FAIR WORK COMMISSION

Matter no.: AM2024/11

Re Application by: The Australian Nursing and Midwifery Federation

---

AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION

OUTLINE OF OPENING SUBMISSIONS

A. Overview

[1] APHA[1] agrees with the description in the AS of the scope of the dispute as between it and the ANMF. As to those matters:

(a) Consistent with principle (and the evidence), progression between classifications and pay-points, where referable to time, should be based on hours of work and not merely service (see B below).

(b) As was the case in the aged care stream, there should be no change to the relativities of pay rates as between Nurse Practitioners and others covered by the Award (see C below).

(c) Any determination in this (non-aged care) proceeding should be limited in application to the non-aged care stream. The Expert Panel ought not consider the ANMF's proposal to 'integrate' the non- and aged-care classification structures without leave being granted to re-open the aged care proceeding the subject of the *Nurses Decision* and providing *all* interested parties (i.e. including aged care participants) with an opportunity to be heard (i.e., by having an opportunity to file evidence, cross-examine, and make submissions) (see part D below).

---

[1] APHA adopts the defined terms and expressions used in the ANMF's submissions dated 20 March 2026 (**AS**).

Lodged by: Australian Private Hospitals Association
Address for service: Herbert Smith Freehills Kramer
Level 24, 80 Collins Street
Melbourne VIC 3000

Telephone: +61 3 9288 1380
Email: Nicholas.ogilvie@hsf.com
Mitchell.brennan@hsf.com
Nicholas.lamanna@hsf.com

B. Progression should be based on hours of actual work, and not mere service

The issue

[2] The ANMF proposes the deletion of cl 15.2 of the Award, which reads as follows:

> 15.2 Progression through pay points-other than aged care employees
>
> (a) Progression for employees other than aged care employees will be:
>
> (i) for full-time employees - by annual movement; or
>
> (ii) for part-time or casual employees - 1786 hours of experience.
>
> (b) Progression to the next pay point for all classifications in clause 15.1 for which there is more than one pay point will have regard to:
>
> (i) the acquisition and use of skills described in the definitions contained in Schedule A—Classification Definitions; and
>
> (ii) knowledge gained through experience in the practice settings over such a period.

[3] The apparent purpose and effect of the proposed deletion of cl 15.2 is that movement between pay-points referable to years (or parts of years) is to occur solely upon the effluxion of time (i.e., service), with no regard for how much or how little on-the-job experience they accrue: see AS[9]. This would affect the following proposed pay-points:

(a) the first two Nursing Assistant pay-points;

(b) all proposed Enrolled Nurse pay-points;

(c) each Registered Nurse/Midwife pay-point within Levels 1 and 2;

(d) each Nurse Practitioner pay-point; and

(e) each Occupational Health Nurse pay-point within Level 2.

The competing positions

[4] The ANMF makes two arguments in support of the deletion of cl 15.2. It argues, first, that the deletion of cl 15.2 is consistent with the approach taken in the aged care stream: AS[209]-[210]. Secondly, it says that cl 15.2 is unnecessary because mandatory CPD requirements ensure that nurses 'broaden their knowledge, expertise and competence': AS[208].

The argument made via the aged care stream should be rejected

[5] In *Nurses Decision*, the Expert Panel made two relevant observations. First, it observed that, as a general proposition, progression through pay-points based on periods of time is inappropriate: *Nurses Decision* [54]-[56]. The Expert Panel removed the annual pay points from Enrolled Nurses and Registered Nurses classifications in the aged care stream on the basis that they were a relic of a public service paid rates regime and incompatible with principle in setting minimum rates in modern awards. The removal of cl 15.2 (then numbered 15.3) from the aged care classification stream reflected that position—the provision was no longer relevant.

[6] Secondly, the Expert Panel observed that, notwithstanding that general principle, progression referable to time could be permissible if (but only if) there was a connection between the passing of that time and the accrual of work value: *Nurses Decision* [58]. This was the basis upon which the Expert Panel accepted some points within RN Level 1 and 2 classifications: time spans appropriately calibrated as a proxy indicator of significant addition in work value. That is, in the context of the role being performed by employees in that classification, the connection to work value lay in the on-the-job clinical experience reasonably assumed to be attained by an employee over the time span.

