Submission No 50

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

Organisation: New South Wales Nurses and Midwives' Association

Date Received: 16 October 2023

Submission to: The implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health

OCTOBER 2023

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Foreword

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes: registered nurses; enrolled nurses and midwives at all levels including management and education, and assistants in nursing and midwifery.

The NSWNMA has approximately 75,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

NSWNMA strives to be innovative in our advocacy to promote a world class, well-funded, integrated health system by being a professional advocate for the health system and our members. We are committed to improving standards of patient care and the quality of services of all health and aged care services whilst protecting and advancing the interests of nurses and midwives and their professions.

We welcome the opportunity to provide a submission to this inquiry.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

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Introduction

The New South Wales Nurses and Midwives Association (NSWNMA) welcomes the opportunity to provide a submission to the inquiry into the implementation of Portfolio Committee No. 2 recommendations specifically relating to workforce issues, workplace culture and funding considerations for remote, rural and regional (RRR) health.

The health outcomes of people living in RRR areas are broadly acknowledged to be worse than their counterparts living in metropolitan areas due to a complex intersection of factors. Nursing and midwifery are significant parts of a greater picture in improving the health and lives of people living in RRR New South Wales (NSW). We know that nurses and midwives have the capabilities, knowledge and skills to play a significant role in improving healthcare equity, access and outcomes for the people of rural, regional and remote NSW. This, however, can not be achieved without significant investment in healthcare workforce, undergraduate and continuing professional education and transformational leadership to bring change to the workplace culture that will create working conditions that make nurses and midwives want to stay and develop fulfilling careers in RRR areas.

The NSWNMA represents over 35000 members outside of metropolitan areas in NSW. Through their accounts of working conditions in RRR facilities and also compelling research evidence, the NSWNMA made 24 recommendations to the original RRR inquiry (Appendix 1). These recommendations seek to create safer, culturally sound and well supported RRR workplaces that are appropriately staffed to ensure safe and effective patient care and also ensure the physical and psychological safety and wellbeing of staff, while taking into consideration the unique local needs of each facility.

The RRR inquiry found concordance with many of the NSWNMA's recommendations and we have seen some positive steps by both the state and federal government to boost nursing and midwifery workforces, however the situation in many parts of RRR NSW is still not seeing the improvements that are desperately needed. Bonuses and incentive schemes to attract talented staff to fill workforce gaps, while well intentioned, have been poorly applied. Further, the underlying working conditions and structures need to be addressed urgently to create conditions that make nurses and midwives want to stay.

We as an association know, through our many active and engaged members who are passionate about their regional and rural communities, that the current challenges are not insurmountable, but they do desperately and collaboratively need to be addressed. We envisage a future with a well-supported, well educated and proficient rural, regional and remote nursing and midwifery workforce where our members will have confidence that they can go to work, provide the best level of care in well resourced and staffed facilities and go home without sustaining psychological or physical injuries.

We thank our members who have contributed to this submission, their insights are honest and valuable. The NSWNMA presents its submission below for the consideration of the select committee.

Findings

- The rural incentive scheme has been poorly and inequitably applied, has caused a lot of angst and misunderstanding amongst NSW health staff and has decreased trust and loyalty of nurses and midwives in NSW health.
- Nurses and midwives state that there is no incentive to remain in their current position when they can find better pay and conditions in other states and territories, or incentives to boost their wage by relocating to an alternative facility. This diminishes established knowledge and impacts on continuity of care.
- Financial incentives are not addressing other evidence based solutions that would attract nurses and midwives to stay and develop careers in RRR positions.
- There are widespread reports of facilities being heavily reliant on overtime and extra shifts, and of nurses and midwives feeling a strong sense of burnout.
- NSW Health continues to lack a culture of respectful listening to healthcare workers. NSWNMA members continue to express their reluctance to speak out about safety issues due to fear of reprisal or career limitation. Others lament that despite speaking out nothing has changed and people keep on leaving.
- Early career and inexperienced nurses are not receiving the level of education, support, clinical supervision and mentoring they need to be able to confidently and safely practice, especially in rural contexts and smaller facilities where they are being pushed to work with a high level of autonomy and accountability without sufficient supports in place.
- Formalised on-call arrangements have been established in some areas and not others. The goodwill of nurses living and working in rural areas should not be relied upon and consistent formalised on-call arrangements must be established for all rural and remote facilities to ensure there is available back-up and experience to provide safe and effective patient care should it be required.
- That virtual care is not being used in a way that promotes the highest quality safety and care of clinicians and patients. Vacant medical shifts are not being covered or medical positions being recruited to with virtual care being inappropriately utilised as a substitute for skilled and experienced clinicians on the ground.
- There needs to be a significant investment in clinical education and professional development, with staff provided with sanctioned time, support and funding to undertake continuing education away from their routine work that will build the knowledge and capability of rural regional and remote nurses and midwives.

Recommendation 1

That NSW Health review the current funding models for all rural and regional Local Health Districts in order to identify any service delivery gaps and provide any recommendations for funding increases.

