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Foreword

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

The NSWNMA has approximately 77,000 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

The 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 Special Commission of Inquiry into Healthcare Funding.

This response is authorised by the elected officers of the NSWNMA.

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Glossary

ACSQHC	Australian Commission on Safety and Quality in Health Care
ACT	Australian Capital Territory
APA	Agency Performance Adjustment
CAHA	Climate and Health Alliance
CCARG	Climate Change Activist Reference Group
CEC	Clinical Excellence Commission
CME	Clinical Midwifery Educator
CNE	Clinical Nurse Educator
Depot	Slow-release injectable anti-psychotic medication
ED	Emergency Department
EN	Enrolled Nurse
FLECC	First Line Emergency Care Course
HCSA	Health care and social assistance
HETI	Health Education and Training Institute
HNELHD	Hunter New England Local Health District
HSR	Health and Safety Representatives
ICU	Intensive Care Unit
LHD	Local Health District
LTIs	Lost-time injuries
MDT	Multidisciplinary team
MGP	Midwifery Group Practice
MHICU	Mental Health Intensive Care Unit
MoH	Ministry of Health
NBH	Northern Beaches Hospital
NDEC	Nurse Delegated Emergency Care

NMBA	Nursing and Midwifery Board of Australia
NP	Nurse Practitioner
NSWNMA	New South Wales Nurses and Midwives' Association
NUM	Nursing Unit Manager
NZ	New Zealand
PCBU	Person Conducting a Business or Undertaking (see Division 3 of the *Work Health Safety Act 2011* (NSW))
PHS Award	Public Health System Nurses' and Midwives' (State) Award 2023
PICU	Psychiatric Intensive Care Unit
PIN	Provisional Improvement Notices
PPP	Public Private Partnership
QLD	Queensland
RATs	Rapid Antigen Tests
RHWIS	Rural Health Workforce Incentive Scheme
RN	Registered Nurse
RRR	Rural, regional and remote
RUSOM	Registered Undergraduate Student of Midwifery
RUSON	Registered Undergraduate Student of Nursing
SHHV	Sustained Health Home Visiting
SIAT	Security Improvement Audit Tool
SNF	Sustaining NSW Families
SRMNAH	Sexual, Reproductive, Maternal, Newborn and Adolescent Health
UHCW	Unregulated Health Care Worker
UHHV	Universal Health Home Visiting
UK	United Kingdom
VET	Vocational Education and Training
VIC	Victoria

VPM	Violence Prevention and Management
WA	Western Australia
WHS	Work Health and Safety
WiC	Walk in Clinic

Introduction

The NSWNMA actively pursues our members' rights and supports member empowerment to influence decision makers for a fair and just society. A fair and just society is one in which all levels of government genuinely value, and invest in, public health services for the benefit of all.

Nurses and midwives exercise their right to a voice on professional and industrial issues through the NSWNMA, and we are committed to ensuring that those voices are heard loudly and clearly at every table where decisions about public health services are made.

Nurses share with society the responsibility for initiating and supporting action to meet the health and social needs of all people and nurses advocate for equity and social justice in resource allocation, access to health care and other social and economic services.[1] Midwives, together with women, work with policy and funding agencies to define women's needs for health services and to ensure that resources are fairly allocated considering priorities and availability.[2]

The NSWNMA is required to influence employers to promote healthy and safe workplaces for nurses, midwives and other healthcare workers as well as provide guidelines that assure a safe environment and healthy communities. The NSWNMA is also required to lobby for working environments that promote healthy lifestyle standards for nurses, as well as influence, pressure and negotiate for fair and decent working conditions.[3]

The safety of those who receive care and services is a responsibility shared by individual nurses and the leaders of health systems and organisations. This involves assessing risks and developing, implementing, and resourcing plans to mitigate these.[4]

From the collective strength and wisdom of our members, the NSWNMA advocates at every opportunity for improvements to the delivery of health services. This advocacy is not for individual gains, but for the collective achievement of a stable, secure and sustainable public health service which provides safe and high-quality care to all.

[1] International Council of Nurses. (2021) *The ICN code of ethics for nurses*
[2] International Confederation of Midwives. (2014) *International Code of Ethics for Midwives*
[3] International Council of Nurses. (2021) *The ICN code of ethics for nurses*
[4] Ibid.

A: The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future

The NSWNMA represents over 50,000 nurses and midwives working in the public sector in NSW. Nurses and midwives are not only the backbone of the public health service; they are the eyes, the ears and the heart. They have an acute awareness of issues that impact service delivery, a deep understanding of systems of work that facilitate the provision of care; and an enduring, but often exploited, empathy for their communities that drives their dedication daily.

Nurses and midwives have long known that widespread implementation of a transparent, safe minimum staffing ratio is the key to the most effective and efficient use of funds to ensure safe, high-quality, timely, equitable and accessible patient/woman centred care. Ratios not only allow the provision of safe care, but they also create safe and supportive working environments that facilitate the long-term development of a sustainable nursing and midwifery workforce.

Nurses and midwives represent over 40% of the public health workforce in NSW and have been united in their calls for nurse-to-patient ratios, improvements to Birthrate Plus (maternity staffing system), and a fair professional wage. They have demonstrated through their actions and their advocacy that they will not be ignored.

Ratios advocacy

After 10 years of successive NSW Coalition governments working feverishly to supress the wages and reduce the working conditions of nurses and midwives, 2022 saw the first strike action for public sector nurses and midwives in almost a decade. Tens of thousands of nurses and midwives made the very difficult decision to walk off the job on four occasions that year in their fight to secure the ability to deliver safe care through the implementation of shift-by-shift ratios.

Those actions led to nurses and midwives securing a commitment from then Opposition Leader, Chris Minns in September 2022 to implement an enforceable shift-by-shift minimum staffing level if Labor won the 2023 state election.

March 2023 saw the commencement of the new Labor government; however safe staffing mechanisms are yet to be implemented. The NSWNMA is working with the Health Minister and the Ministry of Health ('MoH') on the implementation of a new staffing system, but there is still much work to do. The commitment of the current government is just the start; nurses and midwives will not stop advocating until ratios are implemented in every hospital, community health setting, and multi-purpose service in NSW.

End the persistent underinvestment in health services

Healthcare spending on labour costs has historically been framed by governments and the media as a necessary burden and a hit to the budget bottom line. Large figures are highlighted to make those who

manage a household budget sympathise with tough calls, or to justify cuts that 'need' to be made. This rhetoric has permeated society's collective (mis)understanding of government budgets and spending, despite having no basis in economic theory.

The funding of healthcare labour should not be seen as inherently bad or burdensome. Properly funding health services provides a golden opportunity for the government to invest in communities, people and relationships, which is at the core of their function. The proper funding of healthcare labour costs is the single most important *investment* that our government can make in, and for, the people of NSW.

The provision of any health service should not be reduced to achieving the lowest possible price for providing it. The ultimate test for health services is about their adequacy, their timeliness and their quality. It is a false economy to provide a low-quality service and deal with the consequences for the patient when they need to be readmitted or have complications arising from such care.

Successive governments in NSW have been quick to publicise expenditure on health infrastructure for the political goodwill that it brings within the electorate.

Over the last 15 years, governments have proudly announced new hospitals, hospital redevelopments, creation and/or increased funding of specialised services, and expansions of bed capacity. There has been little to no consideration or communication of how such facilities or services will be adequately staffed.

It is an affront to all frontline health workers when governments announce an increase in beds or other expenditure when Local Health Districts ('LHDs') and specialty networks are not adequately staffing their facilities.

There is little point in having brand-new health facilities with additional beds if patients do not receive the quality care they need, due to chronic underinvestment in nurses and midwives.

The cost-saving rhetoric that pervades every level of NSW Health management is that labour costs should be kept as low as possible. This is never more evident than when governments and LHDs/specialty networks spend taxpayer dollars to fight unions and their own employees over the provision of adequate remuneration and safe staffing levels.

Too often the skills, knowledge and experience of nurses and midwives goes unacknowledged. According to Department of Health and Aged Care 2022 workforce data (the most recent available), there is in excess of 30,700 nurses and midwives with a general registration in Australia who are currently not in the labour force.[5] The data also shows a further 11,300 nurses and midwives are looking for work Australia wide. Our members frequently feedback that a contributing factor to leaving the professions is poor working conditions and pay.

The former Coalition government introduced a Wages Policy that inhibited their power to genuinely bargain for improvements to their wages and conditions, whilst cost of living pressures rose. The repeated requests of nurses and midwives for a guaranteed minimum number of staff on each shift to be able to provide safe and quality care have been ignored, and LHDs have routinely and flagrantly breached their *Public Health System Nurses' and Midwives' (state) Award* ('PHS Award') obligations by failing to staff facilities safely to the tune of $1 billion.[6]

[5] Department of Health and Aged Care, 2022 workforce data

[6] NSW Nurses and Midwives' Association. (2023) Media Release - Prosecution case launched over broken health system

The NSW government spends less on health per capita than any other state or territory in Australia[7] and NSW has the lowest number of nurses and midwives per capita than any other state or territory in Australia, with only 1,168 full-time equivalent ('FTE') nurses and midwives per 100,000 people.[8]

The majority of nurse and midwives working in the public sector are beyond stretched. This is evident in not taking breaks, caring for more patients than is safe, working dangerous amounts of overtime, as well as exposure to other many and varied psychosocial hazards that exist in health services. When care is provided by nurses and midwives who are overstretched, they are the ones who suffer. Their physical health, mental health, emotional well-being, relationships and precious time with family and friends is diminished.

Curtailing healthcare labour costs is counterproductive. The opportunities for real budget savings come with a reduction in readmissions, representations, insurance claims, civil claims, legal fees and oncosts to other government agencies who provide social services.

The reduction in those costs should be reinvested in making NSW public health facilities a safe and desirable place to work, where nurses and midwives know they will be supported to provide the care the people of NSW deserve.

Opportunities for change

For the first time in over a decade, there is a genuine opportunity for meaningful change to how health services are staffed in NSW. When NSW Health Minister, Ryan Park, was asked in October 2023 about the implementation of nurse-to-patient ratios, he stated:

> *"no-one is more determined than I am to make sure that we improve staffing in our public hospitals. I am focused on it like no-one else is and I'm determined to see reform in this way, because I think it is the only way in which we continue to enhance the quality of health care that we do for the people of New South Wales, which is focusing on the human capital, not just the infrastructure that we build."* [9]

Any successful systemic change occurs through consultation, and consideration of the experiences and opinions of experts. Nurses and midwives are experts in the NSW public health system and are key drivers of innovation and positive change. This submission incorporates the voices of and input from nurses and midwives at every level, and across wards, outpatient units, maternity, community health, mental health, emergency, management, education, policy, industrial relations and research.

These recommendations promote practice and working environments which are conducive to the provision of safe and quality care, as well as the safety of those providing care. Positive practice environments are characterised by professional recognition, education, reflection, support structures, adequate resourcing, sound management practices and occupational health and safety;[10] and are essential to the well-being of nurses and midwives.

[7] AIHW. (2023). Health expenditure Australia 2021-22, Table 5: Average total health spending per person(a) for each state and territory, constant prices(b), and annual growth rates, all sources of funds, 2011–12 to 2021–22
[8] Department of Health and Aged Care. (2022) Health Workforce Data Tool
[9] NSW Parliament. (2023) Legislative Council - Budget Estimates 2023-2024 uncorrected transcript 26 October 2023
[10] International Council of Nurses. (2021) *The ICN code of ethics for nurses*, Point 2.4

The recommendations of nurses and midwives identify what is needed within the NSW public health system, and beyond, to achieve improvements and efficiencies that will enhance the quality of care and ensure the sustainability of the workforce needed to provide such care.

B: Existing governance and accountability structure of NSW Health

There are considerable advantages, efficiencies and functional gains which can be accomplished through a review of the current governance and accountability structures within NSW Health. Such a review should focus on emphasising the development and retention of a world class public health workforce, supported by a strong centralised administration which provides for consistency and collaboration across the breadth of health services in NSW. Successive NSW governments and NSW Health have over-emphasised and favoured decentralisation and outsourcing at the cost of efficient, high quality service delivery. The long-term result of this is a diminished clinical workforce and myriad inconsistencies and inefficiencies in the delivery of services and application of policies. Reforms in this area are essential.

(i) the balance between central oversight and locally devolved decision making

Decentralisation and devolution have been the main tenets of structural health reform over the last two decades with increasing decision-making power sent to the 15 LHDs and two specialty networks with a decreasing role for the MoH in the operational realities of health services. In the context of the NSWNMAs work, we consistently find the devolution of human resources, workforce and Work Health and Safety ('WHS') leads to a sense of disconnect and inconsistency in the approach of various NSW Health facilities in relation to matters relevant to the nursing and midwifery workforce.

Industrial Relations

Whilst the MoH allocates substantial resources to its Workplace Relations and Human Resources ('HR') functions, it rarely intervenes or participates in any operational or Industrial Relations ('IR') issues at the LHD/specialty network level. Instead, the MoH conducts advisory meetings where it consults with LHDs on issues they escalate. The MoH does not generally participate in industrial or legal proceedings even when they have statewide implications. There is a substantial inefficiency in each LHD/specialty network recruiting and developing its own IR framework, as it leads to a redundancy on tasks where a PHS Award clause or Policy Directive must be subject to 17 separate sources of interpretation and advice, and where similar matters are disputed and litigated at each worksite.

Given the lack of appropriately qualified staff in NSW Health agencies' IR/HR teams, there is an over-reliance on advice from underqualified and inexperienced health practitioners when making findings or determinations. It is not unusual, for example, for the NSWNMA to receive letters from LHDs referencing sections of the *Fair Work Act 2009* despite the legislation not applying to employees of NSW Health. Several LHDs have reported a desire to build a substantial in-house IR function however, this is not feasible given the uncompetitive remuneration for mid-level Health Service Managers, resulting in many skilled practitioners leaving the industry within a short number of years. In recent discussions with a People and Culture Manager from a metropolitan LHD, it was disclosed:

'It is nearly impossible to recruit Human Resources or Industrial Relations Officers with any experience when graduates will get paid more in a mid-tier firm, a union or any private sector employer. And if I don't have the internal capability, I have to brief everything to law firms.'

More significantly, the lack of a central IR body working on operational matters leads to dramatic inconsistencies in the application of NSW Health Policy, Awards and relevant legislation. This subsequently results in unnecessary litigation between unions and the Health Secretary. Some recent examples of inconsistency include:

- The Rural Health Workforce Incentive Scheme ('RHWIS'), where the application of extra funding for hard-to-fill positions in rural health was addressed in a completely inconsistent manner across LHDs (and between facilities within LHDs) leading to the scheme often being counter-productive to its goals and requiring a significant review and revision by NSW Health, which is currently underway.

- Repeated disputes over the application of the same allowances, such as the in-charge allowance for day shift in clause 12 of the PHS Award, the application of a meal allowance for workers who work overtime without being provided a meal, and divergent views on whether the staffing minimums in clause 53 of the PHS Award are mandatory.

- Substantial unfairness occurs where workers are treated differently depending on their LHD/specialty network. In 2023, there have been several litigated matters which stemmed from Nepean Blue Mountains Local Health District ('NBMLHD') engaging in a unique practice of standing down workers without pay when they were perceived to have a disability due to a clear misreading of the Leave Matters Policy Directive[11] and the Premier and Cabinet Memorandum on Workers with Non-Work-Related Injuries.[12] The NSWNMA can provide witness details in relation to these issues.

- Western Sydney Local Health District ('WSLHD') is currently being prosecuted by SafeWork NSW for failures to discharge their duties under the *Work Health Safety Act 2011* (NSW) ('WHS Act') through their unique and incorrect interpretation of NSW Health Policy Directives regarding disciplinary processes and investigations.

- WHS practices are not standardised across NSW Health, leading to repeated disputes and industrial conflict over basic issues of safety and statute interpretation.

In each of these examples, financial expenditure and unnecessary litigation would have been avoided if a central IR body existed within NSW Health.

While there will not likely be a situation where the HR and IR function of LHDs is removed entirely, a centralised IR function would allow for issues to be escalated and then resolved in a consistent and fair manner. We refer to the approach in Local Government where Local Government NSW provides a central IR service which advises and represents councils in employment matters as a model that could be adopted by NSW Health.

[11] NSW Health (2023). Leave Matters for the NSW Health Service, PD2023_006
[12] Department of Premier and Cabinet, (2010). Procedures for Managing Non-Work Related Injuries or Health Conditions, M2010-18

Work Health and Safety

The current 'balance' between central oversight and locally devolved decision-making when it comes to the management of WHS is producing poor outcomes in relation to worker safety, with the healthcare sector experiencing the highest rate of serious injuries of any industry (see **Section F (iii)** for further detail).

There is a lack of clarity around which entities have a legislative duty as a 'person conducting a business or undertaking' ('PCBU')[13] under the WHS Act, (specifically section 19 duties and the duty to consult) and to whom they owe those duties. While we note that NSW Health WHS Better Practice Procedures[14] defines the PCBU as the individual health agency as follows:

> *'Under the WHS Act NSW Health Agencies are PCBUs and are responsible for the primary duty of care for workplace health and safety, as far as is reasonably practicable.'*

We note the MoH develops statewide systems of work through mandatory policies and procedures, security audits and the requirements for some training e.g. Violence Prevention and Management ('VPM'); Health Education and Training Institute ('HETI') determines content of training, and the Clinical Excellence Commission ('CEC') is involved in decision making around a wide range of issues including the Incident Information Management System ('IIMS+') and guidance on infection prevention and control. There is extremely limited or no consultation with HETI and the CEC, despite them making decisions on matters requiring consultation under the WHS Act.

While the MoH determines statewide mandatory policies in relation to WHS, governance around implementation of these policies is the responsibility of each LHD/specialty network and there are no consequences for failure to meet the mandatory obligations. It is the experience of the NSWNMA, that there is widespread non-compliance with important WHS policies such as *Protecting People and Property*[15] and *Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach.*[16]

The most robust process relates to security audits, where each LHD/specialty network must complete security improvement audits every two years where they audit against policy requirements and develop an action plan to address non-compliance. However, it is the experience of the NSWNMA that the audits are often done poorly, and the action plans are regularly not implemented, leaving known security risks unmanaged for many years.

There are many examples of where the balance between central oversight and locally devolved decision making is not working well, another is around emergency preparedness which became apparent in the early stages of the COVID-19 pandemic.

NSW Health's *Public Health Emergency Response Preparedness Minimum Standards* policy directive[17] requires that clinical staff participate in at least one *annual* emergency training exercise if they hold a position where they are likely to be called upon in a public health emergency. Staff must participate in an

[13] Division 3, Work Health Safety Act 2011 (NSW)
[14] NSW Health. (2018) Work Health and Safety: Better Practice Procedures, PD2018_013
[15] NSW Health. (2022) Protecting People and Property: NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies
[16] NSW Health. (2015) Preventing and Managing Violence in the NSW Health Workplace - A Zero Tolerance Approach, PD_2015_001
[17] NSW Health. (2019) Public Health Emergency Response Preparedness Minimum Standards PD2019_007

actual response exercise or a relevant training session. The training must also include re-familiarisation with personal protective equipment ('PPE').

Each LHD is responsible for training hospital staff in preparation for public health emergencies. An Audit Office of NSW report from 2020[18] found only two LHDs had delivered pandemic focused training in the past decade.

> *'Our interviews with managers of emergency departments and intensive care units indicates that most other Districts have focused their emergency training on mass patient trauma incidents such as plane crashes, train crashes and terrorist attacks. While the potential for these types of mass trauma events is real, and warrants training and preparation, significant global outbreaks of diseases have also had potential to threaten NSW communities. In previous decades, global health communities have been at risk of diseases such as the Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS).'*

> *'Our interviews with nurse managers in emergency departments and intensive care units indicate that in the majority of other Local Health Districts, key personnel were unaware of the NSW Pandemic Plan. Interviewed staff also reported insufficient scenario-based training in pandemic responses over the last ten years.'*

A more centralised approach, where annual scenarios are provided by the MoH and appropriate governance structures are in place to ensure these are carried out, would improve the readiness of our health services to respond to public health emergencies and decrease inefficiencies in the public health response.

Another example where the current 'balance' is not working is the 'file flagging' of aggressive patients. NSW Health Policy[19] refers to 'patient alert systems', or 'file flagging', to identify patients and/or their relatives who present a risk to the health and safety of workers and other patients. This system is part of the risk management process and is designed to assist in meeting obligations under WHS legislation.

While this is a statewide policy, each LHD has its own system for 'file flagging' and these systems do not talk to one another, leaving a situation where a patient who may be well known as a high-risk patient in one LHD can present to another LHD without staff being aware of the risk. The NSWNMA is aware of multiple instances where this has been an issue, including when a young woman with an extensive history of violence, well known at Campbelltown Hospital presented at Blacktown Hospital, and as staff were unaware of her history, no appropriate measures were implemented to be able to care for her safely and five nurses were seriously injured.

The issue of 'file flagging' was addressed as Recommendation 8 of the 2018 Parliamentary Inquiry into Violence Against Emergency Services Personnel[20] which recommended:

[18] Audit Office of New South Wales, (2020), Managing the health, safety and wellbeing of nurses and junior doctors in high demand hospital environments, Performance Audit, New South Wales Auditor-General's Report

[19] NSW Health. (2022) Protecting People and Property: NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies

[20] Legislative Assembly, Committee on Law and Safety [Sydney, N.S.W.]. (2017) Violence against emergency services personnel (Report no. 1/56 Committee on Law and Safety)

'NSW Health examine options for a statewide database to share file flagging information about patients who present a risk to the health and safety of staff, patients and others.'

In the Government Response[21] to that recommendation (and a subsequent recommendation for a national 'file flagging' system), NSW Health advised they would establish a 'NSW Working Party' to examine the feasibility and consider options for a statewide database and national 'file flagging' database. To our knowledge, this still has not occurred.

Similarly, the MoH has a policy for VPM training[22] yet LHDs are largely non-compliant, and workers are not getting appropriate access to this essential training. There are no consequences for LHDs of non-compliance with mandatory policies, particularly those designed to ensure the safety of workers.

Where there are mandatory statewide policies, the MoH should have a role in ensuring compliance with these policies.

Central Planning and Corporate

Overreliance on outsourced and contracted services is a significant contributor to inefficiency and substandard performance for NSW Health. A partial solution would be to reconstitute a strong centralised resource for corporate strategy, planning and management which has far too often been outsourced to external consultants.

From 2021-2022, NSW Health increased its expense on contractors by 23%, its expense on external lawyers by 14%, its expense on outsourced patient care by 18.5% and expenses for 'Other Management Services' by 47.5%.[23] Compounding these increases is the fact they mostly occurred in the year following major COVID-19-related expenses. The blow-out in expenses for functions which have previously been undertaken by experts within NSW Health and its bodies is a serious concern and, potentially, undermines the long-term sustainability of public health.

NSW Health must increase the in-house and internal capacity and capability which allows for real workforce planning and development with a view to maintaining a world class public health system into the future.

Recommendations

- NSW Health undertake a review of the current governance and accountability structures within the MoH and NSW Health agencies with a view to improve the consistency and quality of health services and administration of those services.
- NSW Health implement a statewide IR service to manage disputes on behalf of LHDs/specialty networks, to provide clarity and consistency in the application of Awards and policies with such service having the power to give enforceable directives to LHDs on industrial matters.
- The MoH create and oversee a clear framework for the identification, communication and application of the concurrent duties of NSW Agencies as PCBUs under the WHS Act.

[21] Hazzard, B. (undated, tabled 08/02/2018), Government response - violence against emergency services personnel
[22] NSW Health. (2017) Violence Prevention and Management Training Framework for NSW Health Organisations PD2017_043
[23] NSW Health (2022) Annual Report 2021–22: Financial Report

- The MoH audit LHDs/specialty networks' compliance with statewide policies and have the power to enforce consequences for non-compliance.
- The MoH expand the Legal and Regulatory Services branch to provide in-house legal advice and reduce reliance on external counsel.
- The MoH develop and provide internal management services and consulting resources for LHDs/specialty networks.
- The MoH invest a more substantial allocation of resources to workforce planning to reduce avoidance, unnecessary contracting-out and outsourcing.
- The MoH establish a centralised locum or internal short-term labour service.
- The MoH invest in an expanded WHS, security and return to work capability.

(ii) The engagement and involvement of local communities in health service development and delivery

No recommendations to this Term of Reference

(iii) How governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities

Representation of nurses and midwives on LHD boards

Members of LHD Boards are appointed by the Minister for Health and are responsible for managing public hospitals and health institutions and providing health services to defined areas within NSW.

LHD Boards consist of six – 13 members.[24] When selecting board members, the Minister is required to ensure members possess an appropriate mix of skills and expertise to oversee and provide guidance to the LHD. These skills and expertise include:

- expertise and experience in matters such as health, financial or business management;
- expertise and experience in the provision of clinical and other health services;
- representatives of universities, clinical schools or research centres;
- knowledge and understanding of the community;
- other background, skills, expertise, knowledge or experience appropriate for the organisation; and at least one member must have expertise, knowledge, or experience in relation to Aboriginal health. Individuals should be able to demonstrate their ability to represent the interest and concerns of health services in their local community.

[24] Health Services Act 1997 (NSW), s26(2)

Under the *Health Services Act 1997*[25] where there is to be a clinical representative on a Committee of a LHD, the Board is required to consult the Medical Staff Executive Council, Mental Health Medical Staff Council or any relevant Medical Staff Council, or LHD/Speciality Health Network Clinical Council.

While the Board may appoint clinical representation as it considers appropriate, such appointments of nurses or midwives is overlooked. Nurses represent approximately 40%[26] of the total workforce in NSW public hospitals, but do not have mandated membership on a LHD Board. Nurses and midwives are well placed to demonstrate skills and expertise across the spectrum of the above legislated areas and yet they are woefully under-represented on LHD Boards. There are only ten people who have a background in nursing or registration as a nurse and/or midwife across the possible 195 LHD board positions in NSW. Seven LHDs in NSW have no representation from anyone with nursing and/or midwifery experience.

Greater participation by nurses and midwives would enable them to provide considered evidence-based advice, debate and action on relevant issues, and facilitate collaborative and well-informed approaches to issues facing the LHD. Nurses and midwives are well placed to ensure LHD Board decisions are made with awareness of the realities and challenges of the provision of frontline health services to the community.

To maximise the quality and effectiveness of decisions made which strike the important balance of system and local level needs, LHD Boards should be comprised of more nurses and midwives who have experience of delivering frontline care within NSW Health.

Representation of midwives in leadership

The absence of strong midwifery leadership and professional representation at executive levels has been demonstrated to limit midwives' capacity to practice and to operate within gold standard care models.[27] One proposed step, which the NSWNMA supports, is the establishment of a Chief Midwife position in each state.[28] The Chief Midwife would play a pivotal role in driving service innovation and the development and oversight of policies within the midwifery profession. The lack of professional recognition would also be addressed by a Chief Midwife, which is of utmost importance as it is a key factor in the significant workforce crisis driving midwives to leave the profession. Please see **Section F (vi)** for more information.

There is a widespread misunderstanding of the depth of midwifery expertise among government bodies and hospital executives. There are very few midwives with positions at an executive level, leaving the discussions relating to midwifery scope of practice to nurses and medical staff. Despite 'Midwife' being a protected title[29] within federal, state and territory jurisdictions there is no prerequisite for the chief nursing and midwifery officers to have a midwifery qualification. This extends to directors of nursing and midwifery and professors of nursing and midwifery at university level.

Midwives need to be acknowledged as independent practitioners who work collaboratively with medical practitioners, removing the historical dominance of obstetrics over midwifery. The Strengthening Medicare Taskforce recommended all jurisdictions review barriers and incentives for midwives to work to their full

[25] Health Services Act 1997, Sections 39 and 60 Order as to Model By-Laws
[26] Australian Institute for Health and Welfare (2023) Hospital resources 2021–22 data tables
[27] Watkins, V., Nagle, C., Yates, K., McAuliffe, A., Brown, L., Byrne, M., & Waters, A. 2023. The role and scope of contemporary midwifery practice in Australia: A scoping review of the literature. Women and Birth, Volume 36, pp. 334-340.
[28] Council of Deans of Nursing and Midwifery (Australia and New Zealand). (2023). The future of the midwifery workforce in Australia: Position paper
[29] Health Practitioner Regulation National Law (NSW) s113

scope of practice, therefore the implementation of a Chief Midwife is imperative.[30] Statewide programs need to be implemented that enable and empower midwives to work to their full scope of practice within NSW Health facilities, for example enabling endorsed midwives to order medications and diagnostic tests and expanding midwifery-led continuity of care models for all risk women for better outcomes and cost saving benefits.[31] Please see **Section F (vi)** for more information.

Work Health and Safety

Governance and accountability systems in relation to WHS across NSW Health Agencies are currently poor. This is a significant issue given healthcare has the largest number of serious injuries of any industry and injury rates are continuing to climb (see **Section F** for further information about WHS in health). To improve WHS culture and performance requires improved governance and accountability at all levels of NSW Health.

There is little transparency about WHS across NSW Health, particularly when it comes to rates of occupational violence. Recommendation 2 of the NSW parliamentary inquiry *Violence Against Emergency Services Personnel*[32] was *NSW Health consider publishing data concerning violence against its hospital staff, broken down by hospital.*

In their response to the inquiry, the NSW government made the following commitment on 8 February 2018:[33]

> *'NSW Health will publish data on physical incidents and in doing so, will consider the most appropriate information to be published to ensure accountability and transparency is achieved without unintended consequences on hospital attendances.'*

> *'Publishing data at a hospital level may raise concerns with members of the public which could result in patients not seeking assistance from the nearest hospital, with potential consequential health impact. As an alternative option, consideration will be given to publishing data at local health district level which is broadly consistent with the approach taken by the Department of Education, which publishes data by Principal's network, rather than by individual school.'*

This data has never been published.

There are no formalised processes at NSW Health level to meet the objects of s3(c) of the WHS Act of encouraging unions and employer organisations to take a constructive role in promoting improvements in WHS practices and assisting PCBU and workers to achieve a healthier and safer working environment.

This is in distinct contrast to the situation in Victoria, where there is a state Occupational Health and Safety ('OHS') Working Group to enable the Department of Health and the Unions to proactively cooperate in the development and recommendation of measures to improve 'OHS' outcomes, with the intent of improving

[30] Australian Government. (2022) Strengthening Medicare Taskforce Report.

[31] Callander, E.J., Slavin, V., Gamble, J., Creedy, D.K. and Brittain, H. (2021). Cost-effectiveness of public caseload midwifery compared to standard care in an Australian setting: a pragmatic analysis to inform service delivery. International Journal for Quality in Health Care, 33(2), pp.1–6.

[32] Legislative Assembly, Committee on Law and Safety, 2017. Violence against emergency services personnel (Report no. 1/56 Committee on Law and Safety).

[33] NSW Government. (2018) NSW Government Response to the Recommendations from the Legislative Assembly's Inquiry into Violence Against Emergency Services Personnel

employee health and safety, prevent injury, illness and incapacity (and hence workers compensation payments), particularly with respect to the following:

- safe patient and manual handling processes;
- safe rostering practices and prevention of fatigue risks;
- occupational violence and aggression prevention programs;
- education for Nursing Unit Managers ('NUMs'), Acting NUMs ('ANUM') and Midwifery Unit Managers ('MUM') regarding management of employees; and
- workplace bullying.

Key performance indicators for LHDs are reported to NSW Treasury under the NSW Health Outcome and Business Plan. There are currently seven pages of items relating to safety – though these are primarily patient safety matters. Half a page is devoted to staff safety and these are largely unhelpful measures derived from the People Matters survey results (for example, where you could considered to be 'performing' provided the variation on your previous results for 'take action as a result of the survey' had a variation from previous survey ≥-1% - regardless of how poor the previous survey results were).

There is significant work to do on improving safety culture in NSW Health, and without the focused attention of LHD chief executives and senior leadership teams, we will not see the shift in safety culture required. Further consideration must be given to the motivators and drivers of this group to make safety a key focus.

At a facility level, there are opportunities to improve governance, accountability, and transparency around management of occupational violence. In Victoria, all health agencies are required to have an Action Plan to end occupational violence and aggression. These plans are developed in consultation with workers and unions, and progress against the plan is overseen by a committee that includes worker representation such as an OHS committee (and unions can attend and participate). Further detail about this can be found in the Victorian Nurses and Midwives (Victorian Public Sector) Enterprise Agreement 2020-2024.[34]

Recommendations

- The NSW government consider an amendment to the *Health Services Act 1997* (NSW) to require that each LHD Board have at minimum of one nurse and one midwife.
- NSW Health develop strategies to have more midwives employed in management and executive positions to contribute to decision making for the profession at local level.
- NSW Health review WHS reporting at a board level. Standardise the WHS reporting that goes to boards across NSW Health to ensure the information being provided is accessible and useful in assisting officers to understand the nature of the risks and what is being done about them.
- NSW Health provides further training for those who are Officers under the WHS Act on their obligations under s27 of the Act and specifically what this means in the context of occupational violence and psychosocial hazards.
- NSW Health develop appropriate KPIs for Chief Executives ('CE') and senior staff members in relation to WHS. KPIs must be carefully crafted to ensure they drive desired behaviours and do not have unintended consequences (e.g. a decrease in incidents reported is not a good measure as it encourages underreporting). KPIs require both lead and lag indicators. Good guidance on

[34] Nurses and Midwives (Victorian Public Sector) (Single Interest Employers) Enterprise 2020-2024

development of WHS KPIs is provided by SafeWork Australia. Measuring and reporting on WHS (safeworkaustralia.gov.au)

- NSW Health publishes data on assaults on health workers by LHD on an annual basis.
- NSW Health establish a WHS work group with relevant unions.
- Facilities should implement action plans to end occupational violence and aggression with worker and union involvement in overseeing progress against the plan.

(iv) The impact of privatisation and outsourcing on service delivery and health outcomes to the people of NSW

The NSWNMA is strongly opposed to the privatisation of public health services in NSW, and we are well aware of the negative impact it has on the delivery of healthcare and health outcomes to people in NSW. This position is based on our awareness that;

- available national and international evidence demonstrates the privatisation of healthcare is a failed model,
- the failures manifest in lower standards of care; poorer healthcare outcomes; reduced staffing levels; a failure to meet community expectations; economic losses for individuals, government and, at times, the providers; and a diminished trust in government secondary to transparency and accountability failures, and
- and based on economic theory, the failures are entirely predictable.

Failures of privatisation in the delivery of healthcare

The number healthcare privatisation[35] failures in Australia, and the impact of those failures, provides strong evidence it is a failed mechanism for healthcare delivery. At best, it is a risky proposition for governments to consider.

A 2017 report, *Taking Back Control: A community response to privatisation,*[36] examined the impact privatisation has had on Australian communities. The report outlines the breadth of failures across hospitals, disability services, and aged care. With respect to healthcare privatisation, the report notes 13 examples within Australia, excluding aged care and disability services (see **Appendix 1**). Within these examples is a mixture of for-profit and not-for-profit third-party involvement.

The failures are defined by:

- the provider seeking further government funding than what was agreed to in the contract; in one case within six months (La Trobe, Modbury, Royal North Shore);
- the provider becoming unfinancial (Robina);

[35] Privatisation is the transfer, either wholly, or in part, of the delivery and/or ownership of public services and/or infrastructure, to the non-government sector, whether to for-profit, or to not-for-profit providers/owners. The transfer of regulatory responsibility, in whole or in part, is also a form of privatisation. Therefore, Public Private Partnerships (PPPs), Social Impact Bonds (also known as Social Impact Investments in NSW), outsourcing, tendering, mutualisation, voucher systems, leasing, and commissioning should all be seen as privatisation. This reflects a WHO definition of privatisation.

[36] Public Services International. (2017) Taking Back Control – A community response to privitisation

- adverse outcomes and/or patient care being compromised (Port Macquarie, Fiona Stanley, Royal North Shore, Royal Perth, Juvenile Detention in Northern Territory);
- decreased services and/or a failure to meet community expectations (La Trobe, Port Macquarie Base, Modbury, North West Regional Hospitals, Royal North Shore, Royal Perth, Sir Charles Gairdner, Mildura, Juvenile Detention); and
- a reduction in staffing and/or numbers of qualified staff (Port Macquarie, Royal North Shore, Royal Perth, Sir Charles Gairdner)

That healthcare privatisation fails is not new information. In Australia the failures span from 1994 to now. In 2000, a Senate inquiry into public hospital funding explored the interface between private and public hospitals (chapter six) and made the following recommendation:[37]

> *'Recommendation 24: In view of the difficulties currently being experienced at several privately managed public hospitals, the Committee recommends that no further privatisation of public hospitals should occur until a thorough national investigation is conducted and that some advantage for patients can be demonstrated for this mode of delivery of services.'*

The Howard Government did not accept the recommendation, stating simply that healthcare delivery is a matter for the States and Territories, and the sharing of information may lead to more successful privatisation in the future. A thorough national investigation has not been carried out and the failures continued.

International evidence makes it clear the Australian experience of hospital privatisation is not an aberration. In the United Kingdom ('UK') at least twelve heath care privatisation failures have been reported. These include Paddington Health Campus, Durham District Hospital, Hereford, Seacroft Hospital,[38] Hinchinbrook and Peterborough, the Cumberland Infirmary, Walsgrave, North Durham, the Royal Edinburgh Infirmary, the Royal Liverpool and Broadgreen, Norwich and Norfolk, and the Queen Alexandra.[39] Two other privatisation proposals (Staffordshire palliative and cancer services, and *NHS Professionals* (NHS agency staff)) were abandoned by the then government.[40]

The UK's NHS continues to experience failures as a result of privatisation. A 2022 paper published in The Lancet[41] found:

> *'The privatisation of the NHS in England, through the outsourcing of services to for-profit companies, consistently increased in 2013–20. Private sector outsourcing corresponded with significantly increased rates of treatable mortality, potentially as a result of a decline in the quality of health-care services.'*

[37] Commonwealth of Australia (2000). Healing our hospitals: A report on public hospital funding.
[38] McKee, M., Edwards, N. & Atun, R.(2006). Public-private partnerships for hospitals. Bulletin of the World Health Organisation. 84(11). pp. 892-893.
[39] Overpriced and Underwritten: the Hidden Costs of public-Private Partnerships, UK hospital PPPs
[40] Health and Social Care in England: talking the myths Accessed 14 November 2023
[41] Goodair, B (2022), Outsourcing health-care services to the private sector and treatable mortality rates in England, 2013-20: an observational study of NHS privatisation, The Lancet Accessed 14 November 2023

The Guardian newspaper reported at the time, 'the main mental health hospital chains that treat NHS patients have been criticised by coroners and inquest juries dozens of times over the last decade for providing unsafe care.'[42]

These failures replicate the Australian experience with evidence of:

- cost blow outs (though the local Trusts are having to cover the costs and are therefore making reductions in other areas, or are being supplemented by the government);
- reduced services (ward and bed closures);
- staffing reductions, including qualified staff being replaced by unqualified staff; and
- patient outcomes being compromised.