[7] The consent position in relation to pay-points, at least from APHA's perspective, was put on the same basis. That is, the time between each pay-

point was chosen because it represents the appropriate period of *work* required to gain experience sufficient to constitute a significant increase in work value warranting progression to a higher pay-point within the classification level. Clause 15.3 (now cl 15.2 for non-aged care) implicitly conveys that the annual progression is experiential (i.e. FTE work hours), not service per se.[2] Nothing in the *Nurses' Decision* indicates that the Expert Panel's removal of clause 15.3 in respect to the aged care stream of classifications was designed to remove the experiential element from the time calibrators.

[8] The ANMF, on the other hand, seeks to decouple progression from work value. Doing so would be contrary to principle.

The CPD argument should be rejected

[9] Cognisant of the need to demonstrate a link between accrual of service years and work value, the ANMF effectively argues that work value is enhanced sufficiently because nurses are required to attend to CPD. That argument should be rejected.

[10] First, the mandatory CPD obligation is modest. While a nurse is required to complete 20 hours of CPD each year (Heap [189], N-K5), the content of that CPD is neither prescribed nor regulated. Despite there being a recognised need to establish one, there is no national professional development framework, and the 20-hour requirement can be satisfied by merely engaging in 'self-directed study or research': Heap [193], [197].

[11] Secondly, the purpose of CPD is to maintain and update *theoretical* knowledge. It provides a foundation for learning rather than being a substitute for hands-on clinical experience. Completion of CPD alone cannot

[2] The reference in clause 15.2 to 1786 hours is 47 weeks multiplied by the full-time equivalent 38 ordinary hours per week, thereby allowing for the 5 weeks' annual leave (see cl 22.2 of the Nurses Award).

demonstrate increased competence, autonomy or responsibility in the workplace: see Wilson Part F.

[12] The reality is that practical hours—not calendar months or years of employment—are the key indicator of both readiness for registration and ongoing skill development thereafter. This is because three key skill areas cannot be developed via CPD alone: (1) clinical judgement; (2) decision-making and critical thinking; and (3) the capacity to manage complex or unpredictable situations. Consequently, there is an observable difference between nurses who have clinical experience and those who do not: see Wilson Part C.

[13] Understood in that context, only an hours-based progression model, which links progression to accumulated clinical experience and exposure, in turn links progression to work value: see Wilson Part D

<u>The service-based model will lead to negative externalities</u>

[14] Conversely, a model based solely on the effluxion of time would risk inequity and other negative industrial consequences. For each hour of work, a part-timer would be paid proportionally more than their relative value/contribution than a full-timer who has the same period of service (i.e., overvaluing the part-timer's experience relative to that of a full-timer).

[15] Two hypothetical (but realistic) scenarios bear this out. Suppose for each scenario that both Alex and Sam are RNs, and that Alex works full-time while Sam works part time on a '0.4 FTE' basis (i.e., working two 7.6 hour shifst each week). The *first scenario* assumes that they were both registered on the same date. Using the ANMF's progression model, they will both advance to the 'Level 1, 1 year plus' paypoint on the first anniversary of that date, despite Sam having over 1,000 fewer hours of clinical experience (714.4 hours vs 1,786 hours). This becomes more extreme at the next Level 1

paypoint (where the diffential would be 4,286.4 hours (2,857.6 hours vs 7,144 hours)).

[16] The *second scenario* assumes that Sam was registered exactly one year before Alex. At and from Alex's start date, Alex is paid at the 'Level 1, first year' paypoint while Sam is paid at the 'Level 1, 1 year plus' paypoint. This continues until the end of Alex's first year, including the last four months of that year (during which Alex will have more experience than Sam). At the end of Sam's fourth year, Sam will have worked over 2,500 fewer hours than Alex. Despite this, she will move to the 'Level 1, 4 years plus' paypoint and become higher paid than her more experienced colleague.

[17] This could have real consequences when it comes to, among other things, role allocation. In contrast, an hours-based model ensures that a nurse's actual work value is more accurately recognised and rewarded; with relative pay and seniority reflecting that value: Wilson Part E.

Conclusion

[18] The removal of cl 15.2 would lead, at best, to ambiguity. Movement between the time-based pay-points could be construed as being automatic upon the effluxion of time, or upon the relevant period of work at the FTE. If that ambiguity were resolved in favour of the ANMF's proposed position, the removal of cl 15.2 would lead to the inclusion in the Award of a progression referable to time alone (contrary to established principle).

[19] APHA's position is that a form of cl 15.2(a) should be retained to make clear that progression is not merely time based (i.e. period of service) but rather is calibrated to experience based on FTE work to ensure that the pay-point differentiation is properly connected to work value. To align progression with experience, the provision should link progression for all employees (whether full time or not) to hours of work.

