunisation, at the graduate certificate or diploma level (again, in Victoria postgraduate qualification in Maternal and Child Health nursing is a mandatory requirement under the M&CHSPS); and increasingly, further education to Masters level.

5.2 Data describing the ECD workforce

What data collections provide information on the ECD sector and its workforce? How might these data collections be improved?

Information on the maternal and child health nursing cohort of the nursing and midwifery workforce, at a national level, is primarily derived from the data held by the Australian Institute of Health and Welfare (AIHW) (Refer Appendix A). The AIHW publishes the Nursing and Midwifery Labour Force series, releasing a new edition approximately every two years. The publication includes demographic data, clinical area of practice and work setting figures for RNs and ENs in each state and territory and nationally, as well as a general overview.

The AIHW nursing and midwifery workforce publication is the most regular and comprehensive source of nursing workforce information we have available, but it is flawed. The limitations of this data is that, while it is gathered as part of the nursing and midwifery registration process, completion of the workforce survey forms by nurses and midwives is not mandatory. There are also pieces of information missing from the data which would be very useful, such as figures for initial registration of new graduates and overseas qualified nurses in all categories of registration (RN, EN, Midwife and NP); nurses and midwives re-registering after a period out of the nursing workforce; and nurses and midwives not renewing their registration.

Prior to 1 July 2010, workforce information was drawn from each State and Territory Nursing and Midwifery Board registration renewal process. Again, not mandatory, this data was collected on an annual basis by all jurisdictions, except for Western Australia where renewal frequency was every three years. To further complicate the process the States and Territories differed in the time of year that registration renewal occurred. Another problem was ensuring that the survey questions were consistent across each state and territory in order to build a national picture.

The collected data was submitted to the AIHW who compiled, analysed and published it. The AIHW also uses data from the Department of Education, Employment and Workplace Relations for higher education figures; data from the National Centre for Vocational Education Research (NCVER) for VET figures and ABS data for migration figures.

The quality of material published in the AIHW nursing and midwifery labour force publications has been declining over the years since 2000. The deterioration in data quality arose, when the AIHW began to only publish the 'main findings and analysis' separately from detailed results tables. Specifically, the main findings are published in hard copy but the detailed tables are available only online, making these publications more difficult to interpret and consequently are much less user friendly. Ideally, the publication should be available in its entirety in both hard copy and online electronic formats. The most recent edition, published in 2010, shows data from 2008 and is little more than a pamphlet with the bulk of the publication in spreadsheets on the AIHW website, whereas the 2001 edition is quite comprehensive in hard copy and online.

Following the introduction of national registration on 1 July 2010, there is now potential for improvements to be made in the quality of data collected regarding the nursing and midwifery workforce. As each jurisdictional cohort becomes eligible for renewal of registration, a process of realignment is occurring to bring all nurses and midwives in Australia to a common registration and enrolment renewal date. Along with the facility for registration renewal to be undertaken on-line, as well as the survey, the move to a common date will aid in the collection of time-related workforce data.

The survey is still voluntary, but with a nationally uniform renewal date, standard registration categories, along with the Nursing and Midwifery Board of Australia (NMBA) as the main source of data, some of the issues outlined may be resolved. There must be a commitment by the NMBA to collect good quality, comprehensive data to enable effective workforce planning across all categories of nursing and midwifery and in all clinical practice areas. It would be beneficial for the NMBA to work closely with Health Workforce Australia to achieve this end. In addition to a more robust collection of data, it will be necessary for the AIHW to present this data in a comprehensive and user friendly format. Further work is required to determine strategies for improving the completion of the annual workforce survey for nurses and midwives.

Currently the statistics released by the AIHW on nursing and midwifery workforce data are two years out of date by the time the information is published. Attention needs to be given to streamlining the analysis process to promote the timely release of reports and data on nursing and midwifery workforce from the AIHW, to strengthen workforce planning and policy decision making on nursing and midwifery – in this case as it relates to MC&FH nursing.

Other areas for improvement include refinement of the survey tool to capture more precise data on the specialty of MC&FH nurses, sub-specialites, and child health nurses who work in areas other than defined maternal and child health clinics, such as in the community as a generalist community nurse who has child and family health nursing as part of their role.

At a State-based level the ANF is aware that the Municipal Association Victoria conducts surveys from time to time on its MC&FH nursing workforce to assist in workforce planning. It would be useful for one body to collect this State generated data, where it exists, in a central repository, to cross reference with the national data set. Health Workforce Australia would be well positioned to undertake this role.

The ANF recommends:

That the Nursing and Midwifery Board of Australia in conjunction with the Australian Health Practitioner Regulation Agency and Health Workforce Australia, determine strategies for improving the annual collection of national nursing and midwifery workforce data.

6. Institutional arrangements and COAG reforms

6.1 Governments' current role in the ECD sector

Are there examples of jurisdictions or councils with effective policies and programs that could be usefully transferred and applied in other areas of Australia?

The experience in Victoria stands out as being particularly successful in terms of recruitment and/or retention of staff in the MC&FH nursing sector. In that State, local councils employ the M&CH nurses and scholarships are offered annually by either the State/local government to contribute to the cost of tertiary education in maternal and child health.

The Australian Government nursing scholarship scheme administered by Royal College of Nursing, *Australia* also provides funds to contribute to the cost of post graduate studies in maternal and child health. Some of the recipients of such scholarships practice in rural or remote areas, general practice or community health, in addition to those who are in defined maternal and child health positions.

7. Demand for ECD workers

7.1 Demand for child health workers

What factors affect the demand for, and the skills required of, the child health workforce?

Factors which affect the demand for, and the skills required of, the maternal and child health workforce include:

- *Setting:* the metropolitan/rural/remote area where the MC&FH nurse is working affects the demand for and the skill level required. In some rural and remote areas the MC&FH nurse has additional roles, such as the youth nurse or adult community nurse. Skills required will obviously differ depending on the role to be undertaken.
- *Budget:* generally child health services have been funded under a fixed historical-based budget. In many instances there has not been an increase in the numbers in the child health workforce for some time (with the exception of school based youth health nurses). Although there might have been an increase in demand on community services (for example due to increased population in an area) there has not been a concomitant increase in annual budget levels, including funding for additional staff.
- *More child health clinics:* opening up of new suburbs with urban sprawl occurring in most of the capital cities and establishment of new infrastructure including child health clinics.
- *Ethnicity issues:* growth in groups within the community who are from non-English speaking backgrounds requiring MC&FH nurses to understand and acquire additional skills to ensure cultural safety.
- *Community expectations:* increased expectations of the community with some consumers of health services being much more informed about health and child development issues through ready access to internet-based information.
- *Altered disease patterns:* increase in the prevalence of health issues such as: chronic diseases – especially diabetes type 2; mental ill-health; life-style related illnesses such as those related to alcohol or drug dependence impacting on the health of the mother, child and their family.
- *Australian Government reform agenda:* with an emphasis on early intervention and prevention MC&FH nurses may need additional education in identifying strategies for different client groups.

