Submission No 58

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: Australian College of Midwives ACM

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Australian College of Midwives

ACM: For midwives. With women. For the future.

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

ACM Submission

Issued April 2024

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

The Australian College of Midwives

The Australian College of Midwives (ACM) is the peak professional body for midwives in Australia; and welcomes the opportunity to provide a written submission to **'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' (the Recommendations)** inquiry**.** ACM represents the professional interests of midwives, supports the midwifery profession to enable midwives to work to full scope of practice (SoP), and is focused on ensuring better health outcomes for women, babies, and their families. Midwives are primary maternity care providers working directly with women and families, in public and private health care settings across all geographical regions. There are 33,594 midwives in Australia and 1,195 endorsed midwives[1]. ACM is committed to leadership and growth of the midwifery profession, through strengthening midwifery leadership and enhancing professional opportunities for midwives.

Terms of Reference

This submission will address the Select Committee on Remote, Rural and Regional Health terms of reference of the inquiry into the progress of issues relating to the implementation of Portfolio No. 2 recommendations relating to health outcomes and access to health and hospital services. Specifically, we will address:

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, and 26).

Background

Midwives are the most appropriate health professionals to provide primary maternity care to women and newborns throughout pregnancy, labour and birth, and postnatally[2]. Women living in remote, rural and regional NSW should not be disadvantaged when compared with their metropolitan counterparts, or when compared with women living in other states in Australia. Prioritising appropriate remuneration, professional development, and support for midwives living in these communities by enacting the recommendations will impact significantly on the wellbeing of women and families.

This submission was prepared with consultation with the University sector and Local Health Districts (LHDs).

ACM survey

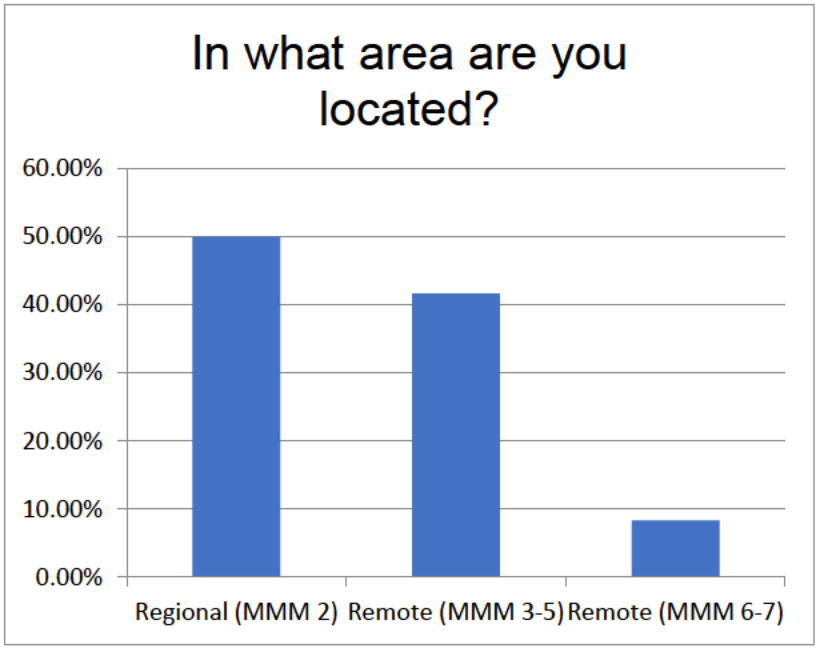
The ACM conducted a survey of midwives working in rural, regional and remote NSW to inform this submission. 25 midwives responded. There are 8775 midwives in NSW[1]. Statistics and quotes will be included throughout. Demographics of respondents are provided below:

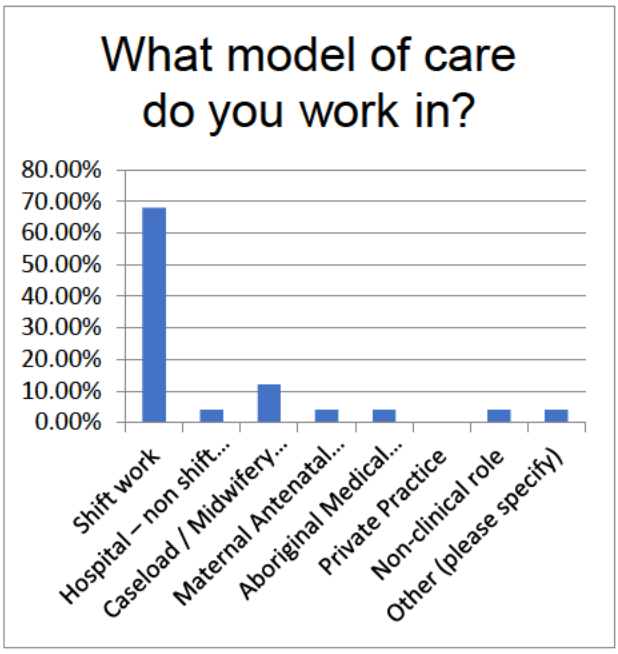
Consent to publish

ACM consents to this submission being published in its entirety, including names.

Consent to provide further information

ACM is available to provide further expert opinion and advice if required.





The priority opportunities for ACM include;

1. Benchmark remuneration for NSW midwives against other states
2. Reconsider remuneration for midwives working in Midwifery Continuity of Care (MCoC) models in light of level of responsibility, and impact of on-call work, and increase to match or exceed other states
3. Introduce adjustments to MCoC award for midwives working in remote, rural and regional areas that consider travel distances and reduced back-up and referral options
4. Work with Universities and health services to increase placement opportunities for midwifery students in remote, rural and regional settings and provide free accommodation and travel for midwifery students attending these placements
5. Ensure that midwives are included in all incentive programs relevant to rural and remote locations
6. Introduce ongoing financial and career incentives to support retention of existing midwives in remote, rural and regional locations
7. Offer career enhancement incentives (with appropriate professional development) to attract and retain midwives to work in rural and remote locations
8. Ensure all incentives offered include part-time employees
9. Re-open rural and remote birthing services and establish new services in under-serviced areas, prioritising MCoC models of care
10. Fund and prioritise the upscale and roll out of Birthing on Country models of care
11. Expand funding for Graduate Diploma Midwifery positions to include adequate backfilling and education
12. Implement introduction of short-term health service housing options to support the transition of new staff to permanent housing, and provide other supports such as childcare

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

For midwives working shift work, there are no formalised on-call arrangements for midwives to support their birthing units in many health services in remote, rural and regional NSW. Call back is usually through a gesture of good will amongst the midwifery staff. Health service executives are frequently not prepared to pay the on-call rate (currently $4.20 - $8.30 per hour). Overtime and call back from planned days off or leave has become standard practice in many health services.

'When required to be on-call, the flat rate is nominal, and you are only considered on-call from the time you are called. On-call shifts are frequently changed by management to normal shifts to avoid paying the increased call-out charge.'

Remuneration for midwives working in MCoC is not in line with other states in Australia. The NSW Pilot Model Annualised Salary Agreement for Midwifery Group Practices allows for midwives to be paid a 29% loading, which is intended to account for shift rates, overtime, on-call etc. By contrast, midwives working in MGP / caseload are paid a higher loading in other states. For example:

- NT midwives are paid a 31.7% loading
- QLD midwives are paid a 35% loading
- SA midwives are paid a 35% loading
- Tasmanian midwives are paid a 35% loading
- ACT MGP midwives are paid a 40% loading

'The pilot agreement is a joke. 29% is not representative of the number of hours spent on-call, and the geographical boundaries we need to maintain in a rural area. If I'm on call I can't go grocery shopping, or book an appointment, or leave town. In the city the calls are shorter with reliable relief. Here it's us or nothing. 29% does not reflect the workload. Our level of skill and autonomy deserves CMS status and more than 29%.'

ACM survey

Midwives working in shift work models describe inadequate and underpaid on-call arrangements that are often changed to suit management rather than midwives.

'If we are on-call, we are still expected to work a shift the next day even if we've been called in, because there is no-one to replace us with to staff the shift.'