C. Nurse Practitioners

[20] As the ANMF acknowledges, the parties agree that the wage rates payable to Nurse Practitioners should reflect the increases determined for that calling by the Expert Panel in the aged care proceeding. The ANMF proposes a further 15% increase, which it says should apply in both the non-aged care and the aged care settings. In doing so, the ANMF proposes a significant change to the Nurse Practitioner pay relative to other nurses.

[21] There is no warrant for that change. The Expert Panel in the aged care proceeding rejected a substantially similar proposal. The ANMF's evidence in support of re-opening the assessment is insufficient to displace those findings in this proceeding. APHA will make comprehensive submissions in this regard after the evidence has been received and the witnesses have been cross-examined.

[22] In the context of an application grounded in gender undervaluation, this outcome is to be expected. Nurse Practitioners have no characteristics that have exposed their work to greater gender undervaluation than other nurses.

[23] What is more, the Expert Panel refused to change the relativity despite the context in aged care being more conducive to such a variation. As the aged care Expert Panel observed, Nurse Practitioners make up a 'very small fraction' of the aged care workforce.[3] Moreover, the reality for aged care— in contrast to non-aged care— was that any pay increases would be funded by the Commonwealth.[4]

[24] Further, the present Expert Panel should be cautious in relation to this aspect of the ANMF's proposal. The ANMF has been overt that its objective

---

[3] *Nurses Decision* [61].
[4] See *Stage 4 Aged Care Decision* [2024] FWCFB 298 at [13].

is that any change in relativities applicable to Nurse Practitioners in the non-aged care stream apply also to the aged care stream. It seeks that variation in this proceeding despite having not applied to re-open the aged care proceeding (or having done anything to otherwise ensure that the parties that would be affected by such a variation are given the opportunity to be heard).

[25] As such, this aspect of the ANMF's proposal is subject to an intractable procedural fairness difficulty. The Expert Panel should not make a determination affecting the aged care stream unless and until it has afforded procedural fairness to all those that would be affected by it.

[26] Further, and relatedly, because the ANMF has signalled an intention to seek a cognate change in relativities in the aged care stream, the Expert Panel should not determine to change the relativities of Nurse Practitioners in the non-aged care stream (i.e., only). If it does so, the ANMF will almost certainly deploy that determination in support of a further application in the aged care proceeding. The more appropriate course, if the ANMF insists on pressing for a change in Nurse Practitioner relativities, is that this aspect of the ANMF's proposal be determined only after *all* interested parties have been provided with an opportunity to be heard (i.e., by having an opportunity to file evidence, cross-examine, and make submissions).

D. The so-called 'integration' issue

[27] APHA does not fully understand the ANMF's 'integration' proposal. At AS[120(1)] it seeks *'a classification structure and rates of pay for RNs, Midwives and OHNs, mirroring the outcome for RNs - aged care employees in the Nurses Decision'*. It makes that submission despite having separately proposed the *'all agreed'* classification structure and pay rates for those callings in the non-aged care stream (see AS page 5).

[28] In these circumstances, APHA understands that the ANMF proposes that the 'integrated' classification structure include, for each calling, the more favourable outcome from the aged care or non-aged care proceeding.

[29] Whether or not that is so, the integration proposal is opposed. It necessarily affects parties who have not been provided with an opportunity to be heard in relation to it (i.e., the parties to the aged care proceeding who are not also parties to this non-aged care proceeding). As is the case in relation to the Nurse Practitioner aspect of the ANMF's proposal, no determination should be made until *all* interested parties have been provided with an opportunity to be heard.

NICO BURMEISTER

HERBERT SMITH FREEHILLS KRAMER
Solicitors for the Australian Private Hospitals Association

27 May 2026

FAIR WORK COMMISSION

Matter No.: AM2024/11

Re Application by: Australian Nursing and Midwifery Federation

---

STATEMENT OF CAROLINE BRYONY WILSON

I, Caroline Bryony Wilson, Director of Clinical Services at Wollongong Private Hospital, of business address 360-364 Crown Street, Wollongong, New South Wales 2500, say as follows:

A. Background

1. I am a Registered Nurse and Director of Clinical Services (**DCS**) at Wollongong Private Hospital (the **Hospital**), which is operated by Ramsay Health Care (**Ramsay**). I have held the position of DCS at the Hospital since April 2021.