The information below, provided by the ANF (Vic Branch), outlines graphic evidence of a major factor in increased demand for MC&FH nurse services:

The major factor affecting demand for M&CH nursing services is the number of annual birth notifications, which in Victoria have increased steadily as follows:

- 63,622 (Maternal & Child Health Services Annual Report (M&CHS) 2004-2005, Department of Education and Early Childhood Development, Victoria (DEECD))
- 66,526 (M&CHS Annual Report 2005-2006, DEECD)
- 70,158 (M&CHS Annual Report 2006-2007, DEECD)
- 71,277 (M&CHS Annual Report 2007-2008, DEECD)
- 71,799 (M&CHS Annual Report 2008-2009, DEECD)
- 73,827 (M&CHS Annual Report 2009-2010, DEECD)

Additionally, MC&FH nurse respondents to an ANF (Vic Branch) Maternal & Child Health Nurses Survey in 2008⁸ identified the now industry standard, 'short' post natal hospital admission for birth, as a factor contributing to the need for MC&FH nurses to possess appropriate qualifications in nursing, midwifery and post graduate child, family and community education.

8. Supply of ECD workers

8.1 Supply, staff retention and turnover

To what extent are ECEC, child health and family support workers experiencing staff retention issues? Are there examples of effective staff retention strategies in the ECD sector? How might such strategies be replicated throughout Australia?

The ageing of the MC&FH nurse workforce is an important characteristic to note, as it is a major factor that affects current supply of nurses working in this sector and is a factor that has the potential to significantly impact on future supply of MC&FH nurses.

As previously mentioned staff retention is not currently problematic due to the current economic climate and the need for many MC&FH nurses to remain in the workforce to assist with family finances. In some States, MC&FH nursing staff has increased their hours of work. However, in others, while staff remain in their substantive MC&FH positions, there is an increasing rate of part time employment. This means that more nurses need to be employed to cover the workload requirements.

If these trends continue over the next seven years there may well be supply issues in relation to attraction, recruitment and retention of child health staff.

Reference has already been made to the success of the strategy introduced in Victoria to attract quality staff to the child health sector and ensure an adequate supply of suitably qualified MC&FH nurses through the provision of scholarships. These scholarships aim to assist nurses and midwives to undertake the relevant post graduate studies that enable them to practice as a MC&FH nurse in Victoria (for example, the Post graduate Diploma of Nursing in Child, Family and Community, or a Masters of Nursing Science in Child, Family and Community). Offering the scholarships has also been a useful strategy in retaining MC&FH nurses by contributing to on-going professional development.

While the scholarships, valued at \$3,500 each, provide welcome financial assistance to successful applicant's, the ANF needs to point out that the full cost of a Post Graduate Diploma of Nursing in Child, Family and Community can vary between \$12,000 to \$14,000 per course. In light of this, the ANF urges the Commission to recommend that State and Territory governments give serious consideration to:

- a) making scholarships available for nurses and midwives to undertake studies relevant to maternal and child health to enter or be retained in the MC&FH nursing workforce, and
- b) making scholarship funding available which significantly contributes to the cost of tertiary level study, especially accommodating for travel costs for rural and remote recipients.

The standard funding range for such scholarships is between \$10,000 and \$15,000. This cost could be jointly funded by Federal and State Governments.

The ANF recommends:

That scholarship programs to support post graduate education for maternal, child and family health nurses be introduced across all jurisdictions.

That the quantum of scholarship funding provided to support post graduate education for maternal, child and family health nurses be sufficient to significantly contribute to the cost of tertiary level study, especially accommodating for travel costs for rural and remote recipients.

The ANF (Queensland Branch) has reported on strategies to delay retirement of MC&FH nurses such as:

- Flexible working hours - 4 and 6 hour shifts/ school hours work
- Reduction in working days - some staff working 1-2 days a fortnight
- Specifying areas/places of work to suit the worker, that is, no home visiting, only clinic based work.

Other factors seen to be important in recruiting/retaining MC&FH nurses and thus improving the future supply of nurses in the sector include:

- Staff safety when working in isolation
- Adequate orientation, support and mentoring
- Access to tertiary child and family health courses
- Adequate access to professional development opportunities – particularly for rural and remote nursing staff
- Providing incentives for staff willing to work in rural and remote areas to provide services to those communities
- Better matching of caseload with staff and material resources
- Enabling MC&FH nurses to work with children and their families rather than expecting a more generalist community role. This occurs particularly in rural communities and will generally not be attractive to a person with specialist MC&FH experience and qualifications.

While the provision of scholarships has proven to be successful in recruiting and retaining MC&FH nurses, the ANF suggests that there be an immediate review of retention strategies and where there is evidence of their success, these be promoted by the Australian Government for application across the country.

The ANF recommends:

That a review of retention strategies for MC&FH nurses be undertaken by the Australian Government as soon as practicable, with a view to promoting applicability across the country. Further, that major stakeholders, including the ANF, should be involved in the review.

8.2 Pay and conditions

In the main, MC&FH nurses are employed in the public sector by respective State/Territory health or human service departments. The one exception is in Victoria where MC&FH nurses are, as previously mentioned, generally employed by local government instrumentalities who are the main body responsible for delivering this service across the State.

With the exception of Victoria, the wages and conditions of M&CH nurses are determined by the respective State/Territory public sector collective bargaining agreements negotiated by the ANF and government/department or agency representatives. A list of current agreements is attached at Appendix B. In Victoria, the ANF negotiates collective bargaining agreements with the respective local government bodies resulting in approximately 75 different agreements. However, wages and conditions broadly reflect those that apply to nurses covered by the public sector agreement.

Union negotiated Collective Agreements covering MC&FH nurses are comprehensive agreements containing wages and conditions of employment including: classifications and career structures; opportunities for professional development and continuing education; post graduate qualification allowances; workload management tools or processes to support adequate staffing levels and skill mix; provisions for payment of penalty rates and allowances; leave arrangements and other entitlements.

Currently, in Australia, there is a small number of MC&FH nurses employed in the private sector, for example, private hospitals with maternity services may employ family and child health nurses. In some instances nurses are employed by pharmacies to provide advice to mothers on child and family health issues. However, the ANF cautions that the nurses undertaking these roles may not always hold the necessary MC&FH nursing qualifications for this practice.

