Submission No 48

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

Organisation: NSW Nurses and Midwives' Association

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NSW NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NSW BRANCH
www.nswnma.asn.au
50 O'Dea Avenue
Waterloo NSW 2017
T 8595 1234 (METRO) • 1300 367 962 (NON-METRO)
F 9662 1414
E gensec@nswnma.asn.au

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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: assistants in nursing (however titled), assistants in midwifery, enrolled nurses registered nurses and midwives at all levels including management and education.

The NSWNMA has approximately 77,500 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

CONTACT DETAILS

NSW Nurses and Midwives' Association

50 O'Dea Avenue

Waterloo, NSW 2017

(02) 8595 1234 (METRO)

1300 367 962 (RURAL)

gensec@nswnma.asn.au

Introduction

The NSW Nurses and Midwives' Association (NSWNMA) expresses gratitude to the Select Committee on Remote, Rural, and Regional Health for extending an invitation to contribute to the Terms of Reference regarding the Inquiry into the implementation of Portfolio Committee No.2 recommendations relating to the delivery of specific health services and specialist care in rural, remote, and regional areas of NSW. We draw your attention that is in addition to our previous submission titled 'The implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding considerations for remote, rural and regional health'.

Our submission delves into addressing aspects 1a, c, d and e where our expertise can offer the most substantial contributions. It is widely recognised that health outcomes for individuals residing in rural, remote, and regional (RRR) locales are generally inferior to those in metropolitan areas, attributable to a complex interplay of factors. Nursing and midwifery constitute integral components in the broader effort to enhance the health and well-being of RRR communities in New South Wales (NSW). We firmly believe that nurses and midwives possess the requisite capabilities, knowledge, and skills to significantly impact healthcare equity, accessibility, and outcomes for individuals in rural, regional, and remote NSW. Nonetheless, achieving this goal necessitates substantial investments in healthcare workforce development, both at the undergraduate and continuing professional education levels, as well as transformational leadership to cultivate a workplace culture conducive to retaining and nurturing nurses and midwives, thereby fostering fulfilling careers in RRR areas.

As an association, we draw upon the insights of our dedicated and engaged members, who harbor a deep passion for their regional and rural communities. While the current challenges may seem daunting, they are not insurmountable; however, concerted, and collaborative efforts are imperative for their resolution. We envision a future wherein a well-supported, highly educated, and proficient nursing and midwifery workforce thrives in rural, regional, and remote settings, with our members assured of providing optimal care in well-equipped and adequately staffed facilities, while returning home without enduring psychological or physical harm.

We extend our gratitude to our members for their candid and invaluable contributions to this submission. The NSWNMA respectfully presents our submission to the select committee for their consideration.

Our key findings

MATERNITY SERVICES

- Formalised on-call arrangements have been established in some areas and not others. This 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.
- 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. Improving the application of this important incentive will assist in it achieving its aims.
- Violence and aggression in emergency departments pose significant risks to nurses and midwives, especially in rural hospitals where staffing is often inadequate and duress response systems are lacking.
- 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.
- Coordination of metro-rural exchange programs for midwifery placements needs improvement to better support students and address logistical challenges.
- Recommencement of the Metro-Rural Exchange programs to enable new graduate midwives to enhance their skill and improve the notoriety of midwifery in RRR locations
- The Association supports NSW Health's implementation of the Mentoring in Midwifery (MIM) program, which aims to cultivate supportive, learning relationships between midwives, student midwives and early career midwives across the state
- The implementation of midwifery continuity of care models in rural, regional, and remote areas is crucial for improving maternal and neonatal outcomes, but challenges include midwife shortages, lack of support for on-call work, and obstacles in establishing therapeutic relationships with General Practitioner Obstetricians (GPOs).
- Reviews of maternity services are ongoing, but the shortage of midwives remains a significant challenge, impacting the quality of care and increasing workload pressures.
- Collaborative efforts between state and federal governments, along with key stakeholders like the NSWNMA, are needed to address staffing issues, improve workplace culture, and ensure safe staffing levels in maternity units.

INDIGENOUS HEALTH SERVICES

- Enhanced access to culturally safe palliative care that respect Indigenous traditions, values, and spiritual beliefs. Encourage collaboration with Indigenous communities to co-design and deliver these services.
- Education and training on cultural competence to encompass a comprehensive pathway towards achieving cultural safety whilst partnering with organisations like the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM).
- Financial support for aboriginal cadets and mature aged students undertaking further education amidst the cost-of-living crisis. Advocate for higher compensation rates, additional support

allowances, childcare assistance, and paid placements to alleviate financial strain and ensure equitable access to education.

MENTAL HEALTH SERVICES, AND DRUG AND ALCOHOL SERVICES

- That NSW Health develop plans to address shortages in mental health nursing staff, training, recruitment, and retention of mental health nurses. This should include increased opportunities for Nurse Practitioners (Mental Health).
- 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 be in need of a mental health assessment.
- 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.
- Review the availability of mental health and drug & alcohol resources, including the use of telehealth options for rural and regional areas.