In 2006, the World Health Organisation released a bulletin which explored public private partnerships ('PPPs') for hospitals.[43] In addition to six of the UK examples cited above, it identified Australia's La Trobe Hospital, the Alzira Hospital in Spain, and Bishop Auckland Hospital in New Zealand ('NZ'). The conclusion makes it clear the risks of hospital privatisation were known:

> *'The theoretical justification for private financing of public facilities, although debated, has come to be widely accepted. However, the practical results seem not to have lived up to what was expected from privately funded ventures. The new facilities have, in general, been more expensive than they would have been if procured using traditional methods and where the public sector does achieve a good deal from a privately funded development, it may have to pay more later to prevent the project from collapsing.*
>
> *One positive finding is that, compared with the traditional system, new facilities are more likely to be built on time and within budget; but these gains seem often to be at the expense of quality. The need to minimize the risk to the parties means that it is very difficult to "futureproof" facilities in a rapidly changing world. Finally, while the processes involved in procuring standard general hospitals are now well established, the complexity involved is increasing, especially with very large projects.*
>
> *Major capital procurement is very difficult in any sector. Examples from the defence sector offer many cautionary tales and there are striking parallels between the difficulties being faced by those procuring a major teaching hospital and the current procurement of two planned British aircraft carriers. However, public–private partnerships to procure hospital services do seem especially difficult.*
>
> *Unfortunately, the debate on the merits of different approaches has been characterized by ideology rather than evidence, with a reluctance to undertake evaluations. In the United Kingdom one of the leading critics of the PFI (Private Finance Initiative) has been subject to vociferous personal attacks by some politicians.*
>
> *It is impossible to say whether the model underlying public–private partnerships is flawed or whether the difficulties with such endeavours are the result of mistakes in its execution. One plausible interpretation is that the additional complexity of public–private partnerships makes all but the most straightforward projects just too difficult. Uncertainty surrounding the role and value of public–private partnerships in healthcare needs urgent resolution.'*

A 2015 report by Eurodad[44] highlighted a case study of a privatised hospital in Lesotho. With the hospital costing the government three times that of the old hospital (consuming half of the country's health budget); the government held the view it would be cheaper to build a new hospital for excess patients, rather than pay the private provider to treat them.

[42] The Guardian, NHS privatisation drive linked to rise in avoidable. Accessed 14 November 2023 deaths

[43] McKee, M., Edwards, N. & Atun, R.(2006). Public-private partnerships for hospitals. *Bulletin of the World Health Organisation*. 84(11). pp. 892-893.

[44] Romero, M, J. (2015). What lies beneath? A critical assessment of PPPs and their impact on sustainable development.

A subsequent report[45] by Eurodad highlighted the privatised Nya Karolinska Solna Hospital in Sweden. The report states:

> *'In 2010, Swedish authorities gave single bidder the Swedish Hospital Partners (SHP) a PPP contract to build and manage the Nya Karolinska Solna (NKS) Hospital. It was intended to be "one of the world's most advanced hospitals", but is now known as the "most expensive hospital in the world".' NKS is still not fully operational due to technical failures. Furthermore, the cost of the project has rocketed — a fact that was only fully exposed in 2015 by journalists at the Svenska Dagbladet newspaper. Meanwhile the private consortium has made a significant profit.'*

This national and international evidence of failures, some severe, demonstrates, whether within a developing or developed nation, whether governments 'go it alone' or are supported by international institutions, healthcare privatisation fails communities. There is a growing international discourse against privatisation in general, at times from unexpected sources.

Former chairman of the Australian Competition and Consumer Commission ('ACCC'), Rod Simms, who identified as a proponent of privatisation, has since critiqued it, citing a lack of regulation and the creation of monopolies. Simms now agrees privatisation is leading to higher prices for consumers.[46] Whilst Simms was referring to infrastructure, and in particular the privatisation of the nation's sea ports, the parallels to health are evident.

Patients accessing cancer services at Sydney's Chris O'Brien Lifehouse saw the privatisation of services previously offered by the adjacent public hospital, with patients paying higher out-of-pocket expenses compared to the services previously offered at the public hospital.[47] It provides these services with a monopoly within the LHD.

Whilst the International Monetary Fund ('IMF') continues to push privatisation in practice, some of its own reports indicate the harm privatisation causes to economies. *The Independent* reported on the IMF's assessment of the UK economy[48] :

> *'The IMF's report takes particular aim at the privatisation of public assets, **the benefits of which it says are often merely an "illusion".***
>
> *The UK has undergone one of the most drastic privatisations of any economy since the early 1980s.*
>
> *Under the Conservative government since 2015, policy has gone a stage further, incentivising departments and local authorities to sell off assets to fund day-to-day spending under the premise that such an approach is necessary to cut the deficit.*
>
> *But the IMF economists said the tendency of governments to focus on debt "misses large swaths of government activity and can fall victim to illusory fiscal practices".*
>
> *When public assets are taken into account, selling a public utility, for example, may do nothing to improve the public finances, the IMF said.*

[45] Romero, M, J. & Ravenscroft, J. (Eds). (2018). History RePPPeated: How public private partnerships are failing.
[46] Hatch, P. (2016) Privatisation has damaged the economy, says ACCC chief, SMH. Accessed 14 Nov 2023
[47] Alexander, H. (2016) Chris O'Brien Lifehouse 'mistakenly' charges public cancer patients from RPA, SMH. Accessed 14 Nov 2023
[48] Chapman, B. (2018) Britain's public finances worse than Gambia, Uganda and Kenya, because of privatisation, IMF finds. Accessed 14 Nov 2023

"For instance, privatisations increase revenue and lower deficits but also reduce the government's asset holdings," the report stated.

Similarly, cutting back maintenance expenditure reduces the deficit and lowers debt, but also reduces the value of infrastructure assets, which could cost more in the long term.'

The IMF released an advisory 'How To Note'[49] which states:

'While in the short term, PPPs may appear cheaper than traditional public investment, over time they can turn out to be more expensive and undermine fiscal sustainability.'

The United Nations ('UN') Human Rights Council's 2018 Annual Report by Special Rapporteur on Extreme Poverty and Human Rights, Philip Alston, looked at the impact of privatisation.[50] The report states:

'The world has been fundamentally reordered by widespread neoliberal economics that has privatized basic public goods — social protections, education, pensions and criminal justice among them — with often disastrous impacts on the human rights of the extremely poor.'

'proponents of privatization — the World Bank, International Monetary Fund (IMF) and parts of the United Nations — claim the private sector is more efficient, innovative and cost effective. Yet, their projects are often costlier and provide inferior service at considerable profit, all while ignoring human rights standards and shelving compassion. There is a "striking disconnect" of the idealized narrative around privatization and the findings of many studies.'

*'The European Union and United Kingdom studies also raise other concerns that warrant brief mention here: (a) conflicts between public concerns over the quality of life and **the private sector's preoccupation with profitability**; (b) the difficulty of avoiding windfall returns to the private sector, while compensating for unanticipated losses through renegotiations; (c) **private sector entities structured to minimize or avoid taxes on profits**; (d) a lack of competition in privatized project design and selection; (e) the risk of private monopolies; (f) the misallocation of risk between parties and excessive remuneration rates to private companies; and (g) inflexible long-term contracts that can leave Governments with expensive "white elephants".'*

Economic theory suggests privatisation risks

From an economic theory perspective, it may be that healthcare privatisation failures are entirely predictable. A 2014 paper[51] by Senior Research Fellow at Sydney University's Department of Political Economy, Phillip Toner, examined the application of Transaction Cost Economics (TCE) theory to the privatisation of Vocational Education and Training (VET) in Australia and found that it 'does not meet the minimum conditions for efficient contracting out'. The paper explores the information asymmetry between a VET student (client) and the private provider. However, aspects of the approach could be used to assess if the conditions are right for the efficient contracting out of healthcare, by considering both the

[49] International Monetary Fund. (2018) How to Control the Fiscal Costs of Public-Private Partnerships
[50] United Nations (2018) Annual Report by the Special Rapporteur on Human Rights
[51] Toner, P. (2014). Contracting out publicly funded vocational education: A transaction cost critique. The Economic and Labour Relations Review. 25(2) 222-239.

government, as the purchaser of health services for public patients from the private operator, and the patient, as the consumer in this economic model.

- Information asymmetry may have been demonstrated in the cases cited in **Appendix '1'** (La Trobe, Modbury), where providers have sought additional funding in order to maintain services, and the financial collapse of the provider (Robina). The early days of Sydney's Northern Beaches Hospital ('NBH'), where inadequate equipment and poor process design were reported, indicates a fundamental lack of knowledge, and therefore preparedness; possibly arising from information asymmetry. In the case of La Trobe, Modbury and Robina, this suggests the third parties underestimated the cost of providing the service within their tender offers.
- Toner's article states

> *'The more important an activity to the survival, profitability or quality of an organisation's output, the higher the risk in contracting an activity out. It is not just direct costs and rewards that enter into agents' decision-making regarding 'important' market transactions; TCE argues that externalities also need to enter into an agent's calculation. The risk of acquiring an 'important' good or service in the external market is increased when such transactions are undertaken only once or very infrequently. This limits the principal's scope for learning from market transactions and for improving outcomes from such exchanges.*
>
> *"We expect the Northern Beaches Hospital to ramp up to $300 million in annual revenue within three years, which will be around 10 per cent of group revenue," Mr James said. "**It's therefore going to be a key part of revenue growth** over the next couple of years as it ramps up.'*[52]

The importance of an efficient and effective healthcare service is well understood in human and economic terms. From the non-government provider's perspective, gaining government contracts in a diminishing private health insurance context[53] may be used as a way to ensure revenue to sustain their business model. In fact, this was admitted by private hospital provider, Healthscope, in a Sydney Morning Herald article.[54]

From the NSW government's perspective, they face the choice of awarding the tender to a known provider (who is already providing a privatised government healthcare service) therefore creating a potential for a monopoly, or they use competition to drive the price down, risking awarding an unknown provider the job of providing healthcare to its citizens. Regardless of the care taken in choosing the provider, nothing prohibits the selling of that business, as was seen in the case of NBH; the government tender went to a known private healthcare provider, which was then purchased by a global asset management organisation. The complexity of healthcare service provision makes it difficult to specify detailed contract performance measures, such as the number of qualified staff, cleaning standards, compliance timeframes, supplier contracts, impending professional practice changes. Toner explains contracts that fail to capture the detail are described as incomplete. Incomplete contracts, Toner argues, increase the risk of opportunism to ensure profit. The examples of failures provided within this submission indicate this has resulted in decreased services, reduction in staffing, and/or reduction in the qualifications of the staff.

Longer term contracts also 'lock-in' the government to a service provider that may not be meeting either government or community expectations, as in the case of La Trobe, Modbury, and Mildura. Toner's analysis also indicates the government may lose knowledge of the service provision, or expertise, and this will disadvantage it in future contract negotiations/renewals.

[52] ibid
[53] Duckett, S. & Nemet, K. (2019) The history and purposes of private health insurance. The Grattan Institute
[54] Kruger, C. (2018) Healthscope suitor weighs up Northern Beaches woes, SMH. Accessed 14 Nov 2023

A core claimed benefit of privatisation is it promotes competition and innovation within the marketplace. Public hospital healthcare is not a marketplace, and therefore assumptions of competition driving down cost cannot apply. For the public, choice is limited by there being one provider in their region unless they can afford private access. The public have very limited capacity to decide between providers (clinicians), and bargaining power is minimal, especially in times of urgency. That some providers do not participate in publishing their costs demonstrates the complexity for consumers, and the barriers to correcting the asymmetry of information that could drive competition.

Whilst academic rigour should be applied to properly assess the correlation of Toner's analysis in relation to healthcare privatisation, a cursory assessment suggests healthcare privatisation fails the minimum conditions for efficient contracting out. Irrespective of confirming an academically sound economic analysis of why the failures occur, it is clear, considering national and international experiences, that the risks are so high as to preclude privatisation being an option.

Transparency and accountability:

A 2017 report[55] by the McKell Institute, commenting on accountability, highlights there are significant gaps in performance data and mixed results which means it is not possible to make an informed decision on the performance of privatised hospitals. The report concludes:

> *'We can see that taxpayers are not given the chance to know how privatised hospitals are performing - whether they are receiving value for money and quality care. The meagre amount of data doesn't allow for any definitive conclusions; this fact alone tells us it is misleading to claim that the private sector delivers a superior or lower cost service. These claims simply are not based in evidence because there isn't any. The absence of data exposes these claims as ideologically driven political rhetoric. Taxpayers and patients deserve better than that.'* [56]

Performance indicators for government run public hospitals are publicly available. Their performances vary and reveal areas for improvement. However, the McKell report demonstrates private providers are not bound to comply with data provision. They make the point that a lack of data transparency can mean the government and/or the public cannot know if the services being provided are meeting key performance indicator ('KPI') benchmarks or community expectations. The report also points out this means there is a lack of evidence that the services are improved. A sound assessment of 'value for money' cannot therefore be made and, given commercial-in-confidence restrictions, cannot be made available for public scrutiny.

A Senate inquiry into public hospital funding[57] in 2000 cited the Western Australia Auditor General's Performance Report of the (then) recently established PPP at Joondalup, which stated there was '*not reliable information to establish that the contract provides net tangible benefits to the state relative to the public sector alternative from either services or facilities*'. That is to say, there was no evidence the state could not have achieved the same outcomes. The NSWNMA also questions the outcomes for the Chris O'Brien Lifehouse.[58] This is a valid argument as the promoters of privatisation claim improved services at lower cost to government. Commercial-in-confidence precludes the community from knowing if this is fact, or how costs are decreased, and there is evidence of KPI and community expectations not being met at these sites.

[55] The McKell Institute. (2017). Privatised Hospitals: An accountability black hole
[56] ibid
[57] Commonwealth of Australia. (2000). Healing our hospitals: A report on public hospital funding. Accessed 14 Nov 2023
[58] http://www.nswnma.asn.au/wp-content/uploads/2016/09/Privatisation-booklet0517-LR.pdf

This links back to Toner's analysis of contract efficiency: Citizens accessing the privatised healthcare service cannot be aware of the contract outcome measures (due to commercial-in-confidence and a lack of healthcare funding expertise) and, given limited exposure, may not have comparators that will allow them to recognise diminished services, or sufficient experiences that can inform their expectations.

Transparency gaps were identified at La Trobe where the then Victorian government refused an order by its own Civil and Administrative Appeals Tribunal to release information. A lack of transparency was also a feature of the NBH privatisation,[59] and a proposal by the former NSW government to privatise five public hospitals; the community and unions representing the workers were not told who the potential providers were, what services would be provided, what staffing, or what employment conditions would be required within the contract, on the premise of commercial-in-confidence. Healthscope was not transparent with the community in its intent to sell NBH to Brookfield. Given healthcare is a human right, it is morally wrong that the rights of corporations to have their government contracts concealed override the human and democratic rights of the community.

The lack of transparency can create a cycle of accountability denial. When the public, or a civil society organisation, or an individual, have a complaint about the provision of service the government can blame the provider. The provider can claim they are meeting contract obligations, whilst never having to release those contracts details, or they blame government funding and/or policies. Whilst the public can change government, they cannot change corporations or the Chief Executive Officers ('CEO').

This lack of transparency and accountability can be linked to the diminished trust in government and disengagement with democracy. In a statement to the *Peoples' Inquiry into Privatisation*[60] sociologist Eva Cox argued people can no-longer see what government represents, that it is increasingly invisible within our communities, where once it was more present; the home phone, the local bank, roads and public transport. Cox argued there is no-longer a sense that public services are something we own, and this is contributing to a breakdown of community and democratic participation. If a community cannot hold a government service accountable, how can they build trust in the politicians elected to provide oversight of those services?

Any for-profit corporation's primary obligation is to their shareholders to whom they are accountable. The legislated fiduciary obligation to ensure they are acting in a way that returns a profit is a clear clash of values, compared to the provision of a well-funded universal healthcare system which lies at the heart of public health.

Taxpayers have a right to hold governments and government departments accountable in ensuring revenue is spent efficiently and effectively whilst meeting the needs of the many, not the financial interests of non-government providers.

Corporate structures related to the use of sub-contracting adds layers of complexity and diminishes transparency when providers need to be held accountable. This has been demonstrated clearly in the Queensland ('QLD') example of the Earle Haven aged care facility. The provider 'walked off' the premises, taking equipment and money, leaving the residents and staff stranded.[61]

[59] New South Wales Nurses and Midwives' Association. (2017) Northern Beaches privatisation still shrouded in secrecy. (2017) Northern Beaches privatisation still shrouded in secrecy.

[60] Public Services International (2017) Peoples Inquiry into Privatisation full report: Taking back control 2017

[61] Kinsella, E. (2019) Gold Coast aged care facility Earle Haven to be referred to royal commission. ABC News online. Accessed 14 Nov 2023

It should be noted not-for-profit organisations are not a safe option for healthcare privatisation. The failures outlined earlier include not-for-profit/charitable organisations. In submissions to the *People's Inquiry into Privatisation* it was clear not-for-profit providers are forced to act like the for-profits, in terms of cutting staff and/or wages, in order to meet budget or to be competitive in tendering, and smaller organisations are unable to compete (leading to monopolisation within the not-for-profit sector).[62]

As a means of further increasing transparency and accountability the Committee's attention is drawn to the Principles and Recommendations contained within the *Taking Back Control* report from the *Peoples Inquiry into Privatisation.*[63] Some of these recommendations are referenced within this submission.

Privatisation of prison health services

Prisoners experience poorer health compared to the general population. Prisoners are more likely to have chronic illness, mental health problems, post-traumatic stress, substance use issues and communicable disease, dual diagnoses of mental health issues and physical or other health problems.[64] They are also more likely to have experience of mental health issues including anxiety, depression, psychosis, and suicidal thoughts.[65]

The manifold disadvantage experienced by prison inmates has clearly and repeatedly been documented, with histories of disrupted families and social backgrounds including abuse, neglect and trauma; poor educational attainment and consequent limited employment opportunities; unstable housing; parental incarceration; juvenile detention; dysfunctional relationships and domestic violence; and previous episodes of imprisonment. With such multiple risk factors for poor health, it is not surprising prison inmates are further characterised by physical and mental health far below that enjoyed by the general population.

Continuity of care is vital with such a vulnerable population, but the frequent transfers between prisons and the different systems in each, means significant disruptions to continuity of care and people awaiting care missing that care or returning to the bottom of the wait list when transferred between facilities.

There is currently no way to properly compare the performance of the health services in private prisons with Justice Health services, despite Justice Health having an oversight role in relation to the privately run custodial health services as privately run services and Justice Health have different KPIs.

The Audit Office of NSW notes:

> *'Justice Health reports to the Ministry of Health on 44 health care performance indicators. The performance indicators in the public prison system do not align with the performance indicators for the private prison health system. The difference in the performance measures means that it is not possible to compare or benchmark performance across the public and private systems over time. The KPI specifications for private prison health service delivery were developed by Corrective Services NSW with some input from the Ministry of Health. KPI specifications for performance monitoring in the public prison health system were developed by the Ministry of Health.*

[62] Public Services International. (2017) Taking Back Control – A community response to privitisation
[63] ibid
[64] Australian Institute of Health and Welfare, 'The Health of Australia's Prisoners 2018' (Report, 30 May 2019) vi, 49; The Royal Australian College of General Practitioners, Standards for Health Services in Australian Prisons (1st ed, April 2011) 2-3; Justice Health and Forensic Mental Health Network, Year in Review 2016-17 (Department of Health (NSW), December 2017) 14.
[65] Justice Health and Forensic Mental Health Network (NSW), 2015 Network Patient Health Survey Report (May 2017) 52-62

Some of the KPIs of the private system are linked with financial abatements if targets are not met. Justice Health is not subject to any penalties for not meeting targets for the public health system. In the private prison health system, there are inconsistencies in the frequency of KPI data validations. Privately managed prisons report monthly on KPI data. Previously, this data was not validated by Justice Health at regular intervals. The Performance Monitoring Assurance Framework indicates that validation of KPI data will be conducted as resources permit. This has resulted in delayed validations, and delays in the issuing of abatements for underperformance in some instances. In July 2021, Justice Health committed to conducting regular KPI validations.' [66]

Our members in privately run prisons reports issues with:

- extended wait times for patients to access basic care;
- difficulties in accessing patients/poor communications with corrections officers;
- significant difficulties for patients accessing mental health services;
- concern for their nursing registration due to inability to provide safe care; and
- unsafe systems of work.

While there is limited publicly available information about the delivery of health services in privately run prisons, we note the recent comments of the Inspector of Custodial services in relation to Parklea Correctional Centre:

'During some seven days on site, we spoke to many inmates and staff across all areas of Parklea CC, both individually and in group settings, with access to health and medical care services the most frequently raised issue of concern… the level of inmate anxiety and concern in relation to access to medical care at Parklea CC during the inspection was extremely high.' [67]

The Legislative Council Committee on Legal Affairs conducted an inquiry into Parklea Correctional Centre and other operational issues in 2018 which found (amongst other matters):

'That the GEO Group Australia failed to meet its obligations in respect of the operation of Parklea Correctional Centre, failed to manage the prison effectively, and failed to recognise and address the significant and systemic problems that occurred there in a timely way.' [68]

These failures had a direct impact on the provision of healthcare to patients at Parklea Correctional Centre. One significant failure regarding the privatisation of prisons, and health services within prisons that has impacted negatively on the provision of health services, is the failure to clearly communicate with the broader community which prisons/prison health services are privatised, and mechanisms for family or friends to raise concerns about the well-being of inmates within those prisons.[69]

On the topic of privatised custodial health, the Australian Medical Association has stated:[70]

[66] Audit Office of NSW. (2021) Access to Health services in custody,
[67] Inspector of Custodial Services. (2022) Inspection of Parklea Correctional Centre,
[68] Legislative Council Committee on Legal Affairs (2018) Parklea Correctional Centre and other operational issues
[69] Coroners Court of NSW. (2023) Inquest into the death of CJ
[70] Australian Medical Association. (2017) The pitfalls of privatising prison healthcare

'Corrections health privatisation heralds countless blows to patient care: the absence of a whole-of-system healthcare advocate, as multiple private providers dilute responsibility for the prison population as a whole; the loss of healthcare provision independent of corrections management, which the WHO calls 'a failsafe to detect and protect against prisoner mistreatment'; the risk of eroding patient-clinician relationships, based as they are on the goodwill and passion of public clinicians; the disintegration of medically skilled oversight, as private prison health providers are overseen by the Department of Corrective Services rather than the Department of Health.'

The NSWNMA does not support privatisation of prisons or of the health services within prisons. Prisons in NSW should have the safety of the community as their primary concern and should be working to reduce recidivism through the rehabilitation of prisoners.

This is in stark contrast to the key concerns of corporations, with directors of corporations having a primary duty of care to their shareholders. This carries a disturbing incentive to both ensure criminal sentencing is harsh while ensuring the prison population remains high and provides little incentive to provide rehabilitation that reduces recidivism.

The broader concerns held by the NSWNMA regarding the privatisation of public health services also apply to the privatisation of prison health services, however the particular vulnerabilities of the prison population combined with the lack of access to any alternative health services, mean the likelihood of serious adverse events and poor outcomes is increased.

Junee Correctional Centre and Clarence Correctional Centre are both managed by corporations who also take responsibility for providing custodial health services despite not being health corporations or having any substantive clinical governance structure.

The NSWNMA welcomes the recent announcement to bring Junee Correctional Centre into public hands, under the management of Corrective Services NSW, with health services to be provided by the Justice Health and Forensic Mental Health Network. This is an important and significant step in the right direction, to end the privatisation of prisons and custodial health services.

The NSWNMA strongly supports the returning of Parklea Correctional Centre, and the transfer of management of Clarence Correctional Centre to Corrective Services NSW at the earliest opportunity.

Focus on Northern Beaches Hospital (NBH)

In May 2013, then Health Minister Jillian Skinner announced expressions of interest would be invited from the private sector to design, construct, operate and maintain a new hospital on Sydney's northern beaches. The creation of the new hospital would see the closure of Manly Hospital and the removal of services from Mona Vale Hospital; privatising those services.

NBH opened on 30 October 2018 as a 486-bed public and private hospital located in Frenchs Forest, run as a PPP. Healthscope/Brookfield operates the hospital and the NSW government purchases clinical services for public patients from Healthscope/Brookfield.

Circumstances at the facility were initially described as unsustainable and unreliable.[71] The media reported the hospital was opened without adequate planning.[72] The CEO resigned shortly after opening following reports of shortages of staffing and supplies.[73] Clearly this is not what the community expects. This demonstrates the risks identified through TCE as discussed by Toner and referenced earlier in this submission.

The 2020 NSW parliamentary inquiry in the Operation and Management of the Northern Beaches Hospital made the finding:[74]

> *'That the public private partnership model underpinning the Northern Beaches Hospital, resulting in public patient services being delivered in an otherwise private hospital, has the potential to negatively affect people from lower socioeconomic backgrounds residing in the catchment.'*

The assumption can be made that people from lower socioeconomic backgrounds in the catchment will be accessing the public services of NBH. Clinical areas in NBH are currently staffed by nurses at levels below that of other NSW public hospitals:

- In public hospital wards inside NBH, staffing levels are maintained at levels from 2018 at 5.5 Nursing Hours Per Patient Day ('NHPPD'). This is reflected as a ratio of 1:4 morning shift, 1:5 evening shift, 1:7 night duty. Within the PHS, the majority of wards are at six NHPPD, a ratio of 1:4, 1:4 and 1:7 and will soon convert to shift-by-shift ratios which improves on NHPPD.
- In the private wards, there are no minimum staffing levels, save for a general requirement in state legislation and regulation (the *Private Health Facilities Act 2007 and Regulation 2017*) to have 'a sufficient number of qualified and experienced staff on duty, at all times, to carry out the services provided by the facility'. What is 'sufficient' is not defined.

NBH staffing may fall further behind NSW public hospitals after a Memorandum of Understanding (MoU) struck between Healthscope and the NSWNMA expires on 31 October 2023. This would mean no enforceable minimum staffing levels in public and private areas of NBH.

The MoU also provided for a model of staffing that only included nurses and midwives providing direct clinical care in the NHPPD. Importantly, this meant Clinical Nurse Educators ('CNE'), Clinical Nurse Specialists ('CNS'), and Clinical Nurse Consultants ('CNC'), along with 'NUM', were not included in the calculation of NHPPD, and instead were to be rostered as 'supernumerary' (i.e. in addition to minimum staffing levels) and are therefore able to attend to their clinical leadership, education, and supervisory duties. There is no guarantee Healthscope will continue this practice.

Taken together, the above means NBH, which is currently below the staffing levels in equivalent public hospitals, could see increases in the disparity between its staffing levels in public hospitals, and the standard of care, along with the safety of staff who will experience increased workloads, would then be threatened. This clearly demonstrates the impact of privatisation; that the profit is made through decreasing the quality of the service, in this case through decreased staffing levels. This is despite over

[71] Aubusson, K. (2019) 'Unstainable', 'unreliable': damning report for new Sydney hospital. SMH Accessed 14 Nov 2023
[72] https://www.theguardian.com/australia-news/2019/jul/09/sydney-hospital-found-to-have-opened-without-adequate-planning-or-preparation
[73] https://www.theguardian.com/australia-news/2018/nov/21/ceo-of-troubled-sydney-hospital-resigns-two-days-after-opening
[74] Legislative Council Committee on Health. (2020) Operation and management of the Northern Beaches Hospital

twenty years of academic, peer reviewed literature (referenced later in this submission), that ratios of 1:4 (6.0 NHPPD) decreases patient morbidity and mortality.

The Sydney Morning Herald revealed a year after being handed $7.5 million to establish an adolescent mental health unit in NBH, no beds had been provided despite rising numbers of youth suicides in the region.[75] Following the story, the government gave the provider eight weeks to provide a plan for commencement of the service. This reflects the concern raised by Toner, referenced earlier in this submission, regarding poor contract management. The government had handed over $7.5 million but had failed to ensure the commissioned service was provided and is only now seeking a 'plan'.

The impacts of privatisation are also felt in the everyday availability of basic medical supplies. At NBH, nurses in the Intensive Care Unit ('ICU') are regularly required to supply standard medications (including basic antibiotics) to general wards out-of-hours as part of the normal course of their duties because the NBH pharmacy, which is sub-contracted to Epic Pharmacy, has limited hours of operation, and standard drugs are not in imprest (i.e. emergency/out of hours stock) in wards. This means an unnecessary increase in the workloads of ICU nurses and ward nurses, who may be required to leave their wards to obtain medications. Public hospitals which have a pharmacy department that dispenses to all wards to maintain stock.

The NSWNMA's submission to the 2020 NSW Parliamentary inquiry in the Operation and Management of the Northern Beaches Hospital is provided at **Appendix 2**. This submission contains detailed concerns held regarding NBH and PPPs. There are indicators the privatisation of health services continues to place the public at risk since that submission was made.

There are a number of commonalities across all of the hospital/healthcare privatisation failures noted within this submission. These include:

- poor evidence of benefit to the state;
- no evidence of benefit to the public (healthcare outcomes);
- evidence of poor outcomes for patients and communities;
- limited Government control over quality of care provided;
- cost overruns;
- poor contract management;
- poor understanding of contract costs (by both government and the provider);
- increased cost to tax payers who are left to rescue the service; and
- loss of jobs and a resultant loss of experience both of which, apart from being devastating for the individual worker, flow on to impacting on patient care.

Most of the information noted in this submission ought to have been known to government at the time the decision to privatise was taken. Given the available evidence, it is clear there must be a moratorium on any further privatisation of any healthcare service. We welcome the NSW government's election commitment to not privatise public services or assets.

The moratorium should remain in place unless there is sufficient publicly available peer reviewed evidence within the fields of economics, sociology, health and other areas, which indicate a need for its return. The moratorium should remain in place until such time that legislative measures are in place which assure

[75] https://www.smh.com.au/national/nsw/how-many-more-kids-need-to-die-father-s-plea-as-health-pledge-stalls-20230723-p5dql8.html

transparency, accountability, and that allow sufficient regulatory enforcement capacity to ensure agreed minimum standards are maintained.

Attention is drawn to the comments made with regard to aged care privatisation, and the privatisation of palliative care in latter sections of this submission. This submission has not commented on the failures within disability and community health settings, however, sufficient examples exist to be able to draw the same conclusion within those areas. Nor has this submission explored the potential failings in the privatisation of cancer services, renal dialysis, or palliative care.

The submission has not commented on the clear evidence that shows publicly funded and publicly run healthcare provision is the most effective and efficient method of delivering universal healthcare. This, in our view, is incontestable when considering the efficiency of the Medicare monopsony; a system that has demonstrated effectiveness by providing Australians with better healthcare outcomes than those achieved in the privatised United States ('US') healthcare system, despite expenditure by GDP being half of that in the US. As stated by UN Human Rights Council's Special Rapporteur on Extreme Poverty and Human Rights:

'There is no substitute for the public sector to coordinate policies and programmes to ensure respect for human rights. Yet privatisation directly undermines the viability of the public sector and redirects government funds to subsidies and tax breaks for corporate actors.'

Governments should take back control of failed privatisations rather than give contracts to new private providers. There is an urgent need to restore confidence in the provision of services where non-government provision of services has failed.

Recommendations

- The NSW government commit to a complete moratorium on privatisation of health care services.
- The NSW government establish an independent regulatory agency to oversee privatised assets and service provision to ensure accountability. Governments must continue to employ sufficiently qualified staff in ministries/departments to evaluate the quality and competence of service providers, and to provide a continued role in strategic advice. Departments/Ministries of government should not be tendering policy decisions out to consulting or accountancy firms.
- There must be **NO** commercial-in-confidence provisions when taking public money to provide public services.
- Providers of privatised health services must, as a minimum, maintain the same employment conditions and standards as the government service it replaced in regard to:
    - wages and conditions of employment;
    - staffing levels;
    - health and safety;
    - equal opportunity employment; and
    - codes of ethics and other codes of practice.
- The NSW government make a regulation under s5(b) of the *Private Health Facilities Act 2007* which provides for minimum mandated shift-by-shift nurse and/or midwife ratios for all classes of private health facilities as defined under s4 of the *Private Health Facilities Regulation 2007.*

- All privatised health services that receive government funding to provide a public service should report annually to ensure services and infrastructure that use public money are open, transparent and delivered to the highest quality. Such reports must contain:
    - a log of all complaints;
    - a comprehensive and detailed, up-to-date cost of services, detailing government funds received and where the money has been spent;
    - measurable KPIs equivalent to, and to the same standard/format as public hospital;
    - feedback from service users on quality;
    - changes to workloads and employment conditions over the short and long term; and evidence that public sector equivalent minimum staffing numbers and standards, including pay and conditions for staff, are met and that accredited qualifications are recognised.

- Bring privatised hospitals into the NSW Health Performance Framework. The next hospital funding agreement signed between the state and federal governments needs to explicitly clarify how privatised hospitals are to be treated in terms of reporting and accountability.

- Publish private hospital performance data on My Hospitals. Private hospitals must be required to report on their performance in the same manner as their public hospital peers through My Hospitals. This includes the same clinical, access and financial performance data that all public hospitals are required to report.

- The NSW government should ensure the operation of correctional and health services at Parklea Correctional Centre and Clarence Correctional centre is returned to the state government at the earliest opportunity.

(v) How governance structures can a support sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centred care to improve the health outcomes of the NSW population

Policy and legislative change

The MoH needs to change its focus towards achieving health system objectives by embedding stakeholder influence and input within decision-making processes. This means a clear commitment to proactively collaborate and negotiate on policy and legislative decisions with stakeholders, instead of a top-down implementation of changes. Consultative processes in policy development encourages buy-in, trust and collaboration between stakeholders and the MoH.

Clinical placements

The NSWNMA regularly receives information from members and education providers around the many issues that exist with the management of clinical placements across NSW. The ongoing development of the nursing and midwifery workforce is a key factor in facilitating the delivery of high quality care into the future. Issues identified include:

- TAFE NSW and smaller RTO's fighting for placements for Diploma of Nursing and Certificate III students which creates delays in the workforce pipeline.

- Bachelor of Nursing students having placements cancelled at the last minute by LHD's with no explanation which has resulted in delays completing their course and entry into the workforce.

- Length of placements and incompatibility with maintaining their essential income earning employment as well as a lack of flexibility.

- Lack of access to appropriate or affordable accommodation for those required to attend placements far from home.

Implementing governance and frameworks that maintain the development through experience and stewardship together with education providers will build a better nursing and midwifery workforce.

Early career workforce

There is a need for frameworks and career pathways within governance structures with numeration scales that support the development of our emerging workforce and our future leaders. NSW Health has no clear nursing or midwifery career pathways that are supported, professionally developed, or encouraged within a consistent framework. Most career advancement has come at the cost of the individual employee and is self-directed. This has seen a significant impact with the loss of senior staff and the increase in nursing turnover rates (see **Section F**).

The loss of highly skilled and experienced nurses and midwives has resulted in many early career nurses and midwives stepping up prematurely to leadership roles without adequate support, training or experience. Our members have reported new graduate and second year nurses and midwives regularly working as the 'in-charge' of shift and second year nurses being appointed into acting clinical nurse educator and clinical nurse specialist roles. There is a need to ensure early career nurses and midwives are well supported in their professional development for them to succeed. Having career pathways embedded within workplace structures that include clear pathways for supported professional development and appropriate remuneration will result in workforce development and sustainability.

Policy Development and Implementation

The NSWNMA membership has raised issues with inconsistencies within LHD's and the MoH over clinical policy development. It has been noted that duplication of policy and often contradictory processes result from this lack of clear governance frameworks for policy development, implementation and auditing. This creates labour intensive review and development processes from key clinicians, e.g. educators who are then taken away from their key role of supporting, educating and developing the workforce. The clinical policy development and implementation process needs to be reviewed, with a view to reducing inappropriate policy duplication and associated expenditure. Our members have advised local level policies are often developed to overcome resourcing or workloads issues. Inconsistencies in clinical policies or protocols between LHDs for like services creates risks to the public and the registration of individual nurses and midwives.

Health service management at all levels have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring they are patient-centred, safe and effective. Governance structures are implemented to monitor and improve the performance of the organisation.[76]. They should not focus on short-cuts to overcome resource issues but rather make sure the right person at the right time is providing the right care. The MoH and LHDs have developed policies seen as a 'quick fix', low quality approach to staffing or resource shortages. Examples of this include:

[76] National Commission on Safety and Quality in Healthcare. (2023) Clinical Governance Standard

- The introduction of 'care assistant' in 2022. This role required no qualifications or experience, yet was initially designed to provide clinical care to patients that would ordinarily be provided by nurses. This short-sighted and short-lived measure was not appropriate and placed the public and workers at risk.

- Current attempts to implement a specialling policy at the LHD level based on funding and staffing shortages that will place added levels of workloads on clinical staff and has the potential to not protect the best interests of the public. Patient specialling is defined as 1:1 observation and care of patient with high and complex needs.

As already discussed, framework and governance structures need to bring together operational matters, risk management and reporting to relevant stakeholders. It also needs to recognise the future work environment is a two-way street: good for employees and improves health outcomes. Better job control and flexibility need to be part of governance structures to support the ability for a continues workforce pipeline thus, retaining and attracting nurses and midwives in NSW.

Our members have expressed their concerns around the shift in the workforce needs after COVID-19. Many of our more experienced members have left the profession, or are planning to, due to the inflexible rostering and a staunch reluctance by LHDs to allow part-time work in many senior and/or management positions. These are partly matters relating to local governance, and partly centralised governance of the MoH, with perhaps neither having a full picture of the impact on the individual nurse or midwife.

A 2018 report from the McKell Institute stated:

> *'with major growth sectors such as healthcare requiring more and more labour, competitive pressures will inevitably see upward pressure on wages for healthcare workers, especially if the skill and training levels of the workforce are to be maintained or improved. This emphasises the importance of a good working environment and career paths for health staff to ensure that staff can be both attracted and retained.'* [77]

Five years and one pandemic later we now know there is a nursing and midwifery workforce crisis which could be curtailed by genuine investment in labour through wage increases and staffing improvements. Instead, there is still reluctance at every level of public health governance to increase wages or expend labour costs in a manner that would improve workplace conditions (i.e. implementation of ratios).

Recommendations

- NSW Health undertake research to map nursing and midwifery career pathways to better understand workforce patterns and major impacts on retention and recruitment.

- The MoH give greater consideration to better identification of clinical policies that can be appropriately utilised across all LHDs/specialty networks as duplication and inconsistencies in practice that cause confusion and risk to professional practice obligations.

[77] The McKell Institute. (2018) Keep NSW in a Healthy State: Investing for a Healthy Future

C: The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all

Investing in nurse and midwife-led population health, health promotion and prevention activities

The MoH *Future Health: Guiding the next decade of care in NSW 2022-2032* report[78] ('Future Health report') highlights more than one-third of the current disease burden is preventable and due to modifiable risk factors, and two-thirds of the disease burden in NSW is caused by conditions that could be managed outside of an acute care setting. However, 85% of NSW Health spending is concentrated in hospitals. Activities related to prevention and promotion currently only receive 10% of NSW Health expenditure, and a mere 5% is invested in community or other care settings.

The Future Health report recognises the need to re-orientate health services into the future, to keep people healthy and well, to effectively manage chronic conditions, and to meet future demands for healthcare in NSW. To achieve this, a renewed focus on, and investment in, prevention and promotion is crucial.[79] Key strategies to achieve this, should ensure:

- Safe care delivered across all settings (safe, high quality reliable care is delivered in a sustainable and personalised way, within hospitals, in communities, at home and virtually)
- People are healthy and well (investment is made in keeping people healthy to prevent ill health and tackle health inequality in communities)
- Staff are engaged and well supported (staff are supported to deliver safe, reliable person-centred care driving the best outcomes and experiences)[80]

Nurses and midwives together with a substantial investment in nursing and midwifery care will be fundamental to achieving these strategic outcomes. However, it is notable that nurses and midwives are barely mentioned within the Future Health Report.