'The on-call remuneration is so small it's not worth putting yourself on-call and getting a sleepless night waiting for the phone to ring.'

'The on-call pay rate is only $4 an hour! Often, we are rostered on-call just before days off, which ruins our time off.'

Midwives working in Midwifery Group Practice commented on the remuneration and the loading which is intended to cover working in an on-call model of care.

'The remuneration for MGP midwives is in line with the award, however it is unfair in comparison with other professions' remuneration when on-call.'

'The level of expertise in care provided is not remunerated. As a midwife with 25 years' experience, I feel that my base rate of pay and loading is pathetic.'

'I left working in midwifery group practice because the pay is so poor. It doesn't cover the on-call adequately, and I earn much more in a different role.'

Inequity in remuneration between states was mentioned by multiple midwives.

'Midwives in regional, rural and remote NSW need to be paid better. I can work over the border for a higher salary.'

'Remuneration is in line with state award, however it's not in line with other states.'

Dissatisfaction with pay and conditions has a high potential to drive midwives out of the workforce[3], and away from working in MGP and in remote, rural and regional NSW. This is also a significant concern in terms of attracting midwives to work in these understaffed areas.

Priority opportunities

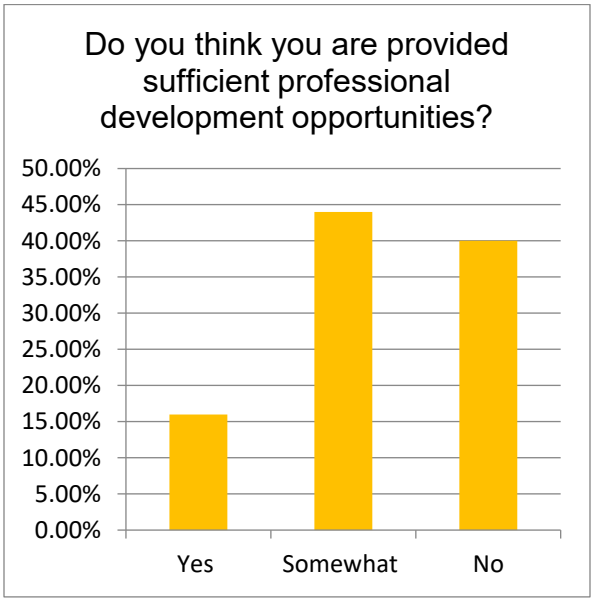
- Benchmark remuneration for NSW midwives against other states
- Reconsider remuneration for midwives working in MCoC models in light of level of responsibility, and impact of on-call work, and increase to match or exceed other states
- Introduce adjustments to MCoC award for midwives working in remote, rural and regional areas that consider travel distances and reduced back-up and referral options

That the rural and regional Local Health Districts increase and formalise professional development opportunities for nurses and midwives, ensuring that rostering accounts for this.

Widespread implementation of this goal has not been achieved, especially in remote, rural and regional settings. In addition, travel and accommodation costs to attend professional development courses are borne by the midwife, and in some areas, travel can be costly and time-consuming.

ACM survey

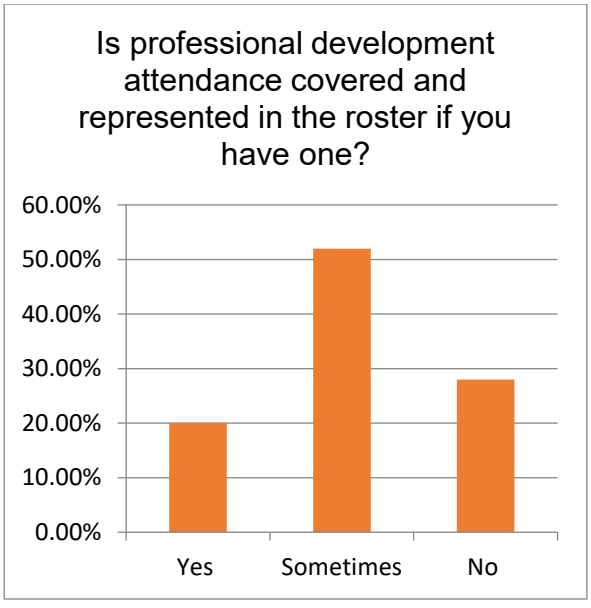
The ACM survey canvassing the lived experience of midwives working in rural remote and regional NSW demonstrated a lack of opportunities and inconsistent allowance in rostering. While professional development is often remunerated, travel and accommodation is not, and given the distances often necessary to attend trainings, this results in inequitable opportunities, financial and time burden when compared with metropolitan midwives. Multiple respondents also commented that they are not able to attend professional development opportunities due to staffing shortages and acuity. Many midwives undertake professional development in their own time and at their own expense.