The ANF recommends:

That there be pay parity for MC&FH nurses within jurisdictions.

8.3 Qualifications and Career Pathways: Getting started in the ECD workforce

How appropriate are qualifications required for entry into various ECD occupations? Do differences in qualification requirements restrict workers ability to move between jurisdictions or ECD sectors? Do newly qualified workers have the necessary skills and attributes to be effective in the workplace? To what extent are qualification requirements a barrier to entering ECD sector? How could barriers be overcome? Do people from indigenous and CALD backgrounds face particular barriers to obtaining entry level ECD qualifications?

The entry qualifications required for the MC&FH nurse are registration as a nurse and preferably a tertiary level child and family health qualification. Midwifery and mental health qualifications are advantageous to this field of work, and in fact nursing, midwifery and maternal and child health postgraduate qualification are mandatory requirements in Victoria under the Maternal and Child Health Service Program Standards.

The core curriculum content for undergraduate programs leading to registration as a nurse does not include child and family health or midwifery and there is no current requirement for universities to include these components in preparatory programs for nurses. Thus there is a necessity for post graduate education in this area. This view is supported by Kruske and Barclay, well respected writers in the field, who support the need for post graduate education for MC&FH nursing and provide the following insights⁵

Undergraduate nursing students are primarily prepared to work within the acute health sector. Most new graduates consolidate their education and have their work practices formed in the hospital setting. The acute care sector absorbs the majority of the health budget and is dominated by a biomedical focus of care.

... [MC&FH] nursing does not sit well within the biomedical model due to its longstanding awareness of the social, economic and cultural influences on health.

Working outside a hospital requires a very different working style – undergraduate education systems do not prepare the [MC&FH] nurse adequately for this.

To be effective, the [MC&FH] nursing workforce must adopt the partnership paradigm, which is fundamentally opposite to the expert model that dominates acute care health services.

To promote and support this change of practice from expert to partnership, the post graduate education system needs to assist [MC&FH] nursing students to differentiate the differences in these two models of care.

What Kruske and Barclay highlight is the essence of MC&FH nursing in forming partnerships and trust relationships with mothers and their babies, within the context of their family unit. This requires that the MC&FH nurse has a base foundation in nursing knowledge, which must be strengthened with post graduate studies in maternal, child and family health to be able to safely and competently deliver early childhood development care services that are responsive to the complex needs of the community.

Evidence exists to support the argument that the qualifications outlined above are appropriate and necessary to prepare registered nurses for the demanding role of a MC&FH nurse, working in our communities with children and their families, who often have complex physical and/or emotional care needs. The Victorian Association of Maternal and Child Health Nurses (VAMCHN) submission to the Productivity Commission has provided detail on research studies that clearly identified positive health outcomes for the child/ren and their families when the attending nurse has a degree in nursing and advanced education preparation as opposed to workers with no formal qualifications.

The issue of nationally consistent qualifications is complex due to the different models of care across jurisdictions. For example, in Victoria MC&FH nurses are employed by local councils to whom all births must be notified within 48 hours of a birth. MC&FH nurses are subsequently notified of all these births and visits commence within days of the birth (often while the mother and baby are still in hospital). It is for this reason that midwifery is an essential qualification for these MC&FH nurses. In some other jurisdictions the process is voluntary on the part of the mother to make contact with the MC&FH nurse, and this may not occur until the baby is six or more weeks old. Midwifery qualifications, while advantageous, may not be as critical in this model of care.

Most of the MC&FH positions are at advanced clinical nurse levels and there is generally no provision for an entry point into the maternal, child and family health field for newly graduating nurses or for nurses with experience in another field, but no MC&FH nurse qualifications, wishing to make a career change. Funding is not generally readily available for orientation and on-going mentoring of nurses wishing to enter the field. An example of clinical mentoring arrangements is shown at Appendix C (Stonnington City Council) - NB. Page 3(i). Due to the autonomous nature of the work of the MC&FH nurse, and the often complex interplay of skills required for managing physical and emotional child/ren and family needs, it is professionally and personally difficult for nurses/midwives to enter the field without having a defined process of preceptorship with an experienced MC&FH nurse.

Nurses are required to undertake their Maternal, Child and Family Health post graduate certificate/diploma without prior experience in the field. Limited clinical contact hours within the maternal and child health sector whilst undertaking the postgraduate course often does not enable confidence for autonomous practice on completion of the course and entry to the field. The ANF therefore argues that funding should be made available to accommodate supernumerary positions under a student fellowship arrangement, whereby postgraduate course participants are able to be employed in the maternal, child and family health sector during their course, with an identified preceptor, to gain the necessary confidence and experience, whilst addressing the supply strategy. The fellowship would employ nurses in the MC&FH nurse workforce at a negotiated given point in their course, starting off in a supernumerary capacity. This supernumerary requirement would diminish over the duration of the course. Providing supports during the postgraduate education of these nurses will facilitate the development of the maternal, child and family health workforce across the country.

In most areas of the nursing and midwifery education and workforce sectors our first nations people and those from non-English speaking backgrounds face particular challenges undertaking courses and integrating into clinical settings. This is no different across the maternal, child and family health sector, and in fact, additional supports may be required to assist transition of Indigenous and CALD background nurses into this field due to the autonomous nature of the work of MC&FH nurses.

The Australian Government's Closing the Gap targets for Indigenous maternal and child care and the increasing numbers of people migrating into Australia from non-English speaking countries requires a strong cohort of Indigenous and CALD nurses within the MC&FH nursing workforce.

The ANF recommends:

That MC&FH nurse qualifications are appropriate for the model of care in each jurisdiction.

That governments at State/local levels provide funding for nurse supernumerary positions, under a student fellowship arrangement, to enable employment of MC&FH nursing postgraduate course participants in the sector, with the support of an identified preceptor, allowing the student to gain necessary confidence and experience for the role whilst also addressing the issue of supply.

That governments at State/local levels provide funding for support structures, such as preceptors, for transition of Indigenous and CALD background nurses into the MC&FH nursing workforce, as part of the supply strategy.

8.4 Future Supply of ECD workers: Workforce Planning

The effects of the ageing MC&FH workforce, the increasing trend in part time employment amongst MC&FH nurses, combined with increasing birth rates, and the Australian Governments reform agenda of increasing efforts on early intervention and prevention and Closing the Gap targets, all mandate that greater numbers of MC&FH nurses will be required into the future.

With the Australian Government's introduction of the national paid maternity leave scheme, and continuation of the 'Baby Bonus' scheme there is every indication that the current trend of rising birth rates will continue.