Primary healthcare

Primary healthcare is where the majority of prevention and promotion activities occur, and primary healthcare nurses are the largest group of healthcare professionals working in this area. Across Australia, at least 82,000 nurses and midwives work outside of the hospital setting.[81] Nurses and midwives are able to contribute to a range of initiatives outlined in the Future Health report, related specifically to prevention, promotion and primary healthcare:

[78] NSW Ministry of Health. (2022). Future Health: Guiding the next decade of care in NSW 2022-2032
[79] Ibid
[80] Ibid
[81] Australian Institute of Health and Welfare. (2023). A profile of primary health care nurses – web report

- Provide population health and health promotion initiatives (focus on promoting positive health behaviours and delivering early risk-based interventions)
- Support people to manage chronic conditions (that will contribute to hospital avoidance)
- Provide out-of-hospital care (face-to-face and virtually) within communities
- Contribute to achieving positive outcomes in line with the '*First 2000 Days, conception to age 5 Framework'*
- Provide crisis mental health care and support mental health and well-being
- Support healthy ageing
- Participate in programs that close the gap in health outcomes for Aboriginal and Torres Strait Islander people[82]

NSW Health must recognise the crucial role nurses and midwives have within primary healthcare, health promotion and prevention. When considering programs, policies, and governance structures to meet the demands of the future, NSW Health must ensure nurses and midwives are consulted and included.

In responding to this term of reference the NSWNMA draws attention to the Queensland Nurses and Midwives' Union ('QNMU') submission to the Health and Environment Committee *Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system,*[83] submitted as **Appendix 3**. The QNMU submission broadly replicates the arguments in this section and additionally, provides further evidence of the cost impacts of underutilisation of nursing and midwifery models of care, along with suggested responses which would inform a NSW response.

Nurses and midwives, employed and utilised effectively within primary healthcare settings, have the potential to transform the delivery of care to people in NSW and have a major role to play in hospital avoidance. However, both existing models of care and lack of recognition of their full scope of practice restricts their contributions. Available data shows there are around 100,770 nurses and midwives registered and employed in NSW[84] and are the largest professional group within healthcare. There are two types of nursing registration, registered nurse ('RN') and enrolled nurse ('EN'). Additionally, an RN may obtain an endorsement from the Nursing and Midwifery Board of Australia ('NMBA') to practise as a nurse practitioner ('NP').[85]

Despite nurses being the largest cohort delivering healthcare, their scope of practice is restricted by healthcare funding arrangements and prescribed collaborative models of care. Disappointingly, in 2022, 539 NPs across Australia were not working in that role, which is a missed opportunity.[86] The impact for people in NSW is evidenced through lack of primary healthcare providers and disparate service provision, particularly in rural and remote areas.

If able to work to and expand their scope of practice, nurses and midwives could enable the number of primary healthcare providers to increase in a cost-efficient manner. This would also provide more choice as well as improving access to affordable, equitable and appropriate healthcare.

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[82] NSW Ministry of Health. (2022). Future Health: Guiding the next decade of care in NSW 2022-2032[82]

[83] QNMU (2021) Submission to the Health and Environment Committee Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system.

Australian Government Department of Health and Aged Care (2023). National Health Workforce Dataset

[85] Health Practitioner Regulation National Law (NSW), s95

[86] Australian Government Department of Health and Aged Care (2022). Fact Sheet Selector Dashboard. Nurses and Midwives

The NMBA define the scope of practice for nurses and midwives and suggest:

> *'While the foundational education of RNs, ENs, NPs and midwives in Australia captures the full breadth of the scope of the profession at the graduate entry level, the scope of practice of individual practitioners is influenced by the settings in which they practise. This includes the health needs of people, the level of competence and confidence of the nurse or midwife and the policy requirements of the service provider. As the nurse or midwife gains new skills and knowledge, their individual scope of practice changes.'* [87]

Connectedness of people to general practitioners ('GP') was found to reduce burden on NSW hospitals.[88] However, access to primary healthcare has become increasingly difficult and bulk-billing GPs have become increasingly scarce. There is a predicted shortfall of 10,600 GPs across Australia by 2031-2032, especially in rural and remote areas.[89] However, many communities are already experiencing this gap,[90] and despite large financial incentives, recruitment and retention of GPs has not grown to the level required,[91] resulting in poorer health outcomes, patient experiences and reduced or delayed access to primary healthcare. Nurses and midwives, working to their full scope of practice have a key role in working with GPs to deliver some services currently only funded for medical practitioners to deliver.

Primary healthcare services have a significant role to play in hospital avoidance, but the funding system in which they operate favours service provision by medical practitioners rather than nurses and midwives providing few opportunities for collaborative care models. GPs have become established as local gatekeepers of primary healthcare services, and funding, in NSW. This has caused a lack of incentive for nurses and midwives' to be employed or undertake activities which are within their scope in primary care. For example, nurses working in GP practices must be supervised by a medical practitioner and can only work to a restricted scope of practice according to specific MBS items undertaken by nurses, that the GP can claim. NSW has a role to play in lobbying for legislative reform, as well as jurisdictional and organisational policy reforms. There is also a need to raise public awareness about how nurses and midwives are a safe and affordable choice of primary health practitioner.

Nurses and midwives provide holistic care using a person or woman-centred framework. Nurses and midwives are expected to meet the standards for clinical practice for their profession and to work autonomously and collaboratively as members of multidisciplinary teams ('MDT'). Working to and expanding their scope of practice by incorporating new areas of clinical work and education presents nurses and midwives with the opportunity of expanded career trajectories, increases job satisfaction, and ultimately enhances care delivery.[92,93]

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[87] Nursing and Midwifery Board of Australia. (2022). Fact sheet: Scope of practice and capabilities of nurses and midwives.

[88] Correll, A. et Al (2021) Lumos: a statewide linkage programme in Australia integrating general practice data to guide system redesign. Integrated Healthcare Journal, 3(1).

[89] Association, A. M. (2022) The general practitioner workforce: why the neglect must end. Australian Medical Association: Barton, ACT.

[90] Murray, R. B. and Craig, H. (2023) A sufficient pipeline of doctors for rural communities is vital for Australia's overall medical workforce. Medical Journal of Australia, 219: S5-S7.

[91] Swami, M. and Scott, A. (2021) Impact of rural workforce incentives on access to GP services in underserved areas: evidence from a natural experiment. Social Science & Medicine, 281: 114045.

[92] Déry, J. et al (2022) Optimizing nurses' enacted scope of practice to its full potential as an integrated strategy for the continuous improvement of clinical performance: A multicentre descriptive analysis, Journal of Nursing Management, 30(1), pp. 205–213.

[93] Colby, A. et Al (2021) ReImagine: Amulti-Disciplinary Quality Improvement Plan to Work at Top of Scope, Journal of Pediatric Nursing, vol. 60, pp. 92–99.

Nurses and midwives are already leading care and undertaking evidence-based practice and person-centred care in their local communities. Still, they are constrained by medical funding models which promote supervision by GPs stifling their ability to work autonomously. Additionally, they may be subject to further restrictions as a result of jurisdictional or organisational policies that constrain their practice despite their education and experience.

Nurse and midwife-led models of care are cost-efficient with positive health outcomes and represent effective, feasible and appropriate ways of delivering care.[94] Evidence suggests NPs produce health outcomes equivalent to medical practitioners for people with chronic health conditions in primary care. [95,] Further, nurse-led care has been found to be more effective than medical care in promoting adherence to treatment and patient satisfaction. [96] American studies conclude that NPs working independently (that is, without the requirement to be supervised by a medical practitioner) increase availability of primary care, the frequency of routine check-ups and quality of care, and decrease emergency department ('ED') presentations by patients with ongoing health conditions.[97] NPs produce direct and indirect cost savings and positively impact the quality of life for people seeking healthcare.

Template examples from other jurisdictions provide models which could easily be replicated in NSW. Introduced in 2012, Walk in Centres ('WiC') in the Australian Capital Territory ('ACT') are a major initiative funded by the Territory government and demonstrate significant progress in the delivery of nurse-led primary health care, enabling nurses to work to an expanded scope of practice.[98] The WiCs are based on a model developed in the United Kingdom ('UK').[99] The five WiCs are situated in population centres across the ACT. They employ a team of nurses and are well supported by the communities they serve, increasing access to free primary health care.[100]

ACT WiC nurses saw 20,552 presentations and tested 26,766 people for COVID-19 with a median wait time of 29 minutes.[101] Community acceptance is high, and since 2021, the WiCs saw an increase of 48.1% in presentations. Of those seen, 81.2% received treatment at the WiC and 5.9% were redirected to the ED, with the remainder redirected to a GP or leaving without being seen.[102] These figures represent a significant number of people diverted from EDs, resulting in cost savings for hospitals, the government and people seeking primary healthcare, as well as reduced waiting times.

This model offers further opportunities for cost-efficiencies in NSW if RNs, ENs and NPs could work to their full or an expanded scope and could also extend to include co-located practitioners or the establishment of midwifery group practices ('MGP'). So far WiC have failed to be adopted in NSW, in favour of medically led urgent care services.[103] Whilst aiming to reduce hospital admissions, these lack the potential to utilise

[94] Liu, C. F., et Al. (2020) Outcomes of primary care delivery by nurse practitioners: Utilisation, cost, and quality of care. Health services research 55(2) pp. 178-189.
[95] Coster, S., et Al. (2018) What is the impact of professional nursing on patients' outcomes globally? An overview of research evidence. International Journal of Nursing Studies 78 pp. 76-83.
[96] Kippenbrock, T., et Al. (2019) A national survey of nurse practitioners' patient satisfaction outcomes. Nursing Outlook 67(6) pp. 707-712.
[97] Traczynski, J. and V. Udalova (2018) Nurse practitioner independence, health care utilisation, and health outcomes. Journal of Health Economics 58. pp 90-109.
[98] ANMF. (2023). Advanced practice nurses caring for communities in need
[99] NHS. (2021). When to visit urgent treatment centres (urgent care services)
[100] ACT Government. (2023). Walk-in Centers (Wic)
[101] ACT Government ACT Health (2022) ACT Public Health Services Quarterly Performance Report. Canberra, ACT Health. July-September 2022.
[102] ACT Government ACT Health (2022). ACT Public Health Services Quarterly Performance Report. Canberra, ACT Health. July-September 2022.
[103] NSW Health. (2023). Urgent Care Services in NSW

nurses working to their full scope as independent practitioners. NPs, or RNs could assess, triage, and treat people likely to present in EDs for low level care episodes like initiation of antibiotic therapy, catheterisation and simple wound care or suturing. Consideration should be given to establishing WiCs in NSW to better utilise the nursing workforce in a manner that would reduce pressure on EDs and improve access to care.

Further examples of better established and successful nurse-led care models include child and family health nurses who offer families in their local community free access to highly skilled nurses and midwives providing advice, assessment, screening, monitoring, education, infant vaccination clinics and more, leading to improved access and outcomes for parents and children.

Midwifery Group Practice

The scope of practice of a midwife provides potential for midwives to work autonomously as demonstrated through models of care such as MGP. In this model, midwives not only work to their full scope which adds to job satisfaction, it is more cost-effective and offers better outcomes for women due to continuity of care, resulting in significantly higher rates of normal birth compared to standard hospital care and private obstetric care.[104] Even though it is proven to be the gold standard of care, MGP models of care only account for 11% of available models. This means there are a lack of available spaces compared with demand, and usually it is only inclusive of low-risk women. Those who are deemed high risk or unaware of the system due to education or language barriers miss out and are often the women who need it the most.

NSW is lagging behind other states when it comes to MGP access. Across Australia, MGP models of care represent 14% of available models of maternity care and in QLD, MGP represents 25% of available models of care.[105] MGPs demonstrate cost savings for health departments due to reduced intervention rate and hospital stays,[106] and were shown to cost 22% ($5,208) less per pregnancy than other models of maternity care.[107] Despite sound evidence as to the economic, health and social benefits of MGP, we are yet to see any meaningful commitment to a commensurate expansion of access to this model of care.

Objective 2 in the NSW Health, *The First 2000 Days*, conception to age 5 Framework, states the health system provides care to all and works in partnership to promote health, well-being, capacity and resilience during the first 2000 days of life.[108] Nurses and midwives are ideally placed to provide community based care for young children and families, operating within multidisciplinary collaborative care models. Community access to nurses and midwives is vital for the success of this initiative.

Incorporating MGPs into community health centres and with midwives working with other health practitioners would help to improve communication and continuity of care by presenting a one-stop shop for women and their families that could be accessed through pregnancy and as their children grow. This type of service, staffed by midwives, child and family health nurses, women's health nurses and mental health clinicians would help prevent women and families from falling through gaps created by fractured service provision and encourage greater community engagement and support.

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[104] Tracy, S. K., et al. (2014). Caseload midwifery compared to standard or private obstetric care for first time mothers in a public teaching hospital in Australia: a cross-sectional study of cost and birth outcomes. BMC Pregnancy and Childbirth 14(1) pp. 1-9.

[105] Australian Institute of Health and Welfare (AIHW) 2023, Maternity models of care in Australia, 2023

[106] Australian Institute of Health and Welfare (AIHW) 2023, National Perinatal Data Collection data availability resource

[107] Callander, E. J., et al. (2021). Cost-effectiveness of public caseload midwifery compared to standard care in an Australian setting: a pragmatic analysis to inform service delivery. International Journal for Quality in Health Care 33(2) mzab084.

[108] NSW Ministry of Health. (2019). The First 2000 Days: Conception to Age 5 Framework

Nurse Practitioners

Nurse Practitioners working collaboratively with other health professionals could improve access to healthcare for NSW communities through health promotion, disease prevention, and health management strategies. It is within a NPs ability to assess and diagnose, order and interpret diagnostic investigations, formulate and assess responses to treatment plans, prescribe medicines and refer to other health professionals within their areas of competence. NPs may also admit and discharge people from health services, including hospital settings. They improve health outcomes for specific patient populations or communities.

The burden placed on EDs continues to increase, often because of avoidable, non-urgent or inappropriate presentations, and exacerbated by people's inability to access primary healthcare.[109] Increasing the primary healthcare workforce offers the opportunity to reduce the number of presentations to EDs, enabling the ED workforce to focus on patients in critical conditions and reduce ramping and waiting times and costs to the health service. The previously mentioned WiC in the ACT provides an example of how this might occur, as do health services for people experiencing homelessness.

People experiencing homelessness have significantly greater health needs than the general population, accounting for a disproportionate use of acute health services and ED presentations. Not only is this expensive, but due to the very nature of EDs, the care available to this group is often inappropriate and lacking in coordination.[110] There are many reasons why people experiencing homelessness disengage from traditional primary healthcare providers, including lack of trust and cost of services in an increasingly privatised context and stigmatisation.

A co-located nurse-led primary health clinic run within a hostel in inner Sydney for men experiencing or at risk of experiencing homelessness is an example of a service set up due to needs identified by the nurses working in that community.[111] The service offers medical and mental health assessments, diabetes management, medicines administration and monitoring of efficacy and side effects, facilitation of prescription dispensing, and case management for those with more complex needs. Other services working at the clinic include a medical practice, specialised preventative management programs, optometry, and podiatry care.

Clinics such as this for those experiencing homelessness and other such services reduce avoidable or inappropriate hospital ED presentations by adopting and promoting preventative care, early intervention, and coordination of services in a safe and trusted environment with nurses providing case management and continuity. However, nurses and midwives working to their scope of practice, especially in nurse-led and midwife-led services, risk criticism, false claims, and a lack of support from organisations that do not support nurses and midwives working autonomously or as part of multidisciplinary teams to deliver primary healthcare.

Further examples of successful NSW nurse-led initiatives include Recovery Camp operating from the University of Wollongong.[112] This nurse-led initiative is targeted at people with lived experience of mental illness and students studying health, including nursing. Each camp is a four-night, five-day immersive experience where health students and clinicians from a range of disciplines and people with lived

[109] Queensland Health (2022) Emergency Nursing. Improving access to care. Vision, solution, opportunity. Queensland
[110] Roche, M. A., et al. (2018). Nurse-led primary health care for homeless men: A multimethods descriptive study. International Nursing Review 65(3) pp. 392-399.
[111] Ibid, Roche et Al (2018).
[112] Recovery Camp. (2023). Recovery Camp

experience of mental illness engage together in recovery-oriented, therapeutic recreation activities that promote mental health, social connection, and physical activity. Research is also embedded into the program. In 2023, the group ran their fortieth camp.

For aged care, having more NPs would greatly reduce ED presentations, ambulance costs and hospital admissions. In rural and regional areas, NPs and RNs who practise at an advanced level make access to health care more accessible and allow more services to be provided to Aboriginal and Torres Strait Islander populations.

NSW should provide support to nurses and midwives wanting to expand their scope of practice through the development of policies and guidelines which provide pathways for development and statewide recognition of skills and competencies.

The success of such initiatives will rely on a change to how primary healthcare is publicly perceived. The use of language by governments and organisations is an important consideration. Primary healthcare is not only provided by GPs. Any discussions of primary healthcare policy must include nurses and midwives and recognise their full potential as providers of primary care and the consequential economic and social benefits.

There are many ways NSW can support the development of nurses and midwives working to their full scope including advocating for the removal of current funding restraints in accessing the MBS by nurses and midwives impacting their ability to work to their full scope of practice in the community. Also, the expansion of the scope of practice for RNs, allowing endorsement as a designated registered nurse prescriber as set out in the recent NMBA consultation on endorsement of scheduled medicines.[113]

Mental health funding

The NSWNMA has significant concerns about current funding arrangements for mental health services in NSW. Funding is not keeping pace with consumers' need for comprehensive, quality mental health services. Our members report significant issues in both community mental health ('CMH') and inpatient mental health that are associated with a lack of investment in these services. Demand for inpatient beds, especially those that are specialised (e.g. parent and baby units) or high acuity (e.g. Mental Health Intensive Care Units ('MHICU')) considerably outstrips supply. The impact of a lack of primary health, community health and inpatient mental health funding and investment is wide ranging. There is a direct impact on EDs when consumers without access to primary or CMH care deteriorate and become acutely unwell. The lack of investment in CMH services also compounds pressure on inpatient units where consumers may remain longer than necessary when there aren't appropriate CMH services to discharge them to.

There are insufficient CMH nurses employed to effectively provide care for consumers in the community. This has seen CMH nurse workloads blowing out, exacerbating issues with recruitment and retention of staff, and limiting the provision of care to those who desperately need it.

Currently we lack any proper systems to manage the workloads of CMH nurses, with high workloads impacting on case managers' experiences of burnout, job dissatisfaction and stress, and more generally,

[113] Nursing and Midwifery Board of Australia (NMBA). 2023. Consultation regulation impact statement

their own well-being and health[114],[115],[116],[117],[118]. These negative outcomes among workers can indirectly spill over to consumer outcomes through the quality of care clients receive and can directly impact care in situations where case managers have limited time for individualised attention to consumers and their families.[119]

The NSWNMA is aware of a metropolitan Sydney-based service where CMH nurses have had caseloads of more than 50 people (in addition to running depot clinics and accompanying non-nurses in the team to visit their consumers when depot medications are required to be administered). The literature suggests '*optimal personal efficacy can be achieved with caseloads of fifteen to twenty clients.'*[120]

While developing models for caseloads in CMH is a complex task (as it needs to consider more than just numbers of consumers, but also matters such as risk; relapse pattern; needs; support; engagement and compliance; contact; and care coordination), this is an area that must be addressed as a matter of urgency to ensure CMH services are able to recruit and retain nurses, as well as provide the necessary services, to keep people out of hospital where possible and assist in prevention of relapse on discharge.

The adequacy of numbers of available mental health beds is also regularly raised with the NSWNMA by members, this includes acute beds numbers and distribution of available MHICU beds.

The consequences of the lack of mental health beds are acutely felt by members working in EDs, attempting to provide care to people who are acutely unwell in inappropriate physical environments and without appropriately trained mental health staff. This is having significant impacts on both those requiring care, and the nurses attempting to provide that care.

Members in another metropolitan Sydney hospital report regularly having patients sitting for up to three days in the ED waiting for an inpatient bed. These wait times have a significant impact on consumers. EDs are not low stimulus calm environments. The noise, bright lights and activity levels associated with EDs increase the level of agitation experienced by many mental health patients, not to mention the discomfort and lack of sleep. Members in EDs are reporting higher levels of aggression and violence towards staff.

> *"Bed block in the MH system has led to patients having extended delays in the Emergency department, sometimes spending days in Emergency. With hospital wide bed block MH patients are commonly cared for in inappropriate corridor spaces, leading to escalations in the behaviour and putting staff and other patients at increased risk of violence and aggression. There have been multiple episodes of scheduled patients being managed in corridor spaces, escalating in their behaviour, and absconding from the department, in the process presenting as a serious risk of*

[114] Acker, G. M., and Lawrence, D. (2009). Social work and managed care: Measuring competence, burnout, and role stress of workers providing mental health services in a managed care era. Journal of Social Work, 9(3), 269–283.
[115] Cosgrave, C., Maple, M., and Hussain, R. (2018). Work challenges negatively affecting the job satisfaction of early career community mental health professionals working in rural Australia: Findings from a qualitative study. The Journal of Mental Health Training, Education and Practice, 13(3), 173–186.
[116] King, R., Le Bas, J., and Spooner, D. (2000) The impact of caseload on the personal efficacy of mental health case managers. Psychiatric Services, 51(3), 364–368.
[117] Salyers, M. P. (1998). Predictors and consequences of staff burnout: A longitudinal study of assertive community treatment case managers [Doctoral dissertation, Purdue University].
[118] Shirom, A., Nirel, N., and Vinokur, A. D. (2010) Work hours and caseload as predictors of physician burnout: The mediating effects by perceived workload and by autonomy. Applied Psychology, 59(4), 539–565.
[119] Spernaes, I., Holborn, P., Whent, A., and Griffiths, K. (2017) A caseload management tool for community mental health teams. British Journal of Mental Health Nursing March/April 2017 Vol 6 No 2
[120] Henderson, J., Willis, E., Walter, B., and Toffoli, L, (2008) Measuring the workload of community mental health nurses: A review of the literature, Contemporary Nurse, 29:1, 32-42.

physical violence towards staff and damaging property. The lack of available MH beds poses a serious risk to staff safety as long Emergency stays extend a patient's exposure to the highly stimulating environment."
RN, metropolitan NSW.

In April 2023, $130 million was allocated to a Mental Health Recovery Program to help people whose mental health is affected by the COVID-19 pandemic.[121] Most of this funding has been allocated to the private sector, in part, to free up more mental health beds. The NSW parliamentary inquiry into the impact of ambulance ramping and access block on EDs[122] demonstrated bed block has been a long-standing issue in EDs across Australia, where patients with acute mental and behavioural conditions disproportionately experience unacceptably long waits in the ED for inpatient mental health care.[123]

Finally, members continue to report issues with the management of extremely high-risk patients, including the numbers and distribution of MHICU beds across NSW. Nurses are frequently working with extremely high-risk consumers in adult acute units as they are unable to access MHICU beds. For example, the eight MHICU beds in Hunter New England LHD ('HNELHD') are designated to cover all of Hunter New England, Mid North Coast and Northern NSW LHDs. There are neither enough beds, nor is this practical (logistically it is difficult to transport extreme high-risk patients from Lismore to Newcastle). Similarly, Illawarra Shoalhaven LHD needs to send MHICU patients to Prince of Wales Hospital in Sydney. To address this difficulty many LHDs/facilities have created areas within their acute mental health wards known by names such as 'observation areas', 'High Dependency Areas' or 'high care areas' etc, where they co-locate their highest risk patients. Unlike MHICUs, these arrangements are in areas often not purpose designed for extreme high-risk patients and do not receive the additional funding required to ensure an adequate number of appropriately trained staff are available to provide safe care. This is leading to significant injuries to nurses and is impacting retention of workers in mental health.

Fragmentation of service delivery in community settings

There has been a rise in the use of not-for-profit and private entities commissioned to deliver community and inpatient services, leading to increased fragmentation of care and privatisation by stealth. The community is often unaware of the shift of these services from the public sector. In 2017, Silverchain were awarded a contract to provide end of life care to NSW Health patients in Western Sydney under the then NSW government's social investment initiative.[124] The project was reported to run over seven and a half years at a reported cost of $80 million.[125]

As the contract was commercial-in-confidence, the detailed arrangements and monitoring of outcomes were not transparent. However, Blacktown City Council along with our members contacted the NSWNMA following its implementation raising concerns about the service. The model adopted was to only provide care for the final days of life, which is contrary to the continuity of care models provided by NSW Health. We received reports from members of care deficits owing to Silverchain not employing enough experienced and qualified staff.

[121] Mental Health Recovery Funding April 2023
[122] New South Wales. Parliament. Legislative Council. (2022). Portfolio Committee No. 2 - Health. Report no. 60, Impact of ambulance ramping and access block on the operation of hospital emergency departments in New South Wales.
[123] Australian College of Emergency Medicine. (2018). Waiting Times in the Emergency Department for People with Acute Mental and Behavioural Conditions
[124] NSW Government. (2017). Deed of Implementation Agreement for Silver Chain Group Community- Based Palliative Care- Social Impact Investment
[125] Financial Standard. (2017). NSW Government make social impact investment for palliative care

We heard reports of patients dying on their way to hospital in ambulances as the understaffed nurse was unable to identify or manage symptoms. Staff employed by Silverchain were not able to access NSW Health patient records in a timely manner which further complicated the care journey. This sort of 'cherry picking' of services ultimately serves the fiscal interests of private providers and shifts the cost of providing more complex or expensive services back onto NSW Health. This money could be invested in community nursing services delivered by NSW Health and would promote quality continuity of care and reduce fragmentation of service provision.

Other examples include the provision of aged care, dementia care and palliative care by Hammond Care, and the provision of drug and alcohol services by Uniting. Headspace, the youth and adolescent mental health service is publicly funded, but privately run. In 2020 the NSWNMA fought the transfer of a publicly run mental health telephone advice line in NSW to Medibank. Medibank half-yearly results 2023 defy current economic trends by seeing a rise in net profit of 5.9% to $233.3 million.[126] Outsourcing services to for-profit companies accountable to shareholders, which could easily be provided by NSW Health, is not an appropriate or accountable use of public funds.

While engagement of these entities is posed as meeting a 'gap' in service delivery, there is a strong case to prevent duplication, achieve economies of scale, and have better integrated services provided by NSW Health. NSW Health has the capability to remedy identified 'gaps' in services and there is no evidence that a privately run company would provide a higher quality of care. The former government's privatisation agenda must be halted and re-focused to building capacity of NSW Health to deliver these services into the future.

Intersection between Public Health and Aged Care

It is the position of the NSWNMA that aged care is a context of healthcare and as such, should be considered part of primary healthcare. The disconnect between federally funded aged care services and state funded health services creates an invisible barrier which disadvantages care delivered to older people in NSW. It also provides ideal conditions for cost-shifting of aged care delivery to the public sector.

The COVID-19 pandemic provided clear evidence of the benefit of having locally delivered integrated services relative to health outcomes. The Commonwealth response, particularly around workforce in infection prevention and control was found lacking; NSW LHDs utilising outreach services provided a solution which ultimately, saved both money and lives.

A key learning from Newmarch House during the COVID-19 pandemic was the need for integrated and well-coordinated primary healthcare.[127] Due to the apparent lack of preparedness of residential aged care facilities, NSW Health stepped in and eventually worked with over 880 residential aged care facilities throughout NSW to improve their level of preparedness and prevent further COVID-19 outbreaks in aged care settings.[128]

Critical work led by NSW Health to support the preparedness of residential aged care facilities included:

[126] Medibank. (2023). 2023 half year results- A solid result with business momentum returning

[127] Australian Government Department of Health and Aged Care (2020). Newmarch House COVID-19 Outbreak [April-June 2020] Independent Review: Final Report.

[127] NSW Health. (2020) NSW Health response to final report of the independent review into the Newmarch House COVID-19 outbreak, and NSW Health. (2022) Protocol to support joint management of a COVID-19 outbreak in one or more residential aged care facility (RACF) in NSW

- the need to ensure aged care staff were well trained in infection control and prevention, and have an infection control lead or champion at each facility;
- that individual facilities held suitable levels of PPE and knew how to use it; and
- that scenario exercises were conducted to test outbreak management plans in the local setting.

All of the above incurred costs were met by the state, despite billions of taxpayer dollars already funding a largely privatised aged care sector in NSW to manage their own organisational response to the pandemic.

The ongoing burden to NSW Health arising from a poorly staffed and governed aged care sector was identified in a joint report on avoidable admissions and delayed discharge undertaken by the NSW Aged Care Roundtable. The findings of which were consistent with a later research paper commissioned by the Royal Commission into Aged Care Quality and Safety.[129] Both papers found avoidable hospitalisations frequently occur citing falls, palliative care, behaviour management of people living with dementia, catheterisation and pressure injury as some of the reasons people are transferred to hospital from residential aged care facilities.[130]

One of the recommendations of both reports was enhanced collection of data on hospital admission and delayed discharge. However, the identified costs to NSW Health borne out of propping up a largely privatised aged care sector in NSW have never been clarified through data collection, despite being highlighted as an area requiring attention.[131]

There is great potential for cost savings through community-based prevention of hospital admissions. Programs such as the Geriatric Flying Squad operating from South Eastern Sydney LHD utilising a multidisciplinary team largely resourced by nursing staff is a good example of a service focused on hospital avoidance which could be rolled out across the state.[132] Additionally, a trial of a Geriatric Rapid Acute Care Evaluation ('GRACE') program for assessing older people prior to hospital admission is currently occurring in South Western Sydney LHD (SWSLHD) based on a program operating from Northern Sydney LHD.[133]

However, as the Whole of Health Program: Aged Care Projects[134] stream identifies, the success of these initiatives relies on strong collaboration and partnership, whereas currently the rollout is ad-hoc and tenuously links to overall governance of the health system. This leads to potential duplication of effort and wasted resources. Additionally, lack of data collection means these initiatives cannot be properly evaluated relative to cost-efficiencies.

A comprehensive and coordinated approach to funding the roll out of these template initiatives across NSW would not only reduce duplication but could enable cost savings relative to hospital avoidance and would have the additional benefit of enabling nurses to work to their full scope of practice.

In response to the recent Aged Care Taskforce – Funding Principles consultation[135] the Australian Nursing and Midwifery Federation ('ANMF') confirmed the decision of its Federal Council to request the federal

[129] Office of the Royal Commission. (2021). Hospitalisations in Australian Aged Care
[130] NSW Aged Care Roundtable (2019). Joint report on avoidable hospitalisations from residential aged care facilities in NSW and delayed discharge
[131] NSW Health. (2021). NSW Health Feedback Aged Care Royal Commission Data Analysis Reports
[132] Jain, S., Gonski, P., Jarick, J., Frese, S., Gerrard, S. (2018) Southcare Geriatric Flying Squad: an innovative Australian model providing acute care in residential aged care facilities, Intern Med J. 2018 Jan;48(1):88-91. doi: 10.1111/imj.13672. PMID: 29314516
[133] https://www.nslhd.health.nsw.gov.au/Services/Pages/GRACE-Hornsby.aspx
[134] NSW Health. (2023). Whole of Health aged care projects
[135] Australian Nursing and Midwifery Federation. (2023). Aged Care Taskforce

government fully investigate the efficiencies and benefits that would be gained by all Commonwealth aged care funding being provided directly to states and territories. They would administer and run the aged care systems in their jurisdictions, with each state or territory determining the most suitable and holistic approach to delivery of aged care services. This would enable localised governance of aged care and provide optimal conditions for integrated models of care aimed at hospital avoidance.

Recommendations

- NSW Health recognises the crucial role of nurses and midwives within primary health care, health promotion and prevention in policy development and service planning and implementation.
- When considering programs, policies, and governance structures to meet the demands of the future, NSW Health ensures nurses and midwives, and their union, are consulted and included.
- NSW Health must lobby for legislative funding reform, as well as jurisdictional and organisational policy reforms to enable nurses and midwives to work to their full scope of practice and expand the delivery of nurse and midwife led primary healthcare services.
- NSW Health run an active education campaign to promote nurses and midwives as primary health practitioners.
- NSW Health consider as a priority the utility and cost effectiveness of establishing WiC in NSW in strategic planning.
- NSW Health ensure the number of MGP positions are increased and consider incorporation of MGPs into community health centres.
- NSW Health develop a caseload management system for community mental health workers to ensure that caseloads are maintained at levels that allow good support for consumers whilst also managing the psychosocial hazards associated with role overload for nurses to prevent psychological injury and burn out.
- LHDs must staff community mental health services appropriately to allow reasonable caseloads to be maintained.
- NSW Health review numbers of mental health beds to ensure appropriate bed numbers are available and EDs are not impacted by bed block.
- LHDs must establish and/or appropriately resource MHICU beds in each LHD.

D: Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency

Nurse/midwife patient ratios

The single most effective measure to improve efficiency and reduce unnecessary cost in NSW Health is the implementation of nurse/midwife to patient ratios in every ward of every public hospital. There is substantial research that demonstrates ratios are associated with improved health outcomes for patients, recruitment, and retention of nurses and midwives. Improved retention results in efficiencies, because the cost of advertising, employing, and training new staff is significantly diminished.

Ratios have been demonstrated to reduce unplanned readmissions to hospital, length of stay and avoidable deaths. Ratios also were associated with a reduction in hospital acquired health conditions such as pneumonia, pressure areas (commonly known as bed sores), urinary tract infections and falls.[136] . All of which add considerable (and avoidable) cost to the health system.

Unplanned readmission in Australia is estimated to cost $1.5 billion per year[137], so even a small reduction in readmission rates presents potential financial benefits of tens of millions of dollars.

A landmark study in Queensland, after the implementation of ratios, compared hospitals with ratios to those without and found the cost savings associated with reduced length of stay and reduced readmission rates was more than double the expenditure on the additional staffing.[138] This study modelled a two-year period for a hospital and found the implementation of ratios over that period would avoid 255 readmissions, saving $67 million. This was more than double the cost of the additional staffing, estimated at $33 million.

There are numerous further studies which report the benefits to patient care delivered by ratios. A summary of the evidence can be found in **Appendix 4** to this submission in *Ratios Saves Lives – Supporting Research*. The evidence is clear and overwhelming and should be embraced by all parts of NSW Health.

Ratios also create better and safer working environments for nurses and midwives, leading to reduced turnover rates and better staff retention. NSWNMA members continue their calls for a health system which allows them deliver the quality of care they want to deliver, and which the people of NSW deserve. The care

[136] Lasater, K. B., Aiken, L. H., Sloane, D., French, R., Martin, B., Alexander, M., & McHugh, M. D. (2021). Patient outcomes and cost savings associated with hospital safe nurse staffing legislation: an observational study. BMJ open, 11(12), e052899.

[137] Deeble Institute for Health Policy Research. (2022) Avoiding hospital readmissions: the models and the role of primary care

[138] McHugh, M. D., Aiken, L. H., Sloane, D. M., Windsor, C., Douglas, C., & Yates, P. (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. Lancet (London, England), 397(10288), 1905–1913.

that is missed in understaffed systems is more often than not care that those outside of NSW Health see as unimportant, but which can have a profound effect on how patients experience the health system.

Nurses and midwives need the time to talk to their patients/women to understand their needs and concerns and to provide them with information and reassurance, during what is often a stressful and difficult time. Nurses and midwives want to provide genuine and high quality person-centred/woman-centred care. This could be making sure a patient has eaten and is hydrated, assessing their physical, psychological, and emotional needs and making sure they feel safe and comfortable. All of the above are essential parts of nursing and midwifery care which all too often are the victims of insufficient staffing levels.

Nurses and midwives are pressured by competing and unrelenting policy and professional demands on a background of understaffing and time limitations. Undertaking vital observations, patient assessments, preparation, checking and administration of medication, detailed risk assessments, simple and complex wound management, documentation, multidisciplinary collaboration, nursing/midwifery team communication and communication with patients' families take precedence. These pressures combined with the unique pressures of any clinical environment, short staffing, aggression and an inability to prioritise personal care (e.g. eating, drinking, sleeping) due to workload create a perfect storm for serious adverse events to occur.

Implementation of ratios ensures there are a transparent and sufficient number of staff to make sure these needs can be met, and patients' and womens' experiences of the health system are positive. Nurses and midwives who go home at the end of a shift knowing they have been able to deliver excellent care because they had the resources they needed are much more likely to continue long fulfilling careers in health, and utilise the vast skills and experience they have been invested with.

The current NSW government has committed to implement a ratios system in five key areas of public hospitals, and while we strongly welcome this and continue to work closely with MoH on its implementation, we believe ratios or equivalent safe minimum staffing systems should be implemented in all clinical areas of the health system.

It has been clearly demonstrated that the widespread implementation of ratios is not a 'cost' to the system, it's an investment in patient care and the well-being of workers that will more than fund itself.

Reducing the cost of avoidable serious adverse events

In the six years between July 2013 and June 2019, $1,060,000,000 was paid out in liability claims relating to adverse events within NSW Health.[139] Since 2019, this data has not routinely been disclosed through the NSW Health annual reporting. iCare now administers claims from the Treasury Managed Fund ('TMF') on behalf of NSW Health. Available data from iCare does not separate health claims from other claims made within the same fund.

The simple number of claims paid above does not begin to quantify the actual cost of the adverse events that led to those claims. There are innumerable and immeasurable ways in which those events will cost NSW Health, other government agencies, nurses and midwives, and of course the people directly affected by those adverse events.

[139] NSW Health. (2019) Annual Report 2018-2019

For an unexpected death that occurs as a result of potential negligence or systems failure for which NSW Health is liable, the costs could include, but are not limited to:

- Health and/or support services for families and affected staff.
- Staff expenses such as leave and backfilling if they are unable to work.
- Workers' compensation for psychological injury.
- Staff costs of undertaking a serious adverse event review ('SAER').
- Legal representation for the police investigation of a reportable death and coronial inquest.
- Legal representation for a SafeWork prosecution.
- Staff costs associated with administration (management, records, patient liaison etc).
- Legal representation to defend civil claims.
- Payment of claims either settled or litigated.
- Costs incurred by agencies and departments including the Crown Solicitor's Office, the Department of Communities and Justice, Legal Aid NSW, the NSW State Coroner's Court, the Health Care Complaints Commission, the Health Professionals Councils Authority, and the NSW Civil and Administrative Tribunal.

The most effective way to avoid preventable, serious adverse events is to consciously invest in the skills, knowledge and time of nurses and midwives. Nurses and midwives have the greatest access to patients/women compared with other health workers and are the last line of defence from systemic and/or clinical errors that cause harm. The ability for a nurse or midwife to regularly and holistically engage and care for people is key to being able to detect such issues however, being hampered by chronic understaffing and poor skill mix means more errors will go undetected.