The response from the previous government spoke to the current funding models of activity-based funding and block funding however the response is noticeable silent on the recommendation to identify service delivery gaps and recommend funding increases. Activity based funding and block funding do not appear to be delivering for rural, regional and remote hospitals and healthcare facilities in NSW. These types of funding may not be taking into account the need for patients to be moved from facility to facility to receive necessary care resulting in multiple short stays, and they are potentially a barrier to developing systems of support and continuity of care that work for clinicians and patients across different care modalities and funding sources (Prior & Schlesinger, 2018).

NSWNMA members working in rural and remote hospitals and multi-purpose services continue to raise their concerns around inadequate and unsafe staffing, including a lack of security and support services to provide safe working environments and high-quality care. The block funding model currently utilised to fund smaller facilities "lacks transparency and accountability regarding volume and type of services being funded" (McNamee, Kobel, Green, & Lago, 2015). Rural and remote hospitals continue to face issues of inadequate staffing to attend to incidents of aggression, duress and patient deterioration and enough skilled and experienced staff to safely and effectively manage the complexities of small facilities out of hours. The current funding tools are used as blunt instruments that do not recognise the unique needs of smaller facilities. As the original inquiry determined- there is no one-size-fits-all approach.

The NSWNMA advocates for evidence based funding models that are linked to patient and population outcomes and also for improved staff outcomes (E.g. Metrics around improved retention, decreased turnover of clinicians, reduction in worker injuries) to be examined that are fit for purpose to meet the needs of each community reliant on rural and remote facilities.

Funding for education would make a real difference. We don't currently have funding for after-hours educators and we no longer have dedicated mandatory education days. Clinical nurse educator's have to try and get education done while staff are working on the floor which is impractical. We are seeing junior nurses enter practice with reduced exposure to clinical practice due to COVID and we also have nurses who need greater support to utilise virtual assist appropriately, and recognise when to escalate care. Due to a lack of focused education we are seeing preventable incidents, like falls, increase due to inadequate opportunities for professional development.

Funding for clinical nursing education would make a tangible difference both for the workforce and patient care.

Recommendation 8

That the NSW Government investigate ways to support the growth and development of the primary health sector in rural, regional and remote areas, and support the sector's critical role in addressing the social determinants of health and reducing avoidable hospitalisations for the citizens of New South Wales.

The NSWNMA recognises primary healthcare and prevention as absolutely vital to a sustainable healthcare system in NSW and a core component of healthcare systems. Nurse practitioners and advanced practise nurses can effectively drive, co-ordinate and contribute to primary healthcare, public health and preventative healthcare efforts that will reduce avoidable hospital admissions and improve health outcomes for people in RRR areas. Research evidence strongly supports the role of nurses in primary healthcare and preventative health. There is scope for nurses to act in navigator or co-ordinator roles that ensure individuals and communities healthcare needs are integrated, there is effective communication between recipients of care and the different services involved in their care, care is comprehensive across all stages of life and that there are seamless transitions of care (Weel & Kidd, 2018)

The cost savings that are realised from primary healthcare must be re-invested into RRR hospitals in recognition that there will be an ongoing need for higher acuity patients presenting who have moved beyond the ability to receive treatment in the primary care context.

Recommendation 11

That NSW Health work with the Australian Government collaboratively to immediately invest in the development and implementation of a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy. This should be done in consultation with rural, regional and remote local government, schools, community services, human services, unions, professional organisations, general practice, pharmacists and community organisations. It should set out a clear strategy for how NSW Health will work to strengthen and fund the sustainability and growth of rural, regional and remote health services in each town including quantifiable targets for tangible improvement in community-level health outcomes, medical and health workforce growth, community satisfaction, and provider coordination and sustainability. It must also address hospital and general practice workforce shortages including General Practitioner, nurses and midwives, nurse practitioners, mental health nurses, psychologists, psychiatrists, counsellors, social workers, paramedics, allied health practitioners and Rural Generalists.

The NSWNMA appreciates the current governments recognition of the extreme pressure, fatigue and burnout being experienced by our members, and Minister Park's determination to turn around the current stream of nurses and midwives leaving our public hospital system. While the implementation of nurse to patient ratios in emergency departments is a good start, it does not address the immediate needs of rural, regional and remote facilities. The current budget will not deliver adequate supply of nurses and midwives to meet mandated ratios.

Along with the solutions called for in other parts of this submission, the NSWNMA strongly advocates for the NSW government to implement the safe staffing, wages and conditions that have been put forward and voted on by the NSWNMA membership. Pay and conditions in NSW are not remaining competitive with our neighbouring states and territories, and we continue to see nurses and midwives vote with their feet.

The NSWNMA remains committed to working with the NSW government on the Safe Staffing Levels Taskforce, and we will continue to advocate for improvements to pay and conditions that meet and exceed those of other states to attract and retain nurses and midwives in RRR areas of NSW.