The following components of the national reform agenda for early childhood development⁹ give clear indication of the need to increase the supply of MC&FH nurses:

- Strengthen maternal, child and family health service delivery as a key plank of a strong universal service platform
- Increase coordination between maternal, child and family health services and education and care and family support
- Improve capacity to assess child health and development between 18 months and 3 years

- Improve support for vulnerable children and their families through better service response and accessibility, particularly children with a disability, children at risk of homelessness, some Indigenous and CALD children, children in jobless families, and children in or at risk of entering the child protection system
- Strengthen the workforce capacity across early childhood development and family support services, particularly around leadership and interdisciplinary practice, to better support children with special needs, and to deliver culturally inclusive services

Workforce planners must therefore, firstly, make estimation of the number of MC&FH nurses who can reasonably be expected to retire from the workforce in the next 5-10 years; and secondly, introduce measures to ensure these MC&FH nurses are replaced in sufficient numbers to match the predicted increased demand for MC&FH nurse services.

Initiatives to improve supply have been outlined in this submission, including the success of scholarships programs offered at Federal, State and local government levels. Other measures are:

- Providing MC&FH nurses with working conditions that are attractive and compete well with other nursing and midwifery health sectors. This may include:
 - o Providing wage parity to MC&FH nurses within jurisdictions
 - o Providing for payment of a “certificate allowance” for MC&FH nurses in recognition of their additional and advanced qualifications, ensuring this payment is based on the applicable enterprise agreement salary rate
 - o Ensuring MC&FH nurse staffing levels and skill mix are adequate and suitable to enable them to continue to provide high quality care, and to have reasonable workloads (this means being able to spend the time with each mother and baby needed to establish a trust relationship and share information to optimise early childhood development).
- Continuing to provide professional recognition for MC&FH nurses through facilitating opportunities for ongoing professional development.

In addition the ANF considers that further support and assistance should be available for registered nurses and midwives to access refresher and re-entry programs. Such assistance may be in the manner of financial assistance to access these programs, or for the government to actively encourage health services to provide access to refresher and the clinical component of re-entry programs at no, or minimal cost to the registered nurse, midwife or health service.

In summary, MC&FH nurse workforce planning must be based on the need to provide adequate numbers of MC&FH nurses to meet the increasing demand for maternal, child and family health care services as indicated by ongoing increases in births in Australia.

Have initiatives to increase supply of ECD workers been effective?

Initiatives to increase the supply of MC&FH nurse have been effective in some jurisdictions, such as the provision of scholarships for post graduate studies critical for the role; and, in some large metropolitan areas entry points have been created and training positions offered which have seen effective supply of MC&FH staff for that area.

There is constant tension in ensuring that workloads are reasonable and client allocation suitable, to enable the provision of optimal MC&FH nursing care. Workforce planning needs to give serious consideration to adopting successful initiatives more broadly, to improve supply mechanisms, so that MC&FH nurse skill mix is maintained to prevent intensification of work, and to enable the ongoing delivery of high quality MC&FH nursing services.

How might the proposed qualification standards, staffing levels and the implied mix of skills and knowledge assist the delivery of the desired outcomes for children?

The ANF stresses that the existing level of qualification and educational preparation required of MC&FH nurse should not be seen as a “barrier” to entering the MC&FH nursing workforce. Rather the qualifications outlined in this paper are essential requirements for competent practice in the early childhood development field as a MC&FH nurse, and the linchpin to providing safe and high quality MC&FH nursing care.

The Victorian experience of specifically funded MC&FH nurse scholarships demonstrates that any perceived disincentive (or “barrier” as referred to in the Productivity Commission’s Issues paper) to undertaking the requisite education preparation of MC&FH nursing, can be successfully overcome.

9. Conclusion

The ANF absolutely supports an appropriately qualified maternal, child and family health nursing workforce which can work within a partnership philosophy to deliver positive outcomes in early childhood development for our communities. As this paper has highlighted there are differing models of care delivery across the jurisdictions. Where there is evidence of strong positive outcomes for mothers and babies these models of care should be assessed for applicability more broadly. The models of educational preparation should also be supported which appropriately prepare MC&FH nurses to deliver care which will achieve the national agendas for improved early childhood development services.

A number of recommendations have been made for consideration by the Productivity Commission in its deliberations on the early childhood development workforce in Australia, particularly in relation to health care services.

The ANF looks forward to participating in on-going consultation and the work of the Commission on early childhood development in relation to maternal, child and family healthcare nursing and care delivery.

10. References

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8. Australian Nursing Federation Victorian Branch. 2008. Maternal and Child Health Nurses Survey Report. (http://www.anfvic.asn.au/multiversions/16877/FileName/MCH_Final_Report_2009.pdf)
9. Commonwealth of Australia. 2009. Investing in the Early Years – A National Early Childhood Development Strategy. An initiative of the Council of Australian Governments. Available at: http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/national_ECD_strategy.pdf

Appendix A

DATA SOURCES FOR CHILD AND MATERNAL HEALTH NURSES

The AIHW records to the clinical area of practice for child and maternal health nurses as family and child health nurses.

EMPLOYED FAMILY AND CHILD HEALTH NURSES

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUSTRALIA
NUMBER	1,511	825	917	366	664	145*	n.p.	121	4,686
AGED 55+	268	176	194		108				913
% AGED 55+	17.8%	21.4%	21.2%	n.p.	16.4%		n.p.	n.p.	19.5%

TOTAL NUMBER AUSTRALIA: 4,686
AVERAGE AGE AUSTRALIA: 46.2 years.

Source: Nursing and midwifery labour force 2008. Canberra: AIHW, 2010. Additional material tables available at <http://www.aihw.gov.au/publications/index.cfm/title/12017>

n.p.: not publishable due to small numbers or concerns about quality of data.

**Note: Recent figure from the Tasmanian Department of Health and Human Services.*

FAMILY AND CHILD HEALTH NURES 1997-2008

	1995	1997	1999	2001*	2003	2004	2005	2007
RN	1966	2685	2934	2946	6823	6759	4989	4536

Source: Nursing and midwifery labour force 2007, nursing and midwifery labour force time series 1995 to 2007. Canberra: AIHW, 2009. Tables available at <http://www.aihw.gov.au/publications/index.cfm/title/10724>

** Note: The large difference between the 2001 and 2003 figures may be explained by a difference in AIHW reporting of clinical areas of nursing. For the years 1995 to 2001 the AIHW nursing and midwifery labour force reports had categories for Child and Family Health, Paediatric and School Children's Health nurses. From 2003 onwards there is a single category called Family and Child Health nurses, which we believe now accommodates the figures for the categories previously listed separately.*

Appendix B

STATE AND TERRITORY AGREEMENTS/INSTRUMENTS COVERING MATERNAL AND CHILD HEALTH NURSES

New South Wales

Public Health System Nurses' & Midwives (State) Award 2011
IRC 1382 of 2010

Australian Capital Territory

ACT Public Sector Nursing and Midwifery Enterprise Agreement 2010-2011
[AE: 882448]

Queensland

Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009
[No. CA/2009/70]

Northern Territory

Northern Territory Public Sector Nurses' 2008-2011 Union Collective Agreement
[Agreement Number: 085623592]

South Australia

Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2010
[File No: 05735/2010]

Tasmania

Nurses and Midwives Heads of Agreement 2010
[T13746 of 2010]

Western Australia

Registered Nurses, Midwives and Enrolled Mental Health Nurses - Australian Nursing
Federation - WA Health Industrial Agreement 2007
[AG 69 of 2007]
(New agreement pending)

Victoria

Separate collective agreements negotiated with approximately 75 Councils across Victoria.