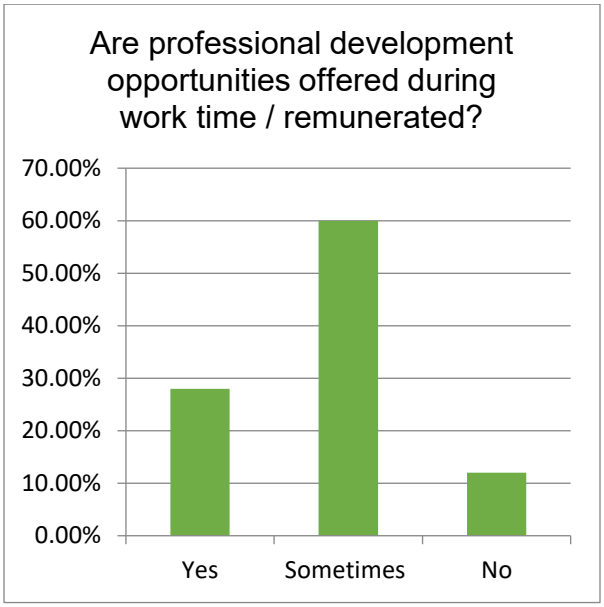


'Never! I can't afford to pay the course fees let alone get approved for unpaid time off work plus the travel and accommodation. It's simply not accessible or equitable.'

'There are no professional development opportunities offered by my employer. Midwives are not encouraged to work to scope of practice.'

'I have to travel to get to professional development opportunities, so while I get study leave there is often accommodation and travel costs I have to fund myself. Sometimes I have to travel 200+km, and there is not sufficient time allowed for safe travel.'





'There is no actual budget for education. My unit manager made me pay for breastfeeding training myself. There are limited job opportunities here and we constantly just plug gaps in staffing, so there is no capacity for us to have extra development time.'

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

There remains significant shortage of midwifery professional experience placements for midwifery students in rural and regional areas. This is impacting on the ability of Universities to increase their student numbers to the accredited programs. In addition, student access to accommodation in rural settings has an impact on their ability to complete midwifery professional experience placements, resulting in low uptake of any positions available.

'If you want to attract midwives to work in underserviced areas, provide appropriate private accommodation free of charge to midwifery students accepting placement in rural and remote hospitals.'

The WNSWLHD Level 3 maternity units have supernumerary base rate funding of $85,000 to facilitate 'home grown' Registered Nurses to study the Graduate Diploma of Midwifery. This funding does not adequately allow a back filling of the position, as it does not allow for shift or weekend work. Increased Government funding for Graduate Diploma Midwifery positions is gratefully received, however there is a significant gap around clinical support and no funding for this support for the extra students attending clinical placement. A clinical midwife consultant who provided input to this submission states that some

training services have only 0.2FTE dedicated to a Clinical Midwifery Educator position, which barely meets the requirements of accreditation as a training hospital. ACM would encourage an evaluation of the Graduate Diploma Midwifery funding model, taking into account the importance of funding, support and education for both single-qualification and post-graduate midwives.

Priority opportunities

- Work with Universities and health services to increase placement opportunities for midwifery students in remote, rural and regional settings and provide free accommodation and travel for midwifery students attending these placements
- Expand funding for Graduate Diploma Midwifery positions to include adequate backfilling and education

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

The GradStart program offers a Metro-Rural Exchange Program, providing exposure for new graduates to rural midwifery opportunities. However in some instances these relationships have existed but have broken down. For example, between 2015-2019 there was a Metro-Rural Exchange in place between WNSWLHD and a metropolitan hospital. However, this program folded when there was no graduate midwife provided by the metropolitan hospital to the rural facility over two consecutive years, which left a gap in the rural roster when the rural midwife took the planned place at the metropolitan hospital.