AGED CARE

- Advocate for increased funding and resources to support specialised education and training for nurses in aged care.
- Call for the expansion of nurse-led aged care services in rural, regional, and remote areas to meet the growing needs of the aging population.
- Encourage collaboration between nurses, aged care facilities, and other healthcare providers to coordinate and guide care for older people.

1) The delivery of specific health services and specialist care in remote, rural and regional New South Wales, including:

a) Maternity services, obstetrics, and paediatrics (including Recommendations 19, 20, 26 and 27(a)

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**

Despite this recommendation the Ministry of Health (MoH) has to date refused to include in the Award an on-call roster system where staffing levels are inadequate to meet roster demands. This means that members are contacted regardless and asked to work extra-hours or overtime. This, in our view, is a default on-call roster where the members are not paid for the inconvenience and feel compelled to answer the call as they know how dire the staffing is at their site.

On call arrangements for nurses and midwives, where staff are required to be on-call on days off, are yet to be formalised across all relevant public health facilities.

- **engage with the emergency departments in their area to develop agreed plans to address security issues with timeframes and regular progress reporting**

There are high rates of violence and aggression in emergency departments across the state, leading to significant physical and psychological injury to nurses and midwives. Regrettably, it's widely acknowledged that instances of violence during pregnancy are all too common, and the period surrounding birth and the early stages of newborn care can be fraught with intense emotions. Mismanagement of these emotions can potentially endanger the well-being of midwives providing care to expectant mothers.

In rural hospitals, where staffing levels are often inadequate, midwives frequently find themselves working alone overnight, leaving them vulnerable to partner violence, either directed at themselves or at those under their care, with minimal support available. Rural and regional hospitals are often poorly equipped to safely manage these risks. In a larger metropolitan hospital setting, pressing a duress alarm summons a 'code black' response, with enough security staff to safely manage the situation, this is not the case rurally.

There are many remote, rural and regional sites where pressing a duress alarm will send a signal to an external monitoring company (which may be interstate). This company will then call the site to check if it is a false alarm before calling the police. In some instances, the nearest police station may be 90 kilometres away. This is not an adequate arrangement to provide a timely and effective duress response to ensure the safety of nurses, midwives, and other health professionals.

- **increase and formalise professional development opportunities for nurses and midwives, ensuring that rostering accounts for this.**

Clause 55 of the *Public Health System Nurses' and Midwives' (State) Award* includes several discretionary provisions for learning and development leave. This extends to leave for short courses, seminars and conferences provided externally to the employer, tertiary and post-graduate study. The leave is applicable to both face-to-face and distance learning. We receive regular feedback from our members advising that when applying for study leave it is seldom granted. This is most often attributed to a lack of staffing or an inability to replace midwives undertaking education, despite the award clearly stating that "*Chief Executives are also responsible for allocating an appropriate budget for learning activities, which may include replacement costs for rostered staff…*"

After engaging with our members in rural and regional areas, we've learned that even fundamental aspects of mandatory education have been scaled back, with the responsibility now falling on Clinical Midwifery Educators (CME). CMEs are having to find time to deliver mandatory training and providing the necessary support to students whilst also being allocated patient care duties, contrary to the Award, leading to excessive workloads for the CMEs and decreased support for the other staff. This creates a challenging environment for learning and assimilating knowledge, undermining our members' ability to deliver consistent, safe, and effective care.

Clinical Midwifery Educators have expressed that this arrangement makes it nearly impossible for them to meet their key performance indicators, as education sessions are often disrupted or left incomplete. Previously, education sessions would occur during the afternoon handover period when a larger number of staff were available. However, this time is now occupied by oncoming staff assisting with patient care, facilitating breaks for morning staff, and attending to other mandated tasks such as safety huddles and comprehensive clinical handovers, involving patient and documentation checks, patient journey boards updates, and restocking emergency equipment. Moreover, modern handover practices emphasise involving patients and their families, necessitating a longer and more thorough process than ever before.

Additionally, some rural facilities have yet to transition to 10-hour night shifts, meaning they lack an extended afternoon crossover period. This further complicates the scheduling of educational sessions and exacerbates the challenges faced by clinical midwifery educators and staff in RRR settings.

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**

While the NSWNMA acknowledges the progress made in meeting nursing recommendations through NSW Health's collaboration with Charles Sturt University (CSU) and their nursing rural generalist program, there remains a notable gap in resources dedicated to RRR midwifery. Rather, there is resistance concerning the role of single qualified midwives in rural and remote hospitals. Single registered midwives (i.e.: those midwives who are not also Registered Nurses) often find themselves pressured to deliver care beyond their scope, while dual registered midwives (i.e.: those midwives who are also Registered Nurses) are frequently tasked with providing additional nursing

care due to the limitations of single qualified midwives. The NSWNMA asserts it is crucial to recognise and respect the distinct roles of each profession in caring for separate patient populations.