2. In my role as DCS at the Hospital, I am responsible for leading and managing clinical operations within the Hospital, in addition to providing guidance and support to clinical managers, career medical officers and Visiting Medical Officers and other key stakeholders. My notable achievements in this role include the development of a new clinical service, the expansion of the theatre complex, the expansion of cardiology clinical services, and the development of an onsite Nurse Practitioner service.

3. As DCS I report directly to the Hospital Chief Executive Officer (CEO) and my direct reports included all clinical department Nurse Unit Managers (theatre, ward and critical care areas), Nurse Practitioners, Allied Health Manager, Education, Quality and Risk and Infection Control Managers.

4. I have been working in the nursing industry since I first qualified as a Registered Nurse in 2003, giving me over 20 years of experience in the profession.

B. Qualifications and work history

5. I hold the following professional qualifications:

    (a) Bachelor of Science in Nursing, Queen Margaret University, Edinburgh, obtained in 2003;

    (b) Postgraduate Specialist Practitioner in Critical Care, Napier University, Edinburgh, obtained in 2007; and

(c) Master of Business Administration in Healthcare, Napier University, Edinburgh, obtained in 2022.

6. I first qualified as a Registered Nurse in 2003. I have worked in various different clinical areas including intensive care, surgical, medical and rehabilitation in both Australia and overseas and within public and private healthcare systems. I have remained clinically active since qualifying in 2003.

7. My experience in management and leadership roles includes the following positions:

   (a) Director of Clinical Services, Wollongong Private Hospital operated by Ramsay from April 2021 to present;

   (b) Director of Clinical Services, Nowra Private Hospital operated by Ramsay from April 2020 to April 2021;

   (c) Hospital Educator, Nowra Private Hospital operated by Ramsay from December 2019 to April 2020; and

   (d) After-Hours Manager, Nowra Private Hospital operated by Ramsay from March 2019 to December 2019.

8. Prior to my employment with Ramsay, I worked in various settings as both a manager and educational manager. My responsibilities in those roles included the development and delivery of education programmes for new graduates, employees new to specialties, and experienced nurses, with a focus on ensuring ongoing professional development and clinical practice improvement.

9. In my current position and previous positions as a charge nurse, I have been involved in the rostering of nursing teams, operational manager and medical officers.

10. In my current position as DCS, I am also responsible for:

    (a) performance appraisals;

    (b) the management of teams;

    (c) provision of guidance and supervision;

    (d) clinical workforce planning including the onboarding of new graduates, workforce development related to new and expanding clinical services and development of our current workforce.

11. I am also on call for the Hospital and am contactable for out of hours urgent clinical issues and enquiries.

12. In this witness statement, I address the issue of whether the time basis for pay progression for nurse related classifications in the Nurses Award should be tied to full-time equivalency. Based on my extensive experience set out above, and the factual matters outlined below, it is my professional opinion that it is necessary to tie the years to full-time equivalency so as to capture and recognise

increases in experience in the job for all nursing staff, pro-rating for those who work part-time or casually who may work less than full time hours.

C. How nursing skills and work value are acquired

13. In my clinical and managerial experience, nurses acquire skills, competence and professional confidence through a combination of theoretical knowledge and hands-on practical experience. This is reflected in the nature of nurse training, which requires the completion of a prescribed number of practical clinical hours as a mandatory component. It is those practical hours, not the number of calendar years spent in study, that are used as an indicator of readiness for registration. Once a nurse has registered, it is at that point that the true foundations of their practice are built.

14. Following registration, nurses typically complete a series of competencies, both generic and specialty-specific, based on their chosen area of employment and specialty. These competencies are developed through the repetition of clinical skills and exposure to the diverse scenarios in which those competencies are applied. Whilst the basic level of nursing knowledge is established during training, the development from novice to competent practitioner, and the ability to apply skills across varying and unpredictable clinical scenarios, takes time, sustained effort and ongoing clinical engagement.

15. Hands-on clinical experience plays a central role in developing clinical judgement, decision-making, and the capacity to manage complex or unpredictable situations, as follows:

    (a) **Clinical judgement**: An example is recognising and responding to the deteriorating patient. Whilst a nurse can learn theoretically what falls within and outside the parameters of a stable patient, detecting subtle changes in a patient's condition, and having repeat exposure to different presentations and scenarios, is a skill set that develops over time and increases situational awareness. Through that experience, the once deliberate and conscious process of recognising deterioration becomes more intuitive, as a result of skill consolidation and pattern recognition.

    (b) **Decision-making and critical thinking**: In my capacity as an educator across ward, critical care and hospital level roles, I have observed clearly that repetition and exposure to clinical scenarios have a direct impact on nursing confidence, capability and critical thinking. The practical application of theoretical knowledge in real-time patient care is what enables a nurse to convert knowledge into competent, confident decision-making.