That NSW Health, as part of its review of the nursing and midwifery workforce implement professional, financial and career enhancement incentives for nurses and midwives who work in rural and remote locations

Grants and incentive schemes

The Rural Health Workforce Incentive Scheme offers financial incentives and non-financial support to health professionals taking up new positions in remote, rural and regional locations. However, this program does not provide any incentive for existing staff to remain in these communities.

‘There needs to be respect for senior and experienced staff. We have been here for years and are not on incentive payments. We are loyal and are expected to carry the load and work extra but no-one cares! There needs to be an incentive for staying.’

Government incentive schemes which aim to attract healthcare workers to rural and remote locations are overwhelmingly focussed on medical professionals, and often exclude midwives. For instance, the HELP for Rural Doctors and Nurse Practitioners Program does not include Endorsed Midwives. Likewise, the Workforce Incentive Program is largely directed at doctors. The recent inclusion of midwives into the Workforce Incentive Program requires promotion to encourage more GP practices to employ midwives, and expansion is required for private midwifery practices to receive the same incentives. Recommendations in the Strengthening Medicare Taskforce Report include increased investment in the

Workforce Incentive Program to improve multidisciplinary teamwork and empower all health professionals to work to their full scope of practice. Expansion to include private midwifery practices and increase inclusion of midwives in general practices would work towards this goal.

While small grants are available for midwives relocating to rural areas, more extensive support programs such as the Remote Area Nursing Pathway and Rural Nursing Scholarships are available to nurses but not midwives. Australia's Long Term National Health Plan specifies the goal of 3,000 new doctors and 3,000 new nurses in rural and remote areas, but midwives are not mentioned in the document. National plans, funding and incentive models should prioritise midwives as the most appropriate health professionals to provide maternity care for well women.

An important consideration when introducing incentives for health professionals to relocate to rural and remote locations is not to overlook those clinicians already living and working regionally. Therefore, an additional consideration is to incentivise midwives who already live in rural and remote locations to remain there, to encourage workforce stability. This must include education and upskilling opportunities.

Accommodation

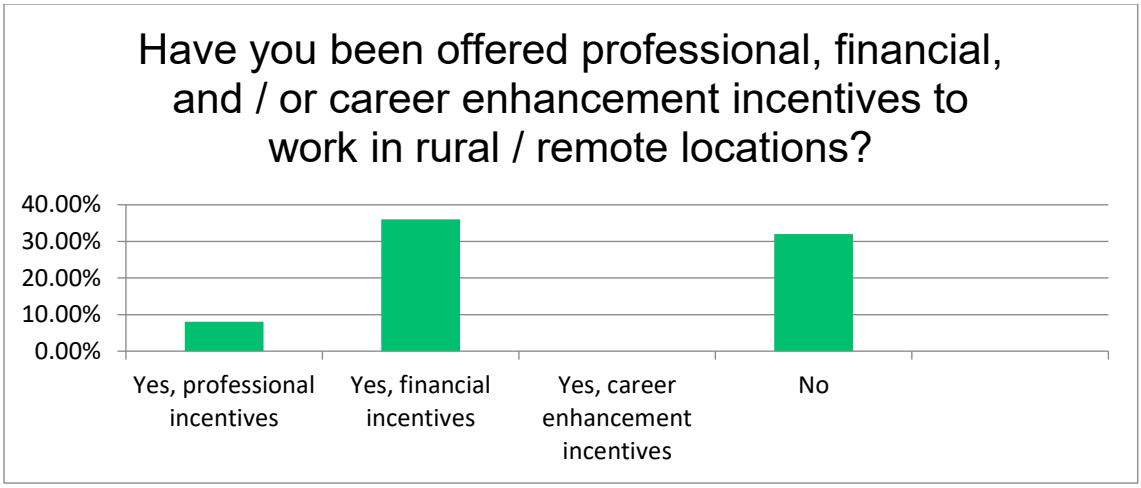
In order to attract and retain midwives in remote, rural and regional areas, support needs to be available to facilitate relocation. It is noted that the NSW Government Welcome Experience aims to smooth this transition, however accommodation is still in extremely short supply, especially short term accommodation. Previously, short term health service accommodation allowed new staff time to find appropriate private accommodation, and the removal of this service has impacted on recruitment of new staff.