Recommendation 16

That NSW Health expedite its review of the nursing and midwifery workforce with a view to urgently increasing nurse and midwifery staffing numbers based on local need across rural, regional and remote New South Wales. The outcome should ensure there are staffing levels that enable optimal patient care and for that care to be delivered in a professionally, physically and psychologically safe environment. NSW Health should publicly report on an annual basis its performance in meeting this outcome.

Australia continues to face a long-term threat of nursing and midwifery workforce shortages. In rural areas the average age of the nursing workforce is older compared with metropolitan sites, this making retention and recruitment of early career nurses a priority for these areas. The issue of retention and recruitment being more pertinent as the COVID-19 pandemic has led to an influx of new residents in RRR areas, resulting in a greater need for infrastructure including healthcare services and support (Rose, Skaczkowski, & Gunn, 2023).

Nurses who work in rural and remote settings play an integral role in providing generalist care and require a specialised skill-set. When examining the early career nurses research showed that there were trends that lead to nursing dissatisfaction and intent to leave the job, these included staffing shortages, lack of support, decreased opportunities for professional development and career progression, fewer educational opportunities, limited resourcing, and difficulties finding accommodation in RRR areas. In addition to this many nurses in RRR settings faced additional challenges *including having greater scope and responsibility* due to limited resources than compared with nurses in larger cities. Despite the many challenges that are faced by the nursing workforce there are positive factors that have influence retention in RRR areas.

Higher retention rates are associated with a greater connection to the local community and area, nurses stayed in these areas when they were offered rural training and supported by the existing workforce to expand their scope of practice to provide services to rural and regional communities (Russell, et al., 2021). These connections and support to grow professionally were more effective over other interventions including financial incentives and regulatory interventions.

Rose, Skaczkowski and Gunn (2023) explored the experience of early career registered nurses in rural hospital within Australia and identified strategies that increase job satisfaction and retention. The participants of the study indicated practical strategies for overcoming the challenges of working in rural areas for new nurses, some strategies are:-

- *Assistance with accommodation and transport.*
  With housing being a one of the key factors limiting the ability for nurses to move to rural and regional areas the study highlighted the need to incorporate this assistance to make the transition less challenging. This included accommodation assistance, linking graduates with locate real estate agencies, dedicated accommodation utilised by new people moving to the area and government funded accommodation prior to relocating from one rural area to another. The NSW government program to build and upgrade healthcare staff accommodation in RRR areas is very welcome, however there must be more measures examined to retain staff in RRR areas. The successful 'Attract, connect, stay' pilot program in Glen Innes (Ingall, 2022) based on an Australian evidence based program is an example that could be utilised across NSW.

  Additionally, assistance with transport was raised, as there are limited or poor modes of transport for those who did not own their own car. A proposal to subsidise fuel costs to lessen the financial burden and pressure for those early career nurses was also suggested.

- *Sufficient orientation and supernumerary time.*
  The transition from student to new graduate can be met with high anxiety, graduates that relocate to rural settings found that this was compounded as they were away from their regular support networks. To decrease these psychological aspects, it was suggested that increased supernumerary time would allow graduates to feel supported and prepared to enter the profession. Further suggestions were that rostering practices to facilitate continuity with the routine of the particular shift would be beneficial during the start of any ward rotation.

- *Increased frequency of contact with clinical facilitators and multiple mentors.*
  The use of clinical facilitators, preceptors and mentors was suggested as a helpful strategy to increase retention and job satisfaction. Having designated staff for early career nurses to support them, whilst also creating a workplace rapport has been beneficial in allowing these nurses within rural and regional settings additional emotional and professional assistance. Establishing formalised mentor programs and embedded clinical supervision within regional and rural settings will improve skill development and increase the capacity and capability of new nurses and midwives to provide safe patient care in the RRR context.

- *Desire for more flexible work and rostering.*
  Many nurses have reported the difficulty maintaining a healthy work and life balance, this is particularly prominent early in their careers. The Australian nursing and midwifery workforce have seen 'burn out' of staff leading to nurses and midwives leaving their respective professions seeing other work that psychologically will not have a negative impact. Early career nurses suggested that having rostering practices would improve their job satisfaction, in addition having greater time between shifts would allow them to feel more refreshed and aid in preventing burn out.

To improve the retention and recruitment of nurses and midwives into rural and regional settings the above strategies must be considered for early career nurses and also nursing staff transitioning to rural practice for the first time. Limitations faced within these areas have included little ongoing investments of finances and time to explore ways of improving retention in these geographical areas.

From a facility that once had a fairly stable nursing workforce, we are now seeing a constant churn of nurses. Junior nurses are working in the medical ward and staffing the emergency department, triaging and treating people presenting at times without the support of a doctor on site as medical rosters aren't being filled. They are taking on high levels of responsibility and accountability, being pushed to advance without adequate education or support and so many are choosing to leave and work in larger facilities or other states where they feel less exposed to professional risk.