    (c) **Capacity to manage complex or unpredictable situations**: Exposure to a variety of clinical scenarios, including activity fluctuations and their impact on time management and prioritisation, and exposure to after-hours emergencies, develops a nurse's capacity to manage complex and unpredictable situations. This breadth of experience is reflected far more accurately in accumulated clinical hours than in years of employment alone.

16. In my experience, the volume of clinical work performed has a direct and significant effect on how quickly a nurse develops skills, competence and confidence. There is a clear and observable difference in confidence and capability when inducting a nurse who attends frequent, regular clinical

hours into a clinical area, compared with a nurse who is present less frequently. It would be unreasonable to expect the same confidence and skill set from a nurse who has four years of experience working full-time or near full-time as from a nurse at the same year of employment who has worked at 0.2 or 0.3 FTE. The volume of hours worked directly determines the volume of clinical exposure, and it is that exposure which drives skill development.

17. In my experience, there is a clear relationship between the amount of concentrated, hands-on clinical time a nurse undertakes and their level of confidence and capability. This is particularly evident in the early stages of a nurse's career, or where a nurse is new to a clinical area or specialty. Nurses who work regular and frequent hours tend to develop greater familiarity with day-to-day processes, integrate more readily with team members, and demonstrate more rapid growth in confidence and competence.

18. Conversely, I have observed that nurses who work less frequent or irregular hours may experience greater difficulty in developing clinical skills, maintaining familiarity with ward routines, and keeping up to date with changes and developments in clinical practice. In my experience, this can be due in part to reduced attendance at clinical update forums, safety huddles and routine education sessions conducted within the hospital.

19. I have also observed similar issues for nurses who predominantly work night shift, or who have less consistent attendance patterns, as they may have fewer opportunities to engage with broader team activities and updates to clinical practice

20. In addition, I have noted that even experienced nurses who take extended periods of leave often require a period of re-adjustment upon their return to clinical work. This includes regaining familiarity with ward processes, clinical workflows, and the general pace and demands of a shift.

21. In my experience, it is not uncommon for a nurse to work one or two 7.6-hour shifts per week according to a 0.2 or 0.4 FTE workload. Nurses working these patterns often remain on them for the remainder of their careers for any number or professional, personal or family reasons. Nurses in these part-time positions perform valuable service but cannot be expected to accrue the same skillset and experience as a nurse working a full-time load.

D. Rationale for an hours-based progression model

22. An hours-based progression model operates by accruing actual clinical working hours as the measure against which a nurse progresses through pay classifications, rather than the passage of calendar years of employment. This approach recognises a nurse's actual exposure and experience in the nursing profession and acknowledges the dedication and time spent working in their chosen specialty. By accruing hours in the role, the model correlates progression directly to experience. Calendar-year progression, by contrast, merely indicates that a person has been employed for a period of time, without providing any indication of that person's actual clinical exposure.

23. An hours-based model aligns progression with actual clinical experience because the accumulation of hours correlates directly to hands-on experience. Such a model provides an accurate indication

of a nurse's actual clinical working hours and can assist with appropriate patient allocation, given that it reflects actual clinical exposure and the range of scenarios the nurse has encountered.

24. I understand that the current requirement for progression through pay points for non-aged care part-time or casual nurses in the *Nurses Award 2020* is the attainment of 1,786 hours experience. In my assessment and based on my over 20 years' working in the nursing profession, the 1,786 hours threshold closely reflects the working patterns of a full-time nurse, taking into account periods of leave and other time away from work throughout the year. In my view, this benchmark provides a fair and practical representation of a full-time team member's working year. It is based on the actual hours a nurse is expected to be engaged in clinical work, rather than simply the passage of calendar time. As a result, the accrual of approximately 1,786 hours provides a meaningful indication of the level of hands-on clinical exposure a nurse has had. This exposure is directly relevant to the development of skill, confidence and professional competence.

25. In my experience, an hours-based progression system supports consistency and fairness by recognising the actual time a nurse spends in clinical practice and developing their skills, regardless of whether they are employed on a full-time, part-time or casual basis.

26. Measuring experience by reference to hours worked more accurately reflects a nurse's exposure to clinical practice, patient care, ward routines and ongoing professional development. By contrast, a system based solely on the passage of calendar time, without regard to the number of hours worked, does not meaningfully distinguish between nurses with significantly different levels of clinical exposure. In my view, such an approach would fail to recognise the depth of hands-on experience gained by nurses who work higher or more regular hours, and would risk equating materially different levels of skill, experience and professional capability.