ACM survey

Respondents to the ACM survey describe limited incentives provided, and an overall frustration with the current system. Midwives working part-time commented that they do not qualify for incentives, despite frequently working above contracted hours. Many midwives work part-time[4], so targeting incentives only to full-time workers does not capitalise on a significant proportion of the potential workforce.

Significantly, no midwives reported being offered career enhancement incentives to work in rural and remote locations. This is a missed opportunity. Midwives working in remote, rural and regional communities are often in positions of increased responsibility and autonomy, with limited support. With appropriate professional development opportunities, career enhancement incentives could be an excellent way to attract midwives to work in underserved communities.

'We're a decent sized hospital, yet we can't recruit. The incentives have yet to work. We sit currently with only 40% of our FTE filled. You can throw money at it but it doesn't stop the fatigue, emotional wear and tear and compassion fatigue.'



'The incentives are an empty gesture. Fix our models of care so we have more autonomy in our practice and rely less on these ridiculously outdated GP obstetric models. Support us to provide safe, women centred care to our communities and you'll find midwives will stop leaving!'

Priority opportunities

- Ensure that midwives are included in all incentive programs relevant to rural and remote locations
- Introduce ongoing financial and career incentives to support retention of existing midwives in remote, rural and regional locations
- Implement introduction of short-term health service housing options to support the transition of new staff to permanent housing, and provide other supports such as childcare
- Offer career enhancement incentives (with appropriate professional development) to attract and retain midwives to work in rural and remote locations
- Ensure all incentives offered include part-time employees

Recommendation 26

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

Midwifery Continuity of Care (MCoC) is a maternity care model where women see the same midwife or small team of midwives throughout their perinatal experience. Midwifery Continuity of Care is known to be the gold standard of maternity care[5]. Women and babies experience reduced interventions and better outcomes, both physically and psychosocially[6,7,8]. MCoC improves satisfaction with the birthing experience and can reduce birth trauma[9]. Midwives are also more satisfied working in MCoC models[10], with lower levels of burnout and psychological distress[11]. In addition, MCoC costs the healthcare system 22% less than other models of care[12]. Midwives provide MCoC in publicly funded models and in private practice. In remote areas where there is genuinely not a safe referral pathway for women experiencing intrapartum complications, an adapted MCoC model which excludes intrapartum care is an option which provides effective primary maternity care during the antenatal and postnatal period. This model of care, known as Maternal and Postnatal Service (MAPS), has demonstrated positive outcomes, is well received

by women[5]. It is the ACMs position that the majority of women in Australia should be cared for in a full MCoC model, and that all women for whom this service is not available should be offered care in a MAPS model. The ACM cautions against health services assuming MAPS is an acceptable replacement for full MCoC and defaulting to MAPS models of care due to assumptions about midwives' preferences or challenges setting up MCoC models.

Widespread implementation of midwifery continuity of care models has not been achieved in Australia, particularly in rural and regional areas. As of October 2023, only 22.1% of women in NSW had continuity of care throughout their perinatal period[13]. This includes care by either midwives or obstetricians[13]. This demonstrates that Recommendation 26 has not been enacted. In addition, 23.6% of women had continuity with either a midwife or obstetrician through their antenatal and postnatal periods only[13]. This is presumed to include women cared for in a Maternal Antenatal Postnatal Service (MAPS).

Midwifery Continuity of Care services, where available, are oversubscribed, demonstrating consumer need to increase this service. For instance, Lachlan Health Service (WNSWLHD) reinstated an MPG program in 2023, and implemented a MAPS program in 2020. All positions in both services are filled, and both are oversubscribed and under-resourced to meet the needs of the communities they service.