Nurses and midwives know the best way to provide high quality care, and thus avoid iatrogenic harm, is to have adequate numbers of suitably trained and experienced staff. This is consistent with the findings of the study published in *The Lancet,* that a hospital without ratios could expect 145 more deaths over a two-year period, compared to a hospital with ratios. Patients receiving a higher proportion of registered nurse hours per day are more satisfied with their care and experience lower patient mortality, reduced length of stay, and less adverse events such as failures to rescue, pressure injuries and infections. The financial savings associated with the ratios abovementioned (of over $67 million) did not include any savings attributable to the avoidance of deaths or serious adverse events.[140]

Investment in prevention and promotion activities, and primary healthcare to address escalating costs

As mentioned in **Section C**, the MoH *Future Health: Guiding the next decade of care in NSW 2022-2032* report ('Future Health report') recognises the need to re-orientate health services, to keep people healthy and well, and to effectively manage chronic conditions. Currently, more than one-third of the current disease burden is preventable (due to modifiable risk factors), and two-thirds of the disease burden in NSW is caused by conditions that could be managed outside of an acute care setting.[141] It is crucial to renew the focus on prevention and promotion activities, while also increasing investment in these areas.[142]

The Future Health report highlights demand for services in areas such as mental health, diabetes, and other chronic illnesses is outpacing the population growth rate due to shifting demographics, and

[140] McHugh, M. D., Aiken, L. H., Sloane, D. M., Windsor, C., Douglas, C., & Yates, P. (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. Lancet (London, England), 397(10288), 1905–1913.
[141] NSW Ministry of Health. (2022). Future Health: Guiding the next decade of care in NSW 2022-2032
[142] Ibid

alterations in disease prevalence. By 2032, it is predicted 750,000 additional people will have multiple chronic diseases, leading to more complex care being required. Health spending is expected to rise at an average annual rate of 5.4%, growing from 29% of total expenses in 2018-19 to 38% per cent by 2060-61.[143]

Furthermore, the *National Preventative Health Strategy* outlines preventable ill-health is putting enormous pressure on the Australian healthcare budget. The 2010 Assessing Cost-Effectiveness ('ACE') in Prevention study demonstrated that prevention interventions in Australia can create savings by offsetting the cost of the interventions by the savings that result from a reduced need to manage and treat diseases.[144]

Investing in quality primary healthcare, prevention and promotion has never been more important. Not only will this enable NSW Health to meet the demands of the predicted healthcare needs of patients, it also provides strategies to address escalating costs, limit wastage and minimise overservicing.

The role of nurses and midwives in prevention and promotion activities, and primary healthcare

Effective, coordinated, multidisciplinary primary healthcare delivers significant benefits that include:

- reduced emergency department visits;
- reduced hospital admissions and readmissions;
- reduced inappropriate healthcare interventions;
- reduced duplication of services;
- care that is better aligned to patient and family needs;
- care that is collaborative;
- decreased total health spending; and
- a healthier, more supported population.[145]

Nurses and midwives are a crucial part of this workforce and are often overlooked. Primary health nurses make up the largest component of the primary healthcare workforce, with at least 82,000 nurses working outside of the hospital setting.[146]

As highlighted in **Section C**, nurses and midwives contribute to a range of population health prevention and promotion initiatives outlined in the Future Health Report. Investing in the expansion of nurses and midwives in prevention and promotion activities, and primary healthcare, will enable NSW Health to re-orientate health services, to keep people healthy and well, to effectively manage chronic conditions and to meet future demands.[147] This will realise cost savings overall for the health system and be crucial in addressing the needs of the state moving forward.

Furthermore, nurses can work across every specialty that is mentioned in the 'focus areas' outlined in the *National Preventative Health Strategy*: alcohol and other drugs; health promotion; cancer screening and prevention; immunisation; and mental health.[148]

Nurses and midwives employed and utilised effectively within primary healthcare settings have the potential to transform the delivery of care to people in NSW and have a major role to play in hospital

[143] NSW Ministry of Health. (2022). Future Health: Guiding the next decade of care in NSW 2022-2032
[144] Department of Health. (2021). National Preventive Health Strategy 2021–2030
[145] Agency for Clinical Innovation. (2021). Navigating the healthcare neighbourhood: Benefits for health professionals
[146] Australian Institute of Health and Welfare. (2023). A profile of primary health care nurses – web report
[147] Ibid
[148] Ibid

avoidance. Health promotion, prevention, effective primary healthcare and hospital avoidance all have a crucial role in addressing escalating costs, limiting waste and minimising overservicing. However, both existing models of care – and lack of recognition of the full scope of practice of nurses and midwives – restricts their contributions. This was expanded on in **Section C**.

Nurse and midwife-led models of care

As referenced in **Section C**, the NSWNMA wishes to draw attention to the QNMU submission to the Health and Environment Committee *Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system,*[149] see **Appendix 3**. In their submission, the QNMU highlighted research that shows nurse-led and midwife-led models of care do not dilute access to, or quality of primary health care services. To the contrary, nurse-led and midwife-led models of care have:

- improved access to healthcare services, particularly in rural and remote areas;
- provided co-ordinated care across acute and community boundaries;
- improved continuity of care by acting as a link between primary health care services and other health service providers;
- increased early intervention of health issues through building a rapport with the patient and community; and
- reduced avoidable ED presentations/hospital admissions and ambulance trips.[150,151]

There are many roles and models of care ENs, RNs, midwives, and NPs undertake in primary healthcare. They include:[152]

- immunisation/vaccinations;
- providing mental health care;
- diabetes education and support for patients in the management of their diabetes;
- drug and alcohol nursing care, support and counselling;[153]
- sexual and reproductive health care, that includes taking sexual and reproductive histories, screening for sexually transmitted infections, contact tracing, and providing information and education to patients; and
- nurse clinics where nurses, within their scope of practice, are the primary provider of care and examples of these clinics include:
    - women's health;
    - lifestyle medication (e.g., weight loss, smoking cessation); and
    - wound management.[154]

[149] Queensland Nurses and Midwives' Union (QNMU). (2021). Submission to the Health and Environment Committee - Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

[150] Douglas, C., Schmalkuche, D., Nizette, D., Yates, P. & Bonner, A. (2018). Nurse-led services in Queensland: A scoping study. Collegian, 363-370

[151] KPMG. (2018). Cost benefit analysis of nurse practitioner models of care. Department of Health, report

[152] Australian College of Nursing. (2015). Nursing in general practice. A guide for the general practice team

[153] Searby, A., & Burr, D. (2020). State of the workforce 2020: Mapping the alcohol and other drug (AOD) nursing workforce in Australia and New Zealand. Queensland: Drug and Alcohol Nurses of Australasia (DANA)

[154] Australian College of Nursing. (2015). Nursing in general practice. A guide for the general practice team

Despite this, as the QNMU submission highlights, some nurse and midwife-led services continue to be contested. These models of care are often only supported when under the direction and supervision of medical practitioners, thereby diminishing the role of nurses and midwives in this area.[155]

As discussed in **Section C**, nurse and midwife-led models of care are cost-efficient with positive health outcomes and represent effective, feasible and appropriate ways of delivering care.[156] Evidence suggests that NPs produce health outcomes equivalent to medical practitioners for people with chronic health conditions in primary healthcare (**see Section F (v)** for expanded information about NP scope of practice).

Midwifery-led models of care

One of the major escalating costs in midwifery is the increasing intervention rate. In the *Mother and Babies* report (2021) only 41% of women went into labour naturally, and a further 28% of those women had their labour medically augmented (sped up).[157] This intervention is often the start of a 'cascade of interventions', from epidurals to instrumental birth and caesarean section, which in turn lengthens hospital stay. These interventions are costly to hospitals and to the women, many of whom suffer long-term physical complications and deteriorating mental health as a result. In a recent submission by the NSWNMA to the NSW Parliament Select Committee Inquiry into Birth Trauma, we highlighted the cascade of intervention and increased birth trauma was also affecting midwives and adding to the concerns about burnout and midwives leaving the profession.

One way to minimise spiralling costs in maternity services is to increase the amount of midwifery-led continuity of care programs such as Midwifery Group Practice ('MGP'). MGPs demonstrate cost savings for health departments due to reduced intervention and hospital stays and were shown to cost 22% ($5,208) less per pregnancy than other models of maternity care.[158] According to the Australian Institute of Health and Welfare ('AIHW') there are over 1,000 different models of care in Australia and only 14% are MGP. As stated in **Section C,** NSW currently has 10.9% of its models reflective of an MGP model, compared to Queensland 24.2% MGP, South Australia 21.1% MGP and Tasmania 17.4% MGP. These states also had the lowest rates of intervention, the shortest hospital stays and the highest breastfeeding rates at 3 months, all addressing the escalating costs to healthcare. The cost implications of breastfeeding can often be overlooked, but research has shown early weaning was estimated to add around $60 million –$120 million to annual hospitalisation costs for gastrointestinal illnesses, respiratory and ear infection, eczema, and neonatal necrotising enterocolitis in Australian hospitals.[159]

While the evidence supporting the effectiveness of MGP models are well-documented, it fails to reach the communities that stand to benefit the most. Research conducted by La Trobe University emphasises the need for culturally appropriate MGP models for First Nations women.[160] The study findings demonstrate

[155] Douglas, C., Schmalkuche, D., Nizette, D., Yates, P. & Bonner, A. (2018). Nurse-led services in Queensland: A scoping study. Collegian, 363-370

[156] Liu, C. F., et Al. (2020) Outcomes of primary care delivery by nurse practitioners: Utilisation, cost, and quality of care. Health services research 55(2) pp. 178-189.

[157] Australian Institute of Health and Welfare (AIHW). 2023. National Perinatal Data Collection data availability resource

[158] Callander, E. J., et al. (2021). Cost-effectiveness of public caseload midwifery compared to standard care in an Australian setting: a pragmatic analysis to inform service delivery. International Journal for Quality in Health Care 33(2): mzab084

[159] Smith JP, Thompson JF and Ellwood DA. (2002). Hospital system costs of artificial infant feeding: estimates for the Australian Capital Territory. Australian and New Zealand Journal of Public Health, 26(6):543-551

[160] McLachlan, H,L, Newton, M, McLardie-Hore, F,E, McCalman, P, Jackomos, M, Bundle, G, Kildea, S, Chamberlain, C, Browne, J, Ryan, J, Freemantle, J, Shafiei, T, Jacobs, S,E, Oats,J, Blow, N, Ferguson, K, Gold, L, Watkins, J, Dell, M, Read, K, Hyde, R, Matthews, R & Forster, D., 2022. Translating evidence into practice: Implementing culturally safe

women enrolled in the MGP model experience reduced rates of preterm birth, low-birth-weight babies, and infant loss.

A noteworthy illustration of this concept within NSW can be found at Waminda, a centre for local aboriginal families located in Nowra. Since 1984, Waminda has been dedicated to serving its community, recognising the importance of understanding and respecting Aboriginal culture in delivering improved healthcare outcomes for women and their families.[161] Waminda's innovative approach involves a decolonisation strategy that has been evaluated through a model of interagency collaboration, which enhances workforce capabilities by fostering shared language and collective learning about colonisation, racism, and Whiteness. This approach contributes to individual, organisational, and systemic decolonisation, ultimately challenging power structures by adopting a trauma and violence-informed practice.[162] This has in turn led to a successful Aboriginal women's health centre helping to close the gap for its community and educating others through research and innovation.

It is imperative such initiatives are replicated across NSW, particularly in remote areas, to mitigate poor perinatal outcomes and reduce the substantial cost burden on the NSW health system.

Staff vacancies contribute to escalating costs

Vacancies within NSW Health cost more than the money saved by not filling in the vacant positions. Whilst reliable vacancy data has been problematic to obtain from the MoH, the corollary indicators of high vacancies are very visible. These indicators include the payment of overtime, agency staff usage and excessive leave balances. All of which contribute to burnout and increased turnover rates for existing nurses and midwives, which further exacerbate future vacancies within the public health sector.[163]

Any strategies to improve financial management within the health sector must consider the effective expenditure on salaries and wages. Salaries and wages are rightly the single largest category of expenditure in the sector, accounting for $14.679 billion or 50.25% of total expenditure in 2022.[164] As the largest employee category, nurses and midwives account for approximately 40.6% of this expenditure.[165]

Part of salaries and wages expense is the use of overtime and agency usage. This type of expense should be utilised to cover unexpected vacancies however, over recent years, has been used to cover long term vacancies. There is a premium attached to this expense compared to a permanent category without any penalty rate/agency rate attached. In 2021, the NSWNMA submitted a freedom of information request under the provisions of the *Government Information (Public Access) Act 2009* ('GIPA Act'), requesting vacancies figures for each LHD.

The data received in response to the request is presented in the **below chart.** As shown, there were over 1,650,000 overtime hours and 1,000,000 agency hours reported in 2021. Taking a conservative approach, if all overtime paid to nurses and midwives by NSW Health in 2021 was at the rate of a Year 1

continuity of midwifery care for First Nations women in three maternity services in Victoria, Australia. eClinicalMedicine Volume 47, 101415

[161] Waminda .(2023). Waminda

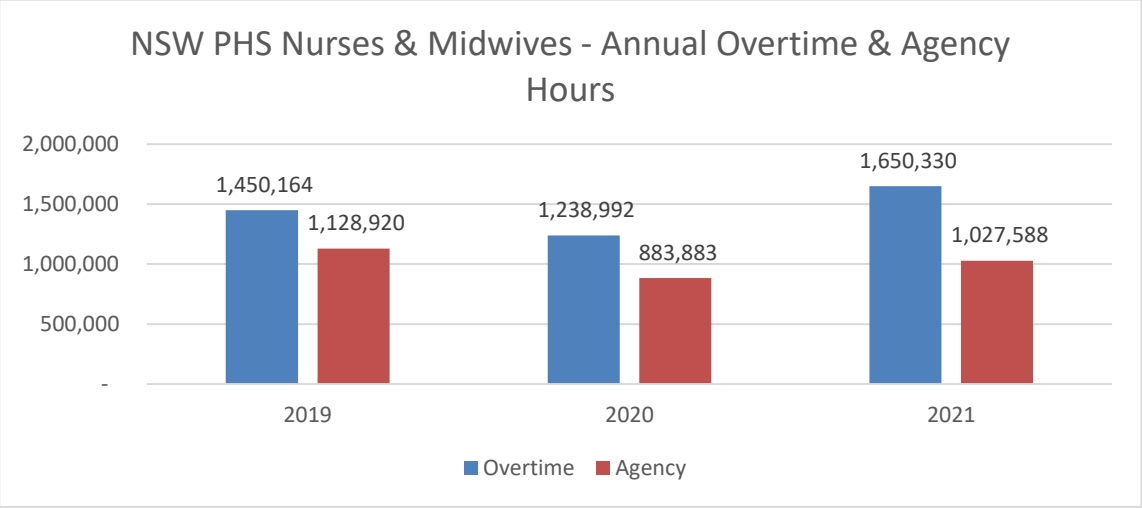
[162] Cullen, P., Mackean, T., Worner, F., Wellington, C., Longbottom, H., Coombes, J., Bennett-Brook, K., Clapham, K., Ivers, R., Hackett, M. & Longbottom, M. 2020, Trauma and Violence Informed Care Through Decolonising Interagency Partnerships: A Complexity Case Study of Waminda's Model of Systemic Decolonisation, International Journal of Environmental Research and Public Health, vol. 17, no. 20, pp. 7363.

[163] Roche, M. A., Duffield, C., Homer, C., Buchan, J., & Dimitrelis, S. (2015). The rate and cost of nurse turnover in Australia, Collegian, Vol 22, Iss 4, P353-358

[164] NSW Health. (2023). Annual Report 2021-22, pg. 132

[165] Australian Institute of Health and Welfare. (2023). Hospital resources 2021–22 data tables

RN/midwife ($49.6974 per hour) this would result in expenditure of an additional $27,339,036 compared with a permanent registered nurse (Year 1) ordinary rate. Agency nurses and midwives are paid well above the applicable award classification and would therefore incur greater expenditure than a non-agency nurse or midwife. Additionally, agency nurses and midwives do not receive the full benefit of this expenditure as remuneration, as a portion is retained by private agencies.



Total Overtime and Agency hours – GIPA 2021 to all Local Health Districts

Excessive annual leave is an indication of staff unable to take their leave entitlement and a further indication of unfilled vacancies. For employers it increases the salary and wages expense by paying entitlements earned at the employees' current rate to be paid years later, often at the higher classification and often after multiple pay increments. For nurses and midwives, it also contributes to burnout, increased sick leave and ultimately higher turnover.

Over the past three years, queries about leave have been the largest 'issue type' the NSWNMA has received from public sector members (NSW Health employees). Numerous members have complained their annual leave requests have been denied or rescinded due to the lack of replacement staff being available. In fact, excessive annual leave was identified as a key repeat issue within the Audit Office of NSW reports for 2021[166] and 2022.[167] In the 2021, the Audit report stated "*managing excess annual leave balances has been reported as an issue for the cluster for more than five years, with the average percentage of employees with excessive leave balances over the last five years being 36.1 per cent*.[168] In 2021 this increased to 39.2%.[169]

Filling vacancies will allow current nurses and midwives to access their earned leave, reduce turnover rates and sick leave. It will also reduce NSW Health wage and salary expenses by reducing overtime, agency usage and delayed utilisation of leave entitlements. As referred to later in **Section F**, available research

[166] Audit Office of New South Wales. (2021). Health 2021
[167] Audit Office of New South Wales. (2022). Health 2022
[168] Audit Office of New South Wales. (2021). Health 2021
[169] Ibid (page 29)

shows patient outcomes are improved when the nursing and midwifery workforce is not experiencing burnout.[170,171]

Improving processes to manage complaints and concerns

Disciplinary processes undertaken by LHDs in relation to nurses and midwives are unnecessarily prolonged. Many investigations exceed the optimal 12-week timeline outlined in NSW Health *Policy Directive PD2018_031 Managing Misconduct*,[172] for seemingly no good reason.

As stated in **Section B**, it is the experience of the NSWNMA that many LHD HR employees do not possess the requisite qualifications, skills or experience to appropriately manage these processes, especially within a reasonable timeframe.

Disciplinary processes cause our members significant anxiety and distress which is compounded by delays. The processes can also cause undue financial hardship and/or disadvantage where they are suspended, or if they have restrictions placed on the days and shift times they are allowed to work, prior to any findings being made. Additionally, the overall legitimacy of the disciplinary process itself is reduced by delays with the capacity of our members to respond to allegations, or witnesses to provide reliable accounts being diminished.

There are often significant costs for NSW Health arising from protracted disciplinary processes, particularly where employees are stood down with pay whilst processes are on foot. The NSWNMA has supported many members over the years who have been suspended with pay for significant periods of time, costing NSW Health both in terms of labour costs relating to an individual, but the flow on costs if their position is filled by overtime or casual/agency staff. In addition to this, there also is the less quantifiable cost to NSW Health and NSW Health employees and their families associated with an employee's forced dislocation and disconnection from the workplace during an investigation.

Most recently, the NSWNMA has notified SafeWork NSW regarding unacceptable delays in three separate disciplinary processes being undertaken by a LHD. This same LHD has, in our view, repeatedly failed to undertake such processes in a timely fashion, in accordance with policy and the NSWNMA has previously put them on notice in this regard. In March 2020, the NSWNMA wrote to this LHD drawing their attention to seven separate disciplinary processes which had collectively taken between nine and twelve months to complete. In July 2023, the NSWNMA again wrote to the LHD identifying a further five disciplinary processes which, at that time, had been ongoing for between five and twelve months. The specific issues raised in the aforementioned SafeWork NSW notification highlight the impact such delays and other poor organisational practices have upon health and safety. These include:

- lack of compliance with the documented policy and procedure timelines required for investigations into staff issues;
- heavy-handed application in the use of investigations into minor allegations;
- lack of procedural justice/fairness;
- unnecessary removal of staff from their usual roles whilst lengthy investigations are undertaken;

[170] Carayon, P & Gurses A P. (2008). Nursing Workload and Patient Safety—A Human Factors Engineering Perspective In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 30

[171] McHugh, M. D., Aiken, L. H., Sloane, D. M., Windsor, C., Douglas, C. & Yates, P. (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals, Lancet 2021; 397: 1905–13

[172] NSW Health. (2018). Policy Directive Managing Misconduct, PD2018_031

- isolation and inadequate support to staff who are being investigated;
- failure to identify complete contextual situations when deciding on outcomes in worker investigations e.g. no consideration given to incidents that occur when there is understaffing in the ward/unit the nursing staff are working, which in and of itself causes anxiety and stress and creates work overload;
- failed informational fairness; and
- lack of interpersonal fairness by not treating people with dignity and respect.

One of the major factors that contributes to the unnecessary incurring of expenses associated with disciplinary processes is the decision taken to undertake an 'investigation' in circumstances where it is wholly unnecessary or inappropriate.

The health sector is increasingly concerned with the potential for litigation and complaints. Logically, an appropriate risk management strategy would include ensuring care is provided by a sufficient number of suitably qualified and experienced staff, and those staff are well supported to be able to provide high quality care.

Unfortunately, however, instead of focusing on prevention, an extraordinary amount of money is expended by LHDs to facilitate punitive responses to individual staff *after* issues arise. Relentless understaffing, staff burnout and the ongoing presence of other psychosocial hazards creates a downwards pressure that impacts care in a way which appear to be solely attributable to the actions or inactions of an individual 'errant' nurse or midwife.

Rather than examining the context in which an error or lapse in judgement has occurred, LHDs are swift to manage the 'risk' they associate with individuals by subjecting them to performance management plans, risk assessments, direct supervision, redeployment, warnings, modification to hours or conditions of employment and drawn-out investigations. Each of those things individually and collectively result in psychological harm to nurses and midwives. Decision-makers who impose such penalties, often with no reasoned basis, hide behind the often nebulous justification that it is necessary for the protection of the public/patients.

Any decision likely to have a negative psychological impact on a nurse or midwife, must only be taken when absolutely necessary and consideration of, and allowance for, contextual factors must be centred so nurses and midwives are not personally bearing the cost of the failure to appropriately resource health services.

Risk assessments, initial reviews and investigations should be designed to ensure there is a clear and mandatory framework that requires consideration of contextual factors. Such a framework is used by the Nursing and Midwifery Council in the UK who have the position:[173]

> *'The evidence is clear that even one-off events or errors are usually caused by multiple contributing factors coming together.1 Wrongly blaming an individual won't change these factors, won't stop underlying issues happening again and ultimately won't help keep people safe.*
>
> *Where systemic issues prevent nurses, midwives and nursing associates from delivering safe care, the system should be accountable. Taking action against an individual in these circumstances doesn't lead to a culture of openness and learning, may give false assurance, direct focus away from a wider problem, and cause a future public protection gap.'*

[173] Nursing and Midwifery Council UK. (2021) Taking Account of Context

One of the key reasons context must be considered is in part to ensure the culture in all NSW Health workplaces are places where workers feel safe to report errors so they can be quickly rectified and/or appropriately managed. There must be recognition also embedded in these processes that workers are human, and errors can occur, especially when they are placed under relentless pressure. A fear-based workplace culture poses a greater threat to the well-being of patients than is currently acknowledged.

When decisions are made to terminate the employment of a worker, there is no consideration given to the cost associated with these processes and there can often be personal biases that feed into decisions made locally. Termination of employment should be an absolute last resort reserved for the most egregious conduct matters.

The cost to NSW Health of losing highly qualified and experienced nurses and midwives because of disciplinary processes is unquantifiable. The investment in recruiting, training and developing nurses and midwives throughout their career is returned to NSW Health in droves. When those nurses are terminated, or more often driven to resign, the loss of their skill and experience is completely undervalued.

Most HR processes contemplate a fixed and limited range of outcomes, and most of these are punitive. Termination, warnings, first and final warnings are the most common approaches taken to 'deal' with a concern.

Some LHD's do consider more remedial approaches. which include education and/or structured reflection. Remedial processes are more effective in improving quality of care compared with punitive approaches which cause risk of psychological harm and a loss of skilled and experienced nurses and midwives.

Work Health and Safety

Improving WHS performance of NSW Health would result in fewer workers injured leading to significant savings. Costs of work-related injuries and illnesses cannot be solely considered in terms of workers' compensation payments, but also include:[174]

- Health system costs including hospitalisation, visits to GPs and specialists, rehabilitations, diagnostics, the cost of pharmaceuticals and other health system expenditures.

- Productivity costs including absenteeism, presenteeism and loss of labour supply due to premature death or permanent inability to work. There are additional productivity losses captured relating to the value of time that families and friends spend caring for a person with a work-related injury or illness.

- Other economic and financial costs associated with expenditure made by individuals with a work-related injury or illness and their families. This is estimated through the total payments made by employers, including compensation payments to the employee, payments for goods and services (such as equipment and modifications to accommodate the injury), legal fees and other non-

[174] Deloitte. (2022). Safer, healthier, wealthier: The economic value of reducing work related injuries and illnesses Technical report, Safe Work Australia

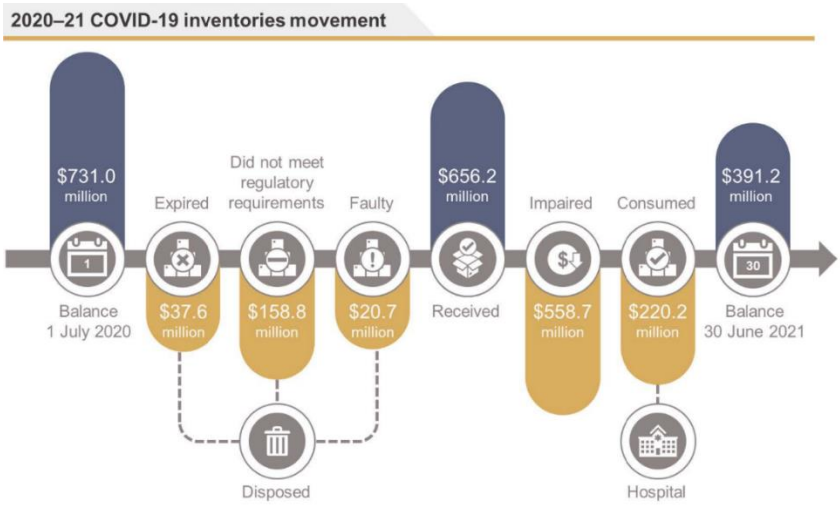
compensation payments. Other costs to employers include training and hiring new staff when an injured worker cannot return to employment.

Potential WHS performance improvements are highlighting in the NSW Health 2021-22 Annual Report, which showed payments to iCare for workers' compensation totalled $241,252,000. In administering the Treasury Managed Fund, iCare NSW implemented the Agency Performance Adjustment ('APA'), replacing the workers' compensation hindsight adjustments. The APA is an opportunity for NSW Health entities to influence impacts by proactively managing workers compensation performance. An unfavourable result of $41 million was declared in 2021–22.[175]

Improving NSW Health WHS performance is essential to reducing costs. Working collaboratively with unions and the safety regulator to address serious safety issues would result in a decrease in the amount of money currently being spent on various legal fees. These expenses include fees for appealing decisions made by SafeWork Inspectors, the costs of **defending** WHS prosecutions, managing enforceable undertakings, efforts to overturn Health and Safety Representatives ('HSR') or provisional improvement notices ('PIN'), and attempts to prevent unions from exercising statutory rights to support members with significant WHS issues.

Stock control

Considerable wastage has been seen in NSW Health due to poor stock rotation and control practices, for example, 2021 saw $775.9 million of COVID-19 inventory impairments and write offs.[176]



Source: Audit Office of NSW

While there were improvements in 2021-22, there was still $451.6 million in COVID-19 inventory impairments and write offs.[177] The figures do not include rapid antigen tests ('RATs'), which are expected to account for a further $186.7 million in impairments.

In addition to the impairments and write-offs of COVID-19 inventory and RATs, another $29.4 million has been allocated for disposal of impaired COVID-19 inventories.

[175] NSW Health. (2022). Health Annual Report 2021-22
[176] Audit Office of NSW. (2021). Health 2021
[177] Audit Office of NSW. 2022. Health 2022

It is unclear what the rates of wastage and impairment are of other consumables across the NSW Health system, but these numbers would suggest they are likely to be considerable.

Improving NSW Health sustainability practices

A strategy to address escalating costs and limit wastage would be for NSW Health to drastically improve and scale up its sustainability practices. In 2022, the Climate risk and net zero program[178] was established to coordinate and scale-up action across NSW Health.

Sustainability initiatives yield a range of advantages, including reduced operational costs for healthcare facilities by cutting waste disposal expenses, safeguarding the environment by diverting waste from landfills, and promoting health benefits by mitigating the effects of climate change.

The Climate and Health Alliance ('CAHA') is Australia's peak body on climate change and health.[179] The NSWNMA is a member of CAHA, and endorsed CAHA's '*Healthy, Regenerative and Just: Framework for a national strategy on climate, health and well-being for Australia'*.[180] This framework is currently being used to guide Australia's first National Health and Climate Strategy, currently being developed by the Department of Health and Aged Care.[181]

The framework outlines policy recommendations for all levels of government and the health sector that will protect the health and well-being of all people in Australia from the impacts of climate change.

Relevant policy recommendations include:

- goal of a net zero emissions healthcare sector by 2035;
- a commitment to 80% reduction in emissions from healthcare by 2030;
- a target of 100% renewable electricity supply and no new gas installations in hospitals and health services by 2030;
- invest in installation and purchasing renewable energy for all hospitals and health and aged care services;
- prioritise environmental sustainability in healthcare facility design, construction and operation, incorporating this into capital works guidelines and minimum standards; and
- develop healthcare procurement policies and practices to ensure the health sector supply-chain (e.g. medical equipment, pharmaceuticals, and protective equipment) is transitioning to environmentally sustainable practice and net zero emissions.[182]

Hunter New England LHD ('HNELHD') has a bold vision to be carbon and waste neutral by 2030, a far more ambitious target than the NSW government target of net zero target by 2050. To achieve this, HNELHD key focus areas are energy, waste, water, transport, procurement, and infrastructure.[183] HNELHD has run various projects aimed at reducing waste and improving sustainability. In 2021, HNELHD saved nearly $1 million by implementing a range of sustainability initiatives in energy, water, fleet, paper and

[178] NSW Health (2023), Climate risk and net zero
[179] Climate and Health Alliance (2023), https://www.caha.org.au/
[180] Climate and Health Alliance. (2021). Healthy, Regenerative and Just: Framework for a national strategy on climate, health and well-being for Australia
[181] Department of Health and Aged Care. (2023). National Health and Climate Strategy
[182] Climate and Health Alliance. (2021). Healthy, Regenerative and Just: Framework for a national strategy on climate, health and well-being for Australia
[183] Hunter New England Local Health District. (2023). Sustainable Healthcare: Together Towards Zero – Carbon and waste neutral by 2030

procurement.[184] HNELHD is an example of what can be achieved when there is leadership and a clear vision for sustainable change.

The NSWNMA convenes a Climate Change Activist Professional Reference Group of members from across the state who are enthusiastic about environmental sustainability and are involved in initiatives/projects in their own departments and/or facilities. Members outside of HNELHD (who are leading by example and appear to have ambitious targets far beyond most other LHDs), report frustration at trying to implement sustainability initiatives in their respective departments. Nurses and midwives represent the largest proportion of the clinical workforce and work across almost every clinical area, their engagement is crucial to effectively drive and implement sustainability initiatives.

Barriers reported by members include:

- No dedicated staff to lead sustainability projects or initiatives (members are often running projects in their own time, in addition to their existing roles - unpaid).
- Contracts and procurements issues (nurses and midwives suggest changing to a specific product that is more sustainable but are told it is not possible due to contract/procurement issues).
- Whole of hospital/facility approach needed – many issues fall on nurses, midwives and cleaners. They need support of executive to drive real change.
- Tension between infection control (wanting everything to be single use) and sustainability –a whole of LHD or facility approach is needed so everyone is on the same page.
- Bureaucracy – nurses and midwives need a simpler way to take ideas to senior management.

"Sustainability projects are run off the goodwill and energy of individuals – usually nurses or midwives; something needs to change, and it really needs to come from the top" – Registered Nurse (hospital sustainability committee member)

"There are just too many hoops to jump through… staff are so time poor, and is just, you know, another thing to do…" – Registered Nurse

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NSWNMA member suggestions include:

- Build sustainability practices into decision-making processes and streamline with dedicated roles (include in mandatory training).
- Amend contracts and procurement to include targets for sustainability (e.g. if one company will do recycling of IV bags, not should be mandated that this is the company to use, and recycling of IV bags is compulsory).
- Tailoring equipment to workflow (e.g. what actually needs to be in equipment/dressing packs in operating theatres).

[184] NSW Health. (2023). Ways to save money and carbon, https://www.health.nsw.gov.au/netzero/Pages/for-local-health-districts.aspx#top-10-ways

- Transition back to reusable cutlery and plates and away from single use water bottles.

Our members agree a coordinated approach, led by NSW Health, is required. Currently, each LHD is at a different stage. Cost effective sustainability achievements and successes in one LHD should be replicated in other without delay.

Education and training will reduce adverse events – the importance of investing in the education of nurses and midwives

The nursing and midwifery professions are both based on a lifelong learning philosophy with ongoing teaching, learning and reflection at the core of the development of their practice. The particular skills a nurse or midwife will need to develop throughout their career will vary depending on their individual context of practice.

Nurses and midwives are often key drivers of change in health services, because they are well placed to identify gaps in services and/or processes. To ensure public sector nurses and midwives are able to continue to critically identify structural issues, service gaps and solutions, they must be supported by their employer to undertake regular education, both within their own workplace as well as outside their workplace.

Nurses and midwives are also considered to be the 'last line of defence' for patients to prevent prescribing errors and other serious adverse events that may result due to fractured care or gaps in systems. For nurses and midwives to continue to be able to work defensively and identify errors that may result in harm, they must be well supported to undertake ongoing professional development.

One of the key features of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals ('Garling Inquiry') in 2008 were the significant recommendations made regarding the need for better systems for education and training of NSW Health staff, with Justice Garling stating '*education and training needs to continue long after graduation' and 'like the railway signal system, the training of new clinicians is a down payment on a safe, good quality system of health care in public hospitals*'.[185]

It was observed in the Garling Inquiry that 'training for everyone in the public hospital system has often been ad hoc rather than planned, too often cancelled if pressure of other business requires or money runs out. This is especially serious in circumstances where junior medical officers and junior nurses are frequently the only professionals on duty through the night to care for patients'. Although we would like to think this statement was not still applicable in 2023, our members tell us otherwise.

Nurses and midwives in Australia are required to undertake a minimum of 20 hours of continuing professional development ('CPD') activities per registration year.[186] Such activities must be relevant to their context of practice and ideally should be 'new learning' which enhances their practice. They may be required to undertake additional hours if they have dual registration and/or an endorsement.

CPD for nurses and midwives is how members of the profession(s) maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.[187]

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[185] Garling SC, P. (2008). Final Report of the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals
[186] Nursing and Midwifery Board of Australia (NMBA). (2016). Registration standard: continuing professional development
[187] Ross, K., Barr, J. & Stevens, J. (2013). Mandatory continuing professional development requirements: what does this mean for Australian nurses. BMC Nurs 12, 9

Whilst a mandatory obligation for individual nurses and midwives, there can be significant barriers to accessing quality CPD activities that are relevant to their context of practice. These include (but are not limited to) the financial constraints of accessing CPD activities, lack of support from their employer for attendance, lack of time available due to workloads, lack of technical support, limited access to childcare and living in rural and remote areas.[188]

A study looking at participation in CPD by nurses found it directly influenced staff efficiency, staff morale, and, importantly, the end users of hospitals—with patients' lives saved because of improved knowledge and practice.[189]

Although employers are not obliged to provide education which meets an individual nurse or midwife's CPD requirements, employers including NSW Health should view practitioners' CPD requirements as an opportunity.

The reality is for most nurses and midwives in NSW, their work-related opportunities for education are limited, ad hoc and largely done through online modules or an in-service if they happen to be rostered on at a suitable time. Our members have also reported a significant decrease in access to face-to-face education opportunities since the start of the COVID-19 pandemic.

Although it is widely acknowledged mandatory education and in-services are to be completed on paid time, nurses and midwives are not provided with any paid time to read new policies or complete non-compulsory online modules available through their My Health Learning online system. Many nurses and midwives report they stay back, arrive early or attend to education during their designated 'break' in order to be able to access mandatory education in paid time.

Nurses and midwives in rural and remote areas report having very little access to any face-to-face education opportunities and fewer if any 'CNE' or Clinical Midwife Educator ('CME') positions. It is not hard to see how such gaps can translate into differences in health outcomes in such areas compared with metropolitan services.

Support for external ongoing education

The PHS Award contains a lengthy and misleading clause regarding a purported entitlement to 'Learning and Development Leave'. Spanning nearly two pages, this clause sets out many parameters for such leave however fails to provide any clear, quantifiable entitlement for a nurse or midwife.

It is the experience of our members that access to such leave and/or funding for conferences is largely dependent on the professional and interpersonal relationships between staff and management.

Investment in education and avoidance of serious adverse events

Investment in education is a way to improve the financial management of health services and avoid wastage associated with preventable adverse events.

Put simply, education saves lives and prevents serious adverse events. The significant and layered costs of preventable adverse events are explored further in **Section F (v).**

[188] Ibid

[189] Ng, Y. (2017). The effect of continuing professional development from the perspective of nurses and midwives who participated in continuing education programs offered by Global Health Alliance Western Australia: A mixed-method study (Master of Philosophy (School of Nursing)). University of Notre Dame Australia

The Australian Commission on Safety and Quality in Health Care ('ACSQHC') position is 'an educated, skilled and qualified workforce is essential to providing care to patients whose condition is deteriorating'.[190] The principles they have outlined for recognising and responding to acute physical deterioration include:

- Recognising patients whose condition is acutely deteriorating, diagnosing the cause and responding to their needs in an appropriate and timely way is essential for safe and high-quality care.

- Recognition of, and response to, acute deterioration requires access to appropriately qualified, skilled and experienced clinicians.

The ACSQHC state that prerequisites for organisations, such as NSW Health, for recognising and responding to acute physiological deterioration include the provision of education and training to staff via a range of methods.

A systematic literature review of nearly 20 years of research found higher nurse education was associated with lower risks of mortality and failure to rescue.[191]

NSW Health has a robust policy and education framework for educating staff on the recognition and management of patients who are deteriorating.[192] This is supported by the CECs 'Between the Flags' educational resources.[193]

This framework exists because the nexus between the level of ongoing education of clinicians and prevention of avoidable deaths is known and acknowledged. The existence of the framework is not a panacea and avoidable deaths still do occur for numerous reasons, one being a lack of access to education.

Workloads are also cited as a contributing factor to preventable adverse events, but it must also be acknowledged workloads impact on the capacity of staff to undertake ongoing education.

Reduce legal costs through the development of information sharing frameworks with unions

The MoH and LHDs currently spend an exorbitant, and unnecessary, amount of money on staff and external lawyers to attempt to impede or delay unions accessing information that are often ultimately provided following a request made under the GIPA Act or pursuant to the WHS Act.