[2010] FWAA 5055



DECISION

Fair Work Act 2009

s.185—Approval of enterprise agreement

Stonnington City Council

(AG2010/11434)

STONNINGTON CITY COUNCIL ENTERPRISE AGREEMENT NO. 7/2010

Local government administration

DEPUTY PRESIDENT HAMILTON

MELBOURNE, 8 JULY 2010

Application for approval of the Stonnington City Council Enterprise Agreement No. 7/2010.

[1] An application has been made for approval of an enterprise agreement known as the *Stonnington City Council Enterprise Agreement No. 7/2010* (the Agreement). The application was made pursuant to s.185 of the *Fair Work Act 2009* (the Act). It has been made by Stonnington City Council. The agreement is a single-enterprise agreement.

[2] I am satisfied that each of the requirements of ss.186, 187 and 188 as are relevant to this application for approval have been met.

[3] The Agreement is approved and, in accordance with s.54, will operate from 15 July 2010. The nominal expiry date of the Agreement is 30 June 2013.

[4] The agreement does not contain a model flexibility term compliant with the Act. Pursuant to s.202(4) of the Act, the model flexibility term prescribed by the *Fair Work Regulations 2009* is taken to be a term of the Agreement.

[5] The Australian Municipal, Administrative, Clerical and Services Union being a bargaining representative for the Agreement, has given notice under s.183 of the Act that it wants the Agreement to cover it. In accordance with s.201(2), I note that the Agreement covers the organisation.

[6] The Australian Nursing Federation being bargaining representatives for the Agreement, have given notice under s.183 of the Act that they want the Agreement to cover them. In accordance with s.201(2), I note that the Agreement covers the organisation.

[7] The Association of Professional Engineers, Scientists and Managers, Australia, being bargaining representatives for the Agreement, have given notice under s.183 of the Act that they want the Agreement to cover them. In accordance with s.201(2), I note that the Agreement covers the organisation.



AGC 11434 / 2010

Stonnington Enterprise Agreement

Expires 30 June 2013
No. 7 2010-2013



City of
STONNINGTON

CONDITIONS OF EMPLOYMENT AGREEMENT

Maternal and Child Health and Immunisation Service

STAFF COVERED

All MCH and Immunisation nurses employed in the City of Stonnington Maternal & Child Health Service.

Maternal & Child Health

WORKLOADS

The parties are committed to providing a quality Maternal and Child Health service to clients of Stonnington through reasonable and manageable workloads.

a) The Stonnington Workload Tool will be utilised in consultation with MCH Nurses & MCH Co-ordinator to review workloads at 3 monthly intervals. The Stonnington Workload Tool will be reviewed in consultation with MCH nurses, MCH Co-ordinator and management annually. A review of permanent staffing levels will be conducted in January each year utilising the Stonnington Workload Tool.

b) Should the review reveal that the Maternal & Child Health nurse workload is in excess of 130 births per EFT, the Council shall take immediate steps to remedy this situation, which can include the engagement of casual relieving staff.

c) In the event the following 3 monthly review reveals that the Maternal & Child Health nurse workload continues to be in excess of 130 births per EFT then Council shall advertise to engage sufficient Maternal & Child Health nurses so that the average workload is 130 for the following year.

Service Coordination;

a) Where appointed, the MCH Coordinator will be paid no less than 10%, above the highest classification rate of pay applicable to a MCH nurse paid in accordance with this agreement.

b) Clinical Support – Higher Duties

- i. The council will authorise 0.2 EFT MCH nurse to provide clinical support to MCH nurses within the service, in the non contracted period of duty of the MCH Coordinator.
- ii. The MCH nurse authorised to provide clinical support as above will be paid a higher duties allowance of 10% in addition to the applicable MCH rate of pay. For the avoidance of doubt, the parties agree that the MCH nurse authorised to provide clinical support to MCH nurses within the service on the non contracted periods of the MCH Coordinator as above, satisfies the requirements of “higher duties” in the Nurses (ANF – Victorian Local Government) Award 2002 and is therefore entitled to be provided the related “higher duties” allowance cited above.

c) Reallocation of client workload for the MCH nurse authorised as above will occur as appropriate and as determined through consultation between the MCH nurses and MCH Coordinator and in accordance with the Stonnington Workload Tool.

- d) The current level of administration support will remain at 15.2 hours.
- e) The parties to this agreement agree that the arrangements above apply to the MCH Nurse & Coordinator structure in place at the making of this agreement. In the event of any future change to the MCH Nurse & Coordinator structure Council may review the arrangements above in accordance with Clause 35 of Part A this agreement, Introduction of Change.

f) Recruitment and Retention

Due to workforce recruitment and retention concerns, Council will pay an increment of 5% for the Enhanced MCH Nurse.

g) Telephone Booking Service

Notwithstanding subclause 1(d) Council also aims to decrease administrative tasks required of MCH nurses and will continue to consult with them on the implementation of a telephone booking service using the Stonnington Workload Tool.

HOURS OF WORK

- a) The spread of ordinary hours will be between 8am to 6pm for an MCH Nurse as stated in Part C of this Agreement.
- b) Hours worked on a Saturday or Sunday shall be paid in accordance with clause 12.3 Part C of this agreement.
- c) All overtime must be approved and where approved, it will be paid in accordance with clause 12 Part C of this Agreement.
- d) Where an MCH nurse assesses a mother and/or child to be at risk and intervention is required immediately (defined as an emergency situation), thus necessitating the nurse to work additional hours in excess of the ordinary spread of hours (8am to 6pm) the nurse will immediately contact the MCH Coordinator to seek approval. Where the Coordinator is not able to be contacted, additional hours may be worked at the Nurses discretion. Such additional time shall be counted as time in lieu calculated at ordinary time and a half (1.50). The circumstances and a risk assessment of the situation must be documented in a detailed report and provided to the Coordinator as soon as possible after the hours worked. The hours worked must be approved prior to penalty entitlements being accessed. These actions must be undertaken in compliance with the MCH Clinical Governance Framework and Child Protection Policy and Reference Guide.