Recommendation 17

That NSW Health work to widely implement the Nurse Practitioner model of care in rural, regional and remote New South Wales, by:

- **funding the recruitment and training of additional Nurse Practitioners to work in rural, regional and remote areas, particularly in facilities without 24/7 doctor coverage, or that utilise virtual medical coverage**

- **working with the Australian Government to address the practical barriers to creating and supporting these roles identified by the Australian College of Nurse Practitioners.**

We welcome the federal governments 'Nurse Practitioner Workforce Plan' as effective utilisation of nurse practitioners will be vital in meeting the needs of the RRR population. We appreciate the NSW Government's investment into health workforce education with the proposal 'to expand training positions for nurse practitioner roles in rural locations that struggle to attract doctors' as nurse practitioners certainly have the advanced level skills and knowledge that would support the healthcare needs of these communities.

The NSWNMA would, however, like to see a clearer and more proactive plan from the Ministry of Health and a pathway as to how an expansion of the nurse practitioner workforce will be achieved in RRR areas in NSW. The federal governments plan is specific with measurable goals as to how the nurse practitioner workforce will be developed, NSW should have a plan reflective of this. Further, our concerns remain that without the appropriate supports, educational and professional development, mentoring and clinical supervision in place, nurse practitioners will also not be retained in RRR areas.

Recommendation 18

That in addition to peer group B hospitals, NSW Health employ a geriatric nurse in all peer group C hospitals. Where a geriatric nurse is not employed, NSW Health develop and provide staff members with annual training in geriatric care to ensure an ageing population is given the best health care when visiting a health care facility.

As the population of older people in rural, regional and remote areas continues to increase and is moving towards being the largest demographic in these areas, there is a need to have structures of support that provide specialised care that meets the needs of aged people and their families.

The response provided by the previous government is completely inadequate and off the mark in reference to this recommendation. While it is true that nurses undertake education in aged care as undergraduates, and it is appreciated that nurses working in NSW Health have access to online learning modules, this does not provide the level of knowledge and specialist aged care expertise that will meet the needs of this ageing population. Nurses with specific aged care education and systems experience can work with aged people, their families, aged care facilities and other providers to co-ordinate and guide care that will avoid hospital admssions, reduce length of stay and allow for efficient and safe transfer of care and communication between services. Programs utilising nurses with specialist skills and knowledge to effectively manage and co-ordinate care for older people are known to reduce healthcare costs, reduce length of stay when admitted and provide safer and more effective care for older people (Australian Institute of Health and Welfare, 2013).

In [Regional Hospital] we had a nurse in a role such as this [aged care navigator] and because of her attitudes, communication skills and her knowledge about services and systems as well as knowledge about ageing, the nurse was very effective in supporting the older person and their families. She assessed astutely, referred appropriately, saved many unnecessary admissions. The role enabled her to work within the hospital and in the community which was necessary so she could refer to community services and then follow up to assess if the referral had been effective and if not, to work with the older person and their family to determine another plan of care… When she retired and with staff shortages, the role was discontinued.

We often have a nurse practitioner, who specialises in pain management, attend our facility to review residents that are recognised by our facility RNs as potentially needing a more effective pain management plan. This has made a big difference to their quality of life and improves their participation, even as much as getting them out of their room and enjoying a communal meal with the other residents. This kind of thinking epitomises Standard 1 - dignity and choice. Dignity is slowly being chipped away and anything that can claw some of it back into the lives of our elderly should be fully supported.

Recommendation 19

That the rural and regional Local Health Districts:

- **formalise and remunerate on call arrangements for nurses and midwives across all public health facilities in accordance with industrial awards**
- **engage with the emergency departments in their area to develop agreed plans to address security issues with timeframes and regular progress reporting**
- **increase and formalise professional development opportunities for nurses and midwives, ensuring that rostering accounts for this.**

Formalisation of on-call arrangements is essential to ensure safe staffing levels and provide vital support to nurses and midwives working in challenging environments, often without the availability of medical officers on-site. Ensuring that nurses and midwives are on-call guarantees that patients in rural and remote areas receive timely and high-quality care, even during emergencies or late-night situations, without relying on luck and the goodwill of nurses coming in to help out when called by their desperate colleagues.

Formalised arrangements for all multi-purpose services would ensure that nurses are fairly compensated for remaining available to meet the often-unpredictable demands of patient care. This will have the added benefits of reducing burn-out and improving retention as nurses will have safer and more predictable working conditions. As has been reported by our members, early career nurses and agency staff unfamiliar with rural and remote facilities are being employed and engaged to fill massive staffing gaps. For these staff it is vital that they have access to a known senior staff member on call should they face an unfamiliar or emergent situation.

In our district we ensure that there is always a senior experienced nurse on-duty or on-call, with formalised on-call arrangements. Out of necessity we are having to upskill junior and inexperienced staff very rapidly, and if they are rostered to work in a facility on afternoon or night shift, they know that they have an experienced person on call should they need them. This means that the senior staff also have certainty of when they need to be available and close-by, they can plan their life around this.