27. For these reasons, I consider that an hours-based system better promotes equity by recognising actual clinical contribution and experience and provides a more accurate reflection of a nurse's development and work value than progression based solely on time elapsed.

E. Equity for part-time and casual nurses

28. Part-time and casual nurses build skills and experience through the same mechanisms as their full-time colleagues, through clinical exposure, the repetition of skills, and hands-on patient care. The difference lies in the rate at which that experience is accumulated. A part-time or casual nurse working reduced hours will, by definition, accumulate clinical experience more slowly than a full-time nurse working equivalent hours over the same period. An hours-based progression model recognises this reality and ensures that progression accurately reflects a nurse's actual contribution and accumulated experience.

29. I have observed that part-time or casual nurses who accumulate hours through additional shifts or maintain consistent engagement tend to progress more quickly in terms of clinical confidence, skill development, and integration into ward routines. Regular and concentrated clinical exposure supports familiarity with processes, team dynamics, and current practice, whereas nurses working

fewer or irregular hours often require more time to achieve the same level of confidence and capability.

30. In my view, an hours-based model ensures that their actual clinical contribution is accurately recognised and rewarded. Those nurses who work greater hours, and who consequently take on greater responsibility, including in-charge roles, mentorship of others, management of high-acuity patients, and specialist functions, are appropriately acknowledged for the breadth of experience and autonomy that arises from that engagement. An hours-based approach recognises the increased critical and operational decisions that experienced, high-hours nurses make on a daily basis.

31. In my experience, relying solely on calendar years for incremental progression risks treating nurses with significantly different levels of clinical exposure and capability as though they are equivalent. This can lead to expectations, responsibilities or role allocation that exceed a nurse's current level of clinical confidence or competence, which may have implications for patient safety, team workload, and the nurse's own professional development. Where progression is based only on time spent in a role, there is a risk of misalignment between perceived experience and actual capability.

32. I believe that the ANMF model does not adequately acknowledge the value of experience gained through hours worked and may unintentionally convey a message that devalues the importance of exposure, clinical experience, and professional credibility developed by nurses who consistently work the hours.

F. CPD and its role in skill development

33. Continuing Professional Development (CPD) is a mandatory requirement for all nurses registered with the Australian Health Practitioner Regulation Agency. In my experience, the most common requirement is that registered nurses complete approximately 20 hours of CPD annually, with higher requirements applying in certain circumstances, such as dual registration or nurse practitioner endorsement. There are also a range of CPD activities through which these requirements may be met, including simulation training, online learning, journal clubs and quality improvement activities.

34. The purpose of CPD in nursing practice is to maintain and update theoretical knowledge, and to introduce new concepts, clinical guidelines and developments in a structured and supervised learning environment. While some CPD includes scenario-based training, it predominantly provides a foundation for learning rather than a substitute for hands-on clinical experience.

35. Completion of CPD alone cannot demonstrate increased competence, autonomy or responsibility in the workplace. Whilst CPD provides essential theoretical underpinning and is a critical element of safe and ongoing professional development, the conversion of that theoretical knowledge into competent and confident clinical practice requires real-life application in patient care situations.

36. An example that illustrates this distinction clearly is the skill of intravenous cannulation - that is, the insertion of an intravenous line into a patient. A nurse may learn the relevant anatomy, the equipment required, and the process of cannulation through theoretical instruction and simulated

practice on a manikin in a CPD setting. However, the skill is developed when cannulating an actual patient. Through real-life, hands-on experience, a nurse learns how a patient's overall presenting condition, hydration status, and history of poor venous access affect the procedure. They develop a feel for the vein, acquire techniques to improve success rates, and develop the clinical judgement to recognise when it is not appropriate to proceed. These skills come from repeat exposure, hands-on experience and guidance from experienced colleagues, and they cannot be replicated in a CPD environment.

37. A nurse might undertake CPD on a topic related to cannulation and thereby update their theoretical understanding about that discipline. But, unless they work sufficient clinical hours, they are not likely (or, at the very least, less likely) to apply, consolidate and build upon that theoretical knowledge in practice.

38. Clinical skills developed through practice can be diminished or lost if there is a reduction in practice hours and exposure, a consequence that CPD alone cannot address or prevent.

Caroline Bryony Wilson

Director of Clinical Services

Ramsay Health Care

Date: 25/05/26