RELIEF STAFF

- a) Reasonable measures will be taken to ensure that the MCH Coordinator position will be backfilled. This will be at a minimum of 0.5 EFT for all periods of planned leave.
- b) Casual/relief MCH Nurses will be paid a minimum of 3 hours per session.
- c) Casual staff shall be appointed to cover 100% of annual leave, sick leave and long service leave and for maintaining workloads in a manner consistent with clause 2 (a) and (b) of this Appendix.
- d) No MCH nurse will have leave refused on account of a lack of relief staff.

PAYMENT OF WAGES

- a) Except for Clause 3 (b) and subclause 5 (e) the rates of pay in Table 1 of this appendix are annualised for the period of this agreement and shall apply to all hours worked in accordance with Clause 3, of this agreement and shall unless otherwise provided for in this agreement be in-lieu of all appropriate allowances, shift penalties and annual leave loading prescribed in Part C attached.
- b) Casual employees will receive a 25% loading for casual employment (which is in lieu of payment for annual leave, sick leave and public holidays) for time worked during ordinary hours.
- c) Qualification allowances will be calculated using the following percentages.

<i>Certificate Allowance</i>	4%
<i>Graduate Diploma</i>	6.5%
<i>Masters Allowance</i>	7.5%

- d) Payment of qualifications allowance based on the EA rates prescribed in the Rates of Pay in Table 1 of this appendix will be phased in over the period of this agreement (pro rata for part time employees).
- e) All MCH nurse salaries will be increased by the amount prescribed in Part A of this agreement and as stated in the Rates of Pay in Table 1 attached to this Appendix.

MULTI SKILLING, PROFESSIONAL DEVELOPMENT AND TRAINING

- a) All employees must be prepared to carry out the full range of duties as is from time to time required by Management provided that the duties are within the limits of the Employees skills, competence and training.
- b) All Employees shall use such equipment as may be required, provided the Employee/s has been properly trained in the use of such equipment.
- c) All Employees must be prepared to undertake specialist skills training which may be provided both on and off the job and will have the ability to access 5 days professional development and/or training per annum which will be provided in line with the approved M&CH Annual Training Plan. Additional requests can be made and will be given due consideration.
- d) MCHN application's for study leave and course reimbursement for gaining a Lactation Qualification such as International Board of Certified Lactation Consultants (IBCLC) accreditation to be included for consideration.
- e) MCHNs required to undertake training outside of normal working hours will be entitled to time in lieu at hour for hour rate.
- f) Provided further that Employees who undertake professional development and training and attend compulsory meetings in accordance with this sub-clause and as such is outside the employee's ordinary spread of hours as determined in clause 3 sub-clause (a) and/or the employee is not rostered to work shall be entitled to time off in lieu without loss of pay at the rate of 1.5 hours for each hour of training.
- g) Relieving M&CH nurses may access 4 x 3 hour paid education meetings.
- h) Clinical Supervision will continue to be provided at the current level of 1.5 hours per month.
- i) Clinical Mentoring

The Council shall offer new graduate or inexperienced Maternal and Child Health Nurses clinical mentoring for a maximum period of twelve months from the date of appointment according to the following maximum formula:

1st month = 8 hours/week

2nd month = 6 hours/week

3rd month = 4 hours/week

4th to/ 12th month = 2 hours/week

The person appointed to act as a clinical mentor shall be supported by backfilling arrangements if possible during periods of mentoring either by a Maternal and Child Health Relieving Nurse or other permanently appointed Maternal and Child Health Nurse, provided that such nurse who is appointed to backfill shall not be disadvantaged in terms of additional workloads.

WORK LOCATION/JOB ROTATION

The Council will ensure that reasonable notice is provided to the employee of the relocation, and that the relocation will not adversely impact on the employee's existing workloads. From time to time an MCH nurse may be asked to undertake sessions at another Centre at short notice.

8. ANNUAL LEAVE

- a) Annual leave shall be rostered so as to ensure that a sufficient number of skilled Employees are always available.
- b) Annual leave shall be taken in periods of not less than 5 days.
- c) Provided that by agreement between the Employee/s and Management annual leave may be taken in periods less than 5 days.
- d) Provided further that the periods when annual leave may be taken shall be agreed to between the Employees and Management.
- e) Management shall not unreasonably refuse a request for annual leave.

9. USE OF OWN CARS

The Council shall provide each MCH Centre with a designated car parking space restricted for the use of MCH nurses during the ordinary spread of working hours.

10. OCCUPATIONAL HEALTH & SAFETY

Stonnington is committed to ensuring the safest possible environment for nurses and clients. As such Stonnington will in consultation with the MCH Nurse OH &S representative, and within 3 months of the commencement of this agreement, perform a thorough risk assessment of all MCH nurse work environments. This assessment will have due regard for the Australian Standard Security for health care facilities Part 2: procedure guide (AS4485.2-1997).

IMMUNISATION NURSES**11. HOURS OF WORK**

The spread of ordinary hours will be as required to meet the needs of the Immunisation Service.

12. PAYMENT OF WAGES

Except for clause 3(b) and subclause 12 (d) the rates of pay in Table 1 of this appendix are annualised for the period of this agreement and shall apply to all hours worked in accordance with clause 11 of this agreement and shall unless otherwise provided for in this agreement be in-lieu of all appropriate allowances, shift penalties and annual leave loading prescribed in Appendix C attached.

Casual employees will receive a 25% loading for casual employment (which is in lieu of payment for annual leave, sick leave and public holidays) for all time worked.

Qualification allowances will be calculated using the following percentages.

<i>Certificate Allowance</i>	4%
<i>Graduate Diploma</i>	6.5%
<i>Masters Allowance</i>	7.5%

Payment of qualifications allowance based on the EA rates prescribed in the Rates of Pay in Table 1 of this appendix (pro rata for part time employees).

All Immunisation nurse salaries will be increased by the amount prescribed in Part A of this agreement and as stated in the Rates of Pay in Table 1 attached to this Appendix.