Barriers to roll out of Midwifery Continuity of Care

There are multiple barriers to increasing the availability of MCoC, some of which are outlined below:

Health system barriers

- MCoC is not mandated or required as part of health service re-accreditation[7]
- MCoC implementation targets are not routinely prioritised in LHD and State Government strategic maternity plans. As an exception, ACT's Maternity in Focus: The Public Maternity System Plan 2022-2032 commits to increasing MCoC to 50% by 2028, and there is a motion to increase this target to 75%. The ACM encourages NSW to join the ACT in leading the way in prioritising gold standard maternity care
- Funding models currently support fragmented maternity care[14]
- General Practitioners have limited understanding of midwifery models of maternity care[15], so are less likely to refer to MCoC models
- Public-facing communication about the role of the midwife often does not explain the full scope of practice of midwives. Most public-facing information indicates that women should go to their General Practitioner first for antenatal information. Health Literacy for women needs to include information about MCoC and the improved outcomes.

Endorsement to prescribe medications

- Endorsed Midwives are midwives who have met the requirements of the Nursing and Midwifery Board of Australia to qualify to prescribe scheduled medicines. This means that they can provide Private Practice Midwifery services which meet all the perinatal needs of a well woman and baby. As an independent practitioner, they can relieve the maternity care burden for GPs and GP Obstetricians working in rural and remote locations
- There are low but increasing numbers of Endorsed Midwives in Australia (see below):

	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	**Total**
As at 30 December 2023	22	177	21	372	94	19	186	214	90	**1195**

Figure 1 – Midwives with scheduled medicines endorsement[1]

- Endorsed Midwives working in public healthcare often cannot exercise their prescribing authority, which restricts medication access for women[15] and leads to workarounds such as blank pre-signed pathology forms[17].

Medicare rebates

- Medicare rebates are not sufficient to cover the cost of a midwife in private practice, especially in remote areas where the midwife may need to travel long distances for an appointment. This leads to the need to charge a gap fee, reducing the availability of affordable maternity care options for women[17].
- Planned birth at home is safe for mothers and babies[18,19]. In rural and remote locations, planned home birth may be a safer option than travelling large distances while in labour or relocating prior to birth. Intrapartum care, which is the most expensive component of perinatal care, is not rebated by Medicare when attended at home by a Privately Practicing Midwife. There is also the requirement for a second midwife at the birth, and the cost for this is passed onto the woman[17].

Insurance

- There is currently only one Professional Indemnity Insurance product available to Privately Practicing Midwives, and this product is only available for Endorsed Midwives, and does not cover intrapartum care outside of hospital or private midwifery practices. This is a significant barrier to midwives working to their full scope of practice to provide primary maternity care in all settings in Australia, and needs to be urgently addressed.

Digital health capability

- Midwives need to be educated on their access rights to MyHealthRecord and usability function. In addition, software is unavailable, and this is a barrier for midwives in terms of cost. Furthermore, midwives require other digital interoperability to ensure safer and more effective handover of care and collaboration when necessary. This needs to include education for midwives, especially midwives in private practice, on use of digital health tools.

Hospital admitting rights

- Most hospitals in Australia do not allow visiting rights for Medicare Eligible Endorsed Privately Practicing Midwives, despite clinical outcomes for women cared for by PPMs with visiting rights being more positive than national statistics[20].
- NSW has low numbers of midwives with admitting rights to hospital. The table below presents statistics on the number of Medicare item 82120 claims. Item 82120 is management of labour and birth in hospital by an endorsed midwife in an MCoC relationship with the woman.

	State								Total
	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	
	Services	Services	Services	Services	Services	Services	Services	Services	Services
Item									
82120	201	457	4,309	20	165	1	4	3	5,160

Figure 2 – Medicare item 82120 processed from July 2010 to June 2023

Enablers to roll out of Midwifery Continuity of Care

It is noted that NSW Health has developed Continuity of Care Models - A Midwifery Toolkit (nsw.gov.au) to assist health services to implement continuity of care models. Recent research demonstrates implementation of midwifery continuity of care in regional and rural areas needs a coordinated ground up approach in which midwives partner with women and promote widespread dissemination of evidence for this model, directed towards consumers, midwives, and hospital management to increase awareness of the benefits[21].