In 2021-2022, NSW Health spent a total of $15,808,000[194] on legal fees. This does not include legal work undertaken by the many solicitors employed under the NSW Health umbrella. That amount represents more than a $2 million increase on the 2020-21 expenditure, and more than double what was spent on legal fees in 2016-2017.[195]

Although the NSWNMA is not privy to any further breakdown, an example of such unnecessary expenditure is evident in a recent Industrial Relations Commission of NSW decision regarding a dispute over the refusal

[190] Australian Commission on Safety and Quality in Health Care. (2023). Recognising acute deterioration
[191] Audet, L., Bourgault, P., Rochefort, C.M., (2018). Associations between nurse education and experience and the risk of mortality and adverse events in acute care hospitals: A systematic review of observational studies, International Journal of Nursing Studies, Volume 80
[192] NSW Health. (2020). Recognition and management of patients who are deteriorating, Policy Directive PD2020_018,
[193] Clinical Excellence Commission. (2023). Between the Flags
[194] NSW Health. (2022) Annual Report
[195] NSW Health. (2017) Annual Report

by the Mid North Coast LHD ('MNCLHD') to provide documents pursuant to a WHS entry request.[196] This dispute spanned over a year and related to safety concerns regarding the nurses working within the MNCLHD mental health units at Coffs Harbour Hospital. Ultimately, the matter was heard for three days and the subsequent decision was the majority of the material sought be provided in accordance with the request.

Unions have an important role to play in being able to highlight and seek resolution to safety issues and hazards that put staff and patients at risk of harm. These issues may not always be readily apparent to those working within facilities, and so a more collaborative approach is needed. When decisions are being made by agencies of NSW Health to throw money at obfuscation and avoidance of known hazards, instead of genuinely engaging with unions and HSRs, they cannot be genuinely complying with their obligations under the WHS Act to eliminate and/or minimise risks.

NSW Health, as a government agency, has obligations to proactively publish particular information on their website in accordance with the GIPA Act, however these obligations relate broadly to policies and contracts. NSW Health maintains other important and relevant data regarding the operation of the public health system (e.g. staffing numbers in each award classification, distribution of staff, permanent and temporary vacancy rates at the hospital level etc) and this also should be publicly accessible without having to make a GIPA application.

Recommendations

- NSW Health implements nurse/midwife to patient ratios in every ward of every public hospital across the state.
- NSW Health invest in the expansion of nursing and midwifery services across prevention, promotion and primary healthcare to enable re-orientation of health services, as outlined in the MoH *Future Health: Guiding the next decade of care in NSW 2022-2032.* This investment will realise costs savings for the broader health budget through hospital avoidance, and a reduction in acute care services.
- NSW Health urgently develop a strategy to increase the number of permanent nursing and midwifery positions to fill existing vacancies to reduce the wages and salary expense, by reducing overtime and agency usage.
- NSW Health review the current processes for managing responses to concerns about individual workers embedded with a framework to factor in context, and a focus on remedial outcomes over disciplinary approaches.
- NSW Health commit to prioritise improvements to WHS performance.
- NSW Health adopt a collaborative approach to working with unions and the safety regulator to address serious safety issues.
- NSW Health establish a statewide committee with relevant unions as a matter of urgency as outlined in **Section B (iii)**.
- NSW Health undertake a comprehensive review of existing stock control measures.

[196] New South Wales Nurses and Midwives' Association v Mid North Coast Local Health District (WHS Right of Entry Dispute) [2023] NSWIRComm 1099

- NSW Health implement evidence-based sustainability initiatives, as a matter of priority, as outlined in *Healthy, Regenerative and Just: Framework for a national strategy on climate, health and well-being for Australia*.

- NSW Health coordinate sustainability initiatives across all LHDs, ensuring that successful initiatives are rolled out across the State.

- NSW Health increase investment in sustainability initiatives, including dedicated staff at LHD and facility levels to implement changes.

- NSW Health recognise the role of nurses and midwives in successful sustainability practices and engage this workforce effectively in any proposed initiatives.

- NSW Health seek a variation to the PHS Award providing a clear minimum entitlement of 5 days paid study leave per calendar year.

- NSW Health facilitate provision of paid protected time for nurses and midwives to read policies and complete online modules through My Health Learning.

- NSW Health investigate and consider the establishment of a rural and remote nursing and midwifery education team to provide face-to-face education across the state.

- NSW Health increase the number and capacity of midwifery led continuity of care models across the state.

- NSW Health invest in specific culturally safe models of midwifery-led care targeted at meeting the needs of marginalised communities including Aboriginal and Torres Strait Islander women.

- NSW Health collaborate with unions to develop a framework or memorandum of understanding for information sharing to reduce costs associated with managing requests for information under the GIPA Act and WHS Act.

E: Opportunities to improve the NSW Health procurement processes and practice to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions

Currently, it is unclear what systems are in place for determining where there is a centralised and coordinated procurement practice and when procurement decisions are left to the discretion of LHDs.

Healthshare NSW has a tender process for goods and services.[197] In most instances, LHDs should collaborate in using this process to eliminate duplication of tendering at each facility for goods and services. Tenders should ensure equipment on tender is fit for purpose and meets relevant Australian Standards and tenders are developed in consultation with key stakeholders. Procurement processes for purchasing bespoke products to meet special needs of tender, or for purchasing from local suppliers, should also be formalised.

Duress Alarms

A variety of suppliers currently provide duress alarm systems to NSW Health. The tender process is flawed in that the provisions of duress alarm capabilities vary between suppliers, this includes variations in the technical specifications of the devices, the contracts for system maintenance and response requirements. Procurement decisions about personal duress alarms appear to be at the discretion of LHDs/facilities, and this is problematic for worker safety.

The tender system should ensure all suppliers meet minimum requirements, including man down functions that cannot be disabled and digital display of location of alarm activation. Such requirements must include testing across all new facilities and where a new system is introduced in a redevelopment, that system should be rolled out across campus to eliminate duplication of systems in place.

NSW Health has clear policy around personal duress alarms set out within Protecting People and Property.[198] This policy outlines who needs to wear personal duress alarms (workers in EDs, and then more broadly based on risk assessment), as well as the features personal duress alarms must have.

The NSWNMA has identified more than ten different types of duress alarms currently being used across NSW Health facilities (there are likely many more). Of these alarms, none were fully compliant with the requirements as set out in Protecting People and Property, (although some were significantly better than others) with issues including:

- alarms do not work in all areas e.g., toilets, staffrooms;
- no signal to user when they activate their alarm;
- systems require nurses to carry multiple items – a duress alarm, a transceiver, and a radio;

[197] Healthshare NSW etendering Website, https://www.tenders.nsw.gov.au/health/
[198] NSW Health. (2022) Protecting People and Property: NSW Health Policy and Standards for Security Risk Management in NSW Health Agencies

- alarm does not go to code black team – this requires a separate phone call;
- location info is not specific, just identifies the ward;
- device does not notify of faults;
- cannot check battery status;
- notifies people off site, but not those onsite;
- hard to use;
- workers not alerted that a duress has been activated;
- clips flimsy so placed in pocket where they are hard to use; and
- screen is too small to be able to read where the duress is occurring.

Not only are different devices being used in different LHDs, but the NSWNMA has also identified two LHDs using at least four distinct types of alarms, and identified situations where different alarms are used in various parts of the same facility. Further, the NSWNMA has identified sites where the device will work in some areas of the facility but not others, even when staff are required to work between both areas (e.g. different devices in mental health and the ED with devices only working in their programmed area, even though mental health nurses may work in the ward and the ED, or may be required to transport patients between the two).

In addition to decisions about which model of alarm to purchase, LHDs are also making decisions about what types of service agreements to enter. These service agreements may influence the features of the device that are accessible, as well as maintenance arrangements and response times when problems with the operations of the system are identified.

These issues around duress devices are causing considerable issues for our members, some examples include:

Grafton Base Hospital**:** improvement notice issued by SafeWork October 2022 over duress alarms working intermittently for 18 months. Notice issued after an incident where a nurse was assaulted, bitten, and barricaded into a room by a patient.

RPA Hospital**:** improvement notice issued by SafeWork in May 2023 over 16 faulty duress tags and no proper systems for testing of alarms. Notice issued after the death by suicide of a nurse working in the ED (the duress alarm did not go off despite the requirement for a 'man down' function). This issue had been raised with the LHD and with SafeWork previously by the NSWNMA in October 2022.

Port Macquarie Base Hospital**:** in March 2023 a nurse in an aged care ward was struck across the face with a plastic bat causing serious psychological and physical injury including broken teeth, swollen face and lips. At the time of the incident the duress system had been non-functional for five months (since October 2022).

Blacktown Hospital: improvement notice issued by SafeWork NSW over '*limited availability and or suitably functioning duress alarms'* after an incident in February 2023 where an ED patient attacked a doctor causing spinal injury, a nurse deployed her duress alarm, but it did not work. Police who happened to be in the ED at the time responded to the screams.

Yass Hospital**:** long-standing non-functional duress alarm system (over 12 months).

Nepean Hospital**:** staff working between two buildings, duress alarms worked in one or the other but not both. Issues with transporting patients between the two buildings (often alone at night).

Maitland Hospital mental health: improvement notice issued by SafeWork NSW August 2022 - the duress alarm/zebra phone system has on numerous occasions failed to initiate a Code Black Response due to technical grounds (remote signal/blackspot, handset failure) and the response time of Code Black Response team including Security staff for staff in the Observation Unit has been excessively long and as such has placed workers and others at increased risk of injury.

Central Coast LHD: replaced all their facilities' duress alarms in 2022 without consultation with staff. In doing so, all facilities lost the 'man down' function and had regular wi-fi black spot issues. After raising concerns with management over many months, it was brought to our attention the LHD had a 'bronze plan' and they were needing to upgrade to the 'gold plan' which could give members the man down function once again as well as a personal officer from the duress provider who would be the case manager for Central Coast LHD.

Sustainability considerations in procurement decisions

As mentioned in **Section D**, increased investment in sustainability would not only lead to waste reductions and an improved environmental footprint, but it would also deliver substantial cost savings for NSW Health. Our members repeatedly identify procurement processes as a barrier to implementing sustainability initiatives in their services.

A policy recommendation outlined in the '*Healthy, Regenerative and Just'* framework is to 'develop healthcare procurement policies and practices to ensure the health sector supply-chain (e.g. medical equipment, pharmaceuticals, and protective equipment) is transitioning to environmentally sustainable practice and net zero emissions'.[199] The *Future Health: Guiding the next decade of care in NSW 2022-2032* report outlines NSW Health is exploring ways to create better procurement models and practices, including 'adopting a more environmentally sustainable approach' and 'establishing sustainable procurement processes'.[200]

Procurement processes are continually highlighted as a barrier to getting projects 'off the ground'. Repeatedly, our members report identifying an issue or a change to practice that could result in either environmental protection (waste reduction) or cost savings; often suggested measures will result in both. However, procurement will be a barrier. Often, members will have an approved business case (sometimes sourced from another facility, or LHD), with associated cost savings, but are told that is not possible due to contract/procurement issues.

These barriers also function in the opposite direction. For example, Baxter Healthcare provides intravenous (IV) fluid bags. Baxter can accommodate 'polyvinyl chloride (PVC) recycling' in a program they claim is diverting more than 200 tonnes of PVC waste from landfill. Launched in 2009, this sustainability program collects and recycle Baxter intravenous (IV) fluids bags, as well as PVC oxygen masks and oxygen tubing.

A Sydney hospital, with an established PVC recycling program, changed from Baxter IV products to another company called Fresenius. When this change happened, the PVC recycling program ceased, as Fresenius don't offer a recycling program.

[199] Climate and Health Alliance. (2021). Healthy, Regenerative and Just: Framework for a national strategy on climate, health and well-being for Australia

[200] NSW Ministry of Health. (2022). Future Health: Guiding the next decade of care in NSW 2022-2032

Recommendations

- Healthshare to enter a designated contract for all personal duress alarms (including preferred models and suppliers) that meet requirements of PPE and provides prompt service for any identified issues. Health Infrastructure to ensure purchases are from Healthshare contract.

- NSW Health develop statewide healthcare procurement policies and practices to ensure the supply-chain (e.g. medical equipment, pharmaceuticals, and protective equipment) is transitioning to environmentally sustainable practice and net zero emissions at a matter of priority.

- Tender process and approval must include a sustainability outcome indicator/measure (such as ISO 24000 – sustainability procurement).

F: Current capacity and capability of NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health service

(i) The distribution of health workers in NSW

Every NSW community member, regardless of where they live, should have access to comprehensive, high-quality healthcare. However, we know people in rural, regional and remote ('RRR') communities in NSW are dying prematurely because of inequitable access to healthcare. People living in RRR communities have greater and more complex need for health services but less access. They have higher rates of coronary heart disease, stroke, chronic kidney disease, mental ill-health and diabetes. The burden of chronic disease is increasing in Australia and for there is a strong gradient in burden across remoteness areas.[201] However, in response to this increased demand on health services, we see poor staffing and skill mix, working in isolation, limited access to continuing education, reliance on colleagues to provide unpaid on-call support, skill shortages, inadequate security and transport services and lack of medical cover.

The NSWNMA represents over 35,000 members outside of metropolitan areas in NSW. We consulted extensively to compile our submission to the 2020-21 NSW parliamentary *Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales* (see **Appendix 5**). This document provides a compelling picture of the issues faced by the nursing and midwifery workforce in RRR communities. The recommendations we made sought to create RRR workplaces that are appropriately staffed to ensure safe and effective patient care, and ensure the physical and psychological safety and well-being of staff, while taking into consideration the unique local needs of each facility.

NSW has the lowest 'Full Time Equivalent' ('FTE') rate of nurses and midwives relative to its population compared to the other states and territories,[202] and our members report extreme and entrenched staffing issues in existing services. These are often exacerbated due to RRR facilities not having access to temporary staff to fill shortages, and not necessarily having access to senior staff to provide support if there is a safety issue and/or adverse event. The available data[203] shows up to 2021, the number of clinical FTE nurses and midwives per 100,000 people in most RRR areas actually increased and yet the pressure of understaffing remains. While the supply of nurses and midwives varies across RRR areas, the nursing and midwifery professions stand out as the best distributed health workforce in Australia.[204] In rural areas, the average age of the nursing workforce is older compared with metropolitan sites, this making retention and recruitment of early career nurses a priority for these areas. The issue of retention and recruitment being more pertinent, as the COVID-19 pandemic has led to an influx of new residents in RRR areas, this resulting in a greater need for infrastructure including healthcare services and support.

[201] Australian Institute of Health and Welfare. (2018). Australian Burden of Disease Study 2018: Interactive data on disease burden
[202] AIHW. (2023). Health Workforce Data Tool
[203] AIHW. (2022) Rural and Remote Health
[204] Ibid.

We know nurses and midwives have the capabilities, knowledge and skills to play a significant role in improving healthcare equity, access and outcomes for the people in RRR communities. Their status as the best distributed health professionals is longstanding. The significant expense of temporary staff, fly-in fly-out medical practitioners could be curtailed if nurses and midwives in RRR areas were supported to work to an expanded scope of practice, in advanced practice roles and/or delivering nursing and midwifery-led models of care.

This, however, cannot be achieved without significant investment in the nursing and midwifery workforce, undergraduate, and continuing professional education and transformational leadership to bring change to the workplace culture, and will create working conditions that make nurses and midwives want to stay and develop fulfilling careers in RRR areas.

Options for accelerated career pathway programs and professional development opportunities to attract nurses and midwives should be explored. For example, employers could fund nurses or midwives to undertake a post-graduate qualification while they are working in a RRR area as an incentive to work in these locations. This approach would be ideal to develop the rural and remote Nurse Practitioner workforce. Professional development opportunities must include protected time, support and funding to undertake this to build the knowledge and capability of rural regional and remote nurses and midwives.

It is crucial to appropriately recognise and remunerate the advanced skills of nurses and midwives that rural and remote services rely on. For example, Nurse Delegated Emergency Care ('NDEC'), the First Line Emergency Care Course ('FLECC') or Emergency Care Assessment and Treatment ('ECAT') prepares and credentials the rural/remote registered nurse to ensure early appropriate management of acute and life-threatening conditions, and to relieve pain and discomfort for patients at hospitals where medical officers are not immediately available.[205] For midwives, the Advancing in Maternity Safety ('AIMS') course prepares midwives to effectively recognise and care for women experiencing emergencies and unexpected situations during pregnancy, labour, birth and the postnatal period and have a deep understanding of the complexities of childbearing and how to care for women experiencing such challenges.

These advanced skills and those of many other nurses and midwives in rural and remote settings, should be valued and remunerated accordingly.

Lack of access to affordable housing has increasingly become a key issue for our members who have considered or are considering RRR practice. Research that explored the experience of early career registered nurses in rural hospitals within Australia, and identified strategies that increase job satisfaction and retention, indicated assistance with housing is a priority.[206] The NSW government program to build and upgrade healthcare staff accommodation in RRR areas is very welcome, however there must be more measures examined to retain staff in these areas. The successful 'Attract, connect, stay' pilot program in Glen Innes based on a proven rural health workforce solution implemented in Canada, is an example that could be utilised across NSW.[207]

The 'Rural Health Workforce Incentive Scheme' while well intentioned has been poorly implemented and resulted in unintended consequences. NSWNMA members report there is a lot of uncertainty around the payments, staff performing the same role in the same facility are being paid different incentive rates due to the cost centre they are employed under, while there are other nurses who report they are not eligible

[205] Emergency Care Institute New South Wales. (2023). Nurse Delegated Emergency Care

[206] Rose, H., Skaczkowski, G., & Gunn, K. (2023). Addressing the challenges of early career rural nursing to improve job satisfaction and retention: Strategies new nurses think would help. Journal of Advanced Nursing, 79(9).

[207] Moran, A. (2022). Attract Connect Stay final project evaluation

for the payment at all when their colleagues are. The incentive has also served to encourage nurses and midwives to leave already understaffed facilities and move to other RRR facilities to get higher payments, with reports of a maternity service in a major regional hospital being near critical service failure as a result. Due to incentives not applying to nurse educator roles, it is acting as a further disincentive to nurses stepping up into those roles and taking on greater responsibility for potentially less pay.

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

Recommendations

- NSW Health invest in and expand of scholarship programs for nursing and midwifery students from rural and remote areas.
- NSW Health facilitate greater access to supported, high quality, extended rural and remote nursing and midwifery placements to provide the immersive experiences that positively influence decisions about rural and remote practice post-registration.[208]
- NSW Health further invest in and expand transition to practice programs in rural, regional and remote settings.
- NSW Health engage in ongoing review and revision of the Rural Health Workforce Incentive Scheme to ensure that unintended consequences are addressed and that it achieves its stated aims.
- The NSW government take action to ensure supply of affordable housing in rural and regional areas. This must be considered a central element of any strategy seeking to address rural and remote workforce development.

(ii) Examination of existing skills shortages

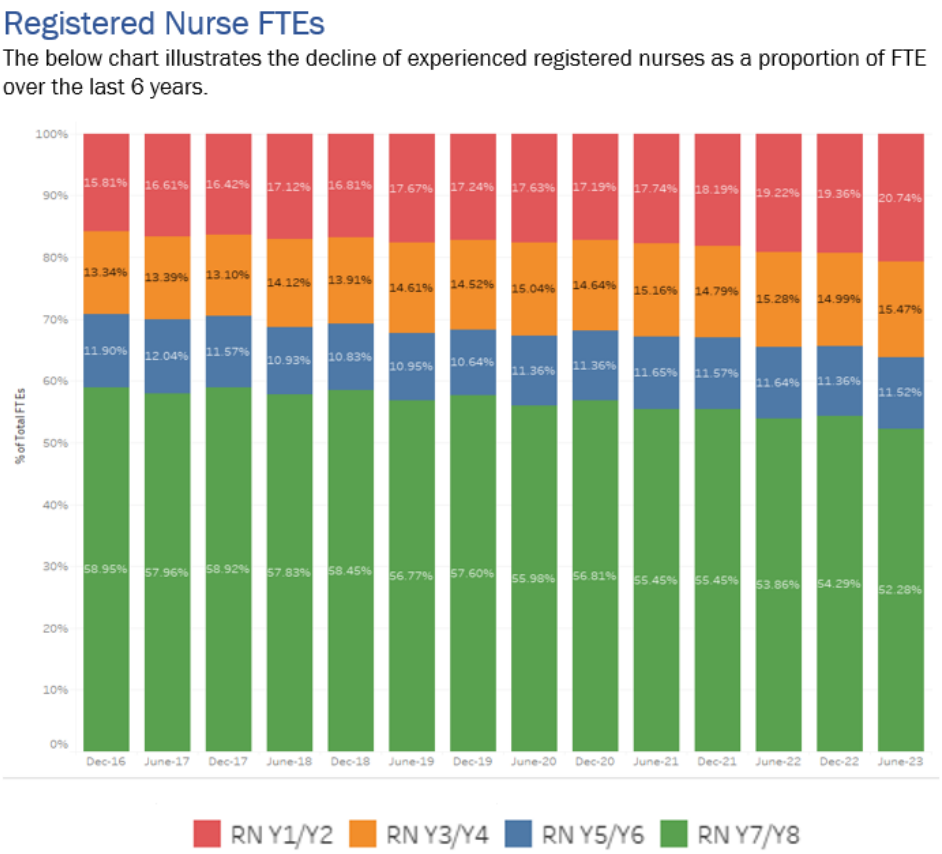
The existing skill shortages of nurses and midwives in NSW is a pressing issue with far reaching implication on the quality of healthcare, the well-being of the population and the health workforce itself. Registrant data from the NMBA identifies the raw number of nurses and midwives in NSW has grown over recent years.[209] Despite this, the healthcare sector has not been able to keep pace with the rising demands of the increasing and ageing population. The gaps in highly skilled and experienced nurses and midwives causes disparity in health outcomes and impacts distribution across geographical locations in NSW.[210]

[208] Jones, D, Randall, S, Williams, A, et al. (2022). Strength of cross-sector collaborations in co-designing an extended rural and remote nursing placement innovation: Focusing on student learning in preference to student churning. Aust J Rural Health. 30: 801–808. doi:10.1111/ajr.12880.

[209] Nursing and Midwifery Board of Australia (2023). Nursing and Midwifery Board of Australia Registrant Data

[210] Mullan, L., Armstrong, K. & Job, J. (2023). Barriers and enablers to structured care delivery in Australian rural primary care. Australian Journal of Rural Health. doi:https://doi.org/10.1111/ajr.12963.

The graph below represents data received by the NSWNMA from the MoH pursuant to applications made under the GIPA Act between 2016 and 2023, which demonstrates the decline in the number of RNs within NSW Health with over 7 years' experience.



Nurse to patient ratios are not just important for patients; poor ratios can negatively affect nurses and midwives in terms of emotional exhaustion and job dissatisfaction, which are associated with costly turnover.[211]

The Ageing Workforce

A significant proportion of the nursing and midwifery workforce is approaching retirement age. The Health Workforce Data from 2022 for nurses and midwives data shows half (49.56%) of the nursing and midwifery workforce in NSW is over 45 years of age.[212] As this workforce retires and reduces their hours, the expertise lost will result in a further burden on the already existing skills shortage within the nursing and midwifery professions.

The Intergenerational Report highlights that Australians are living longer and using more government-funded services.[213] The ageing population poses an ongoing economic and fiscal challenge in the years to come. The care and support sector which includes health, aged and disability care are expected to grow which will require ongoing investments and improvements in delivery of services. For the care and support

[211] McHugh MD, Aiken LH, Windsor C, et al. Case for hospital nurse-to-patient ratio legislation in Queensland, Australia, hospitals: an observational study. BMJ Open 2020;10:e036264. doi:10.1136/ bmjopen-2019-036264
[212] Australian Government Department of Health and Aged Care. (2022) Health Workforce Data Tool
[213] Australian Government (2023). Intergenerational Report 2023 Australia's future to 2063

sector to meet the projected demands in 2049-50 it would need to be twice the size it was in 2020-21. While this presents a strong future of job opportunities, it also presents a challenge for workforce planning.

Since 2002, successive governments have been aware impending shortages of nurses was going to occur.[214] Failure to adequately act upon this advice has led to the now critical workforce challenges. The NSWNMA has heard from members that inflexible rostering and working arrangements has contributed to a lack of skill transfer. Managers are expected to work full time, this not allowing them to maintain carer responsibilities, transition to retirement or effectively impart skills on the next generation. Our members in management roles are retiring earlier because they are not supported to work part time.

> *"Flexible rostering arrangements would allow better skill transfer from outgoing NUMs and those who require part time hours. The expectation is that NUMs and Nurse Managers work full time, this needs to change. We must enable improved succession planning in the manager career pathway." Nurse Manager, regional NSW.*

Succession planning of the nursing and midwifery workforces is now vital for transfer of skills and knowledge. NSW Health must ensure there is a focus on retaining sufficient numbers of well trained and experienced nurses and midwives to meet the challenges of an ageing workforce.

> *"Working in a regional emergency department, we have seen our most senior nurses leave the profession. Their experience and skills unfortunately leave with them. The current workforce does not have the experience to meet the demands of the community. Better workforce planning should have occurred to reduce the gap that now exists. We just want to provide our community with the care they deserve." Emergency nurse, regional NSW*

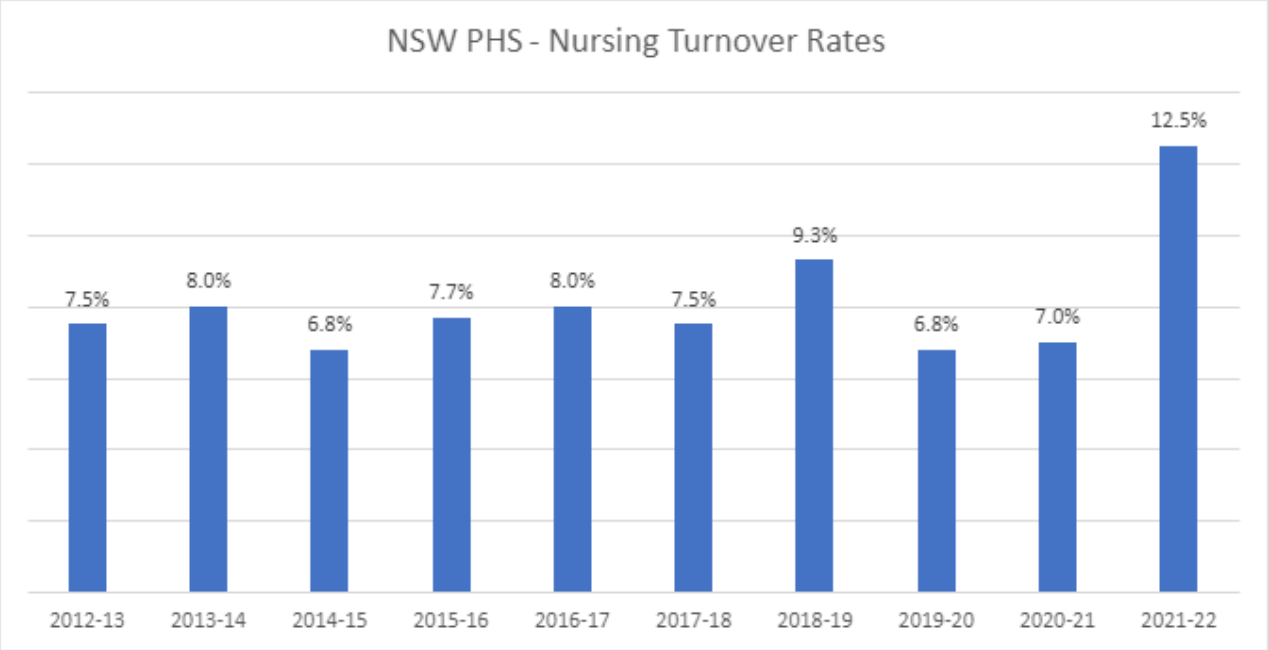
Early career nurses and midwives leaving the professions

Losing early career nurses and midwives is a multifaceted issue with significant implications. Despite their relative lack of experience, they represent the future of our workforce, and substantial investments have already been made in their training. A study estimated the cost of training a nurse to be between $100,000 and $176,000, demonstrating a neglect to invest in retaining these valuable individuals results in significant, and likely avoidable, financial losses.[215] Data revealed the average cost per FTE on staff turnover rates in ACT, NSW, and WA, ranges from $17,728 to $104,686.[216] This cost analysis encompassed expenses related to terminations, temporary replacements, advertising, and training. The turnover rates in the NSW public health system are alarmingly high. The table below represents data compiled from each of the NSW Health Annual Reports with estimates of the percentages based on graphs contained within each report.

[214] Parliament of Australia. (2002). Report on the Inquiry into Nursing - The patient profession: Time for action Chapter 2 - Nurse shortages and the impact on health services

[215] Segal, L, Marsh, C, & Heyes, R. (2017). The real cost of training health professionals in Australia: it costs as much to build a dietician workforce as a dental workforce. J Health Serv Res Policy.22(2):91-98. doi: 10.1177/1355819616668202.

[216] Roche, M,A, Homer, C, Duffield, C, Buchan, J,M. (2014). The rate and cost of nurse turnover in Australia. Collegian. DOI: 10.1016/j.colegn.2014.05.002



Source: NSW Health Annual Reports 2013-2022

Multiple factors contribute to the departure of early career nurses and midwives.[217] A report by the Rosemary Bryant Research Centre indicates that 80% of early career nurses and midwives (years 1-4) experienced abuse or threats in the workplace, compared to 67% of those with over ten years of experience. A literature review performed supports these findings, suggesting that new graduates frequently feel unsupported and undervalued due to a culture of 'eating their young', a term used to describe the sadly normalised bullying of early career nurses.[218] Many new graduates report a lack of access for supervision, with many CNE's and Clinical Nurse Specialists ('CNS') having to take on patient loads due to understaffing.

> *"I was taken off my educational role multiple times to fill in staffing shortages. Some examples include when patients would be sent to the ward from the emergency department to wait in corridors for hours until a bed became available or when sick leave wasn't able to be backfilled. During these times, I would be allocated to take care of patients. When this happened, I tried my best to continue to assist with competencies and support junior nurses, but it's hard when you have your own patient load. I voiced my concerns around the award to the patient flow manager multiple times however, I was told that short staffing is an 'emergency'. This was happening multiple times a week."*
> *former Clinical Nurse Educator, metropolitan NSW.*

Research concerning midwifery students' experiences of bullying has highlighted the lack of education and support for mentors, preventing them from effectively caring for women while simultaneously teaching students.[219] A potential solution lies in encouraging experienced midwives to be workplace mentors for students, providing them with enhanced training and support in areas such as adult learning principles,

[217] Sharplin G, Brinn M, & Eckert M. (2022). Impacts of COVID-19 and workloads on NSW nurses and midwives' mental health and wellbeing. A report prepared for the New South Wales Nurses and Midwives' Association. 2023. Adelaide, Australia.

[218] Hawkins, N, Jeong, S, & Smith, T. (2019). Coming ready or not! An integrative review examining new graduate nurses' transition in acute care. Int J Nurs Pract; 25:12714. https://doiorg.ezproxy.newcastle.edu.au/10.1111/ijn.12714

[219] Capper, T. M. W. (2021). Midwifery students' perceptions of the modifiable organisational factors that foster bullying behaviours whilst on clinical placement. A qualitative descriptive study. Women and Birth.

role modelling, and skills and confidence development in students. Offering greater continuity of mentorship would also better prepare students for their new graduate year.

The Rosemary Bryant Research report also emphasised early career nurses and midwives were frequently being asked to work double shifts, with 29.4% of early career nurses and midwives compared to 17.4% of their senior counterparts being requested to undertake double shifts 2-3 times per week. Early career nurses and midwives often grapple with overwhelming workloads and high-stress environments, driven by the demands of patient care, extended shifts, and emotionally taxing situations encompassed within a framework of poor support. Unsurprisingly, this leads to moral injury, burnout, and attrition.

The Research was conducted amidst the challenges of the COVID-19 pandemic. During this period, 54.9% of early career nurses and midwives were asked to work beyond their designated scope of practice, compared to 43.2% of their more experienced colleagues. The inadequacy of support and mentorship for these nurses and midwives exacerbates their inclination to leave the profession.

Prioritising increased funding for education is imperative, however this investment will only yield substantial results once the workforce shortage is addressed. Within the health sector clinical educators are continually being redirected to address staffing shortfalls on wards which limits their capacity to support both staff and students. This also impacts on wage cost as these CNEs/CMEs are being paid to provide care that could be provided by a lower industrial classification of nurse or midwife.

Additional concerns for early career nurses and midwives include shift work and pay. Irregular shift work and extended working hours can detrimentally affect physical and mental health, prompting some to reconsider their career choice altogether. More flexible working options with higher hourly wages (i.e. casual or agency work) can be an appealing option for many looking to have greater job control, however this can come at a cost for individuals' of their professional development and accrual of leave entitlements. For NSW Health, they bear the cost of replacing the position only to effectively employ the same person at a much higher rate. Rural contracts, when offered, frequently come with bonuses and accommodation, neither of which are extended to those on permanent contracts with NSW Health leaving no incentives for working a permanent, full-time job in RRR communities (this is examined further in **Section F (iii)**).

Addressing these challenges necessitates improvements to remuneration, working conditions, the provision of adequate support and mentorship, ongoing professional development, and the promotion of a culture of respect and recognition for early career nurses and midwives. By addressing these factors, healthcare organisations can enhance retention and ultimately improve the quality of care they provide without incurring unnecessary additional costs.

Aged Care Skills Shortage

Australia is experiencing a growth in the ageing population which will lead to an increased demand for aged care services. The Australian Institute of Health and Welfare reported 16% of Australians are aged 65 and over.[220] With this percentage expected to increase significantly over the coming decades, the demographic shift will result in increased demand on the aged care workforce.

The aged care sector has often been seen as a less attractive specialty to others with lower rates of recruitment and retention of nurses.[221] This has been amplified due to significant pressure with staffing

[220] AIHW. (2023) Older Australians

[221] Traynor, V. et al. (2023). Nursing students love working with older people- but have mixed feeling about working in aged care. Australian Nursing & Midwifery Journal, 28(1), 40-41.

shortages, skill mix, low pay, poor working conditions and the increased negative attention from the Royal Commission.[222] The Aged Care Workforce Census Report reported the nursing profession made up only 23% of the direct aged care workers, while unregulated health care worker ('UHCW') accounted for 71%.[223] The data demonstrates currently there is an inadequate skill mix in aged care and this was highlighted in the Royal Commission which found 'Inadequate staffing levels, skill mix and training are principal causes of substandard care in the current system.'[224]

This is having a flow on effect as residents are sent to hospital more frequently due to the inability to appropriately manage their healthcare needs at aged care facilities, leading to cost shifting to the NSW public sector. Depending on the long or short-term treatment, follow-on care requirements are causing delays in hospital discharge of these aged care residents due to a lack of skilled nursing staff that can provide care for residents in the aged care facility. Unlike registered and enrolled nursing staff, unqualified, unskilled and untrained staff are unable to deliver specialist care such as changing of suprapubic catheters and complex wound dressings. Both international and Australian research indicates a direct correlation between the proportion of registered nurses in a nursing care model and patient mortality, if there are lower levels of registered nurses in the model there were increased negative outcomes.[225,226]

The aged care sector provides an area to develop fundamental nursing skills including assessment, therapeutic communication and assisting residents with activities of daily living. It is these foundational skills that create the basis of nursing practice and the availability of providing this level of care is important to train the next generation of nurses. Students have exposure to aged care through roles such as AINs and during clinical placement. Joint polls conducted by the University of Canberra and University of Wollongong showed 70% of nursing students loved working with older people however, only 13% wanted to work in residential aged care as a new graduate or in the future. Negative aspects identified by students within this sector included dissatisfaction with the quality of care able to be provided, distress at the resident's experience, and the decreased level of support and access to education during the new graduate transitional year. These factors have significant impacts on MPSs recruitment to provide healthcare in RRR communities and in geriatric wards in public hospitals. The ANMF 2022 survey of aged care members showed 21% of workers intended to leave their employment within the next 12 months, and 37% within the next 1 to 5 years.[227] Without a skilled aged care workforce admissions and re-admissions which could be preventable will increase.

In reviewing this data, is it integral advocacy and improvement of this sector must be a priority to boost the workforce in the short term, whilst laying foundations for long-term improved outcomes. The federal government has made commitments to strengthen and increase the aged care workforce, such as improved wages, skilled migration visas and establishment of the Aged Care Taskforce. However, this is not enough. In **Section C** it is recommended investigation of funding changes occur from the Commonwealth to states and territories, as this may provide local governance and integrated models of care. To meet the increasing skill shortages, further solutions can include the development of low-cost retraining options for nurses who would like to return to the industry and continued incentives for the ageing workforce to participate in the workforce thus lessening the negative impacts on productivity and economic

[222] The Committee for Economic Development of Australia. (2022). Duty of care: aged care sector crisis.
[223] Department of Health. (2020).Aged Care Workforce Census
[224] Royal Commission into Aged Care Quality and Safety.(2021) Final Report: Care, Dignity and Respect
[225] Aiken, L.H. et al. (2014). Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. The Lancet, 383(9931), 1824–1830. doi:https://doi.org/10.1016/s0140-6736(13)62631-8.
[226] Duffield, C., Diers, D., O'Brien-Pallas, L., Aisbett, C., Roche, M., King, M. & Aisbett, K. (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. Applied Nursing Research, 24(4), pp.244–255. doi:https://doi.org/10.1016/j.apnr.2009.12.004.
[227] ANMF. (2022). National Aged Care COVID-19 Survey 2022

growth. Further, improvements can be made by providing supported transition to practice educational programs and mentorships for early career nurses to attract and retain those individuals, ensuring the sustainability of the aged care sector along with educational scholarships to increase the expertise of the existing workforce.

Mental Health nurses

The importance of quality mental health care has gained increasing recognition worldwide over the last few years of the COVID-19 pandemic and an evaluation of the capability of NSW Health to meet current and future demand is warranted. Given the importance of a skilled workforce in addressing the global mental health crisis, a sufficient number of skilled and experienced mental health nurses are integral to providing the required care and account for 44% of the global mental health workforce.[228] The WHO World Mental Health Report highlights there is a scarcity in skills within this workforce.[229] Mental health nurses can contribute to discharge planning and aftercare support which can reduce hospital readmissions, resulting in significant cost saving for the healthcare system. If working in a community mental health service, mental health nurses can effectively reduce admissions to acute-care facilities and address service gaps that exist in RRR settings.[230]

The AIHW data shows 1 in 5 adults and 1 in 7 young people experienced a mental health disorder in the previous 12 months and $11.6 billion dollars was spent on mental health services in 2020-21, equating to approximately 7% of the total government health expenditure.[231]

Within Australia, there have been over 55 public inquiries into mental health services over the last 30 years, however minimal notable improvements to services have resulted.[232] The NSWNMA has received feedback from its members that underfunding has resulted in demand for services far outstripping supply. Recognition of the value and potential of mental health nurses needs to occur, as this cohort of specialised nurses can reduce the economic burden and help to minimise costs by allowing them to mitigate risk, provide early intervention and support those who are vulnerable in the community.

Some mental health incentive programs have led to successful outcomes however, it is currently significantly underfunded in NSW. Having sufficient community mental health services with appropriate numbers of skilled and experienced staff with manageable caseloads can address and alleviate the burden on facility based mental health services.

A recommendation within the QLD parliamentary committee inquiry last year was for funding to be provided to support scholarships for mental health qualifications for nurses. To address the increasing need for mental health nurses an exploration of funding scholarships for further education of mental health nurses needs to occur.

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[228] Lakeman, R., Foster, K., Hazelton, M., Roper, C. & Hurley, J. (2022). Helpful encounters with mental health nurses in Australia: A survey of service users and their supporters. Journal of Psychiatric and Mental Health Nursing.

[229] WHO (2022). World mental health report: Transforming mental health for all

[230] QLD Parliament (2022). Inquiry into the opportunities to improve mental health outcomes for Queenslanders Report No. 1.

