Key dates

Total funding is allocated by NMP 31 October 2013
CNME Plan (Part A) due 29 November 2013
CNME reports (Part A & B of template) due 29 August 2014

Funding cash flowed throughout the year by normal funding mechanisms

Program overview

The Continuing Nursing and Midwifery Education (CNME) grant to health services supports the cost of development and delivery of education programs for nurses and midwives. Focus includes skills and knowledge in clinical practice in the acute care workforce.

While nurses and midwives have an individual responsibility to ensure they are professionally prepared for registration, employers also have a responsibility to ensure that their staff have the knowledge, skills and competence to undertake the work required of them to meet the organisations service needs. At both the local and system level ongoing professional development builds capacity in the health system. Access to continuing education is also a factor in recruiting and retaining nursing and midwifery staff.

Amount and purpose

The CNME Grant is paid to eligible public health services to support planned acute nursing and midwifery educational activities. These are aimed at improving patient care and service provision in the acute sector/setting. The grant is to assist with the delivery of targeted educational activities. The focus being on reducing clinical risk and improving the skills and knowledge, of nurses and midwives caring for patients/clients during an acute episode of care or acute deterioration.

The state-wide funding of CNME is capped. Funding for individual services is allocated annually and is based on total nursing and midwifery FTE and a measure of Victorian acute activity targets. In the rural regions, funding is allocated to consortia of health services.

CNME funding is to support a planned, dynamic and evidence based approach that links educational interventions with improvement in clinical risk (or reduced risks or adverse outcomes) in the acute context. Although a 12 month plan is required, CNME funds can (and should) be used flexibly to address any emerging clinical risks identified within the 12 months.

Eligibility

Health services

To be eligible, the health service must be:

- a public health service. This refers to all public hospitals, metropolitan health services and multipurpose services identified in schedules 1, 2, 3, 4 and 5 of the Health Services Act 1988\(^1\).
- providing acute care services
- providing educational activities to support nurses and midwives in their acute care sector/areas.

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\(^1\) In relation to Albury-Wodonga Health: only services and staff employed at the Wodonga Hospital campus are eligible.
Nursing and Midwife education programs

The education programs must meet the guiding principles for CNME programs (Attachment one) and be:

- Planned professional development activities designed to meet the educational objectives of the health service/consortium to improve management of patients during an acute episode.
- Activities including accredited or non-accredited courses, workshops, study days, web based or self-directed learning activities.
- Activities that have a focus on clinical skills, direct patient care and evidence based care initiatives for acute care service provision/interventions and highest priority learning needs in the organisation, based on needs analysis and clinical risk framework.

Eligible activities

CNME funds can be used to offset the activities and costs associated with:

- staff education needs analysis
- review of clinical risks across the organisation
- education program scoping and development
- direct costs associated with program delivery, including a maximum of 20% of total annual allocation for training equipment (for example an ALS training mannequin or ICT), but excluding backfill for staff to attend
- evaluation, monitoring and reporting of outcomes of program.

Ineligible programs/activities

CNME funding is NOT to be used to support activities that are not specific to acute including:

- courses/programs designed to meet legislative compliance and/or mandatory training (including OH&S such as manual handling/no lift, violence/aggression, emergency and disaster management)
- core hospital competency requirements such as basic life support, falls prevention, orientation programs, and information technology/upgrades
- courses/programs designed for initial registration for registered or enrolled nurses and midwives
- formal postgraduate education (graduate certificates, graduate diplomas or masters degrees), refresher or re-entry programs or pre-registration courses for INMGs
- learning and development activities specifically funded through other department or agency funding, specific training grants or programs (including activities for early graduate programs and enrolled nurse grants for acute care or medicines capability)
- activities designed specifically for basic/core knowledge and skills development in aged care, rehabilitation, palliative care or mental health services.

How to apply/submit

CNME funding is conditional on the submission and approval of a targeted education and monitoring plan. This needs to address the highest priority acute care clinical risks identified by the organisation or consortia. Health Services are required to submit a CNME plan which will include reporting at the beginning of the funding cycle and an update on the outcomes at the completion of the financial year.

The number of educational activities that health services/consortia will report on will be aligned to the allocation amount. Organisations/consortia who receive:

- under $100,000 will report on five CNME activities
- over $100,000 will report on ten CNME activities.

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2 Specific cases to fund ICT (including e-learning infrastructure) may be made to NMP but will require justification and costings.
It is anticipated that from time to time health services will need to amend their planned programs to provide intervention for an emergent risk/issue. This new CNME activity can replace a planned activity if needed and be reported at the end of the financial year.

CNME Plans (on the 2013-2014 CNME template provided – Part A) are to be submitted by the health service/consortium with signed agreement by the Director of Nursing (DON) or CNME nursing executive representative (for regional consortia). The template is available at: http://www.health.vic.gov.au/nursing/furthering/continuing.