Victoria and Queensland offer additional training opportunities for nurses to enhance access to primary care and emergency services in rural and remote communities. This supplementary training enables nurses to supply and administer scheduled medications following specific guidelines. The current midwifery endorsement process is both costly and time-consuming. Introducing midwifery prescribing in RRR communities could significantly enhance access to care for women, particularly in cases of unintended pregnancies. Women in RRR areas are 1.4 times more likely to experience unintended pregnancies, and with the prevailing stigma and limited access in small towns, having more endorsed midwives would offer greater options for women seeking care**.**

Moreover, whilst the NSWNMA acknowledges that NSW Health has introduced the Rural Nursing Pathways in Practice (RNPiP) for nurses, encompassing career supports and opportunities, including e-learning modules, an equivalent pathway is not similarly afforded to NSW midwives. Of utmost importance for our midwifery members, such pathways would ensure a well-supported, well-educated, and professionally skilled RRR midwifery workforce, and is therefore necessitated.

Considering practical placements, members have highlighted their collaborations with universities but have encountered challenges in communication and planning regarding placements in the metro-rural exchange program. Students placed in rural hospitals often undergo a metro placement to enhance their understanding of specific aspects of midwifery. Unfortunately, these placements are not always well-coordinated, with last-minute notices often impacting childcare and accommodation arrangements. It's imperative that more thorough planning is invested in these placements.

A successful exchange program has been established in Broken Hill, where metro students participate in rural placements with on-site accommodation provided. This positive experience has the potential to influence midwifery students to consider rural employment opportunities and improve retention rates whether on a permanent or temporary basis, once they are qualified.

Members in Broken Hill have also informed us of a community country university centre where students access their facilities including computers, Wi-Fi and free printing to assist with university study.

- **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**

Regarding the plight of new graduates, the NSWNMA underscores an inequality within NSW Health's initiatives. While the 12-month Metro-Rural Exchange program has been available to new graduate nurses, offering exposure to diverse clinical environments, such opportunities have been denied to new graduate midwives in 2024. This program, split between six months in a rural setting and six months in a metropolitan one, not only broadens experience but also bolsters Remote, Rural, and Regional (RRR) facilities. Previously, this program successfully ran between RPA and Orange hospitals.

With 69% of midwives concentrated in urban areas nationally, rural regions face critical staffing shortages. Research demonstrates the Metro-Rural Exchange program's potential to elevate midwifery in RRR locales. It fosters skill refinement, augments maternity care outcomes, and fosters effective collaboration. Therefore, the NSWNMA advocates for reinstating a similar program for new graduate midwives in 2025, contingent upon collaborative efforts between metropolitan and rural NSW Health facilities to establish learning objectives and supportive structures.

Furthermore, the Association endorses NSW Health's Mentoring in Midwifery (MIM) program, aimed at nurturing supportive relationships among midwives, student midwives, and early career professionals state-wide. The initial post-registration years are pivotal for skill development and confidence building, yet lack of support often leads to burnout and attrition. Research indicates a concerning trend of early career midwives leaving the profession due to insufficient support, resulting in workforce instability and compromised care. Implementing the MIM program in RRR areas can fortify the midwifery workforce, ensuring they operate to their full potential and provide optimal care for mothers and babies.

- **implement professional, financial and career enhancement incentives for nurses and midwives who work in rural and remote locations.**

Our poor experience with the Rural Health Workforce Incentive Scheme has been raised with the government regarding consistency and transparency, principally from the incentives largely being at the discretion of Chief Executives, pursuant to a policy which does not have the specificity of an award. These problems are exacerbated by changes to the scheme which are made somewhat informally with little guidance or detail. These changes, such as the doubling of incentives to $20,000, appear to remain outside of policy.

The Rural Heath Workforce Incentive Scheme is based on a federal framework (Modified Monash Model), but is applied to a state-based program using a NSW Health policy, which each LHD applies slightly differently. Whilst the districts will report there is criteria which they measure applications against, such as hard to fill positions (advertised at least twice), there is the ability for the Chief Executive to exercise some discretion. For example, Queanbeyan Hospital was excluded from the scheme based on its proximity to the ACT however, that is also a reason it should be incentivised. Queanbeyan, just like Tweed, cannot compete with another state/territory with superior wages and conditions. In the Queanbeyan scenario, the LHD lobbied NSW Health and had the decision overturned, which shows there is capacity to amend the criteria, but also outlines a worrying lack of understanding by government about recruitment barriers.

There is also LHD inconsistency with eligibility criteria. For example, HNELHD offers a retention bonus to CNEs, but Southern NSW LHD does not. In SNSW LHD the consequence for some sites is CNEs resigned their positions and took Registered Nurse positions that attract the incentive.

Another example of the inconsistency is between Batemans Bay and Moruya. These two sites are managed as one (Eurobodalla), and staff work over both sites. However, if the staff member's position has a Batemans Bay cost code, they are not eligible as Batemans Bay is excluded. The net effect is that staff working together in the same unit are treated differently. In short, the scheme is very divisive and has led to resignations. This contrasts the retention needs of our members.

As Treasury urges all public services to make savings, LHDs have looked to their largest group of employees to make the savings. In Southern NSW the initiatives have had a deleterious effect, including the removal of FTE leave relief. In contrast, the LHD continues to incentivise Drs, and is now offering locum shift remuneration of $3000 per shift.