Professional development and education continue to be identified by NSWNMA members working in RRR areas as lacking, unavailable, poorly funded and difficult to access. While positive steps have been made through programs such as the “Rural nurse generalist program delivered virtually and via on-line learning and mobile clinical nurse educators, this is not meeting the educational and professional development needs of the RRR nursing and midwifery workforce. Nurses and midwives working in rural areas require sanctioned time for professional development, and supportive structures in place for preceptorship and clinical supervision.

While, as per the government's response, there are award arrangements for learning and development leave, our members frequently state that they are denied access to this leave due to there not being enough staff to cover clinical shifts. We have had numerous members also raise concerns that they have been blocked from professional development or career advancement after speaking out on issues of staffing and safety. To genuinely support nurses and midwives professional development needs, NSW should implement a program similar to the Queensland Government that pays up to $2500 professional development allowance and two weeks of paid professional development leave inclusive of travel and education costs for nurses and midwives working in regional and remote locations.

In one of our smaller facilities in our district there are 6 new graduate nurses and 1 FTE clinical nurse educator who is responsible for educating 200 staff. The new grads get minimal support, especially when they work after hours as there is no after hours CNE on duty. District management told me that the 2 FTE new graduate CNE positions that had been recruited to were put on hold due to there being funding issues between the Ministry of Health and the LHD.

Staff are not being re-accredited in FLECC or other advanced skills as there's no incentive to do so, no recognition and no reward for working to an advanced level. There is no time given off the floor to re-accredit in advanced life support or basic life support, it's just expected to be jammed into a busy shift. This is not conducive to learning when you are thinking about your patients and what needs to be done.

Recommendation 20

That NSW Health, as part of its review of the nursing and midwifery workforce:

- **develop stronger partnerships with the university sector to more proactively engage local people and support them through rurally and regionally based education, training and professional development to become qualified nurses and midwives**
- **develop partnerships between rural, regional and metropolitan Local Health Districts to devise programs for nurses and midwives who are either early career, specialised or are experienced to practice in rural and remote locations**
- **implement professional, financial and career enhancement incentives for nurses and midwives who work in rural and remote locations.**

The NSWNMA is pleased to see positive steps in the direction of meeting this recommendation. We have partnered with Charles Sturt University (CSU) around examining some of the issues and solutions ub RRR nursing and midwifery, and are supportive of innovative post-graduate programs like the Graduate Certificate in Nursing focusing on rural and remote nursing and developed with industry to better prepare nurses for working in this context of practice. We also commend the proposal to introduce scholarships and subsidies for nursing and midwifery students that will encourage them to take positions in RRR areas. We do, re-iterate as elsewhere discussed, that there needs to be support systems enacted that will ensure the safety and success of these early career clinicians.

The 'Rural Health Workforce Incentive Scheme' while well intentioned has been poorly implemented and resulted in unintended consequences. NSWNMA members report that there is a lot of uncertainty around the payments, staff performing the same role in the same facility are being paid different incentive rates due to the cost centre they are employed under, while there are other nurses who report that they aren't eligible for the payment at all when their colleagues are. The incentive has also served to encourage nurses and midwives to leave already understaffed facilities and move to other RRR facilities to get higher payments, with reports of a maternity service at a major regional hospital being near critical service failure due to this. Due to incentives not applying to nurse educator roles, it is acting as a further disincentive to nurses stepping up into those roles and taking on greater responsibility for potentially less pay.

The rural incentive scheme is inequitable, for those who don't receive it, like some EN's, there is a sense of being unappreciated. The level of incentive that you get depends on what cost code you were employed under, so while all the nurses work across both the ED and the medical ward, the ones employed under ED's cost centre get a higher bonus than those under the ward cost centre. It just doesn't make sense. It has really broken people's loyalty. If they can get better money elsewhere, they go. We've already had a few resignations and there will be more.

Recommendation 26

That the NSW Government implement the midwifery continuity of care model throughout rural, regional and remote New South Wales.

The NSW Health's Connecting, Listening, and Responding document has outlined goals that prioritise women's-centred care. Goal 1 emphasises the importance of respectful and inclusive care, which includes culturally and psychologically safe practices, particularly vital in regional, rural and remote (RRR) communities. Goal 6 highlights the need for various continuity of care models, including those tailored for Aboriginal women. These goals align with Recommendation 26, which advocates for the implementation of midwifery continuity of care throughout RRR communities.

There are successful examples of midwifery continuity of care models in RRR communities. For instance, Byron Bay boasts a Regional Midwifery Group Practice (MGP) that offers publicly funded homebirths for low-risk women. They also have a birth centre, fully staffed by MGP midwives, with an on-call arrangement, ensuring efficiency and cost-effectiveness. The collaboration with the Emergency Department further enhances the safety of their service. This model allows women to choose their birthing location without the additional costs of a privately practicing midwife, and the team's achievements have been recognised at the Australian College of Midwifery's NSW annual conference.

In a remote setting, Broken Hill, which experiences around 240 births annually, a solely MGP model is used, supported by the obstetric team due to the area's remoteness. To ensure safety they maintain an effective escalation system involving the intensive care unit. To prevent burnout, midwives divert overnight calls to the hospital for triage, and MGP midwives are called in when the woman presents in labour. An impressive 100% satisfaction rate was reported in their recent survey. They also birth about 40 Aboriginal mothers per year and work alongside the Aboriginal health MGP team in the community.