CNME plans (Part A) are to be sent by email, marked with ‘CNME Plan 2013-14 – your Health Service name’ by 29 November 2013 to nursepolicy@health.vic.gov.au.

CNME Reports (Parts A & B of template) are to be submitted by email, marked with “CNME Report 2013-14” by 29 August 2014 to nursepolicy@health.vic.gov.au.

### Disbursement & conditions

CNME grant funding is provided via normal funding mechanisms to health services or regional consortia fund-holders. Health services will receive advice on their total 2013-14 allocation of CNME funding in writing by 31 October 2013.

The following approach is applied to CNME funding allocations:

- **40%** of total funding is allocated to the rural sector (in recognition of increased costs associated with providing education in rural areas).
- Metropolitan service allocations are based equally on total nursing/midwifery FTE (as at 30 June 2013 and a measure of acute activity derived from total acute health expenditure budget for 2013-14.
- Department of Health (the department) rural regional allocations (five) are based on total nursing/midwifery FTE and a measure of acute activity derived from total acute health expenditure budget for each region.

### Reporting

CNME funding reporting is annual. The number of educational activities that health services/consortia report is based on the funding allocation. Health services/consortia who receive:

- **under $100,000** will report on five education activities
- **over $100,000** will report on ten educational activities.

For each education activity the following information is required:

- rationale for education
- intervention (including method, approach, number of episodes planned)
- percentage of required staff who attended/utilised the education activity
- impact for example: measurable outcome.

It is expected that health services will amend their plan in 2013-14 in response to any emergent clinical risks that are identified where CNME activity is indicated. This may necessitate the substitution of the new activity for one of the planned activities. The template provides space to report on any changes to the plan.

Health services are required to maintain records of expenditure and provide evidence of programs and funds reconciliation if requested by the department.

### Regional collaborative models

Collaborative models between health services promote efficiencies in education provision and reduce duplication and cost. For CNME funding collaboration is formalised through the establishment of consortia within regions. One collaborative model which is currently followed in various forms by DH rural regions is the ‘highway model’. This type of collaborative model is highly recommended. An example is Grampians region:

‘The Grampians ‘Highway Model’ provides education to nurses up and down the Western Highway which runs through the centre of our region. Instead of doubling up on particular clinical topics at each of our 12 health services, we prioritise the topics and offer them at particular sites so staff from multiple services can attend.’

Agreement on fund holder and consortia structure within each region is the responsibility of all DONs within the region in consultation with Nursing and Midwifery Policy and the department regional representatives (attachment three describes the key roles and responsibilities of consortia members). There is a minimum of one and maximum of four sub-regional consortiums per the department rural region. Consortia must
nominate a single fund holder (refer to attachment two for details of 2013-14 consortia). Administration fees must not be charged for CNME activities. However, the department rural regions where the entire region is a single consortia with one fund holder model (complete regional approach) may be agreement provide a 5% administrative fee (deducted from the total regional allocation) for the fund-holder.

Contact
For enquiries regarding the CNME grant, please contact:
Alana Smythe, Nursing & Midwifery Policy
Email: alana.smythe@health.vic.gov.au or
Ph: 03 9096 7528
Attachment 1: Guiding principles for CNME programs

Programs funded through the CNME grant are to be based on the following principles:

**EQUITY AND ACCESSIBILITY as demonstrated by:**
- education activities that are accessible to nurses and midwives employed by the health service on a part time, full time, bank or pool arrangement
- programs that are based on collaborative models of education. For metropolitan health services, this includes programs offered across campuses of the health service and networks with other metropolitan or rural health services. For regional health services this includes all consortia members.

**HEALTH DELIVERY NEEDS as demonstrated by:**
- clear educational objectives
- programs which support the strategic directions, clinical and service needs of the organisation
- program planning based on a training needs analysis involving nurse executive and participants
- responsiveness to changing/emerging priorities throughout the funding period.

**EVIDENCE BASED APPROACH as demonstrated by:**
- application of accepted educational principles in the development and delivery of programs (self directed learning, reflective practice models)
- utilisation of best practice knowledge and evidence based practice in the content being delivered
- use of program logic and health evaluation methodology in evaluation of programs
- evidence of recognition of interdisciplinary learning and practice models in planning and delivery of programs.

**OPTIMAL USE OF AVAILABLE RESOURCES as demonstrated by:**
- strategies to maximise the available funding
- strategies to support sustainability of learning
- provision of measurable data on educational outcomes
- program delivery using a consortia model
- commitment to the sharing of resources
- evidence of cost effective program delivery modes/models.