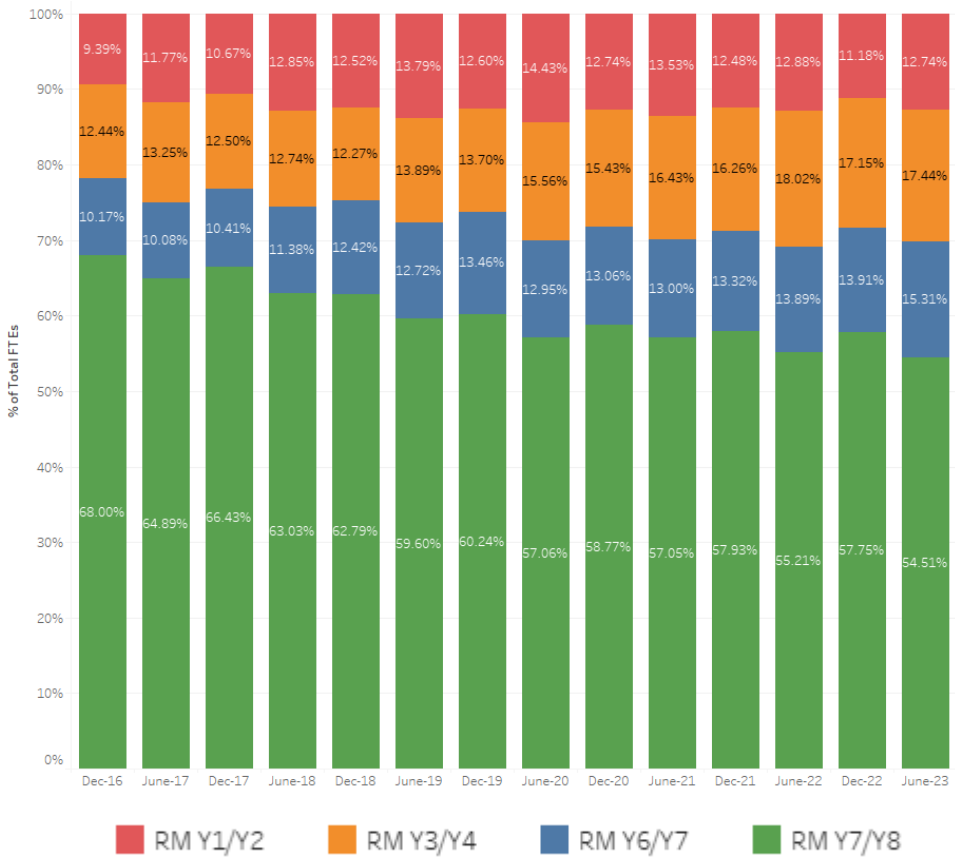
[231] AIHW (2023). Mental Health- Reports & data

[232] Francis, C.J., Johnson, A. & Wilson, R.L. (2022). The personal cost of repetitive mental health inquiries that fail to result in change. Collegian. doi:https://doi.org/10.1016/j.colegn.2022.05.001.

Midwifery

In 2022, the La Trobe University School of Nursing and Midwifery released its FUCHSIA Report on future proofing the midwifery workforce in Victoria. The report identified significant FTE deficits (135 FTE) across the workforce with most (76%) of services not adequately staffed with midwives. A key finding that contributed to the dire workforce status was the lack of experienced midwives, a high midwifery turnover and many midwives either retiring or looking for improved work/life balance, remuneration, or to avoid shift work.[233] While the research was Victoria based, NSW is experiencing an acute shortage of midwives which is impacting on the wellbeing of nurses and midwives.[234]

The below graph illustrates the decline of experienced midwives as a proportion of FTE over the last six years, based on data received under the GIPA Act. This indicates the number of midwives with over 7 years' experience has fallen from 68% in 2016 to 54% in 2023.



The prevailing midwifery skill shortages are a multifaceted issue, with multiple underlying factors costing NSW Health significantly. These issues include the medicalisation of childbirth, an ageing workforce, and evolving scopes of practice. Each of these aspects has notable financial implications for the healthcare system.

[233] Matthews, Robyn; Forster, Della; Hyde, Rebecca; McLachlan, Helen; Newton, Michelle; Mumford, Sharon; et al. (2022). FUCHSIA Future proofing the midwifery workforce in Victoria: A state-wide cross-sectional study exploring health, well-being and sustainability. La Trobe. Report. https://doi.org/10.26181/21729068.v1

[234] Sharplin G, Brinn M, Eckert M. (2023). Impacts of COVID-19 and workloads on NSW nurses and midwives' mental health and wellbeing. A report prepared for the New South Wales Nurses and Midwives' Association. Adelaide, Australia.

The growing medicalisation of childbirth has led to increased obstetric interventions, resulting in an escalation of healthcare costs.[235] The heightened presence of obstetric procedures and interventions during birth has the potential to cause birth trauma, leading to short and long-term medical and psychological problems for women, their families, and midwives. These medical interventions often necessitate prolonged and costly hospital stays and may result in lifelong medical issues, further straining the healthcare system.

The medicalisation of birth has not only compromised the well-being of mothers but also led to vicarious trauma among midwives. This phenomenon has contributed to burnout, increased sick leave, and midwives leaving the profession, in turn leading to a depletion of midwifery skills.

Such impacts have resulted in the loss of crucial midwifery skills. Midwifery students now primarily observe medically induced labour, relying heavily on technology to monitor contractions, manage epidurals, and assist medical practitioners in instrumental deliveries.[236] This shift has led to a deficit in the skills required to assess a woman's stage of labour by noise and touch, support women through the transformative process of labour, understand the physiology and mechanisms of the second stage of labour, and effectively assist a woman to birth her baby.

The increasing medicalisation of birth has also raised medico-legal concerns, leading to defensive medicine practices aimed at safeguarding against potential legal repercussions including professional complaints and/or civil claims. As the focus on 'normal' birthing experiences diminishes and interventions increase, both the mother's and baby's risks rise, creating a ripple effect which actually increases the risk of medico-legal issues arising.

Documentation plays a significant role in this context. Midwives are frequently pulled away from the woman to write extensive documentation, contributing to the erosion of development of hands-on skills, support, and the development of trusting therapeutic relationships which are integral for midwives to provide safe and effective care.

Midwives are unable to learn or perform skills such as perineal repair, as there is pressure to document and move the woman out of the birthing room. The move to online documentation has, at times, resulted in less detailed information being recorded which can impact on the care provided.

There is a lack of governance regarding the standardising and documentation of clinical competencies within NSW Health, with midwives having to complete assessments for competencies they are already proficient in, if they want to transfer to a different LHD or even a different hospital within the same LHD. This reaccreditation is time consuming and often midwives will give up on such skills as they cannot always get time off to complete the process. Some traditional midwifery skills, such as waterbirth, due to medico-legal regulations, are managed as competencies as well, which can also lead to the erosion of these skills if no one can supervise them in practice.

[235]Clesse, C, Lighezzolo-Alnot, J, De Lavergne, S, Hamlin, S & Scheffler, M. (2018). The evolution of birth medicalisation: A systematic review. *Midwifery* 66 161-167

[236] Schoene, B,E,F, Oblaeer, C, Stoll, K, & Gross, M,M. (2023). Midwifery students witnessing violence during labour and birth and their attitudes towards supporting normal labour: A cross-sectional survey. *Midwifery* 119, 103626 https://doi.org/10.1016/j.midw.2023.103626

Geographical disparities can exacerbate skill shortages, particularly in areas where access to midwifery professionals with specific skills are limited.[237] This shortage of skilled midwives may leave regions without the benefit of midwives, which can increase the risk of adverse outcomes.

To mitigate the impact of midwifery skill shortages, a multifaceted approach should be considered. There needs to be a focus on retention and prioritisation of retaining midwives by providing support to address vicarious trauma and reduce burnout. This can include access to debriefing services and clinical supervision.[238]. Additionally, providing career advancement pathways, increased remuneration, flexible rostering options and safe levels of midwifery staffing will support the recruitment and retention of midwives.

Providing additional support for RRR area midwives, including training and skill expansion will enhance their scope of practice and facilitate holistic care for women and their families. Examining and updating policies related to obstetric interventions will ensure they align with improved outcomes and effectively manage costs. By enabling midwives to work to their full scope of practice, including the ability to offer continuity models of care, and permitting endorsed midwives to utilise their skills within NSW Health facilities will also support the recruitment and retention of midwives, especially in rural and regional NSW.

By implementing these strategies, NSW Health can begin to address the pressing issue of midwifery skill and staffing shortages, thereby improving the quality of care provided to women and their families.

Increasing paid nursing and midwifery clinical facilitators

The use of nursing and midwifery facilitators provides a strengthened clinical learning environment, opportunity to link theory into practice and if effectively utilised enhances the skills and training of the next generation of nurses and midwives. Facilitators are registered nurses or midwives who are employed to support and supervise students whilst on clinical placement. The employment may be through a health facility, tertiary provider, or third-party agreement with universities. Students have reported that they learn more from their clinical facilitator than from other any other educator or learning experience.[239] For example, South Western Sydney LHD ('SWSLHD') employs clinical facilitators full-time across all shifts in a supernumerary capacity to support students. This enables SWSLHD to scale up the number of clinical placements, thereby increasing the number of students into undergraduate programs and ensures a high standard of clinical placement, student support and transition into practice as registered nurses.

Currently, there is a clinical facilitator skills shortage. This shortage has been impacted by a range of differing factors including: the general nursing and midwifery staffing shortages, reduction in facilitator hours, skilled clinicians leaving the workforce, competing workforce opportunities allowing facilitators to choose work that pays more, and the expansion of nursing and midwifery programs including increases in student numbers. As student numbers have increased, facilitator hours have decreased, placing an increased workload on facilitators leading to burnout. Some facilitators who were employed by hospitals were frequently asked to undertake clinical work when there was understaffing, leaving them feeling

[237] Kensington, M, Rankin, J, Gilkison, A, Daellenbach, R, Crowther, S, Deery, R & Davis L. (2018). 'Living the rural experience-preparation for practice': The future proofing of sustainable rural midwifery practice through midwifery education. Nurse education in practice. 143-150 https://doi.org/10.1016/j.nepr.2018.06.001

[238] Catling, C, Donovan, H, Phipps, H, & Chang, S. (2022) Group Clinical Supervision for midwives and burnout: a cluster randomized controlled trial, BMC Pregnancy and Childbirth https://doi.org/10.1186/s12884-022-04657-4

[239] Ryan, C. & McAllister, M. (2019). The experiences of clinical facilitators working with nursing students in Australia: An interpretive description. *Collegian*, 26(2), pp.281–287. doi:https://doi.org/10.1016/j.colegn.2018.07.005.

undervalued and unable to provide the support needed to students whilst being used as an alternative labour source.

These factors have led to a lack of recruitment and retention of these roles and the inability to support and mentor students. Some facilitators may lack expertise in particular specialty areas and/or have minimal knowledge of hospital/LHD policy, which creates inconsistencies between education from hospital/facility staff and facilitators. NSWNMA members have reported a decrease in facilitator hours with some not working a full 8-hour shift. If facilitators are not available, students are left with minimal support while on placement. It would be remiss to assume all the support requirements from facilitators would be on a morning shift, for example, if students were rostered on an evening shift. Students at times experience trauma or stress while on clinical placements requiring immediate debrief and support to prevent long term negative implications. Data trends have shown nursing and midwifery student withdrawal rates have increased (see **Section G**). If students are unable to be appropriately supported by this skilled workforce, the flow on effect will be further withdrawal rates and a negative experience of the healthcare system.

> *"The turnover of facilitators is huge. I know the university previously 'outsourced' to agencies as they were having difficulty recruiting and retaining their own staff. They had agency staff travel over 2.5 hours away on multiple occasions when they couldn't find facilitators."*
> *University nursing lecturer, regional NSW.*

It is important to address the shortages of nursing and midwifery clinical facilitators. To improve this skill shortage area, greater efforts at recognition of these integral roles must occur, including education and training opportunities to promote skills development within this workforce and sourcing facilitators from hospitals or facilities, to provide education with local policy and specialties. A review of working arrangements must occur to prevent facilitators being used as an alternative to short staffing and increased funding needs to be implemented to increase facilitator numbers to meet student rates to minimise risk of these students leaving the professions.

Skills development of the workforce

The process of nursing and midwifery skills development is ongoing and essential to enable the workforces to deliver high-quality and safe care. However, the workforce is faced with several challenges that are restricting their ability to develop, enhance their skills and meet the growing needs of the community. Currently there are many factors negatively impacting the development of the workforce, these elements consist of, but are not limited to:

- Resource limitations and budgetary constraints. Many facilities have limited access to educational material, simulated labs, and technology for training with the lack of resources being more prominent in rural, regional, and remote areas. Nurses and midwives are unable to access the necessary tools and equipment to build their skills.

- Increased patient acuity and workload has increased across the healthcare sectors. The prevalence of chronic conditions is increasing in Australia. In 2020-21 close to half of the Australian population had one or more chronic health conditions.[240] The increasing complexity of care has increased workloads, care responsibility and administration, leaving limited time to focus on skill development.

[240] Australian Institute of Health and Welfare (2023). Chronic disease overview

- Chronic staffing shortages. This factor has made skills development increasingly difficult. Providing basic care and maintaining safety are the main priorities for nurses and midwives with the currently the workforce is struggling to achieve this. Nurses and midwives are working longer hours and often experience burnout. Dedicating time to skills development has continued to decrease thus reducing workforce capability to care for people with more complex and acute presentations.

- Decreased incentives for skills development. The expertise and dedication required within the nursing and midwifery professions are at times not recognised nor compensated. This financial disparity can discourage professional skills development when the return on investment is minimal to none. Depending on geographical location, career progression may be limited with fewer opportunities for advancement and application of advanced skills. These unclear or limited career progression pathways result in attrition and a lack of motivation for nurses and midwives to develop further skills. Additionally, a stagnant less skilled workforce can obstruct implementation of cost-saving innovations, further increasing healthcare expenditure.

- Lack of mentorship. The staffing shortages experienced through nursing and midwifery impacts senior clinicians' ability to provide supervision and mentorship to students and early career nurses and midwives, thus hindering skills acquisition. Nursing and midwifery competencies and skills at times requires re-accreditation or re-assessment to keep in-line with best practice guidelines and the inability to provide mentorship and education has impacted the currency of practice and care available to the community.

"Our cancer service has been allowed to run on the assumption that staff will run the service on good faith rather than appropriate staffing levels. We have fantastic nurses who set the standard for cancer services, and this has been through working unpaid hours and going over and above their designated roles as there is a failure of the Executive to grant senior nursing roles. Failure in acknowledging the requirements and advancing therapies compounded with growing numbers of patients coming to our service now mean that our community and patients will pay the price of delays in treatment and unqualified and accredited oncology nurses giving chemo. The risk is that these oncology nurses are not supported through education to understand the changing landscape of oncology nursing and so may not know the drug's side effects and implications on patient treatment. This is unsafe and not a risk that our team want our community facing." Oncology nurse, regional NSW.

Investing in nursing and midwifery skills development can positively impact care, contribute to cost efficiency and overall financial sustainability of the healthcare system. To address this effectively the government and health organisations need to create skills pathways for professional development, investigate allocated funding requirements, resource limitations and appropriately compensate professionals that pursue skills advancement. When nurses and midwives are appropriately skilled, they can effectively assess and treat patients thereby reducing the risk of errors, healthcare associated infections, adverse events, re-admission to hospital and related costs.

Recommendations:

- NSW Health develop strategies for the retention of experienced nurses and midwives including flexible working arrangements for all positions to facilitate better skills transfer.

- NSW Health investigate workplace culture across LHDs and its impacts on retention of early career nurses and midwives.
- NSW Health undertake research into the precise cost of, and factors impacting, staff turnover.
- NSW Health direct LHDs not use CNEs and CMEs to fill staff shortages, allowing them to focus on the education of staff to improve and upskill the workforce.
- The NSW government investigate changes to Commonwealth aged care funding models, to prevent cost shifting from private providers to public services.
- NSW Health implements safe staffing ratios in all areas, across the state, to increase retention and capability of the nursing and midwifery workforce.
- NSW Health implement facility based, fully funded and flexible re-training options to allow nurses and midwives to return to practice.
- NSW Health allocate greater funding to support more robust transition to practice programs and mentorship for early career nurses and midwives.
- NSW Health implement targeted incentive programs which include scholarships to encourage nurses and midwives to develop specialised skills in clinical areas of need, including aged care.
- NSW Health immediately allocate funding to provide specialised and continuing mental health education for mental health nurses, including scholarships.
- NSW Health re-implement a funded post-graduate certificate program for all mental health nurses.
- NSW Health implement a strategy for the recruitment and retention of midwives with a focus on providing supports that address vicarious trauma, providing career pathways for midwives that include recognised expansion of their scope of practice, additional training for rural and remote midwives and permitting endorsed midwives to practice to their full scope within NSW Health.
- NSW Health develop a coordinated approach to provide clinical supervision and debriefing access for midwives.
- NSW Health examine and update policies related to obstetric interventions to align with evidence-based practice and aim to improve outcomes by reducing intervention rates.
- NSW Health employs clinical facilitator full-time across all shifts in a supernumerary capacity within hospitals and facilities to ensure a high standard of clinical placement, student support and transition into practice as registered nurses and midwives.
- NSW Health direct LHDs not use clinical facilitators as an alternative labour source.
- NSW Health consult with the tertiary sector to undertake a review of nursing and midwifery clinical facilitator engagement models, assess the current skills shortage and develop workforce strategies to resolve this.

(iii) Evaluating financial and non-financial factors impacting on the retention and attraction of staff

Financial factors impacting on the retention and attraction of staff

Wages and superannuation

Our members consistently tell us, second to workloads, wages are the next most significant factor that impacts on retention and recruitment of staff. Nurses' and midwives' wages have been historically suppressed by the chronic undervaluing of feminised workforces and in NSW specifically, the chronic undervaluing of public services by successive Coalition governments from 2011-2023.

Despite achieving the win of 'professional rates of pay' long ago nurses and midwives in NSW have had to fight each year for paltry increases that do not adequately reflect their education, skills or experience. Most importantly, wages for nurses and midwives in NSW simply do not recognise the critical and complex nature of their work, or how essential their services are to the community.

The average wages of nurses and midwives in NSW lag significantly behind the national average, and are the third lowest in the country. In the bordering states/territories of VIC, QLD and ACT, nurses and midwives earn approximately $14,000, $11,000 and $9,000 more per year respectively. Compared with a Victorian colleague, this equates to an extra $527 a fortnight or 12% more.[241]

Table 3.4: Average salaries[(a)(b)] ($), full-time equivalent staff(b), public hospital services, states and territories, 2021–22

	NSW[(c)]	Vic[(d)]	Qld	WA[(e)]	SA[(f)]	Tas[(g)]	ACT	NT[(h)]	Total[(h)]
All levels of reporting									
Specialist salaried medical officers[(i)]	304,159	459,528	462,721	n.a.	467,511	248,034	465,931	n.a	406,339
Other salaried medical officers[(i)]	137,147	172,896	162,041	246,983	165,722	317,589	141,930	n.a	174,337
Salaried medical officers—total[(i)]	*189,597*	*277,925*	*251,327*	*246,983*	*272,840*	*293,442*	*241,839*	n.a	*241,751*
Nurses—total[(i)]	*109,936*	*123,650*	*120,448*	*105,813*	*108,194*	*116,277*	*118,958*	n.a	*115,567*
Diagnostic and allied health professionals	94,611	107,498	113,953	95,940	113,433	108,651	135,870	n.a	103,251
Administrative and clerical staff[(k)]	87,154	98,052	96,054	92,915	73,196	77,875	97,374	n.a	91,382
Domestic and other personal care staff	61,877	80,889	88,242	74,702	55,872	66,565	58,255	n.a	74,476
Total	**106,884**	**131,919**	**128,102**	**115,466**	**118,594**	**120,362**	**127,041**	n.a	**120,088**
Administrative level									
Public hospital	116,020	n.a.	132,040	115,098	119,896	121,845	127,041	n.a	121,274
Local hospital network	105,749	132,030	113,612	118,758	n.a.	112,220	n.a.	n.a	127,354
Jurisdiction	58,875	102,956	122,163	98,935	79,178	n.a.	n.a.	n.a	62,863
Total	**106,884**	**131,919**	**128,102**	**115,466**	**118,594**	**120,362**	**127,041**	n.a	**120,088**

Source: AIHW. (2023) Hospital Resources Tables

It is important to note the above 'average' wage factors in the wages of nursing management and higher classifications of clinical staff. The starting salary for an RN in NSW also lags behind neighbouring states and is over $10,000 lower than the starting salary for an RN in QLD at just $70,050. Wages in NSW for ENs are also staggeringly low compared with other states, with the starting salary for an EN in NSW being approximately $6,000 lower than QLD, and $3000 lower than the ACT.

Nurses and midwives feel this undervaluing deeply. In 2011, the O'Farrell government announced a 'public sector wage cap' of 2.5% per annum. In what can only be described as a galling misuse of power, the right of public sector workers to collectively bargain for improved wages and conditions was destroyed by the then government passing legislation which constrained decisions of the Industrial Relations Commission

[241] AIHW. (2023) Hospital Resources Tables

of NSW regarding wages and conditions. The recent lifting of this cap by the current NSW government provides an opportunity to repair the damage caused by over a decade of wage stagnation.

The wages of nurses and midwives rose only by a maximum 2.5% per annum from 2012 to 2020, which included the superannuation guarantee contribution ('SGC') increases of 0.25% in both 2013 and 2014, and there were almost no additional entitlements in PHS Award conditions. In 2020, public sector workers received a pay rise of 0.3%. That announcement was made at the height of the first year of the COVID-19 pandemic when nurses and midwives were working in unthinkable conditions, putting themselves and their families at risk around the clock to provide care to the people of NSW.

At a time when every level of government, and every member of the community, expressed their 'thanks' for the work nurses and midwives were undertaking, their wages were effectively cut. In 2021, just as the state was entering the throes of the Delta variant outbreak and heading into another lockdown, the government announced a return to their 2.5% Wages Policy, with one catch – the 0.5% component was not going to be paid, but instead represented the Commonwealth-legislated increase to the mandatory SGC.

In 2022, the NSWNMA commissioned The Australia Institute's Centre for Future Work to undertake research into the impact of the former governments' wages policy on nurses and midwives. The report found by the end of the 2021-22 financial year, experienced nurses and midwives working full-time earned approximately $17,500 less per year as a result of the pay caps, equating to $335 per week. On a cumulative basis, this resulted in the loss of $80,000 from the commencement of the wage cap.[242]

'The arbitrary pay cap system in NSW has contributed to falling real wages, made it more difficult to attract workers to vital service roles, and undermines wage growth across the broader labour market.'

The report also highlighted the cumulative impact of the wage cap on superannuation, finding SGCs were reduced by $1739 in 2021-22 and cumulatively by $12,500 by 2024. The impact of these wage caps will affect NSW nurses and midwives well into their retirement.

Nurses and midwives who were effectively having their pay cut due to CPI increases, whilst working 8 to 12 hour shifts, plus overtime, in full PPE were provided with cupcakes and pizza from management of LHDs, as a 'thank you' for their hard work. It's not hard to see how the lack of genuine recognition and sufficient remuneration over a prolonged period impacts workforce retention.

What is not often recognised is people who might be contemplating a future career in nursing or midwifery are witness to these public displays of disrespect. Students on placements watch as the experienced nurses and midwives around them are fed up and take to the streets demanding better wages and working conditions.

The message sent to the potential nursing and midwifery workforce is they will not be well remunerated or valued, and they will have to fight for any meagre improvement in their wages and conditions. This not a foundation for developing a sustainable workforce.

[242] The Australia Institute and New South Wales Nurses and Midwives' Association. (2022) The Cumulative Costs of Wage Caps for Essential Service Workers in NSW

The NSW government must proactively and publicly demonstrate they are committed to paying nurses and midwives a fair and sustainable wage, and making reparations for the damage caused by the pay cuts of the former Coalition governments.

Enrolled nurses

The well-utilised education and career trajectory of EN to RN, or AIN to EN to RN represents an important and accessible pathway that provides many nurses with the ability to prepare for, and access, tertiary education, and often gives them the ability to work in a nursing role while they study.

Financially, there is little incentive in the short term for experienced ENs to undertake a Bachelor of Nursing and obtain registration as an RN. Whilst ENs who undertake a Bachelor of Nursing are generally given recognition of prior learning which reduces their course duration to approximately two years full-time, they are still required to undertake hundreds of hours of unpaid clinical placements which can be financially prohibitive and impact their current employment arrangements.

If an experienced (5+ years) EN employed by NSW Health obtains registration as an RN, not only do they have no guarantee of obtaining an RN position in their current workplace (despite widespread vacancies), but their salary would only increase by $27.80 per week. Positions in new graduate programs for RNs are temporary positions, upon the conclusion of which RNs can apply for permanent positions. For an EN who has the security of permanent employment, transition to a new graduate program results in the risk of losing this security.

Housing affordability

Nurses and midwives should be able to access quality, affordable housing that is suitable for their needs, including within reasonably close proximity to their work. Proximity to work is particularly relevant to nurses and midwives because of the unpredictable and inconsistent nature of their working patterns, including shift work, on-call, and unplanned overtime.

Sydney is currently the most expensive city in Australia to rent a property (median $775/week house, $680/week unit). Over the September quarter, capital city dwelling rents rose by 1.9%. Meanwhile, rents in regional areas rose 0.7%, taking Sydney rents to 10.6% annual growth.[243] The median house price in metropolitan Sydney is $1.3 million and for units it is $820,000.[244] Residential vacancy rates in Sydney are 1.4%, Hunter region 1.2%, Wollongong 1.2%, Broken Hill/Dubbo 1.2%.[245] By comparison, the average base take home salary for an AiN) is $845/week, an EN $1009/week and a RN $1236/week.

The housing affordability crisis is a pivotal issue where issues of recruitment and retention of nursing and midwifery workforce are concerned. In a recent member survey, 76% of respondents said a lack of affordable housing was a problem, and over half indicated they were insecure in their current accommodation or didn't have a steady place to live. In addition, 90% want to live near their workplace and access to affordable housing influences their employment decisions, while 69% of respondents said they were experiencing rental stress.

Some members have reported they are unable to take up offers of employment due to their inability to secure suitable housing. Many are considering relocating to areas, most commonly interstate, where not

[243] CoreLogic. (2023). Quarterly Rental Review Report – October 2023
[244] CoreLogic. (2023). Hedonic Home Value Index
[245] SQM Research. (2023). Residential Vacancy Rate: Region Hunter Region

only is housing more affordable but wages and conditions are superior and mandated ratios ensure a higher quality practice environment.

> *"We cannot save for a deposit to buy our own home, so we're trapped renting. As the rent increases and my salary increase does not keep up, being able to buy is less and less likely. I don't feel settled here and we always have the worry that the landlord will end our tenancy and we won't be able to afford anywhere else. It does affect our mental health. We plan to relocate to QLD in the next few years where there are more chances to buy and where nurses are paid more." NSWNMA member*

Non-financial factors impacting on the retention and attraction of staff

Poor rostering practices

Poor rostering practices pervade the health sector. Many nurses and midwives are employed on rotating roster/shift arrangements, whereby their employer is able to roster them to work at any time, on any day, including non-consecutive days off. Section 4(xvi)(a) of the PHS Award requires consecutive days off "where practicable". NSWNMA members note that managers frequently can and do rely on an excuse of understaffing to fill their rosters with nurses and midwives on single days off. This makes nursing and midwifery less attractive, causing further understaffing and exacerbating the problem.

For nurses and midwives working, or wanting to work in the public health system, it is generally a condition of employment that they agree to work a rotating roster. This requirement makes it incredibly difficult, and in some cases impossible, for nurses and midwives with childcare or other carer's responsibilities to enter or continue work in this sector. The NSWNMA has assisted countless members who have had difficulty negotiating a level of certainty in their working arrangements so they may be able to accommodate their carer's responsibilities. The difficulties associated with obtaining childcare places as well as the fees and charges which may be applicable for any change in childcare days only exacerbates this problem.

Employers rarely present these changes as being something which the employee has any choice about. The absence of a requirement for employers to consult directly with unions generally, means consultation with employees takes the form of one-on-one meetings where managers often use their position of power to impose unsuitable rostering requirements upon employees.

Whilst there is legislation preventing discrimination on the basis of carer's responsibilities, there is a general view amongst employers that being available to be rostered at a time of the employer's choosing constitutes an inherent requirement of a nursing or midwifery job.

Although the provision of health services 24/7 may be an operational requirement, it does not and should not be translated as being an inherent requirement of a nursing or midwifery position. Such an interpretation, advanced by many employers, including NSW Health, only appears to apply to those nurses or midwives who provide direct clinical care, resulting in frequent conflict with employees regarding issues of work flexibility and carer's responsibilities.

The current laws do not provide adequate protection in relation to rostering practices and anti-discrimination protections are difficult to pursue.

Lack of access to flexible work arrangements and job control

It is the experience of the NSWNMA that LHDs/specialty networks require the maximum level of availability and flexibility from nurses and midwives in terms of their hours of work, whilst providing very little flexibility

in return. This has an obvious impact upon the ability of workers to care for children or other family members.

These issues disproportionately affect women due to prevalence of women in nursing and midwifery (87% and 98% respectively)[246] as well as undertaking care roles within families. The unfairness of this, both generally and in terms of gender equity, is compounded by the fact healthcare workers are generally paid less than their counterparts in some other male dominated industries.

In the NSW public sector, nurses and midwives are entitled to request flexible work arrangements. When this is agreed to, they are placed on a Temporary Individual Rostering Arrangement ('TIRA').

Unfortunately, these TIRAs are increasingly being granted for a three-month period with employers having an expectation during that time the employee will 'solve' the care need which necessitates the existence of the TIRA in the first place. This is despite the known lack of access to childcare in unsociable hours and the indefinite nature of other types of care responsibilities.

The process of having to review a TIRA every three months with discussions that include: *"yes, I still have children", "yes, they're three months older than they were last time", "no, I still don't have childcare on these days/nights"*. Not having the security of knowing whether a further TIRA will be approved, is a tyranny which creates unnecessary and stressful barriers to workforce participation and care.

Many nurses and midwives carry the dual load of caring for children as well as ageing parents and for those, this process exacerbates the already difficult challenge of balancing responsibilities.

To clearly illustrate the experience of our members, below are a few examples (out of many thousands) of the practical reality of this legislative and policy failure:

- A member was subject to a formal disciplinary process after being rostered for a shift they were unable to attend due to their carer responsibilities as a parent of young children. This occurred in circumstances where the manager had long standing notice of the unavailability of the member on that day. The member notified their manager several weeks prior to the shift they were unavailable as they had to care for their children. The member was told it was their responsibility to organise a 'shift swap' with a colleague and if they could not do that, then they would need to attend the shift.

- A member working in a public hospital who is a single parent with very limited support was denied flexible working arrangements upon her return from parental leave.

- A member who was a victim of domestic violence and left her home was denied flexible work arrangements despite needing to find emergency housing in an area with a well-known shortage of affordable rental accommodation.

- For members working in non-clinical roles who access flexible work arrangements, the remaining hours of their role are frequently not backfilled, leading to them continuing to be expected to manage a full-time workload on reduced hours.

- Members who return from parental leave being demoted, terminated or subject to adverse action.

[246] Nursing and Midwifery Board of Australia. (2023) Nurse and Midwife Registration Data Table – June 2023

These scenarios occur *despite* the right to flexible working arrangements being embedded within industrial instruments, as well as the obligation for employers to comply with anti-discrimination legislation by providing reasonable adjustments to rosters for those with carer responsibilities to enable them to participate equally in employment.

Employees should be given more control over when they can be required to work. This need is particularly pressing in the health sector. Rotating roster/shift arrangements should be the exception, not the expectation, and employers should be required, as far as possible, to provide ongoing certainty to employees as to when they will be required to work.

Career progression and flexible work – a gendered issue

Men in nursing are promoted to leadership positions in disproportionate numbers,[247],[248] and have comparatively greater opportunities to work in senior roles.[249] Management and senior clinical positions are far more likely to be worked during sociable hours, and therefore not require the flexibility possibly needed by other staff. This cultural issue within nursing leads to women being disproportionately disadvantaged in their need to access flexible work arrangements.

A recent study of nursing students' perception of gender-defined roles in nursing, found: *'It is obvious with the male students that, while they realise they encounter several challenges due to being a minority in a female-oriented profession, at the same time they have greater opportunities for professional advancement.'*[250]

Most management positions are not offered on a part-time or flexible basis. Our members who are employed in full-time management positions have been redeployed into other roles on return from parental leave when returning on reduced hours. This is despite an explicit clause in the PHS Award which provides 'her' the right to return to 'her' former position.

It is commonly reported by our members once their initial flexible work arrangement has ended, management are unwilling to approve any further requests. Members are advised the solution is to either drastically reduce their permanent hours or convert to casual employment. This is unnecessarily pushing many members (predominantly women) into insecure work.

Women who work part-time or take substantial periods of parental leave have their career development limited and their yearly progression through pay increments is slowed.

Complexity of access to Family and Community Services ('FACS') Leave

Access to FACS leave is a PHS Award entitlement which enables nurses and midwives to be able to care for their family or undertake important community service when required.

[247] Brown B. (2009). Men in nursing: re-evaluating masculinities, re-evaluating gender. Contemporary nurse, 33(2), 120–129.

[248] Smith, B. W., Rojo, J., Everett, B., Montayre, J., Sierra, J., & Salamonson, Y. (2021). Professional success of men in the nursing workforce: An integrative review. Journal of nursing management, 29(8), 2470–2488.

[249] Woo, B. F. Y., Goh, Y. S., & Zhou, W. (2022). Understanding the gender gap in advanced practice nursing: A qualitative study. Journal of nursing management, 30(8), 4480–4490.

[250] Prosen, M. (2022) Nursing students' perception of gender-defined roles in nursing: a qualitative descriptive study. BMC Nurs 21, 104

The PHS Award entitlement has a different calculation depending on your length of service, though the approximate three days per year granted is insufficient and access is often dependent on the manager of the day.

Members report being denied access to FACS to attend the funerals of close family members and friends, providing care to family members who reside out of their household or taking a family pet to the vet following a life-threatening injury. Despite some of these events clearly falling within the remit of the FACS leave entitlement, access is inconsistent, and approval is given or withheld on the whim of individual managers.

We have members who, in terrible situations, have called their manager to seek access to FACS leave only to be told that it is not approved and that they need to attend work.

The NSW Health Leave Matters Policy Directive[251] outlines examples of events where FACS leave may be utilised and is clearly not an exhaustive list. FACS leave operates as a support for nurses and midwives when they are in a dire or unexpected situation or to help them fulfil their caring responsibilities outside of work.

Sadly, this is not an isolated attitude within NSW Health, despite being antithetical to a sector based on caring and compassion.

Access to such leave is an integral benefit for nurses and midwives as it provides them with an assurance and security in managing competing priorities of family and work.

The culture of individual workplaces, facilities, LHDs/specialty networks and agencies play a big role in retention of staff. It is essential there is a sector-wide focus on ensuring staff feel well supported, especially at difficult times.

Insufficient access to sick leave

Full time nurses and midwives working for NSW Health are entitled to 76 hours of sick leave per annum under the PHS Award, which equates to 10 days for most (the minimum under the National Employment Standard), but for those who work 12-hour shifts, this equates to 6.33 days.

Not only do NSW lag behind every other state and territory when it comes to sick leave entitlement for nurses and midwives; they also lag behind most public sector workers in NSW. This is difficult to believe, given they are regularly at risk of exposure to the transmission of pathogens. In the NSW Public Sector, police officers receive 15 days, paramedics 14 days, teachers 15 days plus special sick leave provisions, and fire fighters 18 days.

Victorian nurses and midwives in their first year of service have access to 91 hours of personal leave. From their fifth year they accrue 152 hours per year, approximately 19 days. QLD provide 20 days (including carers leave), TAS provide 19 days, ACT provide 18 days, with NT, SA, WA all providing 15 days.

Nurses and midwives in NSW have fought for many years for an increase to their sick leave entitlement. Even when working on the frontline at the height of COVID-19 outbreaks, their entitlement did not increase. Nurses and midwives wanting to exercise caution when not feeling well were required to deplete their sick leave balances and either take annual leave or unpaid leave so they did not put patients at risk. They

[251] NSW Health. (2023) Leave Matters for the NSW Health Service PD2023_006

continue to exercise caution and should be encouraged and supported to do so with the provision of adequate sick leave.

Work Health and Safety

To improve the retention of nursing and midwifery staff, urgent action must be taken to stop injuring them. Sick and injured workers cannot provide high quality care. The rates of serious injuries and the lack of physically and psychologically safe workplaces is leading to an exodus from the professions.

The healthcare and social assistance sector has the highest numbers of serious injuries of any industry in Australia, (24,100 nationally, with the next highest being construction with 15,600 serious claims), and unlike other industries, there has been an upward trend in serious injuries over the last decade. [252]

The Australian Work Health and Safety Strategy 2023-2033 identifies the health care and social assistance ('HCSA') industry as a priority industry due to the high frequency of serious workers' compensation claims. HCSA serious claims have risen from 7.5 per million hours worked in 2017-18 (compared to an 'all industries' rate of 5.5) to 10.0 in 2020-21 and 8.8 in 2021-22.

The Centre for Work Health and Safety conducts an Australian work health and safety survey. The 2023 survey responses from the Healthcare sector were most alarming. Results show healthcare workers felt more exposed to hazards, including harassment, sexual harassment and bullying, than workers from other industries. Almost one out of two healthcare workers experienced a form of harassment or bullying on a monthly basis, and there were indications sexual harassment was also more predominant in this industry.

Healthcare workers felt less aware of their and their employer's WHS rights and responsibilities and were also less empowered to participate in WHS discussions than their colleagues in other industries. Healthcare workplaces were not perceived as great places to work from a WHS perspective, being viewed as less prepared to manage WHS and less committed to it than workplaces in other sectors. The lack of time and resources, but also the de-prioritisation of WHS, were the main barriers to good WHS identified by healthcare respondents. [253]

Additionally, the survey found a significant rise in burnout and psychosocial harms in Australian workplaces especially in healthcare, with nearly two-thirds of workers reported experiencing burnout.

Other important research published in the last 12 months also reflects serious concerns about WHS in our sector. The 'Design for Care' study looking at psychological injury in healthcare in NSW is based on workers' compensation claims data supplied by State Insurance Regulatory Authority ('SIRA'), and we believe it significantly underestimates the extent of the issues because of nurses' and midwives' reluctance to claim for psychological injury due to concerns about the potential impact on their registration. [254]

Key findings from this study include:

- Healthcare workers are twice as likely to experience psychological injury as workers in other industries.
- Claims are growing rapidly. (claims for nurses and midwives increased by **150.6%** between 2012-15 to 2018-21).

[252] SafeWork Australia. (2023). Key Work Health and Safety Statistics Australia 2023

[253] Centre for Work Health and Safety. (2023). Australian WHS Survey 2023

[254] Gelaw, A., Sheehan, L., Gray, S. and Collie, A. (2022). Psychological injury in the New South Wales Healthcare and Social Assistance industry: A retrospective cohort study. Healthy Working Lives Research Group, School of Public Health and Preventive Medicine, Monash University.

- Nurses and midwives represent the largest number of claims within the industry.