One of the barriers to widespread implementation includes a lack of midwifery staff. Research has demonstrated that new graduate midwives are prepared and well supported to transition to work in midwifery continuity of care models and this addresses the barrier to implementation of staffing the models[22]. An evidence-informed framework has guided the development of workshops to support midwifery students to be employed in MCoC models at the time of graduation and assist with implementation[23]. To date these workshops have been implemented in the Hunter New England and Central Coast Local Health Districts.

Rural and remote birthing services

Birthing services in remote areas have seen progressive closure over a number of years, with 138 rural maternity units closed across Australia between 1995 and 2005[24]. Closure of local birthing services increases cost and risk for women and babies, including financial, emotional and safety risks[25]. Rural and remote women frequently need to drive up to four hours to access their nearest maternity service, and to relocate for a month or longer while awaiting birth[26]. Inaccessibility of perinatal care leads to women avoiding seeking healthcare until concerns are urgent, and travel distances result in roadside births[25], unintended home births, and births attended by ambulance officers or inadequately trained nurses or doctors. The financial burden to families of a lack of local maternity care services includes accommodation, travel, and childcare costs, and current subsidy schemes are insufficient and not well known [25]. There is also a significant social, cultural, and emotional burden for women and families when services are not located in their community, a burden which is overlooked when only clinical outcomes are considered [26].

Closures have been based on concerns about distance to the nearest facility with the capacity to perform an emergency caesarean section, however these concerns do not take into account the volume of high-level evidence for the safety of midwifery models of care for low-risk women [25]. Outcomes for women being cared for in small centres are as good as or better than for women in larger hospitals[24].

Small maternity facilities are often closed when workforce pressures change, or availability of medical professionals fluctuate. An alternative to closure of these essential services is to accommodate the option for facilities to flex between level 2 and 3 birthing services (supporting more or less complexity and intervention) depending on relevant factors.

Priority opportunities

- Re-open rural and remote birthing services and establish new services in under-serviced areas, prioritising MCoC models of care

First Nations Populations: Birthing on Country

For Indigenous women and babies, intrapartum care in their community is culturally important. Deep spiritual connection to their homeland is a part of their heritage, and ensuring their babies spiritual connection to the land by Birthing on Country is deeply significant[27]. In addition, Indigenous women often

experience racism from health professionals, and travel to distant urban hospitals does not allow for inclusion of family support [27].

Indigenous babies are twice as likely to be born preterm as non-Indigenous babies, which leads to increased morbidity and mortality rates[28] and Indigenous mothers are 2-3 times more likely to die in childbirth[29]. In the Birthing in Our Community model, designed by Mater Hospital, women are cared for by a midwife in a continuity of care relationship alongside a First Nations Family Support Worker. Care in this model has shown a 5.34% to 14.3% reduction in preterm births, along with a saving to the health care system of $4810 per mother-baby pair (in a 2023 study) [28].

Birthing on Country models are being implemented around Australia, but face barriers. These include legislative[29], as well as issues already outlined in relation to MCoC such as inadequate MBS items and lack of Professional Indemnity Insurance policies for out-of-hospital births[30]. Other challenges include requirements for medical practitioner presence to licence a Level 2 private maternity facility, inflexible and expensive unsubsidised insurance policies for hospital birth, and funding [30]. The RISE framework has been proposed and tested as a model to support widespread implementation of Birthing on Country models[31].

Priority opportunities

- Fund and prioritise the upscale and roll out of Birthing on Country models of care

Conclusion

Advancement towards implementation of the Recommendations is slow. Feedback from the University sector, Local Health Districts, and midwives working in remote, rural and regional communities reflects limited progress in the areas discussed above. The ACM urges that more decisive actions be taken to facilitate the implementation of the Recommendations, and improve conditions for midwives, women and families living in remote, rural and regional NSW, and seeks to increase and prioritise ongoing stakeholder engagement with NSW Health, Government and LHD's.

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