The NSWNMA acknowledges the 2024 initiative by Health Education and Training (HETI) to provide a one-time rural support incentive of $1000 for new graduate nurses and midwives relocating to Remote, Rural, and Regional (RRR) areas in NSW. This incentive targets specific regions such as Murrumbidgee, Illawarra Shoalhaven, and Far West NSW. Notably, priority is given to Aboriginal and Torres Strait Islander new graduates, aiming to foster greater representation among Indigenous members. However, with only 1.3% of the midwifery workforce identifying as Aboriginal and Torres Strait Islander, the accessibility of the incentive remains limited.[1]

Furthermore, the incentive allocation process is stringent and highly competitive, with all applications subject to thorough review by a panel. While any support is appreciated, the Association questions the cost-effectiveness of a one-time $1000 payment, particularly considering the escalating cost of living. This concern is compounded by the increased expenses associated with remoteness, including higher costs for necessities such as food and petrol. While the incentive represents a step forward, its efficacy in addressing the financial challenges faced by new graduates remains questionable.

Recommendation 26

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

NSW Health's Connecting, Listening, and Responding document outlines goals that prioritise women's-centred care.[2] *Goal 1* emphasises the importance of respectful and inclusive care, which includes culturally and psychologically safe practices, particularly vital in 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 this service. The 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 and paediatrics. 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

[1]AHPRA. (2020). “Health Profession Demographic Snapshot.”

https://www.nursingmidwiferyboard.gov.au/About/Health-profession-demographic-snapshot.aspx.

[2] NSW Health. (2023). Connecting, listening, and responding: A Blueprint for Action – Maternity Care in NSW

Aboriginal health MGP team in the community. The midwives not employed within the MGP model staff the wards for walk-ins, however, they also work in isolation, which is for a considerable safety concern that impacts clinical work with collaboration inhibited

Despite the recognised advantages of continuity of care RRR communities face significant barriers in establishing and maintaining such models. The Association is currently engaged in discussions with several Local Health Districts (LHDs) to establish Midwifery Group Practices (MGPs) in these areas. However, while we acknowledge the benefits, ensuring the safety of our members and the community must remain the top priority.

Common challenges reported by our members include a shortage of midwives, particularly those willing to work within the midwifery-led or Midwifery Group Practice model. Issues such as midwives residing too far from the hospital to be on-call, lack of suitable childcare options for on-call work, reliance on fly-in-fly-out midwives, and fatigue among midwives unfamiliar with the midwifery-led continuity of care model are prevalent. Additionally, short-term contracts, often offered in RRR settings, come with incentive schemes not available to permanent staff, discouraging midwives from seeking permanent positions and disrupting continuity of care.

Another issue is the absence of midwifery leadership, with nurse managers often making decisions regarding midwifery models of care without adequate understanding of their functionality. Additionally, relationships with General Practitioner Obstetricians (GPOs) can pose challenges, as they are funded to provide antenatal care, rendering a midwifery model of care unfeasible. While some GPOs may permit one appointment with the midwife for educational purposes, this falls short of a true midwifery-led model.

Although issues with GPOs may arise, maternity services cannot operate without them, necessitating the establishment and maintenance of therapeutic relationships. For instance, the closure of the Muswellbrook maternity unit in 2022, retaining only antenatal and postnatal services, highlights the challenges. Efforts to reopen the birthing services as a midwifery-led unit face obstacles due to the lack of local GPOs, raising safety concerns. A robust transfer plan to the closest maternity hospital in Singleton becomes imperative in such cases.

The NSWNMA asserts more initiatives are needed to attract obstetricians to RRR Australia to ensure communities have access to safe maternity services, like those in metropolitan regions.

The NSWNMA acknowledges the profound significance of Aboriginal and Torres Strait Islander culture, which emphasises a deep connection to land and Country. This connection not only shapes identity but also encompasses responsibilities, spirituality, social kinship, and emotional well-being. Recognising the importance of honouring this connection, the concept of Birthing on Country emerges as a vital approach for Indigenous Australians. It advocates for childbirth support services to be returned to Indigenous communities, ensuring cultural control and spiritual connection to land and Country for Aboriginal and Torres Strait Islander mothers and babies[3].

In alignment with this principle, the NSWNMA advocates for a midwifery model of care that promotes increased Indigenous representation in the workforce, cultural competence, and the development of programs centred on Birthing on Country. Waminda, an Aboriginal health centre situated in Nowra, serves as a commendable example of Birthing on Country, offering culturally safe and holistic care to women and their families. Their approach prioritises the principles of Birthing on Country,

[3] Charles Darwin University. (n.d.) “Birthing on Country.” https://www.birthingoncountry.com/

delivering respectful and culturally appropriate care to the community with a focus on continuity throughout the pregnancy, birth, and postnatal periods.