Waminda, an Aboriginal health centre located in Nowra, offers culturally safe and holistic care to women and their families, ensuring continuity of care throughout pregnancy, birth, and the postnatal period. They prioritize the ideals of "Birthing on Country" and provide respectful culturally safe care to their community.

Despite the benefits of continuity of care, there are barriers in RRR communities hindering its setup and sustainability. A shortage of midwives and midwives in leadership roles presents challenges in establishing and maintaining MGP programs. While maternity units seek guidance from successful examples like Broken Hill, easier access to such assistance is needed. Moreover, short-term contracts, common in RRR work, come with incentive schemes like lump sums or accommodation, which are not available to permanent staff. This discourages midwives from pursuing permanent positions in RRR communities and disrupts the promised continuity of care. Additionally, accommodation and childcare issues prevent experienced midwives from returning to work or working full-time, hindering workforce expansion in RRR areas. *Establishing extended hours childcare facilities at hospitals or ensuring places are available to the children of nurses and midwives within communities could significantly support increasing the workforce in RRR communities.*

I moved to MGP as it offered improved work-life balance and more fulfilling and sustainable work. The MGP services in our district work well, but maternity services in the hospital are suffering. The acuity is high, the workload is too great and there are less and less senior staff due to retirement and burnout. There seems to be poor workforce planning and major delays in recruitment which are exacerbated by a lack of affordable accommodation locally.

Recommendation 30

That NSW Health:

- **commit to providing continuity of quality care with the aim of a regular on-site doctor in rural, regional and remote communities**
- **commit to a model of care under which virtual care technology is used to supplement, rather than replace, face-to-face services**
- **where virtual models of medical care are operating, roster additional suitably trained nursing staff to assist in the provision of the physical care usually attended to by the medical officer**
- **provide staff members with training on how to effectively use telehealth and other virtual models of care**
- **create a public information campaign specifically targeted to rural, regional and remote communities in order to assist patients to effectively engage with virtual care, including factsheets and checklists to set expectations and support positive interactions**
- **ensure that the use of virtual care, if required, is undertaken in consultation with community members, health providers and local governments in rural, regional and remote areas**
- **investigate telehealth cancer care models to improve access to cancer treatment and care including the Australasian Tele-trial model to boost clinical trial participation in regional areas.**

The NSWNMA recognises virtual care and virtual assist as valuable tools for supporting clinicians in RRR areas, however NSWNMA members raise concerns that there are still insufficient skilled clinicians on the ground, both medical and nursing. Despite strong representations from both the community and clinicians in the original inquiry that there need to be sufficient and skilled staff available in regional, rural and remote areas who are supported by virtual care, we are receiving concerning reports from members that virtual care is being used in lieu of medical staff and is often relied on by early career nurses with minimal back-up by senior skilled clinicians on-site.

> NSW Health have asserted that virtual care
>
> > "… should not be used as a strategy to replace face-to-face care that otherwise would be available. Rather than replacing face-to-face care, virtual care is designed to complement existing services by connecting patients with clinical expertise."

We would assert that virtual care *must* not replace skilled clinicians in providing quality clinical care on the ground. Virtual care needs to be paired with nurses and other clinicians that are educated, confident and capable. Currently this education is scant, inadequate or at best difficult to access due to short staffing. Nurses also report that staffing impacts on their ability to refresh their clinical skills and knowledge to remain clinically current.

Highly skilled nurses and midwives are not recognised or remunerated for their level of skill, it is just expected that nurses are generalist trained and should do the job asked of them without further

professional recognition, higher gradings or pay. This is a disincentive for nurses to upskill or maintain higher level skills (E.g. FLECC or similar) and an incentive to leave facilities where they have the same pay for high accountability to work somewhere with more support and less accountability.

Virtual care is being used in our facility as a substitute for doctors. Often when a medical shift can't be covered, we're told it's fine, that the nurses can use virtual care instead. These are often junior nurses who are expected to run the facility, triage and treat emergency patients without any doctors physically present. Staff are resigning due to the lack of doctors and the increased risk. We know that there are medical vacancies but currently there are no positions being advertised. It seems middle management are making decisions that are not morally or ethically based or in the best interests of safe patient care.

Recommendation 32

That NSW Health and the Local Health Districts improve the cultural safety of health services and facilities by engaging with Aboriginal Elders and local communities to:

- **revise and incorporate local content into cultural awareness training such as Respecting the Difference: Aboriginal Cultural Training**
- **listen to their experiences of the healthcare system and seek guidance around what cultural safety strategies should be applied in their areas**
- **include prominent Acknowledgements of Country in all NSW Health facilities as a starting point.**

Recommendation 33

That NSW Health and the Local Health Districts, particularly those located in rural, regional and remote areas, prioritise building their Indigenous workforce across all disciplines, job types and locations. This should include additional funding targeted at increasing the number of Aboriginal Care Navigators and Aboriginal Peer Workers.