This study demonstrates a pressing need to focus on prevention and early intervention in the industry and highlights key areas for targeted activity including addressing bullying, workloads, and occupational violence.

The mental health and well-being impacts on nurses and midwives is evident in research conducted by the Rosemary Bryant Research Centre. Around 15 in every 100 nurses and midwives who responded to questions around workplace stressors indicated symptoms of post-traumatic stress disorder. Demands of the job (including work-life conflict) and indicators of burnout (such as exhaustion and disengagement) were the most salient factors contributing to these symptoms.

- Most nurses and midwives reported their workload was too high; and their hours were higher than they would like them to be.
- Over half (58%) of those who responded to questions on career intentions plan to leave their current roles within the next five years, and 37% plan to go within 12 months. Overall, 22% indicated they want to leave the health profession entirely.[255]

Another important study into the mental health of Australian healthcare workers involved analysis of data from the Australian COVID-19 Frontline Healthcare Workers Study, an online survey of healthcare workers conducted during the second wave of the COVID-19 pandemic in Australia.

- Overall, 819 (10.5%) of 7,795 healthcare workers reported thoughts of suicide or self-harm over a 2-week period.
- Healthcare workers with these thoughts experienced higher rates of depression, anxiety, post-traumatic stress disorder and burnout than their peers.
- Fewer than half (388/819) of the healthcare workers who reported thoughts of suicide or self-harm sought professional support.
- Strong and sustained action to protect the safety of healthcare workers, and provide meaningful support, is urgently needed.[256]

The 2022 NSW Health People Matters survey results similarly reflect a workforce in crisis, with genuinely concerning results to the new question on burnout, as well as to the questions '*I can keep my work stress at an acceptable level*'; '*I have the time to do my job well*' and to the questions around bullying and exposure to violence.

A failure to address the WHS issues in the sector has serious implications for the nurses and midwives who are injured or who go to work each day feeling unsafe and has significant implications for health organisations and the delivery of health services. Services are at risk of negative outcomes including but not limited to:

- Increased worker's compensation costs plus costs of replacement staff.
- Staffing deficits leading to service delivery issues and increased psychosocial risk to workers arising from role overload.
- Loss of skilled workers and costs associated with staff turnover.

[255] Sharplin G, Brinn M, Eckert M. (2023). Impacts of COVID-19 and workloads on NSW nurses and midwives' mental health and wellbeing. A report prepared for the New South Wales Nurses and Midwives' Association. Adelaide, Australia.

[256] Bismark M, Scurrah K, Pascoe A, Willis K, Jain R, Smallwood N. (2022). Thoughts of suicide or self-harm among Australian healthcare workers during the COVID-19 pandemic. Aust N Z J Psychiatry doi: 10.1177/00048674221075540.

- Civil and/or criminal proceedings for failure to meet WHS obligations.

The key WHS issues to be addressed within NSW Health include:

- Management of psychosocial hazards, in particular:
    - Addressing role overload by ensuring safe staffing is provided by implementing ratios.
    - Providing job control by improving access to flexible working arrangements and providing worker control around rostering.
    - Ensuring adequate staffing to minimise excessive use of overtime
    - Ensuring systems for addressing bullying and harassment (including sexual harassment) are fit for purpose and reflect a positive duty to eliminate risk as well as being appropriately trauma informed so as not to cause further harm to those raising issues.

- Prevention and management of violence and aggression through:
    - Improved communication of risk;
    - Risk management plans with appropriate controls
    - Robust systems for rapid escalation of concerns/additional support when risk is identified
    - Training of managers and workers
    - Adequate bed numbers for high-risk patient cohorts in purpose-built wards with adequate numbers of highly trained staff, where staffing considers the safety of workers as well as the needs of patients, (this may include specific units for high-risk patients with behavioural and psychological symptoms of dementia (BPSD); mental health; acquired brain injuries and those who have behaviours associated with drug and alcohol use).
- Improvements to management of hazardous manual tasks to minimise musculoskeletal disorders.

Poor workplace health and safety culture combined with high rates of serious injuries to nurses and midwives are negatively affecting the current capacity and capability of the NSW Health workforce. Action must be taken to eliminate physical and psychological risks so far as is reasonably practicable and to minimise any risks that cannot be eliminated.

The introduction of changes to the Work Health and Safety Regulation in October 2022 makes clear that a PCBU must:

- identify reasonably foreseeable psychosocial hazards that could give rise to health and safety risks; and
- introduce, maintain and review control measures to eliminate (or minimise) psychosocial risks to health and safety so far as is reasonably practicable.

In determining what control measures to implement, a person must have regard to all relevant matters, including:

- the level of exposure of workers and others to the psychosocial hazards;
- how the psychosocial hazards may interact or combine;
- the design and systems of work, including job demands and management of work;
- the design and layout, and environmental conditions, of the workplace;
- workplace interactions or behaviours; and
- the information, training, instruction and supervision provided to workers.

NSW Health must appropriately address the significant psychosocial risks to nurses and midwives in accordance with WHS legislation and in full consultation with workers and their representatives. This will require change at all levels of the health system. Where Health fails to meet their obligations to proactively manage psychosocial risks to nurses and midwives, appropriate enforcement action should be taken by SafeWork NSW.

Where nurses and midwives are psychologically injured at work, better systems must be put in place to support these workers to minimise the effects of secondary injury arising from poor workplace support. Appropriate support and early intervention will reduce lost time injuries, reducing workers compensation cost and loss of skills to the employer and reducing loss of income, poor morale and feelings of isolation for workers.

Recommendations

- The NSW government amend the *Health Services Regulation 2018* to require minimum shift-by-shift nurse/midwife staffing in all public hospitals and health facilities.
- The NSW government increase the wages of nurses and midwives by a significant amount to bring them in line with neighbouring states and reduce the impact of 10 years of wage suppression. This is a key step to attract and retain nurses and midwives now and into the future.
- The NSW government increase the superannuation for nurses and midwives above the minimum SGCs to create a specific additional benefit. This would recognise and take steps to correct the disproportionately low superannuation of nurses and midwives.
- NSW Health create a supported pathway for ENs to obtain registration as an RN, including guaranteed permanent employment as an RN, flexible work practices to accommodate clinical placements and commencement of their salary on a higher RN increment to recognise their experience as an EN.
- NSW Health review the Leave Matters Policy Directive to clearly increase discretion by employees to determine the circumstances under which they can access FACS leave.
- The NSW government seek a variation to the PHS Award to increase sick leave for nurses and midwives to 15 days per annum.
- Improve WHS outcomes for nurses and midwives and create safe workplaces at several levels across NSW Health by:
  - Improving governance and reporting of WHS matters;
  - Driving safety culture, with a significant shift towards focusing on staff safety as well as patient safety;
  - Improving incident reporting systems (IIMS+) to address current barriers to reporting, this requires improvements to the IIMS+ system itself, but also to how reports are addressed and consultation and feedback to affected workers;
  - Improving training for managers on WHS responsibilities, in particular consultation, risk management, incident investigation and post incident support;
  - Post incident support including but not limited to access to Employee Assistance Programs (EAP), with current arrangements as to number of sessions available and how to access these services varying between LHDs;
  - Ensuring workers have access to relevant training e.g. VPM training

- The NSW government ensure the new psychosocial regulation is enforced, and early intervention measures are implemented to minimise harm to nurses and midwives and combat the growing levels of psychological harm being experienced across the workforce.

(iv) Existing employment standards

A detailed response is provided in **Section F (iii)**.

(v) Role and scope of workforce accreditation and registration

Clinical Placements

In NSW, clinical placement hours for nursing and midwifery students are unpaid, this contributes to financial hardship and a significant time burden which impacts their well-being.[257] Most nursing and midwifery students undertake some paid employment while studying as a supplement to, or instead of, the applicable Commonwealth assistance payment. For most students, this payment equates to a maximum of approximately $300 per week.[258] Relying on solely on that payment is not an option for most as puts them nearly $190/week below the poverty line.[259] Students receiving a payment are only able to earn $240 per week before it impacts on their payment.[260]

The vast majority of nursing and midwifery students are located in Sydney or major metropolitan areas (e.g. Newcastle or Wollongong). Given the median weekly rent for a unit in Sydney is $680,[261] and the majority of students in NSW undertake their courses in Sydney, it's easy to understand why most students need to work in paid employment for substantial hours whilst undertaking coursework.

The failure and withdrawal rate of students has been increasing with only 66% of students completing their degree and a 10.4% drop out rate in the first year; and when surveyed financial issues affected 62% of students' health and well-being.[262] The impact on financial and time burdens by students often results in high levels of physical and emotional fatigue, reduced capacity for carer responsibilities, poor access to family support structures and reduced capacity to attend to assessments.

Compared with men, women in Australia bear the majority of the burden of unpaid labour which includes caring responsibilities, with 71.8% of primary carers being women.[263] Being a primary carer significantly influences decisions regarding education and career pathways. Women who enter higher education are faced with greater constraints on their time, with the continuing prevalence of traditional gendered

[257] NSW Nurses and Midwives' Association. (2023). Position Statement on Financial and Time Burden Faced by Nursing and Midwifery Students.
[258] Services Australia (2023) https://www.servicesaustralia.gov.au/how-much-austudy-you-can-get?context=22441 [accessed 4 November 2023]
[259] Australian Council for Social Services. (2022) Poverty in Australia 2022: A snapshot
[260] Services Australia (2023) https://www.servicesaustralia.gov.au/what-personal-income-test-for-youth-allowance-for-students-and-australian-apprentices?context=43916 [accessed 4 November 2023]
[261] CoreLogic. (2023) Quarterly Rental Review – October 2023
[262] Usher, K., et al. (2022). The financial challenges for Australian nursing students attending placement-based work-integrated learning. Collegian, 29(2), pp.154–160. doi:https://doi.org/10.1016/j.colegn.2021.07.005.
[263] Australian Nursing and Midwifery Journal. (2023). Heavy burden of clinical placements needs review

expectations and the perception that higher education students can study full time.[264] These restrictions limit the ability for equal opportunity for career advancement and can lead to lifelong gender inequalities, including lower superannuation balances. A higher proportion of students from regional and remote areas were found to be mature aged, female, from low socio-economic status areas and from Aboriginal and Torres Strait Islander backgrounds. This cohort of students, at times, are under-represented as disadvantaged when participating in higher education. Due to financial, time and carer stress, these students are associated with higher unemployment rates and further disadvantaged whilst undergoing their studies.

Currently, grants are available to support students with their clinical placements. However, grants that are available do not encompass the full financial burden faced by students. The available financial placement assistance is based on the distance between a student's home and placement, with larger grants awarded if the student travels over 751 km.[265] For some students, travelling 751 km from their home is not an option due to their paid work and/or family obligations. Other forms of financial help available for full-time students includes Youth Allowance (16-21 years of age), Austudy (over 25 years of age) and Abstudy (which are payments for Aboriginal and Torres Strait Islander students). All these payments are subject to various assets tests.[266] Constraints are placed on students who receive financial assistance from the government, such as meeting the eligibility criteria and ensuring their household income does not go above the threshold. The NSWNMA welcomes the NSW government announcements regarding improvements to grants including study subsidies and the 2024 rural undergraduate scholarship.[267] However, these improvements are not available for all nurses and midwives who are enrolled in study with limits of 850 nursing and 150 midwifery scholarships per year. The limited financial assistance can lead to feelings of inequity among students.[268] The below excerpt has been taken from the 2019 Report of the Independent Review of Nursing education, since its publishing date the problem has grown.[269]

> *'A particular problem for regional placements is cost. Medical students on regional placements have their travel and accommodation costs covered, whereas nursing students are often expected to pay their own expenses. This anomaly should be corrected.'*

Members have also reported significant concerns with access to accommodation on placements. A member recently advised they had a two-week placement in a regional coastal town during the school holidays, in order to attend the placement they had to stay in a caravan at a cost of $2,000 for the two week period.

The NSW Health Aboriginal Nursing and Midwifery Cadetship program is a placement model that offers financial support, clinical placements and mentoring opportunities for Aboriginal and Torres Strait Islander

[264] Crawford, N. and Emery, S. (2021). 'Shining a Light' on Mature-Aged Students In, and From, Regional and Remote Australia. Student Success, 12(2), pp.18–27. doi:https://doi.org/10.5204/ssj.1919.
[265] New South Wales Government. (2023). Undergraduate clinical placement grants 2022 - Nursing and midwifery scholarships
[266] Australian Government. (2023). Services Australia- Income tests
[267] NSW Government. (2023). Study subsidies to boost health workforce
[268] NSW Government. (2023). Health worker study subsidies will bolster recruitment and retention
[269] Schwartz, S. (2019). Educating the Nurse of the future Report of the Independent Review of Nursing Education. Department of Health. Commonwealth of Australia.

peoples. This cadetship aims at building the local workforce and relationships for students in their own communities.[270]

As expanded on in **Section F (vi)** the benefits of the role for the undergraduate student AIN/AIM model, has allowed them to feel like part of the hospital team, experience in direct patient care, and making a real impact with their professional growth. The students reported a greater sense of autonomy, opportunities to develop critical thinking skills, enhanced confidence, and mastery in basic nursing/midwifery skills. The undergraduate student AIN/AIM role can also provide a means for financial support while studying. These roles are beneficial to supporting skill development along with placements.

Supporting student nurses and midwives through their clinical placements is an investment in the future healthcare workforce. Remuneration must include compensation commensurate to paid employment and provide additional funding for accommodation and parking. This ease in financial burden by students will ensure a steady supply of skilled and qualified nurses and midwives that can meet the growing healthcare demands of the population and fill skills shortages. By using the Aboriginal nursing and midwifery cadetship program and the undergraduate student AIN/AIM model and their effectiveness at addressing shortages of healthcare professionals as examples, the government can replicate this for other nursing and midwifery students to encourage retention and recruitment into communities and facilities.

Funding for students should be controlled by the government to ensure employers can't utilise students as a means of alternative labour to fill existing shortages. This would not be dissimilar to the recent government commitment to pay student police officers $1,360 per week plus superannuation and allowances while they study the Goulburn Police Academy. By supporting the future workforce through paid clinical placements at a minimum, nursing and midwifery education will be more accessible and attractive to prospective students and better secure the pipeline of a future nursing and midwifery workforce.

Clinical Facilitator Models

Clinical facilitators play a pivotal role in the education and development of future nurses and midwives. Their importance stems from several critical functions including being the bridge between theory and practice, mentors to guide students through the complexities of healthcare and maintaining high standards of patient safety and quality care. Clinical facilitators are a legitimate sub specialisation within nursing and midwifery and need to be considered within the workforce numbers.

Within Australia's nursing and midwifery curricula there are various models used for clinical facilitation of students.[271] As expanded on in **Section F (ii)** clinical facilitators can be employed by either the tertiary providers, health facilities or a third-party employer such as an agency. As clinical facilitators are not always employed by the hospital or health facility often practice issues arise in relation to context of practice of the facilitator. For example, a clinical facilitator from a residential aged care context of practice asked to facilitate within a large teaching hospital.

It has been highlighted by NSWNMA members that current clinical facilitators hours are not in line with student's placements. This leaves students on placement with no facilitator to support them which can lead to unfavourable experiences of the health sector. A suggestion has been that the ideal facilitators would be nurse educators within a facility, this allowing them to be familiar with the clinical area, local

[270] New South Wales Government. (2023). NSW Health Aboriginal Nursing and Midwifery Cadetship Program - Nursing and midwifery scholarships

[271] Ryan, C & McAllister.,M. (2019). The experiences of clinical Facilitators working with Australian nursing students in Australia: An interpretive description. Collegian, 26(2), pp. 281-287

policy and facility governance, ideally placing them to bridge the gap between theory and practice. This is something that needs to be considered when looking at the development of the workforce to be work ready. Research by Mathisen (2023) showed clinical facilitators who had the above working arrangements were familiar with both settings enabling them to have perspectives from 'the other side', which contributed to an enhanced understanding and collaboration between the organisations.

> *"I can communicate and argue in a different way because I have first-hand experience from both places."* [272]

When clinical facilitators are familiar with both settings, they can identify inadequate coherence between what the students were taught in the academic setting and the clinical reality of placement; this allowing them to support the theoretical application and provide cohesion of knowledge. The result are students who are better prepared for the workforce once they graduate, this preparation is vital for retention of the future workforce.

Therefore, the NSWNMA advocates the development of health facility employed clinical facilitators is a way to ensure students attending clinical placements have the best learning experience and helps support them to be the best prepared to enter the workforce once graduating. This model of clinical facilitation may be something that needs to be federally funded to support the workforce nationally. Recommendations for clinical facilitators is addressed in **Section F (ii).**

Clinical Nurse and Midwifery Educators

Educators play a significant role in the skills development and mentoring of the nursing and midwifery workforce. A well-prepared nursing and midwifery workforce fostered by educators, reduces turnover rates. High attrition rates are costly, as discussed in **Section F (ii)**, by ensuring nurses and midwives are adequately educated and prepared the sustainability of the workforce can occur. Saving funding on recruitment and orientation.

During the transition into practice, early career nurses at times are overwhelmed if not exposed effectively to the realities of the workplace. CNEs and CMEs support early career nurses and midwives during this transition. These educational roles are important for the onboarding process and increase early career nurses and midwives' professional knowledge and confidence.[273]

Whilst CNEs and CMEs foster skills development, they also enhance the quality of care for patients. Competent and confident nurses and midwives are less likely to make errors, which can lead to legal costs, payouts, and extended hospital stays. Indirectly these educators contribute to a decrease in healthcare associated costs if able to be utilised appropriately.

The COVID-19 pandemic has had considerable occupational and psychological impacts on the healthcare industry. These impacts have had flow-on effects to the CNEs and CMEs. The work of CNEs and CMEs was significantly affected, as face-to-face sessions and other professional development opportunities were

[272] Mathisen, C,. (2023) Practice education facilitators perceptions and experiences of their role in the clinical learning environment for nursing students: a qualitative study. *BCM. 22(165).*

[273] Ohr. S., Holm, D & Giles, M,. (2020). The organizational socialization of new graduate nurses and midwives within three months of their entrance into the health workforce. *Australian Journal of Advanced Nursing.* 37(2). Pp.3-10

cancelled. Educators were required to develop flexible strategies and modalities to deliver education, this paired with a rapidly developing need to re-train skills in preventing disease transmission.

The research by Wynter et al., (2022) examines the mental well-being of educators was affected substantially with increased workloads, long hours, and an insufficient educational workforce. This resulted in educational participants reporting burnout, anxiety, and depression due to perceptions of not being able to adequately fulfil their roles as educators.[274]

While the above research focused on effects of the COVID-19 pandemic the subsequent sequelae are still felt in the healthcare industry. This has led to delayed skills development of nurses and midwives, an influx of new graduates to alleviate the staffing shortages and an educational workforce who are still recovering from the psychological impacts of this time.

In discussions between the MoH and NSWNMA in 2022, educators spoke about the impacts an increased new graduate workforce would have on existing educational support structures, the importance of supernumerary days for new graduate nurses, and to highlight the shortages of educators in NSW. Some improvements have been made to educator recruitment however, this has not been consistent across LHDs. Some NSWNMA members have reported increases to the full-time equivalent positions in their workplaces, while others have not. One LHD reported that there were 10 new graduates to 1 CNE in 2023, while previously there were 4 new graduates to 1 CNE. This results in the CNE having minimal time to strengthen and build advanced skills for other established nurses.

Preceptor Support for Students and Early Career Nurses and Midwives

Nurses and midwives who are transitioning from student to new graduate may not be familiar to hospital practice and can find the realities of the hospital environment confronting in their first year of practice. This experience of 'reality shock' is still felt by new graduate nurses and midwives.[275] The use of the preceptorship model in supporting students and early career nurses and midwives is aimed at reducing the experience of shock as they enter the profession and placement. The cost-efficacy of this model lies in its ability to expedite the transition of early career nurses and midwives into competent practitioners.

This role focuses on local socialisation and clinical development of the preceptee. This includes the preceptor being paired up with the preceptee, this can be for short durations and often may only be one shift. Nurses and midwives that take on this role often have an increased workload as they still have the responsibility of looking after their own patient loads. The model utilises leverage of the knowledge and skill from the existing workforce to enhance patient safety through well-prepared nurses and midwives.

Nurses and midwives who agree to take up these preceptor roles often do not benefit from any reward, are at times not supported in this role, and express that it increases their workloads. Students and new graduates have reported that at times they feel alienated and not accepted as no one is willing to preceptor them.

[274] Wynter, K. et al. (2021). The Impact of the COVID-19 Pandemic on Australian hospital-based Nursing and Midwifery Educators. *Collegian*, 29(3), pp.271–280. doi:https://doi.org/10.1016/j.colegn.2021.10.007.

[275] Lennox, S., Skinner, J., & Foureur, M. (2008). Mentorship, preceptorship, and clinical supervision: Three key processes for supporting midwives. *New Zealand College of Midwives, (39)* pp. 7-12

Studies in Canada and Australia have shown there is a correlation between commitment to the role of preceptor if there is an availability of benefit and reward.[276] Some LHDs offer preceptor programs with aims of preparing preceptors for the role, this has been successful in encouraging the uptake of the role and allowed collaboration with other preceptors. However, preceptor models are not consistent throughout LHDs with many areas not providing a program.

By providing remuneration for taking on this role it would demonstrate the important value placed on supporting the next generation of nurses and midwives, while also recognising the importance of the current workforce. This may be applied like an in-charge allowance that is currently awarded. When nurses and midwives feel valued, they strengthen their commitment to the workforce, ultimately leading to competent practitioners and retention.

> *'The important and often unrecognised role of the preceptorship team must be highlighted. Preceptors offer invaluable support in nurturing the graduate; in particular, the skill they provide in regard to 'challenge vs support' model of educational leadership with novice nurses must be recognised and celebrated.'* [277]

Supernumerary days for new graduates

The introduction of mandatory 5 supernumerary days in the PHS Award is welcomed by the NSWNMA. The provision of supernumerary days at the beginning of transitioning to practice has proven to be effective in easing stress and allowing a smooth integration into clinical areas for new graduates. New graduate co-ordinators from various LHDs have reported previous struggles in advocating for supernumerary days, and new graduates were often given a full patient load due to staffing shortages.

While the introduction of 5 supernumerary days has allowed new graduates time to initially transition into the health industry, more can be done. The inclusion of 2 supernumerary days for each subsequent transition/rotation should be introduced to assist in orientating the new graduate to the differing clinical environment. Various contexts of practice have different routines and expectations. This can result in 'transition shock' for new graduates if not appropriately mitigated through support and orientation.

The term 'transition shock' is a relatively new concept used to describe the experience of moving from the comfortable and familiar role of the pre-registration nursing student to the professional RN, EN or midwife. The initial and most dramatic stage in this theory of role adaption occurs over the first four months of professional practice.

> *'Time for education is limited, as is allowable time off the floor for debrief. In this current climate, time appears to still be granted generously for medical colleagues but is still largely absent for the nursing profession. In this fiscally challenged environment, who will lead the change to promote education as*

[276] Hallin, K. and Danielson, E. (2009). Being a personal preceptor for nursing students: Registered Nurses' experiences before and after introduction of a preceptor model. Journal of Advanced Nursing, 65(1), pp.161–174. doi:https://doi.org/10.1111/j.1365-2648.2008.04855.x.

[277] Wakefield, E. (2018). Is your graduate nurse suffering from transition shock?, Journal of Perioperative Nursing: Vol. 31 : Iss. 1 , Article 5.

the solution to not only transition shock amongst graduates but also as a potential way to maximise staff retention in the long term?[278]

The support and development of our early career nurses and midwives is a key solution around retention building of our workforce.

Recommendations

- The NSW government urgently review remuneration for nursing and midwifery students on clinical placements, including compensation commensurate to paid employment.
- NSW Health provide funding and/or grants to cover full accommodation and parking costs for students.
- NSW Health examine the positive outcomes of the Aboriginal Nursing and Midwifery Cadetship and undergraduate student AIN/AIM models with a view to replicate them for all nursing and midwifery students.
- NSW Health require LHDs/specialty networks be transparent with the allocation of funds to support clinical educator roles and their structures across the LHD's.
- The creation of a consistent preceptor program to be implemented across NSW Health facilities.
- Preceptor allowance be applied to nurses and midwives who participate in preceptorship of students and early career nurses and midwives.
- NSW Health will increase mandatory supernumerary days for new graduate nurses and midwives to 5 days during the first transitional rotation and 2 days for every subsequent rotation.

(vi) The skill mix, distribution and scope of practice of the health workforce

It has been shown through research and outcomes from Victoria and Queensland that nurse and midwife ratios contribute to better productivity, hospital efficiencies and continuity of patient care. Minimum nurse/midwife to patient ratios is economically sound which has proven to save lives and improve patient outcomes.[279]

With the current planned rollout of ratios in five key areas as mentioned in **Section D,** the appropriate skill mix needs to be considered and factored into budgets and shift planning tools. The link between better skill mix and positive patient outcomes has now been established in many countries.[280] This is also supported in the McKell Institute report *Keep NSW in a Healthy State, Investing for a Healthy Future*. Notwithstanding the importance of capital infrastructure investment in health services and the potential for technology to improve the quality, equity and efficiency of services, good health services are only

[278] Wakefield, E. (2018). Is your graduate nurse suffering from transition shock?, Journal of Perioperative Nursing: Vol. 31 : Iss. 1, Article 5.

[279] QNMU. (2022). Submission to productivity Commission Australia's Productivity Performance. Brisbane,

[280] Duffield, C., Twigg, D., Roche, M., Williams, A. and Wise, S. (2019). Uncovering the Disconnect Between Nursing Workforce Policy Intentions, Implementation, and Outcomes: Lessons Learned from the Addition of a Nursing Assistant Role. Policy, Politics, & Nursing Practice, 20(4), 44-56.

possible if there are sufficient well-trained and experienced health practitioners and other staff to provide these services. [281]

Skill mix plays a significant role in the current economic planning for the future. As the McKell report highlights, there are two ways the demands for staff can be approached — the preferred option where workers have good remuneration and working conditions and there is a good working environment, thus stimulating greater recruitment and retention; or the second, least preferred, where people with less training are prepared to accept lower pay and conditions being used to fill the gap. The first option is fundamental to providing a stable and high-quality healthcare system both now and into the future.

The McKell report states:

> *'As with most human services, the quality of healthcare services is substantially a function of the quality of the staff delivering those services, whether the services involve specialists, GPs, nurses, allied health staff, care-workers, or other staff. This arises from the unique interpersonal quality of care labour, where the technical and personal skills of each worker together with his/her personal relationship with the service user means that the "labour itself is essentially the product". In turn there is limited scope to reduce the number or overall skill level of staff directly delivering a service without having significant negative effects on the quality and outcomes of the service.'*

It also worth considering the demand and increasing expectation for quality services is increasing with the number of consumers, this then drives the need for quality skilled staff to provide those services.

Based on the work of Baumol and others, it has been long-established in mainstream economic theory (albeit a finding often overlooked by policy-makers and commentators in human services) that in those fields where labour itself is the product, there are significant intrinsic and largely immutable limits to the extent to which productivity can be increased, especially in those sessions where trained and skilled staff have to deliver the services.[282]

While some components of healthcare services may be undertaken by less qualified staff reducing costs without harming the quality of the service, in general, reducing the quantity or quality of labour in the direct delivery of services is likely to have negative effects on service quality. The limits on productivity gains in some sectors have further effects both in and beyond the sector. For workers to be attracted to these sectors in the numbers and skills required, they must be paid wages reflecting the higher wages being paid elsewhere in the economy.

The employment of undergraduate nursing and midwifery students,AINs and AIMs, within NSW Health has had significant benefits, as it provides exposure to hospital environment and supplements their theoretical learning. This experience is an important workforce development step however, there are also risks associated with use of unqualified staff within the nursing and midwifery teams.

The NMBA Decision-making Framework for Nursing and Midwifery states:

> *Organisations in which nurses and midwives work must ensure there are sufficient resources to enable safe and competent care for the people for whom healthcare services are provided. This includes policies and practices that support the development of nursing and midwifery practice within a risk management framework.*

[281] McKell Institute (2018). Keep NSW in a Healthy State, investing for A Healthy Future
[282] McKell Institute (2018). Keep NSW in a Healthy State, investing for A Healthy Future.

The substitution of health workers for nurses or midwives must not occur when the knowledge and skills of nurses or midwives are needed. Under the National Law, nurses or midwives must not be directed, pressured or compelled by an employer to engage in any practice that falls short of, or is in breach of, any professional standard, guidelines or code of conduct, ethics or practice for their profession.

This position had to be stated due to the economic pressures on middle management to increase the proportion of lesser-paid staff. Although that approach may give the appearance there are sufficient staff, the substitution of nurses with AINs or midwives with AIMs creates unnecessary risks for patients/woman and staff. There is strong evidence the substitution of nurses results in poorer patient and nurse outcomes with higher numbers of adverse patient outcomes on wards using nursing assistants.[283]

The same research showed staffing issues in wards persisted despite the addition of nursing assistants and there was variability in their knowledge and skills, finding:

The disconnect between policy intention and outcomes reflects a top-down approach to role implementation where assistants were presented as a solution to nurses' workload problems, without an understanding of the causes of those problems.

AINs and AIMs are an important support to the nursing and midwifery workforce, and they should be well supported to work within a clear and limited scope suited to the level of their knowledge and skill. Clarity around scope is key to protecting AINs and AIMs and ensuring they are not placed in situations that are unsafe for them and unsafe for patients/women. The foundational skills of personal care and assessment must clearly remain within the scope of nurses and midwives as this is a key component of providing holistic patient/woman-centred care.

Variations in skill mix in NSW Health 2005-2023

The NSWNMA has compiled data received from the MoH pursuant to numerous requests made under the GIPA Act regarding the use of AINs, ENs, RNs, midwives and CNS/CMS classifications.[284] During the period 2005-2023 there was a:

- 75% increase in the use of Assistants in Nursing (2.24% to 3.92%)
- 47.8% decline in the use of Enrolled Nurses (18.58% to 9.7%)
- 15.7% increase in the use of Registered Nurses/Midwives (66.26% to 76.68%)
- 24.9% decrease in the use of Clinical Nurse/Midwife Educators (12.92% to 9.7%)

This shows an increase in the use of AINs and also a concerning decline in clinical nurse educators and clinical midwifery educators. As stated above there needs to be caution when substituting for nurses and midwives for other workers, due to the evidence that this does contribute to poorer patient outcomes and increased mortality. Ensuring that AINs and AIMs are undergraduate students and increasing clarity to all staff of the parameters of AIN and AIM tasks will facilitate better support, better communication and reduce the likelihood of improper delegation.

[283] Duffield, C., Twigg, D., Roche, M., Williams, A. and Wise, S. (2019). Uncovering the Disconnect Between Nursing Workforce Policy Intentions, Implementation, and Outcomes: Lessons Learned from the Addition of a Nursing Assistant Role. Policy, Politics, & Nursing Practice, 20(4), 44-56.

[284] New South Wales Ministry of Health. (2023). GIPA Decision for headcounts and full-time Equivalents employed under the Public Health System Nurses and Midwives (state) award 2021, New South Wales: GIPA23/203.

A proven way to positively develop the nursing and midwifery workforce is the implementation of the Registered Undergraduate Student of Nursing ('RUSON') and Registered Undergraduate Student of Midwifery ('RUSOM') Model. This model started in Victoria and is the Undergraduate employment model for nursing and midwifery students. RUSON/RUSOM is a person currently enrolled at a university undertaking a nursing or midwifery course, who is registered with the NMBA as a student; and who at commencement their employment and has completed at least twelve months of their undergraduate program.

The program is structured as follows:

- RUSONs and RUSOMs work above the legislated nurse/midwife to patient ratio. They work under the delegation and supervision of the registered nurse or midwife and are not to be given sole allocation of patients.
- The hours the RUSON/RUSOM work hours do not count as part of their Academic Clinical Placement hours.
- Once employed as RUSON/RUSOM they are given priority for employment in Transition to Practice programs following completion of Undergraduate degree.[285]

The research by Sweet et al (2022) found having such a role allowed undergraduates to feel part of the hospital team, enabled direct involvement in patient care, and that they made a real impact with their work. Undergraduates reported a greater sense of autonomy, opportunities to develop critical thinking skills, and enhanced confidence and mastery in basic nursing and midwifery skills.[286] The undergraduate student model allows students to promote and develop their clinical skills by an immersion in the clinical environment and direct exposure to the workforce. This contributing to increased readiness upon graduation for the role of a nurse or midwife. The undergraduate student model can also provide a means for financial support while studying. As the undergraduate student model is different from AINs that currently work in health, the undergraduate student model allows for a greater scope of practice allowing for increased retention of the workforce as it is more prepared.

> *"The registered undergraduate student of nursing (RUSON) workforce model has been previously implemented successfully in Victoria, providing support to health care systems and alleviating nursing workforce shortages. The role benefits the student as it promotes development of clinical skills by immersion in the clinical environment, provides a means for financial support while studying and builds skills for work readiness upon graduation."*[287]

NSW Health currently employs undergraduate nursing and midwifery students as AINs and AIMs. The scope of practice for the undergraduate student of nursing employed as an AIN in the acute care environment is

[285] Victoria State Government. (2020). *Registered undergraduate student of nursing (RUSON) Employment and implementation guide*

[286] Sweet, L., Vasilevski, V. and Sweeney, S. (2022). The introduction of registered undergraduate students of midwifery in a tertiary hospital: Experiences of staff, supervisors, and women. Women and Birth. 44-56

[287] McLachlan, H.L., Forster, D.A., Ford, R.L. and Farrell, T. (2011). Addressing the midwifery workforce crisis: Evaluating an employment model for undergraduate midwifery students at a tertiary maternity hospital in Melbourne, Australia. Women and Birth, 24(4), 173–179.

consistent with that outlined in the NSW Health Assistant in Nursing Acute Care Position Description, however this differs from the RUSON/RUSOM model. [288]

The NSWNMA is aware of a current trial program being run between Western Sydney University, South Western Sydney LHD, Western Sydney LHD and Nepean Blue Mountains LHD that is based on the RUSON model. However, the NSW trial consists of employing undergraduates in temporary positions for a 2-year period, the model involves placement being held in the hospital where the undergraduate works. There are some limitations to this trial, currently there is only one university in partnership and placements are limited to the facility in which the undergraduate works. The NSWNMA would be supportive of wider implementation of this undergraduate AIN model if the evidence after the trial demonstrates its effectiveness.

Enrolled Nurses

Enrolled nurses ('EN') play an integral and valuable part of the healthcare team, they are skilled, experienced and perform a wide range of duties. Within health services the utilisation of ENs results in patients' needs being met in a timely and safe manner. ENs can work to their full scope of practice in models of care that clearly understand the extent of their training. Despite the integral part EN's play in the healthcare system, they are unable to practice to the full extent of their professional capability and are often overlooked as a solution to workforce needs. The numbers of ENs registered as a proportion of nurses has remained stagnant over the last decade. In June 2013, there were 13,459 ENs registered in NSW compared with 14,096 in June 2023.[289] When contrasted with the increase in RNs during that same period (being from 67,809 to 97,911), the reduction in utilisation of ENs can be better understood.

There are two other important factors to consider with EN numbers, the first being for many it is a step in that pipeline. Secondly, cuts the former state and federal Coalition governments made to TAFE and technical education resulted in the fees for a Diploma of Nursing outstripping the fees for a Bachelor of Nursing from 2017-2022. With the recent decision of the federal government for fee-free TAFE places to address skills shortages, an opportunity has been provided for the NSW Health to develop and channel resources into increasing EN numbers.

The shortage of registered nurses in many other countries has prompted for an increase proportion of ENs. The utilisation of ENs has the capability of bridging the gap in the healthcare system that will enable faster care delivery due to the time to complete training requirements.[290]

Care assistants

The NSWNMA has concerns regarding the introduction and continued use of care assistants. Care assistants were a temporary casual class of unqualified staff engaged to support the health workforce during COVID-19. Care assistants were not required to have any work experience or skills. Our members have disclosed there have been incidents with negative patient outcomes associated with care assistants.

[288] Kenny, A., Nankervis, K., Kidd, T. and Connell, S. (2012). Models of nursing student employment: An Australian action research study. Nurse Education Today, 32(5), 600–605.

[289] Nursing and Midwifery Board of Australia (2023) Nurse and Midwife Registration Data Tables – June 2013 and June 2023

[290] Milson-Hawke, S. and Higgins, I. (2003). The scope of enrolled nurse practice: A review of the literature. Contemporary Nurse, 14(2), pp.129–137.

Despite previous assurances as to the temporary nature of the position, 134 people remained employed in this role as at February 2023.[291]

If the pathway of cheaper and less skilled labour is accepted by NSW Health, then so too is the consequence of poorer patient outcomes. The care assistant role actively impeded the provision nursing and midwifery care as it was stated that 'basic care' was within the 'scope of practice' of care assistants. Inexperienced and unqualified staff should not be tasked with providing care. It is not appropriate, nor is it fair to the patient, clinical staff or the care assistant themself.

The use of less skilled positions creates a disruption within the nursing and midwifery workforce pipeline. Therefore, it is an important these foundational skills remain in the nurses and midwife models of care to support the development of our future workforce.

Skill mix and workforce distribution needs should focus on investing in highly-skilled workers and the development of highly-skilled workers to increase the quality of patient care. Investing in the nursing and midwifery workforce and specifically in undergraduate AIN models is an investment in the future, and a key strategy in building a scalable workforce that addresses the projected nursing and midwifery workforce gaps.

Nurse Practitioners

The NMBA states Nurse Practitioners ('NPs') provide high levels of clinically focused, autonomous nursing care in a variety of contexts within Australia. NPs are meant to work to their full scope of practice in their own specialty area. They are cost effective, efficient, and capable members of the healthcare team. They are advanced practice nurses who provide complex, thorough nursing care. Yet in NSW they are not employed to their full potential.

NPs possess the authority to practice both independently and autonomously at a level of practice beyond that of a registered nurse. Australian NPs have extensive post-graduate clinical experience and have completed mandatory prescribed education at a master's level. They provide complete episodes of healthcare, using an advanced nursing model of care. They are the essence of primary healthcare.

NPs practice collaboratively with other health professionals to improve access to healthcare for Australian communities through health promotion, disease prevention, and health management strategies. It is within a NPs ability to assess and diagnose health problems, order and interpret diagnostic investigations, formulate and assess response to treatment plans, prescribe medicines and refer to other health professionals within their individual areas of competence. NPs may also admit and discharge consumers from health services, including hospital settings. When utilised effectively NPs improve health outcomes for specific patient populations or communities. The role NPs play in the health system is integral, this demonstrating that increasing the number of NPs across the country will improve overall health outcomes for the public and reduce presentations to hospital.

The table below shows the number of nurses who held endorsement between 1 April 2022 and June 2022.[292] Despite NSW having more RNs than any other state or territory (by over 8,000), we have only the third highest number of NPs.

[291] New South Wales Ministry of Health. (2023). GIPA Decision for Headcounts of Care Assistants – Employed at 14/02/2023 and total employed from 13/04/2022 (GIPA23/293)

[292] Nursing and Midwifery Board of Australia. (2023) Nurse and Midwife – Registrant data table

Profession	Endorsement	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	No PPP	Total
Nurse	Nurse Practitioner	61	617	33	704	198	54	641	318	30	**2,656**
	Scheduled Medicines - Rural and isolated practice	5	50	29	824	10	21	281	29	9	**1,258**

* The above numbers under 'Midwife - Scheduled Medicines' reflect those midwives who have met the NMBA Registration standard for endorsement for scheduled medicines for midwives.