Additionally, the NSWNMA acknowledges the stark underrepresentation of Aboriginal and Torres Strait Islander members within the current midwifery workforce, comprising only 1.3% of employees nationally. This lack of representation poses barriers to service access and results in a significant deficit in culturally appropriate care, leading to health disparities for Indigenous mothers and babies. Indigenous women are often less likely to engage with mainstream maternity care, which may not align with traditional birthing practices. Furthermore, disparities in outcomes are exacerbated in remote areas, where Indigenous women disproportionately give birth.[4]

Aligned with the insights of The Aboriginal and Torres Strait Islander Health Performance Framework, the NSWNMA acknowledges the preference of Indigenous Australians to receive care from Indigenous health professionals. Furthermore, evidence suggests that the most effective midwifery models of care are those that foster continuity and trust. Maternity services that involve a known Indigenous care provider throughout the antenatal, intrapartum, and postpartum periods are highly valued by Aboriginal and Torres Strait Islander women. Specifically, care provided by an Indigenous midwife, midwifery student, or supported by an Aboriginal Liaison Officer (ALO) is particularly esteemed.[5]

Regrettably, the already limited presence of Aboriginal and Torres Strait Islander health professionals available to provide this culturally safe care is at risk of further decline due to the prevalence of racism within our workplaces. This concern arises from the discrimination experienced by Indigenous staff members, both from members of staff and from the public. This distressing pattern not only jeopardises the diversity and inclusivity of our workforce but also hampers the well-being and career advancement opportunities of our Indigenous colleagues.

Considering this urgent issue, the NSWNMA urges the Ministry of Health (MoH) to work with the NSWNMA Member Circle (Aboriginal and Torres Strait Islander network) and other representative organisations in formulating proactive strategies to combat workplace racism. These initiatives should not only strive to eradicate discriminatory conduct but also cultivate a culture of respect, empathy, and recognition for the unique contributions of Indigenous healthcare professionals.

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[4] Sivertsen, N; Deverix, J; Gregoric, C; et al. (2022). “A Call for Culture-Centred Care: Exploring Health Workers’ Perspectives of Positive Care Experiences and Culturally Responsive Care Provision to Aboriginal Women and Their Infants in Mainstream Health in South Australia.” Health research policy and systems 20 (1): 132–132.

[5] Lai, G; Taylor, E; Haigh, M; et al. (2018). “Factors Affecting the Retention of Indigenous Australians in the Health Workforce: A Systematic Review.” International journal of environmental research and public health, 15(5).

Recommendation 27

That the rural and regional Local Health Districts, and those metropolitan Local Health Districts that take in regional areas of the state, review their maternity services in order to develop plans for midwifery, GP Obstetrics, specialist Obstetrics and newborn services.

It has been noted that many LHDs have undertaken reviews of their services, but the most obvious issue is the shortage of midwives who are willing to work in midwifery. The number of midwives not working in midwifery is hard to determine, but the AHPRA data from December 2023 show that there are 309 midwives on the non-practising register, and there will also be other dual qualified midwives not captured here, currently employed as a registered nurse.[6] There are approximately 300 midwives, according to data from the National Health Workforce Dataset (NHWDS), employed outside of midwifery and looking for employment in the profession. With the current midwifery shortage, this number is hard to understand, and more work needs to be done to explore this.[7]

The NSWNMA recognises that permanent employment affords numerous benefits for both employers and employees, including increased engagement with professional development programs, as well as improved career and home life planning. Moreover, permanent employment can generate a more sustainable midwifery workforce through enhanced attraction and retention rates. The NSWNMA acknowledges that in RRR communities, where the midwifery workforce is often plagued by staff shortages, invoking significant rostering difficulty and inhibiting continuity of care, more needs to be done to attract and retain permanent staff members. Despite this, as an example, a mere six of 36 new graduate midwifery positions were permanent positions within HNELHD in 2024.

Highlighting this, RRR location Scone Memorial Hospital offered only one temporary fulltime position. So long as employees are not offered job security, quality training and strong workplace culture with opportunity for professional development, our members in RRR locations will continue to be plagued by staff shortages.

As well as LHDs there are multiple groups of key stakeholders reviewing this crisis in maternity and coming up with recommendations that could impact RRR. One of these groups is an expert advisory group to improve birthing experiences through the delivery of a blueprint for maternity services. The 52-page blueprint details 10 maternity service goals, including respectful and inclusive care, and timely information regarding outcomes during labour and birth. Without an increase in funding for midwifery staffing levels the blueprint is at risk of failure. A key target is for all women to be offered debriefing post-delivery; this is aimed at decreasing birth trauma. This requires adequate staffing to deliver. Workloads on postnatal wards, combined with poor skill mix means that quality debriefing opportunities are missed.

Following this we draw your attention to the Legislative Council's Inquiry into Birth Trauma, and the recommendations within our submission to that Inquiry. Of key relevance for this hearing is the need to significantly increase the number of midwifery-led models of care where midwives and endorsed midwives can work to their full scope of practice. This will not only improve the quality of care and reduce costs but will assist in the recruitment and retention of midwives into RRR NSW.

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[6] https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

[7] https://hwd.health.gov.au/resources/information/nhwds.html

Lastly, we wish to bring to your attention ongoing Federal Government initiatives, such as Midwifery Futures, which receives funding from the Nursing and Midwifery Board of Australia. This project aims to assess the current state of Australia's midwifery workforce and develop strategies to support policy and regulatory changes. Additionally, the National Maternity Workforce review project, led by Queensland, the ACT, and the Northern Territory, is conducting literature reviews and forums to gain insights into current trends in midwifery. Furthermore, a scope of practice review, which is not solely about midwifery, is underway. It is imperative for the State Government to collaborate with the Federal Government and key stakeholders like the Association to devise solutions to the challenges identified in these reviews and initiatives.