Recommendation 34

That NSW Health and the Local Health Districts prioritise formalising partnerships with all Aboriginal Community Controlled Health Services to support the delivery of health services and improve the health outcomes of First Nations people in New South Wales. These partnerships should include formal documentation of service delivery responsibilities and expected outcomes.

The NSWNMA supports the above recommendations for First Nations people living in and accessing healthcare in RRR areas. Our First Nations members would welcome consultation and conversation on matters that have an impact on first nations people, their care, education and their working lives. We as an association feel it is necessary to emphasise that many of our First Nations members do not feel culturally safe in their workplaces, whether that be mainstream or Aboriginal Medical Services. A strong effort to meet recommendation 33 and ensure that Aboriginal people are given every opportunity and support to establish careers in all areas and disciplines in healthcare will go a long way to creating health services that are safe, welcoming and inclusive for First Nations workers and people accessing healthcare services.

Recommendation 38

That the NSW Government ensure that the development of the next Rural Health Plan:

- **acknowledges that rural and remote health systems are fundamentally different to urban and regional city health systems**
- **includes genuine consultation with rural and remote communities**
- **contains realistic, measurable and quantifiable goals in terms of tangible health outcomes**
- **provides the funding and support required to deliver against those goals.**

The NSWNMA welcomes any opportunity to work together with the Ministry of Health and the NSW Government around realising the 'NSW Regional Health Strategic Plan 2022-2032'. As outlined in other parts of this submission, we look forward to seeing how the plan will be implemented to 'strengthen the regional health workforce'. The goal of nurturing a positive workplace culture is vital to creating a psychologically safe workplace at all levels. Nurses and midwives also need to be confident that they can provide feedback without fear of retribution, and speak out about working conditions and know they are respectfully heard and there will be transparent and tangible efforts made for positive change. Efforts to 'streamline recruitment and retention', and to investigate and improve the rural incentive scheme will go a long way in re-building trust and loyalty.

Recommendation 40

That NSW Health and the rural and regional Local Health Districts:

- **commission an independent review of workplace culture including complaints management mechanisms and processes to align with a culture in which feedback from staff is encouraged, based on values of openness, continuous improvement and respect**
- **implement complaints management training for staff, particularly those in management positions • commission the conduct of independent and confidential staff satisfaction surveys to measure progress and cultural improvements over time**
- **review and enhance whistle blower protections to ensure staff feel comfortable in speaking up, with training material to be developed and implemented across the Local Health Districts to support this change**
- **develop and fund a plan to eliminate bullying and harassment within the rural and regional Local Health Districts.**

Members continue to report a culture of fear with frequent reports of members being targeted simply for speaking out about issues of inadequate staffing, safety and patient risk. Members report having their career options limited without explanation or their work unfairly scrutinised when they are doing nothing more than advocating for safe and effective patient care, as they are obliged to do in line with the code of conduct and standards for practice of the nursing and midwifery professions. Training and education need to be strengthened for staff to understand the process of speaking out for safety and questioning clinical decisions assertively. This has been identified as a particular issue for internationally qualified nurses who have different cultural perceptions and practices regarding speaking up to someone in a position of authority, even if they know that person is wrong.

> *A senior manager was able to comb through the data from the people matter survey. We are not a big district, and for some of the respondents she was able to identify who they were based on their responses, then she targeted them and it was quite clear they were being bullied. The processes have been improved and people can provide feedback without identifying themselves, but there is still a reluctance to do so.*

At a rural hospital staff have consistently raised their concerns that nurses are unable to maintain their accreditation to administer chemotherapy due educational resourcing. Currently the training of staff has been placed with Clinical Nurse Consultants to manage in conjunction with providing advanced patient care. Complaints have been raised by staff and business cases to improve education and staffing have been submitted and rejected by hospital executive management. This has resulted in role overload and decreased satisfaction from the Clinical Nurse Consultants. Staff have attempted to write to the local member of parliament to further raise their concerns however this letter was also ignored by hospital executive management.

Without appropriately credentialed staff patients are placed at risk and staff are unable to meet their professional obligations to ensure their training is current and in-line with industry standards. Safework NSW has a requirement for staff to attend training in this specialty area at least every two years and the antineoplastic drug administration course (ADAC) requires clinical competencies to be reassessed on a yearly basis.

Recommendation 41

That the NSW Government establish an independent office of the Health Administration Ombudsman to receive and review concerns about the administrative conduct of management of Local Health Districts and NSW Health from staff, doctors, patients, carers and the public. The Health Administration Ombudsman is to be empowered to review administrative decisions of NSW Health and Local Health District management, including but not limited to, alleged coverups of medical errors or deaths, false or misleading data, inaccurate communications and/or media reporting, Visiting Medical Officer accreditation decisions, staff blacklisting, and bullying or harassment of whistle-blowers. Additionally, the Health Administration Ombudsman is to provide an annual report to Parliament and the public.