Appendix 14 - MCH										
Increment 1 paid in Pay Period commencing (Indoor) 3 July 2010 (Outdoor) 10 July 2010 3.5% or \$35				Increment 2 paid in Pay Period commencing (Indoor) 2 July 2011 (Outdoor) 9 July 2011 3.8% or \$38				Increment 3 paid in Pay Period commencing (Indoor) 30 June 2012 (Outdoor) 7 July 2012 4.0% or \$40		
Position	Hourly	Weekly	Annual	Hourly	Weekly	Annual	Hourly	Weekly	Annual	
Qualified MCH Nurse Year 1	\$40.57772	\$1,541.95	\$80,181.57	\$42.11967	\$1,600.55	\$83,228.47	\$43.80446	\$1,664.57	\$86,557.61	
Qualification Allowance - Certificate	\$1.07400	\$40.81	\$2,122.22	\$1.39980	\$53.19	\$2,766.00	\$1.75218	\$66.58	\$3,462.30	
- Diploma	\$1.74525	\$66.32	\$3,448.61	\$2.27467	\$86.44	\$4,494.76	\$2.84729	\$108.20	\$5,626.24	
- Masters	\$2.01375	\$76.52	\$3,979.17	\$2.62462	\$99.74	\$5,186.26	\$3.28533	\$124.84	\$6,491.82	
Qualified MCH Nurse Year 2	\$41.44187	\$1,574.79	\$81,889.13	\$43.01666	\$1,634.63	\$85,000.91	\$44.73732	\$1,700.02	\$88,400.95	
Qualification Allowance - Certificate	\$1.07400	\$40.81	\$2,122.22	\$1.41774	\$53.87	\$2,801.45	\$1.78949	\$68.00	\$3,536.04	
- Diploma	\$1.74525	\$66.32	\$3,448.61	\$2.30383	\$87.55	\$4,552.36	\$2.90793	\$110.50	\$5,746.06	
- Masters	\$2.01375	\$76.52	\$3,979.17	\$2.65826	\$101.01	\$5,252.72	\$3.35530	\$127.50	\$6,630.07	
Enhanced Home Visiting Nurse Year 1	\$42.60659	\$1,619.05	\$84,190.63	\$44.22564	\$1,680.57	\$87,389.87	\$45.99467	\$1,747.80	\$90,885.46	
Qualification Allowance - Certificate	\$1.07400	\$40.81	\$2,122.22	\$1.44192	\$54.79	\$2,849.23	\$1.83979	\$69.91	\$3,635.42	
- Diploma	\$1.74525	\$66.32	\$3,448.61	\$2.34312	\$89.04	\$4,630.00	\$2.98965	\$113.61	\$5,907.56	
- Masters	\$2.01375	\$76.52	\$3,979.17	\$2.70360	\$102.74	\$5,342.31	\$3.44960	\$131.08	\$6,816.41	
Enhanced Home Visiting Nurse Year 2	\$43.51399	\$1,653.53	\$85,983.64	\$45.16752	\$1,716.37	\$89,251.02	\$46.97422	\$1,785.02	\$92,821.06	
Qualification Allowance - Certificate	\$1.07400	\$40.81	\$2,122.22	\$1.46076	\$55.51	\$2,886.45	\$1.87897	\$71.40	\$3,712.84	
- Diploma	\$1.74525	\$66.32	\$3,448.61	\$2.37373	\$90.20	\$4,690.49	\$3.05332	\$116.03	\$6,033.37	
- Masters	\$2.01375	\$76.52	\$3,979.17	\$2.73892	\$104.08	\$5,412.10	\$3.52307	\$133.88	\$6,961.58	
Immunisation Nurse Year 1	\$36.89007	\$1,401.82	\$72,894.77	\$38.29189	\$1,455.09	\$75,664.77	\$39.82356	\$1,513.30	\$78,691.36	
Qualification Allowance - Certificate	\$1.47560	\$56.07	\$2,915.79	\$1.53168	\$58.20	\$3,026.59	\$1.59294	\$60.53	\$3,147.65	
- Diploma	\$2.39785	\$91.12	\$4,738.16	\$2.48897	\$94.58	\$4,918.21	\$2.58853	\$98.36	\$5,114.94	
- Masters	\$2.76675	\$105.14	\$5,467.11	\$2.87189	\$109.13	\$5,674.86	\$2.98677	\$113.50	\$5,901.85	
Immunisation Nurse Year 2	\$37.61014	\$1,429.19	\$74,317.64	\$39.03933	\$1,483.49	\$77,141.71	\$40.60090	\$1,542.83	\$80,227.38	
Qualification Allowance - Certificate	\$1.50441	\$57.17	\$2,972.71	\$1.56157	\$59.34	\$3,085.67	\$1.62404	\$61.71	\$3,209.10	
- Diploma	\$2.44466	\$92.90	\$4,830.65	\$2.53756	\$96.43	\$5,014.21	\$2.63906	\$100.28	\$5,214.78	
- Masters	\$2.82076	\$107.19	\$5,573.82	\$2.92795	\$111.26	\$5,785.63	\$3.04507	\$115.71	\$6,017.05	

Report: Maternal and Child Health Nurses Survey 2008

Introduction and Methodology

In December last year ANF in conjunction with the Victorian Association of Maternal and Child Health Nurses (ANF Vic Branch Special Interest Group), conducted an online survey of Maternal and Child Health Nurses about their views on the qualification requirements to practise as an MCH Nurse.

The survey was emailed to 325 MCH Nurses from both the ANF database and the VAMCHN SIG database. A further 164 were posted to MCH Nurses whose email addresses we did not have. A total of 489 survey invitations were distributed, with 293 completed surveys returned to the ANF (60% response rate). Results were analysed using SPSS and thematic analysis conducted of the open ended questions. The results are presented in this report, including themes that highlight the importance of underpinning Midwifery and General Nursing qualifications to the Maternal and Child Health Nurse.

Brief Outline of Survey

Participants were asked to respond to the following 4 questions:

1. A midwifery qualification provides comprehensive knowledge and skills which are essential for MCH nursing. Participants were asked to respond to this statement by stating the extent to which they agree/disagree.
2. Please provide some evidence (including examples and case studies) to support your response [to question 1].
3. A general nursing qualification provides comprehensive knowledge and skills which are essential for MCH nursing. Participants were asked to respond to this statement by stating the extent to which they agree/disagree.
4. Please provide some evidence (including examples and case studies) to support your response [to question 3].

Key Findings

1. A midwifery qualification provides comprehensive knowledge and skills which are essential for MCH nursing.

Participants were asked to respond to this statement by stating the extent to which they agree/disagree. Results are presented below.

Response	No. of Respondents	Percent (%)
Strongly agree	230	78.5%
Agree	13	4.4%
Neither agree nor disagree	4	1.4%
Disagree	8	2.7%
Strongly disagree	37	12.6%
Missing	1	0.3%
Total	293	100.0%

The vast majority (83%) of respondents strongly agree/agree that a Midwifery qualification is an essential prerequisite to Maternal and Child Health Nursing.