Alongside these initiatives the Association is party to a working group, as a sub-set of the Safe Staffing Levels Taskforce. This working group is reviewing Birth Rate Plus™ which is the staffing tool for larger maternity sites in NSW. Many smaller regional services have their staffing levels set by the employer through a review of the previous year's activity and current bookings. This requires greater scrutiny to ensure the staffing levels are adequate. Without Birth Rate Plus districts are often handing down staffing profiles without proper consultation with the midwifery unit manager, which means there is usually a general lack of understanding of how the maternity unit is run. Members tell us when activity is reviewed outpatient activity is often overlooked due to a lack of admin capture, and in smaller hospitals this can make up most of the work leading to a poorly staffed service. The Association is actively seeking greater collaboration with the Ministry of Health in addressing how midwifery staffing levels are agreed in smaller sites.

c) Indigenous health services (including Recommendations 23, 31, 32, 33, 34, 35 and 43)

Only recommendations 23, 32 and 33 will be addressed at this time.

Recommendation 23

That NSW Health, in conjunction with The Australian and New Zealand Society of Palliative Medicine, the Royal Australian College of General Practitioners, the Royal Australasian College of Physicians and the Aboriginal Health and Medical Research Council of NSW urgently establish a palliative care taskforce to:

- **plan palliative care access and services of equivalence to those living in metropolitan areas**
- **map who is currently providing palliative care services and their level of training, as well as where these services are offered**
- **establish an agreed, uniform state-wide platform for the collection of palliative care and end of life care data to allow for clinical benchmarking of regional palliative care services**
- **investigate and promote innovative models of palliative care services**
- **ensure culturally appropriate palliative care services are available to First Nations peoples**

The Association acknowledges the critical need for culturally appropriate end-of-life care that respects Aboriginal and Torres Strait Islander traditions, values, and spiritual beliefs. Palliative care holds a unique significance within Aboriginal and Torres Strait Islander cultures, reflecting the deep connection to land, spirituality, and community. For Aboriginal and Torres Strait Islander peoples, the journey towards the end of life is deeply intertwined with cultural practices, storytelling, and the

passing down of knowledge from elders to younger generations. Therefore, it is essential that palliative care services for Indigenous elders and their families are delivered in a manner that respects and honours these cultural norms.

The NSWNMA recognises the challenges faced by Aboriginal and Torres Strait Islander communities in accessing palliative care services that are culturally safe and responsive to their needs. Historically, there has been a lack of understanding within mainstream healthcare systems about Indigenous cultural practices and beliefs surrounding death and dying. This has often resulted in Indigenous peoples feeling alienated or misunderstood when seeking end-of-life care.

Initiatives led by organisations such as the National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) play a vital role in advocating for equitable access to culturally safe palliative care services. By promoting awareness and understanding of Indigenous cultural practices and values within the healthcare sector, NATSIAACC strives to ensure that Aboriginal and Torres Strait Islander elders receive the respect and dignity they deserve during their final days.

The association stands in solidarity with NATSIAACC and other Indigenous-led initiatives, recognising the importance of fostering environments that uphold cultural integrity and promote holistic healing practices in palliative care settings. By working collaboratively with Aboriginal Peak bodies and Indigenous communities, NSWNMA is committed to advocating for the provision of culturally appropriate end-of-life care that honours the unique needs and preferences of Aboriginal and Torres Strait Islander peoples. Through ongoing support and engagement, NSWNMA seeks to contribute to the improvement of health and well-being outcomes for older Indigenous adults as they navigate their end-of-life journey with dignity and respect.

We take the opportunity to highlight the importance of employers being more mindful of Aboriginal and Torres Strait Islander staff when they require extended leave for cultural responsibilities like sorry business. This emphasis on understanding patient and family needs should also encompass staff members.

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**

The New South Wales Nurses and Midwives Association (NSWNMA) acknowledges and appreciates NSW Health's dedication to mandatory training through the implementation of the 'Respecting the Difference: An Aboriginal Cultural Training Framework'. Recognising the essential role of education in fostering awareness and understanding of Aboriginal culture within healthcare settings. NSWNMA views this framework as a foundational tool that initiates crucial conversations and actions aimed at promoting cultural competence and sensitivity among healthcare professionals. However, NSWNMA emphasises that mandatory education alone is just one component in the journey towards achieving cultural safety for Aboriginal and Torres Strait Islander people.

The Association draws your attention to the APHRA policy 'Guidance for Nurses and Midwives'.[8] This guidance offers advice for nurses and midwives on collaborating effectively with Aboriginal and Torres Strait Islander Health Practitioners to deliver culturally appropriate healthcare and enhance the health outcomes of Indigenous communities. Nurses and midwives are urged to interact with everyone in a culturally sensitive and respectful manner, nurturing transparent, empathetic, and professional relationships. The NMBA requires that nurses and midwives practice without prejudice and uphold professional respect. Additionally, Aboriginal and Torres Strait Islander Health Practitioners may benefit from this guidance when working alongside nurses and midwives.