The previous governemnt's response to the idea of there being an independent body to receive and review concerns about the administrative conduct of LHD management was not a position of support and indicated that it would serve to duplicate current authorities. NSWNMA members continue to strongly indicate that there remains a workplace culture of fear and that when concerns are raised they do not seem to be taken seriously or are simply ignored. Our members need to know where they can appropriately escalate their concerns when they are not addressed locally.

While it may not be efficient or effective to institute a new independent body to have oversight of complaints from staff, patients, carers and the public, the NSWNMA advocates for and supports that the functions of the Healthcare Complaints Commission and the NSW Ombudsman are made clear to NSW Health staff. We note that a commitment was made to ensure that NSW Health staff have better access to the existing oversight bodies and we would be interested in being advised of the progress of this to date.

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Appendix 1

NSWNMA Recommendations to Original Inquiry

1. First Nations people in regional, rural and remote parts of NSW should have access to Aboriginal Community Controlled Health Services.

2. Aboriginal health liaison staff should be available to all First Nations peoples who are admitted to inpatient care.

3. That NSW Health adopts the NSWNMA 2018 Ratios claim as the minimum nursing numbers required on each shift. See Appendix C for details of this claim.

4. That every aged care facility has a minimum of one registered nurse on duty 24/7.

5. That staffing and funding for aged care facilities be re-considered with reference to the findings of the Aged Care Royal Commission and the ANMF National Aged Care Staffing and Skills Mix Project Report.

6. That all rural and regional hospitals currently covered by the NHPPD (or equivalent ratios) convert NHPPD wards to six NHPPD in order to be equal to metropolitan hospitals in terms of staffing and skill mix.

7. That NSW Health recognise minimum staffing ratios are necessary to provide safe patient care but may not be sufficient to ensure the safety of staff, especially in smaller facilities with very limited staffing numbers. In this case, staffing numbers should be determined by ratios plus a risk assessment of numbers required to provide an effective duress response.

8. Wherever there is an emergency department open 24/7, regardless of its delineation or classification (however named), that facility requires minimum staffing of three nursing staff rostered on duty, two of whom are suitably qualified to attend to an acute emergency presentation.

9. That the Nurse Practitioner (Generalist) model of care and role in regional and rural areas is properly implemented. This will require funding to be directed towards recruitment and development of additional Nurse Practitioners to work in rural and regional areas, particularly in sites without 24/7 medical officers reliant on virtual medical officer coverage.

10. Where rural and regional sites do not have access to medical officers 24/7 and are reliant on virtual medical officer coverage, there must be a minimum of one registered nurse rostered on-call and within 15 minutes to the site, to be present and provide physical in person support to respond to emergency events.

11. That nurses and midwives are paid all their Award entitlements.

12. Any service relying on staff to be available during their time off work to respond emergencies should formalise this on-call roster and pay appropriate on-call allowances.

13. Review nursing and midwifery incentives with reference to Queensland Health's Remote Area Nursing Incentive Package.

14. Every site must have the capacity to provide a timely and effective duress response, regardless of the size or location of the facility.

15. NSW Health should undertake a review of existing duress arrangements in place across regional/rural facilities. This should consider at a minimum, the staffing numbers across each shift, the availability of security staff by shift and the availability of external resources, including external security companies and police.

16. The Association recommends that visible, uniformed, unarmed security staff be positioned in close proximity to emergency departments, psychiatric units and other areas of the hospital where violent incidents may occur.

17. Increased funding for mental health services in regional, rural and remote areas to ensure suitable services are available at all levels of care provision, from community-based care through to Mental Health Intensive Care Units (MHICU).

18. That more specialist mental health beds be made available for older persons who require MHICU.

19. That NSW Health develop plans to address shortages in mental health nursing staff, training, recruitment, and retention of mental health nurses. This should also include increased opportunities for Nurse Practitioners (Mental Health).

20. NSW Health to review EDs currently gazetted as mental health assessment facilities. Where these facilities are unable to undertake this work in a way that ensures the safety of nurses (whether due to physical limitations of the facility, the staffing levels, lack of access to security staff and police to enable a suitable duress response), they should be removed from the “declared mental health assessment” list.

21. Work with local police and other relevant groups to decrease inappropriate drop offs of intoxicated persons. This should include a clear agreement on when it is appropriate to bring a person to a declared facility for assessment, as well as training to improve understanding of when a person may need a mental health assessment.

22. If intoxicated persons with acute severe behavioural disturbances are to be managed in hospital environments, this must occur in secure facilities with suitable staffing arrangements to ensure risk can be managed effectively.

23. Review the availability of mental health and drug & alcohol resources including the use of telehealth options for rural and regional areas for patients presenting to EDs under the influence of psychostimulants such as “ice”, both for immediate management and longer term referral and treatment.

24. Revise systems in place for community nurses and midwives in keeping with chapters 16 & 17 of Protecting People and Property – NSW Health policy and standards for security risk management in NSW Health agencies.

Submission to:

The implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health

OCTOBER 2023

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