**ACCOUNTABILITY as demonstrated by:**
- strategies to ensure quality programs
- health services providing their education program plan, which documents objectives and proposed planned outcomes
- health services submitting an annual report of activities and measured outcomes³
- health services providing evidence of expenditure of grant funding, for auditing purposes when requested by Nursing and Midwifery Policy, for example evidence of provision of education and associated cost analysis.

³ A template is provided for this purpose.
## Attachment 2: Department of Health Rural CNME consortia

<table>
<thead>
<tr>
<th>Fundholder</th>
<th>CNME Consortia members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LODDON MALLEE REGION</strong></td>
<td></td>
</tr>
<tr>
<td>Bendigo Health Care Group</td>
<td>LM regional program</td>
</tr>
<tr>
<td>Mildura</td>
<td>Northern Region: Mildura Base Hospital, Robinvalne District HS, Manangatang (Campus), Mallee track health &amp; Community services</td>
</tr>
<tr>
<td>Swan Hill &amp; District Health Service</td>
<td>North Central: Bendigo Health Care Group, Kerang &amp; District HS, Boort District HS, McVor Health &amp; Community Services, Inglewood &amp; District HS &amp; Swan Hill District HS</td>
</tr>
<tr>
<td>Echuca Regional Health</td>
<td>Campaspe: Echuca HS, Cohuna District Hospital, Kyabram and District HS, Rochester and Elmore District HS</td>
</tr>
<tr>
<td>Maryborough District Health Service</td>
<td>Central Goldfields: Maryborough Hospital, Kyneton Hospital, Castlemaine Health, Maldon District Health Service E-learning</td>
</tr>
<tr>
<td><strong>HUME REGION</strong></td>
<td></td>
</tr>
<tr>
<td>Goulburn Valley Health</td>
<td>Hume: Goulburn Valley Health Service, Northeast Health, Albury/Wodonga Health, Alexandra District Hospital, Alpine Health, Beechworth HS, Benalla and District Hospital, Cobram District Hospital, Kilmore &amp; District Hospital, Mansfield District Hospital, Nathalia District Hospital, Numurkah District HS, Seymour District Memorial Hospital, Tallangatta HS, Yarrawonga District HS, Yea and District Memorial Hospital, Upper Murray Health</td>
</tr>
<tr>
<td><strong>GRAMPIANS REGION</strong></td>
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<tr>
<td>Ballarat Health Services</td>
<td>Ballarat Health Services, Beaufort &amp; Skipton H S, Djerriwarrh HS, Dunmunkle HS, East Grampians HS, East Wimmera HS, Edenhope District M H, Hepburn HS, Rural Northwest Health, Stawell Regional Health, West Wimmera HS, Wimmera Health Care Group</td>
</tr>
<tr>
<td><strong>GIPPSLAND REGION</strong></td>
<td></td>
</tr>
<tr>
<td>West Gippsland Healthcare Group</td>
<td>West and South Gippsland: Bass coast/South Gippsland Hospital/Gippsland Southern HS/ West Gippsland Health Care Group. East Gippsland: Bairnsdale Regional HS Orbost HS and Omeo HS, Central Gippsland: La Trobe Regional HS/ Central Gippsland HS / Yarram and District HS</td>
</tr>
<tr>
<td><strong>BARWON REGION</strong></td>
<td></td>
</tr>
<tr>
<td>Barwon Health</td>
<td>Area 1: Barwon Health</td>
</tr>
<tr>
<td>Colac Area Health</td>
<td>Area 2: Hesse Rural HS, Lorne Community Hospital, Otway Health, Colac Area Health</td>
</tr>
<tr>
<td>South West Health Care</td>
<td>Area 3: South West Health Care, Moyne HS, Terang and Mortlake HS</td>
</tr>
<tr>
<td>Western District Health Service</td>
<td>Area 4: Western District HS, Portland District Health, Casterton Memorial Hospital, Heywood Rural Health</td>
</tr>
</tbody>
</table>

*HS=Health Service
Attachment 3: CNME Rural Consortia roles & responsibilities

Consortia are cooperative groups that work together to identify and address issues of common concern for the region they represent.

There is an underlying assumption that the structures and relationships of the department rural consortia for CNME are based on good communication and collaborative effort to optimise nurses and midwives access to education programs and enable more efficient use of funding.

The role and responsibilities of the consortia members include that they will:

- convene regional consortia committee at agreed times
- ensure a minimum of one representative from each health service within the consortium is represented on the consortium committee
- elect consortium chair
- nominate regional fundholder
- ensure consortium fundholder fulfils responsibilities
- facilitate effective communication processes between all members of the consortium
- coordinate regional needs analysis and education programs
- facilitate a collaborative CNME program that meets the needs of all health services and the region
- ensure agreement with all health service representatives for the use of CNME grant funding
- ensure communication with the department rural regional staff and Nursing and Midwifery Policy
- develop and implement a dispute resolution process
- consider the role of other consortia especially in regard to highly specialised or hard to access training