Considering this, the Association urges NSW Health to expand its training initiatives to encompass a comprehensive pathway towards achieving cultural safety for both patients and the NSW Health workforce to eliminate racism. One exemplary model for such advancement is exemplified by the 'Cultural Safety Training for Nurses and Midwives' developed by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). This program, known as Murra Mullangari: Introduction to Cultural Safety and Cultural Humility, operates across three progressive phases: Cultural Awareness, Cultural Sensitivity, and Cultural Safety.

During the Cultural Awareness phase, participants delve into foundational concepts, understanding the essence of Aboriginal culture, its significance, and historical context. Moving into the Cultural Sensitivity phase, emphasis is placed on developing nuanced understandings of cultural nuances, communication styles, and respectful engagement practices. Finally, the Cultural Safety phase equips participants with actionable strategies and tools to actively foster culturally safe environments within clinical settings. This ensures that care delivery is respectful, inclusive, and responsive to the needs of Aboriginal communities and the workforce.

By adopting and expanding upon such initiatives, NSW Health can significantly enhance its commitment to cultural safety. This will ultimately lead to improved health outcomes and experiences for Aboriginal patients, while simultaneously fostering a more inclusive and equitable healthcare system for all.

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.

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.

Navigating the Aboriginal Cadetship amidst a cost-of-living crisis presents a blend of opportunities and obstacles. On the positive side, embarking on further education opens doors to career

[8] The Nursing and Midwifery Board of Australia (NMBA) and the Aboriginal and Torres Strait Islander Health Practice Board of Australia (ATSIHPBA). (2024). *Guidance for nurses and midwives: What nurses and midwives need to know about Aboriginal and Torres Strait Islander Health Practitioners*. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/Fact-sheet-Working-with-Aboriginal-and-Torres-Strait-Islander-Health-Practitioners.aspx#:~:text=Nurses%20and%20midwives%20are%20expected,of%20racism%20and%20professionally%20respectful.

progression, skill enrichment, and personal fulfillment. Mature-aged individuals opting for a career change often bring a wealth of life experiences, enriching the learning environment for themselves and their peers. Moreover, returning to education serves as a beacon of inspiration for families and communities, encouraging lifelong learning pursuits.

However, formidable challenges lie ahead. Financial strain emerges as a prominent hurdle, with mature-aged students grappling with the costs of tuition, textbooks, and daily expenses while receiving a compensation of $600 per fortnight (for 40 weeks annually) and $500 support allowance per semester. For Aboriginal students already juggling numerous responsibilities such as work and family commitments, this financial burden amplifies stress levels and time constraints. Striking a balance between these obligations may necessitate sacrificing income or career stability, potentially jeopardising financial security.

Socio-economic complexities further exacerbate the situation, especially for parents compared to their high school graduate counterparts. Parents shoulder the added weight of childcare, education, and healthcare expenses alongside limited avenues for career advancement due to caregiving duties. Consequently, they may experience social isolation and encounter impediments in pursuing educational and professional aspirations.

Despite these formidable challenges, access to support services, flexible learning modalities, and financial aid can embolden cadets to surmount obstacles and realise their educational dreams. By addressing socio-economic barriers and tailoring resources to their needs, including bolstered financial assistance, paid internships, participation in mentoring initiatives like the Deadly Aboriginal and Torres Strait Islander Nursing and Midwifery Mentoring (DANMM), and provision of social well-being workshops, cadets can be empowered to navigate the complexities of the Aboriginal Cadetship with resilience and determination.

d) Mental health services, and drug and alcohol services (including Recommendation 11)

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.

NSW Health recognises that around 40% of violent episodes occur in mental health units, making mental health an important area of focus in violence prevention. Prevention and early intervention of mental health disorders is an important element of reducing exposure to violence.

Poor resourcing within mental health services along with a limited specialised workforce in regional, rural and remote areas is reaching a critically unsafe level for both staff and clients. Our members identified insufficient numbers of mental health intensive care (MHICU) beds and insufficient numbers of beds available for older persons requiring MHICU. Currently older persons requiring an MHICU admission are being inappropriately accommodated in the limited MHICU beds or worse, in general aged care facilities.

Small rural/regional hospitals with Emergency Departments gazetted as declared mental health assessment centres are another area of concern for the Association. There appear to be around 14 small rural hospitals that have been gazetted as “mental health emergency assessment centres” in what appears to be an attempt to restrict the transport of patients by ambulance and/or police to larger facilities.

It's difficult to comprehend the benefit for an extremely unwell and behaviourally disturbed patient to be transported to the emergency department of a small rural hospital lacking adequate staffing and mental health training. This situation, compounded by prolonged waits for telehealth mental health assessments and subsequent transfers to larger facilities with mental health beds, raises concerns about the patient's well-being and appropriate care. It can be unsafe for the staff who are trying to manage highly volatile patients despite having limited or no mental health training, inadequate staffing to be able to implement a restraint if required, no seclusion room and no local police presence.