2. Please provide some evidence (including examples and case studies) to support your response [to question 1].

When asked to provide evidence, the following themes emerged. The themes all relate to knowledge/skills/abilities that stem from the respondent's midwifery qualification and are used in their role as an MCH Nurse. The main themes that were highlighted are: Lactation skills/breastfeeding advice/establishment of breastfeeding assistance (37%); knowledge of conception, pregnancy, foetal development, childbirth and postpartum (29%) and having the skills to assess/recognise physical and psychological symptoms/complications with both mother and baby (22%). Whilst the following is reported in percentages, please note that respondents were able to highlight numerous themes, therefore the percentages do not add up to 100%.

Top 5 Themes	Percent (%)
1. Lactation skills/breastfeeding advice/establishment of breastfeeding assistance	37%
2. Thorough knowledge of conception, pregnancy, fetal development, childbirth and postpartum	29%
3. Skills to assess and recognise physical and psychological symptoms/complications with both mother and baby	22%
4. Midwifery is vital to MCHN role/essential to total patient care and best practice	21%
5. Allows to empathise with the woman and provide counselling about all aspects of women's health/imperative for the nurse to function holistically and empathetically	20%

Other themes that emerged include:

1. Midwifery provides knowledge to talk to parents to debrief after labour & delivery/answer any questions raised on delivery/dispel myths and clarify any misunderstandings.
2. Provides good knowledge of antenatal and delivery complication.
3. Allows for antenatal and postnatal skills, knowledge and advice.
4. Enables good follow up care and to continue the care and education of a mother and child, including support for the family and parenting advice.
5. Provides sound understanding of complications in newborns e.g. jaundice, in SCN, NICU, premature babies.
6. Understanding of the impact of a difficult and/or traumatic labour and the ability to recognise postnatal depression.
7. Assists with the understanding of the childbirth experience and health related issues of the mother.
8. Knowledge of newborn physical development, and childhood health and development.
9. Ability to refer to, communicate with, and accept referrals from other health professionals and/or other agencies.
10. Provides skills and abilities to recognise complications and/or illness that may not have been diagnosed and treated while an inpatient.
11. Knowledge of difficult/dangerous conditions of pregnancy is an essential part of the MCHN role e.g. pre-eclampsia/HELLP syndrome, pregnancies incompatible with life.
12. Provides an understanding of the mother/baby relationship and of their emotional wellbeing following delivery.
13. Midwifery together with General Nursing qualifications and MCHN training are all equally important.

14. Knowledge of the "hospital experience" helpful to mothers.
15. Provides knowledge of female reproductive system/skills to provide fertility advice.
16. Provides an understanding and ability to provide assistance with stillborn and neonatal death.
17. Victoria has a superior service to other states and countries due to Midwifery requirement.
18. Midwifery is important for the professional standing of MCHNs.
19. Ability to provide advice and support for mothers whose babies have ongoing serious conditions, e.g. Cerebral Palsy, Downs Syndrome and/or special needs e.g. naso-gastric feeding/oxygen therapy.
20. Midwifery provides skills to act immediately to avert crisis for mother/baby.

3. A general nursing qualification provides comprehensive knowledge and skills which are essential for MCH nursing.

Participants were asked to respond to this statement by stating the extent to which they agree/disagree.

The vast majority 70% of respondents strongly agree/agree that a General Nursing qualification is an essential prerequisite to Maternal and Child Health Nursing.

Response	No. of Respondents	Percent (%)
Strongly agree	164	56.0%
Agree	40	13.7%
Disagree	12	4.1%
Neither agree nor disagree	23	7.8%
Strongly disagree	52	17.7%
Missing	2	0.7%
Total	293	100.0%

4. Please provide some evidence (including examples and case studies) to support your response [to question 3].

When asked to provide evidence, the following themes emerged. The themes all relate to knowledge/skills/abilities that stem from the respondent's General Nursing qualification and are used in their role as an MCH Nurse. The main themes that highlighted are: provides a background knowledge which is essential for safe practice (33%); provides skills and knowledge to make assessments/recognise symptoms and treat various conditions that are not covered in Midwifery (30%); and to provide holistic family care, which recognises that MCH nurses not only care for mother and baby but their role extends to the whole family (26%). Whilst the following is reported in percentages, please note that respondents were able to highlight numerous themes, therefore the percentages do not add up to 100%.

Top 5 Themes	Percent (%)
1. Background basic knowledge/anatomy and physiology/essential for safe practice	33%
2. Provides skills and knowledge to make assessments/recognise symptoms and treat various conditions, that are not covered in Midwifery	30%
3. Holistic family care/best practice including knowledge of hereditary patterns/allergy	26%
4. General nursing together with mid are essential prerequisite for MCH nursing, provides well balanced education/Vic MCH service is superior	12%
5. Referral to other health specialists	10%

Other themes that emerged include:

1. Provides knowledge to talk to parents/answer questions/provide support and advice/debrief.
2. Gives skills to be able to care for the mother when she has a pre-existing medical condition and how it impacts on parenting.
3. The importance of mental health/psych issues e.g. postnatal depression.
4. The need for a sound understanding of surgical and medical procedures/post-op care
5. General nursing is an essential prerequisite.
6. Paediatrics/neonatal experience is important.
7. Allows for the understanding of medications/pharmacology.
8. Provides a knowledge of the mother's experience within the hospital system/processes.
9. Assists working as a sole practitioner.
10. Provides a sound understanding of childhood development.
11. Helps to give confidence and reassure the client.
12. Assists with the health and wellbeing of mother and child, e.g. knowledge of good nutrition and exercise/healthy lifestyle.
13. Helps to engage with vulnerable families, e.g. provides the skills to recognise domestic violence/substance abuse.
14. Enables an understanding of infectious diseases/immunisation.
15. Provides skills and abilities to recognise complications/illness that were not diagnosed and treated while an inpatient.

Where to from here?

ANF (Vic Branch) has received a letter from Mr Nigel Fidgeon, CEO of the Nurses Board of Victoria, informing us that "At the February 2009 Nurses Board of Victoria Board meeting, the Board determined to continue with the current regulation of Maternal and Child Health Nurses due to the impending introduction of the national legislation for the accreditation and registration for health professionals...."

Clearly, further work relating to the qualifications of MCHNs will be an issue to be dealt with by the new National Nursing & Midwifery Board following 1 July 2010. This work will relate to issues such as the current Victorian requirement for a nursing undergraduate degree and midwifery postgraduate qualifications, appropriateness of direct entry midwives undertaking MCH nursing and MCHNs versus early childhood development worker.

ANF thanks MCHNs for their participation in this research we have conducted and we will continue to advise you on this important matter.