Another pressing concern for our members in remote areas is the rising occurrence of inappropriate drop-offs of intoxicated individuals for mental health assessments.

We receive reports from members detailing instances where behaviourally disturbed intoxicated individuals are brought to emergency departments or mental health units by police for assessment, despite the inability to assess them until they sober up. This results in aggressive individuals being left in hospital settings while they await sobriety, rather than in a police setting. The Association acknowledges the competing demands on police resources and acknowledge the potential for health issues to be overlooked in a police environment. There is a need for settings that are better equipped to manage acute behavioural disturbances associated with drug or alcohol intoxication with appropriately qualified staff in sufficient numbers to manage episodes of violence and aggression.

If intoxicated individuals must be managed in a hospital setting, it is imperative that it be a secure environment with appropriately trained staff and safe staffing levels to mitigate risks. Despite there being at least four NSW Parliamentary inquiries since 2013 related to alcohol and other drugs (AOD) use and treatment in NSW, this has not resulted in the needed change to prevention, treatment, and management of AOD that will make a tangible difference to rural clinicians. The reported prevalence of workplace violence and aggression experienced by nursing staff in NSW is anywhere between

50% and 98% depending on context of practise.[9][10] The Australian Institute of Health and Welfare[11] data shows that people accessing treatment for (AOD) in NSW predominantly utilised counselling services (41%) which would lend itself well to telehealth. This, however, is only a small part of what is needed in rural communities. The remaining 59% of people accessing care and treatment for AOD require appropriate services on the ground, inclusive of the approximately 10% requiring acute intervention usually accessed initially via an emergency department.[12]

The Alcohol and Drug Foundation identify that primary care and preventative measures (Awareness raising, early intervention, supporting better practise and consulting with communities for tailored interventions relevant to local need) will be better placed to reduce AOD misuse.[13] This requires trained clinicians who are provided with genuine and ongoing education and professional development in addiction medicine to recognise and refer members of the community for early intervention and treatment. Staff working in rural health facilities need education, support and adequate numbers of staff for safe working conditions and optimal care. This must be guided by identified local need in consultation with clinicians to ensure the safe management of people presenting with acute presentations related to AOD use.

The NSWNMA appreciates the NSW Ministry of Health openly acknowledging the critical workforce shortages that are impacting on attraction, recruitment, and retention of qualified AOD workers in the AOG workforce census.[14] This census identified a 14% nursing vacancy rate in AOD across NSW. In regional public AOD services, registered nurses and nurse practitioners were identified as being two of the top three roles with the longest recruitment time to fill. As the workforce census acknowledges, 'Nurse practitioners are an integral, yet underrepresented position within the sector. It is appreciated that since the "Special commission of inquiry into the drug 'Ice'" that investment has been made into workforce education (amongst other initiatives) in the AOD sector. For nurses, however, this only extends to 31 targeted scholarships that will enable them to achieve a graduate certificate in AOD. We believe the capabilities of nurses could be better built upon and supported through greater targeted funding. Registered nurses working in AOD that receive support (E.g. study leave, mentorship and scholarships) to undertake a Master degree to become nurse practitioners would help to alleviate service gaps in rural areas. This would also be applicable to mental health, allowing nurses to build valuable careers that would aid in retention of skilled clinicians in RRR areas.

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[9] Cabilan, C. J., Johnston, A. N. B., & Eley, R. (2020). Engaging with nurses to develop an occupational violence risk assessment tool for use in emergency departments: A participatory action research inquiry. International Emergency Nursing, 52, 100856.

[10] Pich, J., Oldmeadow, C., & Clapham, M. (2019). Violence in nursing and midwifery in NSW: Study report. Retrieved from NSW Nurses & Midwives' Association website: https://www.nswnma.asn.au/wp-content/uploads/2019/02/Violence-in-Nursingand-Midwifery-in-NSW.pdf

[11] Australian Institute of Health and Welfare 2023 Alcohol and other drug treatment services in Australia annual report https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-australia/contents/state-and-territory-summaries/new-south-wales

[12] Ibid.

[13] Alcohol and Drug Foundation 2016. Is there a pill for that? The increasing harms from opioid and benzodiazepine medication https://cdn.adf.org.au/media/documents/ADF-Prevention-Research-September-2017.pdf

[14] NSW Health 2022. NSW Alcohol and Other Drugs Workforce Census Report https://www.health.nsw.gov.au/aod/resources/Publications/aod-workforce-census-report.pdf

The NSWNMA will continue to advocate for improved rights of our members to access education and professional development, and we look forward to being consulted on the Ministry of Health's 'NSW Alcohol and Other Drugs Workforce Strategy' to attract, retain, and increase the capability of AOD nurses.

e) Aged care and palliative care (including Recommendations 18, 23 and 24)

The NSWNMA provided information regarding recommendation 18 in the previous submission. Our position remains unchanged that there is a necessity to have trained nurses with specific advanced skills and education around aged care and the needs of older people.

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 to this recommendation provided by the previous government is completely inadequate and not in line with the intent of 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 admissions, 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.[15]

[15] Australian Institute of Health and Welfare. (2013). Dementia care in hospitals: Costs and strategies. Canberra: AIHW.