There are little to no additional risks or other health impacts from NPs working to their full scope. The Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) provide a barrier to NPs accessing rebates. The issues with claims to rebates are a constant struggle for NPs, especially those in rural areas or private practice. Patients are often required to go to GPs when the NP has already done the workup, causing unnecessary duplication of services and increased difficulties if there are no doctors available. The MBS and PBS requires reform to enable NPs to provide the care they are educated and trained to do for the public.

The NSWNMA strongly advocates for changes to NP arrangements with doctors to enable them to be eligible for government subsidies. The idea of advanced practice is not a new concept in nursing. The arrangement with doctors is unnecessary and present significant impacts for NPs that work in rural, regional, and remote areas where there are no doctors. Medicare must become more inclusive of NPs. Australians living in rural and remote areas deserve access to equitable healthcare, they should not be disadvantaged over their metropolitan counterparts.

Unfortunately, there is still a perception doctors are the keepers of the healthcare system. Doctors form part of the healthcare team and are equal to their colleagues including nurses, midwives, endorsed midwives and NPs. It is time to acknowledge nurses, midwives and especially endorsed midwives and NPs as equal partners. Primary healthcare should focus on a multidisciplinary workforce which includes GPs, NPs, nurses, midwives, and other allied health professionals, who work alongside each other to share knowledge, advice, and information with aims of improving patient outcomes. As health professionals we must work together and not in competition, our aim is to increase the health workforce across the board to improve our failing health system.

The Final Report of Inquiry Acute Care Services in NSW Public Hospitals (2008) discussed the role of NPs and the issues that arise with divisions made between doctors and NPs with Garling J remarking '*the rigid demarcation between what a doctor's job is, and what a nurse's job is, needs to be consigned to history. Once the concept of teamwork is accepted as the norm in treating a patient, it is easier to see why a qualified nurse practitioner should be able to do many jobs once reserved for doctors.*'[293] It is unfortunate 15 years later, this still has not occurred.

> *"Healthcare is a team game, and a patient is best served when every discipline within that team can play their part to the fullest extent. Multidisciplinary care (MDC) has been shown time and again to provide high patient engagement and strong patient outcomes. But it also benefits the practitioners who are more likely to enjoy their work and therefore remain in healthcare."* [294]
> *Professor Mary Chiarella and Ken Griffin.*

[293] NSW Government. (2008). Final Report of Inquiry Acute Care Services in NSW Public Hospitals Overview
[294] Chiarella, M. & Griffin, K. (2022). What the strengthening Medicare Taskforce: Must do to modernise the primary health care workforce. Pearls and Irritations, John Menadue's Public Policy Journal

The work by the federal government's Strengthening Medicare Taskforce to increase allocation of funds to NPs is welcomed. As addressed earlier, the disparities between metropolitan and rural, regional and remote areas are significant. Areas cannot be totally dependent on GPs as data shows 1 in 5 Australian rural areas do not have a GP.

> *"One can only speculate why such a significant limitation on health professional leadership was placed on planning for our future Medicare models. Whilst there is no doubt that, in many instances, general practitioners (GPs) are the centrepiece of primary medical care, it is not accurate to suggest that they are always the centrepiece of primary healthcare."* [295]

There are currently 109 NPs working across aged care in NSW, they are integral in greatly reduce ED admissions, ambulance costs and hospitalisations. Many of these NPs also work in palliative care, they can prescribe and administer medications to those ageing people who are dying yet they are not able to write a death certificate. Consequently, they must spend time waiting for the doctor to come into the home or nursing home to sign the death certificate. This can take any length of time as the GPs are very busy and the unnecessary wait can cause already grieving relatives more distress.

The NSWNMA views the current arrangement between NPs and doctors to be unnecessary and hinders access to healthcare for vulnerable people in NSW. The NSWNMA continues to advocate for Medicare to become more inclusive of NPs and for communities to have access to healthcare rather than fronting the cost of Medicare subsidies.

Recommendations

- The NSW government consider amending section 39 of the *Births, Deaths and Marriages Registration Act 1995* to allow Nurse Practitioners to be able to complete a Notification of death.
- The NSW government lobby the federal government to collaborate on mechanisms to increase the number of Nurse Practitioners and Endorsed Midwives and broaden prescribing and referral rights and access to MBS and PBS.

Midwifery

Midwifery is an autonomous profession with inherent professional accountability.[296] While midwives are responsible for defining their own scope of practice, the way they practice is regulated by national and local guidelines and policies. The prevailing culture of medicalising childbirth has created barriers that inhibit midwives from fully realising their professional scope.[297] The resulting inhibition and lack of recognition contribute to workforce attrition, a concern not unique to Australia but experienced worldwide.

A report, led by the United Nations Population Fund ('UNFPA') in collaboration with the World Health Organization ('WHO') and the International Confederation of Midwives ('ICM'), 'The State of the World's

[295] Chiarella, M. & Griffin, K. (2022). The Strengthening Medicare Taskforce: All healthcare workers are on the front line. Let's get them on the front foot. Pearls and Irritations, John Menadue's Public Policy Journal

[296] International Confederation of Midwives. (2018). ICM Definitions

[297] Clesse, C, Lighezzolo-Alnot, J, De Lavergne, S, Hamlin, S & Scheffler, M. (2018). The evolution of birth medicalisation: A systematic review. Midwifery 66 161-167

Midwifery' 2021 has identified four areas of investment that could enable midwives to work to their full scope of practice:

- Workforce and Planning - This encompasses investments in well thought out strategies that acknowledge the autonomy and professional scope of midwives. It involves directing resources towards underserved areas, particularly in primary healthcare, and creating work environments that promote gender-transformative practices.

- Education - The report highlights the need to invest in education, educators, and training programs to ensure all midwives can practice to their full capacity.

- Midwife-Led Improvements in Sexual, Reproductive, Maternal, Newborn and Adolescent Health ('SRMNAH') Service Delivery - The report suggests investments in enhancing communication and partnerships, as well as optimising roles for midwives through midwife-led care models.

- Midwifery Leadership and Governance - To further enhance the role of midwives, the report recommends creating senior midwife positions, such as a Chief Midwife in each state, and providing opportunities for midwives to actively influence health policy development. Demonstrating clear career progression for early career midwives is seen as a crucial tool for retaining this workforce.

The report concludes when midwives are fully educated, licensed, and integrated into a multidisciplinary team, midwives can meet about 90% of the needs of SRMNAH interventions, but currently midwives only make up just 8% of the global SRMNAH workforce. Boosting that number can be transformative to saving not only money but lives.

However, a fundamental concern moving forward is the lack of a clear definition of extended scope. This absence of definition could potentially lead to a loss of essential skills and underutilisation of midwives, in turn incurring additional costs for NSW Health. To try to address this, a literature review identified four key areas to define extended scope of practice: preconception, antenatal, labour and birth, and postnatal care. The most defined extended skills encompass prescribing, ultrasound, abortion care, and primary healthcare.[298]

The research also highlighted advanced scope or extended skills are often associated with rural areas, where midwives adapt to provide women-centred care and align their skill acquisition with the specific community needs. In Australia, rural midwives work to an expanded scope of practice, offering comprehensive care from routine antenatal, intrapartum, and postnatal care to case management scenarios where they are finding accommodation for families, liaise with specialists not available in their community and provide emergency and high-risk midwifery care when needed. This approach is outlined in the National Consensus Framework for Maternity Services.[299] Utilising midwives to their full scope could reduce the need for costly locums or visiting medial officers.

However, extended scope of practice must be accompanied by appropriate remuneration. The rural and remote midwifery workforce is currently facing a crisis, and incentives are needed to attract professionals to provide specialised care. In Victoria and Queensland, they have rural and isolated practice registered nurses ('RIPERN'). These nurses complete extra study to extend their skills to help provide improved care

[298] Toll, K., Sharp, T., Reynolds, K. and Bradfield, Z. (2023). Advanced midwifery practice: A scoping review. Women and Birth

[299] Australian College of Rural & Remote Medicine. (2008). National Consensus Framework for Rural Maternity Services.

to their rural community. They are also paid at a higher rate, which not only helps retain the rural workforce, but incentivises midwives to extend their scope and move to rural areas.

Prescribing is another example of how midwifery scope of practice can be extended. The number of endorsed midwives in Australia has grown significantly. While there were only 157 in 2014, as of June 2023, there were 1,089. In NSW however, there are only 157 endorsed midwives, and many of them are underutilised within the public health system. Allowing midwives to prescribe could potentially reduce errors, decrease waiting times, and improve care delivery.

Recent legislative changes in Australia provide an opportunity to reorientate abortion services to be woman-centred, accessible, and integrated into primary maternity care services. The prescribing rights of MS-2 Step means endorsed midwives can prescribe medication for abortion, but in the public system where most terminations are happening, midwives cannot use their endorsement. Not allowing midwives, who have undertaken further study to become endorsed, is another way NSW Health are limiting the development and utility of midwives.

Midwifery Group Practice ('MGP') is another model that allows midwives to work to their full scope of practice. The benefits are three-fold, including improved outcomes for women and babies, reduced burnout for midwives, and cost savings for the healthcare system. This is explained in greater depth in **Section D**. Continuity is now factored into the midwifery curriculum and in a survey of midwifery students, 90% said they felt working in MGP would provide them with the most satisfaction. All maternity services need to provide or increase their availability of MGP places for midwives, women and the cost saving for NSW Health. The current demand for midwives to work in MGP exceeds capacity in NSW Health, and addressing this issue is recognized as a workforce retention concern.[300]

NSW Health need to review the annualised salary attached to MGP. The loading received on top of the annualised salary in NSW is 29% which was decided upon in 2014 with a review date of 2019.[301] Other jurisdictions such as Tasmania and the ACT are paid a substantially higher wage. Midwives working in the MGP model in Tasmania receive a 35% loading, whilst the ACT receive a 40% loading.[302] [303] This lack of appropriate renumeration is adding to the workforce attrition.

Some further recommendations that would enable midwives to work to their full scope include short term funding or paid scholarships in protected time to extend or reinforce the skills of the midwife., with the long-term goals of introducing skills such as cannulation and suturing.

Short-term renumeration for endorsed midwives with the plan to incorporate those skills into the undergraduate/postgraduate course would enable those who are already qualified to use their skills, and encourage others to undertake the course until we have closed the gap with the new graduates.

In conclusion, there is a need for a comprehensive strategy to enable midwives to practice to their full scope. This includes defining extended scope, addressing policy barriers, ensuring appropriate remuneration, and incorporating additional skills into the curriculum. By taking these steps, we can

[300] Council of Deans of Nursing and Midwifery (Australia and New Zealand). (2023). The future of the midwifery workforce in Australia: Position paper

[301] NSW Health. (2014). Pilot Model Annualised Salary Agreement for Midwifery Group Practices

[302] ACT Public Sector Nursing and Midwifery Enterprise Agreement 2020-2022

[303] Nurses and Midwives (Tasmanian State Service) agreement 2019

empower midwives to provide comprehensive, woman-centred care, improve healthcare outcomes, and reduce workforce attrition, ultimately benefiting women, families, and the healthcare system.

Recommendations

- The care assistant role does not roll out to any other LHDs and care services remain within nursing and midwifery models, as undergraduate AIN/AIM models assist the nursing and midwifery workforce.
- That, pending positive outcomes from the South Western Sydney LHD trial, NSW Health adopt an Undergraduate AIN/AIM program based on the RUSON/RUSOM model in more facilities across NSW.
- Skill mix be factored into ratios and staffing tools.
- NSW Health invest in education and develop policy to support midwives to expand their individual scope of practice.
- NSW Health support the creation of senior midwifery positions, including a Chief Midwife in NSW.
- NSW Health ensure appropriate industrial mechanisms are in place to provide additional renumeration for those working to an extended scope of practice.
- NSW Health develop policy to support endorsed midwives to using their skills in within the public system
- NSW Health invest in more midwifery-led continuity of care models including those that allow for flexible working conditions for midwives.
- NSW Health review the MGP annualised salary agreement with a view to ensuring parity with other states.
- NSW Health create more opportunities for midwives to work in community health, to support the aims of the First 2000 Days framework.

(vii) Use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements

See **Section D** – cost of vacancies and **part (xi)** of this section.

(viii) The relationship between NSW Health agencies and medical practitioners

No recommendations to this term of reference.

(ix) Opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives

Expanded scope of practice for nurses, see **Section C** and **Section D** of this submission, and **Section F (v)** of this submission.

Expanded scope of practice for midwives, please see **Section F (v)** of this term of reference.

(x) The role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system

Community health services and primary healthcare settings more broadly are crucial to reduce pressure on the hospital system. An essential component in delivering primary healthcare is through multidisciplinary teams, working together to improve health outcomes for patients. Health practitioners from a range of health disciplines, and with various skill mix form part of these multidisciplinary teams. As mentioned in **Section C**, primary health nurses make up the largest component of the primary health care workforce, with at least 82,000 nurses working outside of the hospital setting.[304]

Multidisciplinary primary healthcare services deliver comprehensive, coordinated primary health care, providing significant benefits, outlined in **Section D.**

Midwifery

As stated in **Section C**, incorporating midwifery group practices ('MGP') into community health centres working alongside other health practitioners would help to improve communication and continuity of care by presenting a one-stop shop for women and their families. This care could be accessed through pregnancy and as their children grow. The opportunity to move midwives and women into the community setting when experiencing a low-risk pregnancy would not only remove logistically issues of parking and clinic space for the hospital, but it would remove the institutionalised feeling of being a 'patient'. For some women and families entering a health facility can be triggering, often leading to non-attendance in the pregnancy period. Relocating antenatal and postnatal care into the community reaffirms that childbearing is a normal part of life and does not always need hospitals, doctors, and may reduce intervention. Offering more opportunity for postnatal visits in the home may also shorten hospital length of stay, not only saving the money, but providing a more appropriate service for women and their families.

Objective 2 in the MoH *First 2000 days*, conception to age 5 Framework, states the health system provides care to all and works in partnership to promote health, well-being, capacity, and resilience during the first 2000 days. [305] Nurses and midwives are ideally placed to provide community-based care, operating within multidisciplinary collaborate care models which is vital for the success of this initiative. This type of service, staffed by midwives, child and family health nurses, women's health nurses, mental health clinicians, and nurses working to the top of their scope would help prevent women and families from falling through the gap and encourage greater community engagement and support. In addition, the role of the endorsed

[304] Australian Institute of Health and Welfare. (2023). A profile of primary health care nurses – web report
[305] NSW Ministry of Health (2019) The First 2000 days: Conception to Age 5 Framework, p 20

midwife in the community health setting would reduce medical practitioner workloads as they could be responsible prescribing and ordering diagnostic tests.

Nurse Practitioners in Primary Healthcare

To facilitate the broader provision of services by NPs in primary healthcare, there is a need to increase the number of RNs being endorsed to practice as an NP. In the foreword of the Department of Health and Aged Care's *Nurse Practitioner Workforce Plan*,[306] the Assistant Minister for Health and Aged Care, Ged Kearney stated:

> *'The Nurse Practitioner Workforce Plan aims to enhance the accessibility and delivery of person-centred care for all Australian communities through a well distributed, culturally safe nurse practitioner workforce. It provides strategic direction for the next 10 years and beyond. It details how to remove the barriers currently facing the workforce and build the workforce, while increasing to care for all Australian Communities.'*

> *'Greater professional development opportunities including mentoring and education were supported by NPs during the public consultation. Mentoring promotes a positive work environment, fosters learning and job satisfaction.'*

The utilisation of mentorship models has proven positive with most NPs embracing this within their own practice within primary healthcare. Mentoring promotes a positive work environment and fosters learning and job satisfaction. Greater professional development opportunities including mentoring and education were supported by NPs during the public consultation of the Workforce Plan. The Australian College of Nurse Practitioners welcomed the launch of the plan as it set out steps to reduce barriers in accessing healthcare, enabling NPs to work to their full scope and capabilities.

Having an ageing population with increasingly complex comorbidities results in higher demands on health services. The safe and quality provision of care now and into the future requires an experienced, well-trained and diverse health workforce. Further support for education providers and employers is required to empower RNs to undertake a Master of Nursing (Nurse Practitioner). The Workforce Plan has promoted the changes required in the health system however, the profession and government needs to support the workforce to allow the plan to come into fruition.

The Workforce Plan builds on existing resources, such as the Advanced Nursing Practice for the Australian Context to provide national consistency on the scope of NPs and advanced practice roles, and provides greater clarity and understanding for nurses, employer, consumers, health professionals and other stakeholders.[307]

There remains a huge task ahead for all involved in the development of NPs to embrace the vision to grow the workforce and to better utilise their skills so that they can deliver the safe, quality and accessible care that people deserve.

[306] Department of Health and Aged Care. (2023). Nurse Practitioner Workforce Plan
[307] Department of Health and Aged Care. (2022) Advanced Nursing Practice for the Australian Context

The NSWNMA shares Assistant Minister Kearney's views on what success of the Workforce Plan will look like.

> *'Successful implementation of this Plan will mean that Australian communities will have a better understanding and awareness of the role of nurse practitioners with greater access to nurse practitioner services.*
> *It will also mean that nurse practitioners will have the support they need to work to their full scope of practice and that the nurse practitioner workforce will grow and reflect the diversity of the community. Achieving the Plan's intended outcomes will need coordination and collaboration from all governments and key stakeholders across Australia.'* [308]

NSW must take this opportunity and all work together to achieve a primary healthcare NP workforce that leads to better overall health and reduced healthcare costs. The NSWNMA supports the Australian College of Nurse Practitioners and Australian Primary Health Care Nurses Association recent letter to the Department of Health and Ageing stating currently, the most significant barriers preventing Australia from realising the full benefit of the NP workforce are:

1. Funding structures - MBS rebate restrictions that affect the patients of Nurse Practitioners in primary care are well known, and despite a wide range of clinical evidence and substantial examples demonstrating the adverse effect of these MBS restrictions- they remain. This continues to put patients at risk, duplicates services, and adds cost to the health system. Support parity of rebates, and equal reimbursement for equivalent services is needed.

2. Collaborative arrangements - The purpose of implementing the Nurse Practitioner role in Australia was to increase the flexibility of the health workforce, however these collaborative arrangements can impact directly on patients access to care, especially where they are misinterpreted, or used to limit the practice of a Nurse Practitioner, and where a person may not be able to access a medical practitioner. We strongly urge the government to remove collaborative arrangements as the Determination is an example of over-regulation resulting in current and future potential unintended consequences.

3. Recruitment and Retention - Workforce shortages, due to an ageing nursing workforce (average age of 43 years) and the impact of COVID19 are major challenges facing the Australian health system. The health system needs to attract new nurses, particularly from under-represented groups to primary healthcare to offset a looming shortage. This is vital if the primary health care workforce is to be able to deal with the rising number of ageing Australians and the impacts of COVID-19.[309]

Recommendations

- NSW Health investigate the implementation of MGP (or a similar continuity of midwifery care model) for antenatal and postnatal care in community health centres, particularly in rural areas with a shortage of GPs and Obstetricians.

[308] Department of Health and Aged Care. (2023). Nurse Practitioner Workforce Plan

[309] ACNP & APNA. (2023). Australian College of Nurse Practitioners (ACNP) and Australian Primary Health Care Nurses Association (APNA) joint response to: Australian Government Department of Health Increasing access to health and aged care: a strategic plan for the nurse practitioner workforce (the Plan)

(xi) Opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers

Excessive reliance on temporary agency nursing staff is known to have deleterious effects on patient safety. There are significant patient safety benefits associated with consistency of staff providing continuity in care delivery because the work is known and can be undertaken efficiently, teamwork is enhanced, and less supervision is necessary.[310] It is well known nurses and midwives choose agency work for the flexibility and improved pay rates.

The NSWNMA regularly receives feedback about WHS and patient safety matters arising from the use of temporary agency security staff and agency AINs rather than workers directly employed by their health agency, with concerns as follows:

Security staff

The role of a security officer in a health facility is very different to that of a bouncer or a security guard at a retail store and requires different training as well as the experience of working within a clinical team. Members report feeling frightened to call a duress when they need one, if they know it will be agency staff responding, as untrained workers can escalate a situation further and are reported to use undue force.

As noted by Mr Peter Anderson in his interim report into Improvements to Security in NSW Hospitals.[311] What the hospital system does not require are security staff that:

- do not understand that their role is not that of a nightclub bouncer and building guard
- have a 'punitive' attitude to their role
- do not understand that their role is one of being part of a clinically led team
- do not have a commitment to the policy of de-escalation as the first response
- think it is acceptable to sit down and spend time on their mobile phones
- want to be quasi police in either appearance, attitude or performance.

Security officers working in health in addition to holding a security licence, should also have completed '*Security in the Health Environment'* training to ensure they understand how clinical conditions may be contributing to patient behaviours as well as NSW Health VPM training to understand how to work with the clinical team to deescalate, and where necessary restrain patients in a safe manner.

In addition to creating WHS issues and patient safety issues, there is considerable waste in health funding arising from the use of agency security rather than directly employed security. Western Sydney LHD ('WSLHD') is reported to have an over reliance on the use of agency security staff, with the Sydney Morning Herald reporting WSLHD had spent close to $40 million dollars for private security at Auburn and Blacktown Hospitals, as well as two drug treatment centres between 2020 and October 2022.

In this same article dated 13 July 2023, the Herald reported sighting a scathing internal audit that found WSLHD did not have 'any processes' to check whether the guards were trained or even licensed to work as private security. Instead, NSW Health left it up to the contracted private security company to ensure their guards had valid working with children checks and security licences. The audit warned lack of

[310] Duffield. (2009). Implications of staff "churn" for nurse managers, staff, and patients. *Nursing Economics.*, *27*(2), 103–110.

[311] Anderson, P. (2019). Interim Report: Improvements to Security in Hospitals

oversight had left the LHD open to 'significant reputation and financial risks [if] untrained or uncertified security staff are let into the facility, near the patients, children and other visitors'.[312]

The NSWNMA supports directly employed permanent security staff, with directly employed casual pools to fill temporary vacancies and use of agency security only as a last resort.

Assistants in Nursing

NSWNMA members have concerns about the widespread practice of employing agency AINs as patient specials with patients displaying aggressive behaviours, as this often places the person who is least equipped caring for the most high-risk patients.

Any worker providing care to a patient displaying aggressive behaviours should first have undertaken NSW Health VPM training and have a comprehensive understanding of the local systems of work in place in the facility to manage violence. Agency AiNs are unlikely to have completed VPM training or to have a detailed knowledge of local systems of work. Additionally, people providing specialling should have appropriate clinical skills to identify any deterioration in the patient's clinical condition, e.g. specialling of patients with behaviours associated with their mental health condition requiring a patient special, should be specialled by a mental health trained nurse or a patient with behavioural and psychological symptoms of dementia ('BPSD') requiring a special should be cared for by someone with training and experience in dementia/BPSD.

An NHS Case Study of recruiting and training an internal workforce to provide specialling rather than using agency staff as patient specials found improvements in relation to incidents of harm and significant cost savings associated with the new model.[313]

Recommendations

- NSW Health directly and permanently employ security officers, backed up by an appropriate casual pool, with labour hire only used as a last resort.
- All security officers working in NSW Health facilities must complete 'Security in the health environment' training and NSW Health VPM training.
- NSW Health develop and implement a statewide policy on the use of patient specials, to ensure that agency AINs or inexperienced staff are not utilised to special high-risk patients.

[312] McGowan, M. (2023). NSW Health spent $40 million on private security but didn't check their credentials
[313] NHS. (2016). *Improving care and safety of at-risk-patients- from 'specialling' to enhance care*

G: Current education and training programs for specialist clinicians and their sustainability to meet future needs

(i) Placements

Increases to clinical nurse and midwife educator positions

A detailed response is provided in **Section (v) Clinical Nurse and Midwifery Educators** and **Preceptor Support for Students and Early Career Nurses and Midwives**

Recommendations

- The NSW government urgently review remuneration for nursing and midwifery students including compensation commensurate to paid employment. Financial support be provided during clinical placements, similar to the recent government commitment to pay student police officers while they study.
- NSW Health provide funding or grants to cover full accommodation and parking costs for students.
- NSW Health examine the positive outcomes of the Aboriginal Nursing and Midwifery Cadetship and undergraduate student AIN/AIM models with a view to replicate them for all nursing and midwifery students.
- NSW Health invest in recruitment of more CNEs and CMEs to meet the rising demands from increases to new graduate numbers and to increase skills development of the current workforce.

(ii) The way training is offered and overseen (including for internationally trained specialists)

Training of specialised nurses

The term 'advanced practice' with reference to nursing has been faced with some confusion about what 'advanced' signifies. In 2020, the Chief Nursing and Midwifery Officer defined 'advanced practice' as nurses practicing at an advanced practice level incorporating professional leadership, education, research, and support systems into their clinical practice.[314] This is not defined by any title or industrial classification. The only regulated and recognised 'advanced practice' role in Australia is the role of the nurse practitioner ('NP'). An NP is an RN who has an endorsement granted by the NMBA as an NP (see **Section C and D**).

[314] Chief Nursing and Midwifery Officers Australia. (2020). Advanced Nursing Practice- Guidelines for the Australian Context.

The Advanced Nursing Practice Guideline (2020) states there is a minimum educational requirement for advanced nursing practice, this being the relevant post graduate qualification. To advance in nursing practice further education is required, whether that be through skill acquisition like competencies, tertiary education, or specialist training such as training days.[315] Nurses who want to advance in their speciality area frequently fund the associated costs themselves. This being a barrier to skills and practice advancement for nurses who can't afford specialised training.

> *"Our hospital does some basic training in extracorporeal membrane oxygenation (ECMO). The training provided is not enough to become proficient in this skill and gain competency at my facility. To become competent, I had to travel to Melbourne and pay to do a course at my own expense. I wanted to do this last year, but I couldn't afford it. I want to advance in my skills so I can help my community and workplace, but it is hard when it comes at a high price." Intensive Care Unit nurse, regional NSW.*

While post graduate scholarships are available through NSW Health, there are parameters that restrict study.[316] Applicants are only eligible for one scholarship per program of study, this restricting an applicant from upgrading their qualification; and applicants are only eligible for one scholarship in a three-year timeframe, potentially delaying a nurse from further study if they are not able to pay the cost of their next course. These scholarships are only available for post graduate studies and do not extend to ease the financial costs of courses to advance clinical skills.

The only area of practice for which a specialised scholarship is available is mental health however, access to this is limited to programs of study offered by the Health Education Training Institute ('HETI'). HETI mental health courses are significantly more expensive than accessing the same course at a university with a Commonwealth supported place. This means even with a scholarship, nurses who undertake a HETI mental health qualification would be financially worse off compared with funding their own university based post-graduate qualification.

Currently, there is a lack of role clarity among health facilities, creating further barriers to utilisation of nursing skills and decreased clinical career opportunities. While position descriptions exist within NSW Health, these may vary between LHDs/specialty networks or facilities and they are only available when vacancies are advertised. The lack of availability of information and clarity around career progression creates a barrier for development of advanced practice and impacts the views of people contemplating nursing as there is not good community awareness of the diversity of roles and work within nursing.

These factors are contributing to educated RNs moving away from advanced practice roles to other senior nursing positions such as management, policy or education. This leads to a loss of clinical leadership and expertise in specialised practice settings. NSWNMA members have reported instances where their specialised skills have been deemed interchangeable between specialties by LHD management, despite being outside their individual scope of practice.

> *"While I was a neurology clinical nurse educator, I was directed to educate on the oncology ward while the educator took leave. I was able to do some generic education for the oncology staff however, was not able to assess any of their specific speciality skills for example the administration of*

[315] Jokiniemi, K. et al. (2023). Differentiating Specialized and Advanced Nursing Roles: The Pathway to Role Optimization. Nursing Leadership. Vol. 36, no 1, pp-57-74.

[316] NSW Government. (2023). *2023 postgraduate scholarships - Nursing and midwifery scholarships*

chemotherapy. The oncology staff could not progress in their specialist education during this time."
Educator, metropolitan NSW.

Specialised nurses practising at an advanced practice level are key to the provision of high quality care. Their roles include advocacy, mentorship, implementation of innovative models of care and improved access to high quality services to facilitate improved health outcomes. Additionally, these nurses can alleviate the burden on other health professionals in areas where they have shared competencies, resulting in more efficient and collaborative care. Organisational structures must support the continuation and development of these roles and understand their importance to improve workforce flexibility and sustainability.

Recommendations

- NSW Health significantly expand and review their current nursing scholarships to ensure a a well-funded and well-advertised program for scholarships to facilitate the development of specialised skills and knowledge in a range of clinical areas (e.g. mental health, neurology, oncology, renal, paediatrics, intensive care, emergency, community health). Access to such scholarships should not be limited by time or program of study.
- NSW Health develop guidance for nurses wanting to work at advanced clinical practice level.

(iii) How colleges support and respond to escalating community demand for services

No recommendations to this term of reference

(iv) The engagement between medical colleges and local health districts and speciality health networks

No recommendations to this term of reference(v) How barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW

Utilisation of Nurse Practitioner services

Allowing NPs to practice to the full extent of their education and training holds immense potential to bolster the supply, accessibility, and affordability of specialised care. NPs are highly skilled nurses who can diagnose, treat and manage patients, and are proven to be cost efficient. NPs can bridge gaps between patients and specialised services, allowing accessibility to expertise without lengthy wait times or potential geographical barriers, this being particularly important for remote populations.

Research conducted in 2020 at the Sydney Adventist Hospital Palliative Care Service focused on NP-led care models.[317] Data from this study showed that patients were less likely to die in hospital and had fewer hospital admissions, this leading to better patient experiences during end-of-life care. The mean estimated cost per patient dropped from $32,038.80 to $15,406.33 during the study when compared to the existing models of care. These results give strong evidence that NP models of care result in economic benefits and improved patient outcomes.

Despite the additional service delivery that could be provided through NP-led models of care, there are barriers such as the Medicare Benefits Schedule ('MBS') and Pharmaceutical Benefits Scheme ('PBS'). Access of benefits under MBS and PBS is limited for NPs and many 'nursing' benefits require 'supervision' of a Medical Practitioner in circumstances where it is entirely within the scope of practice of the NP to independently undertake the service/prescription. Lack of access to rebates consequently reduces potential workforce expansion of NPs. To claim rebates patients are required to go to GP's creating unnecessary duplication of services, this causes further issues in remote areas when there is at times no local doctor. As expanded on in **Section F (v),** more NPs are needed to address health needs across NSW, greater reform must occur to the MBS and PBS to allow easier access to rebates and allow an expansion of the NP workforce to provide much needed care in NSW.

Implement a strategy for training, recruitment and distribution of CNEs and CMEs

The lack of skilled clinical nurse educators ('CNEs') and clinical midwife educators ('CMEs') has been contributing to a lack of skills development, knowledge transfer as well as issues with local accreditation of skills/competencies, impacting on the safety of nurses and midwives, patients and women as well as health service delivery.

Members from Lismore Base Hospital's oncology service recently contacted the NSWNMA for assistance when they realised none of the nurses in the service were up to date with relevant accreditation, and that nurses were working with cytotoxic medications and waste despite either having no 'safe handling of cytotoxic medications and waste' accreditation or a lapsed accreditation.

A root cause of this issue was the absence of an accredited 'Anti-Cancer Drug Administration' CNE within the oncology ward, meaning nurses did not have access to a suitable accreditor to get their practical assessment completed. Unsafe handling of cytotoxic medications and waste leading to exposure, has serious health risks including (but not limited to) cancer, hair loss, reproductive health complications, abdominal pain, and liver damage. Poor handling of cytotoxic chemicals can also impact on the health and safety of other people within the ward including patients not undergoing cytotoxic therapies, visitors, and other workers.

Recommendation

- The NSW government lobby the Commonwealth to review the MBS and PBS to facilitate better utilisation of NP services, especially in regional and remote areas.
- NSW Health implement an urgent strategy for training, recruitment and distribution of CNEs and CMEs.

[317] Moreton, S.G., Saurman, E., Salkeld, G., Edwards, J., Hooper, D., Kneen, K., Rothwell, G. and Watson, J. (2020). Economic and clinical outcomes of the nurse practitioner-led Sydney Adventist Hospital Community Palliative Care Service. Australian Health Review, 44(5), pp.791. doi:https://doi.org/10.1071/ah19247.

H: New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation

Midwifery models of care

Midwifery models of care have been discussed in **Section D** of this submission, including the health benefits for women by reducing intervention, job satisfaction for midwives and cost benefits for the health system.

Midwifery scope and the extended scope of the midwife has been discussed in **Section F,** including the benefits of practicing to full scope for retention and efficiency/cost saving, and appropriate renumeration for extended skills.

Sustainability

A consultation paper for the Department of Health and Aged Care '*National Strategy for Climate Change and Health*'[318] highlights the significant contribution transport has to emissions in health care. In England, 18% of emissions from the National Health Service are related to transport (including vehicles owned by the health system, electric vehicles charged within the health system, and employee commuting and supply chain transportation). Accounting for emissions associated with patient and visitor travel to and from healthcare services is challenging. NSW Health is currently undertaking a carbon audit process, but it is unclear when this is expected to be finalised.[319]

Investing in low carbon models of care, that may not involve travel to and from a centralised acute care facility (where clinically appropriate), can provide health, environmental and economic benefits. For example, emissions reductions from vehicles can reduce air pollution, thus reducing the exacerbation of respiratory diseases. This is a win-win, providing cost savings to health services both directly and indirectly.[320]

The CAHA *Healthy, Regenerative and Just: Framework for a national strategy on climate, health and well-being for Australia* framework recommends delivering high-quality care with a low greenhouse gas emissions footprint. Recommendations for state governments include:

- implementing low carbon models of care to reduce exposure and build community and sector resilience to climate change threats (e.g. shifting from a reliance on centralised facilities, adopting

[318] Department of Health and Aged Care. (2023). *National Health and Climate Strategy*, https://www.health.gov.au/our-work/national-health-and-climate-strategy

[319] Ministry of Health. (2023). *Net zero in local health districts, specialty networks and health organisations*

[320] Climate and Health Alliance. (2021). *Healthy, Regenerative and Just: Framework for a national strategy on climate, health and well-being for Australia*, https://assets.nationbuilder.com/caha/pages/2769/attachments/original/1655869490/caha-framework-2.0-FA.pdf?1655869490

'hospital in the home' approaches and localised service provision, and using information communications technologies to provide guidance);

- investing in health promotion and primary prevention and a multidisciplinary integrated workforce to ensure access to healthcare where it is needed and reduce demand for expensive, high emissions acute tertiary health care;
- investing in initiatives designed to target over prescribing and identify and eliminate low value care; and
- investing in an appropriately trained and skilled aged care workforce to build the capacity of services to implement sustainable healthcare measures.[321]

As outlined previously in this submission, nurses and midwives are well placed to deliver effective, evidence-based health care outside of the acute tertiary healthcare setting. Nurses can deliver community-based care such as 'hospital in the home', health promotion and primary prevention activities.

Investing in nurse-led public health and preventative health education

Nurses form the largest occupational group in the primary healthcare sector, and the healthcare sector in general, and are best placed to provide broad support at a population level to increase health literacy, provide education to improve self-care and to enable people to age in place longer by living in their own homes. Chronic health conditions make up 46% of preventable hospitalisations. It was found from 1970 to 2000, at least $2 billion was gained in net benefits through health promotion in tobacco reduction. Additionally, other cost savings estimates in Australia in preventative healthcare include $8 billion in extra earnings and $4 billion in savings by allowing 170,000 extra Australians to enter the workforce. 60,000 fewer people being admitted to hospital annually would save $2.3 billion in hospital expenditure per annum.[322] With NSW being the most populous state, it has the most to gain in potential savings through health promotion and illness prevention.

Early Childhood models of care

Nurses and midwives provide healthcare to people across the entire spectrum of life. The *'First 2000 Days Framework'* is a strategic policy document which outlines the importance of the first 2000 days in a child's life from conception to five years of age.[323] It has been found that early developmental environments have enduring epigenetic impacts on health and well-being.[324] Nurses and midwives work in partnership with families.

The Sustained Health Home Visiting (SHHV) and Sustaining NSW Families (SNF) models of care fall within the First 2000 Days Framework and have been expanded in NSW These programs should continue to receive further funding and expansion across NSW, particularly in rural and remote regions. These

[321] Climate and Health Alliance. (2021). Healthy, Regenerative and Just: Framework for a national strategy on climate, health and well-being for Australia

[322] Australian Government (2021). National Preventative Health Strategy 2021 – 2030, https://www.health.gov.au/sites/default/files/documents/2021/12/national-preventive-health-strategy-2021-2030_1.pdf

[323] NSW Ministry of Health, 2019. The First 2000 Days Framework, Sydney: NSW Ministry of Health.
NSW Ministry of Health, 2021. Maternal & Child Health Primary Health Care Policy. [Online] Available at: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2010_017.pdf [Accessed 20 October 2023].

[324] Munns, A., 2023. Community child health nursing: exploring the way forward. Australian Journal of Child and Family Health Nursing, 1(20), pp. 6-9.
https://journals.cambridgemedia.com.au/application/files/9816/8482/2236/munns.pdf

programs promote child health, support family function, and reduce the impacts of disadvantage. SNF is led by specially trained child and family health nurses who assist families through:[325]

- a partnership and strengths-based approach to working with families;
- regular detailed assessments of children and families;
- early and supported referrals to other services when needed;
- using a structured, program tailored to each family's needs;
- supporting parents with the transition to parenting and for each phase of their child's development; and
- providing health promotion and brief interventions to ensure a healthy and stimulating environment for children.

Clinicians work in partnership with other professionals, including nurses and midwives, allied health and general practitioners across the community and acute care sectors. These programs complement Universal Home Health Visiting ('UHHV'). UHHV programs must continue to be supported and expanded to ensure early interventions by nurses is maintained and improved, including improved access to nurses to implement the Safe Start Guidelines.[326] Child and family health nurses provide care and support to families with children in their first 5 years to ensure that they have the best possible start in life by supporting their health, well-being, capacity and resilience. Evidence supports the existence of critical development windows for this age group, with these window periods continuing to close regardless of external events.

What happens from conception to five years of age has been shown to have lifelong implications, including impacts on:

- school performance
- adolescent pregnancy
- involvement in the criminal justice system in adolescence
- risk of drug and alcohol misuse
- risk of antisocial and violent behaviour
- health factors including obesity, elevated blood pressure, depression, coronary heart disease, diabetes, premature ageing and memory loss in older age groups.

Buurtzorg Model of care

Innovative models of care, such as the Buurtzorg model should be explored. The Buurtzorg model of care is a nursing-led model developed in the Netherlands in 2006.[327] The Buurtzorg model of care involves nursing staff providing personal, social and clinical care to people in their own homes. The model is person centred where the professional attunes to the client and their context, taking into account the living environment, the people around the client, a partner or relative at home, and on into the client's informal network; their friends, family, neighbours and clubs as well as professionals already known to the client in their formal network.[328]

Since the launch of the initial neighbourhood care team ('buurt' =neighbourhood, 'zorg' =care), Buurtzorg Netherlands has grown rapidly to over 10,000 nurses and nursing assistants across 850 self-managing

[325] NSW Ministry of Health, 2023. Sustained Home Health Visiting. [Online] [Accessed 20 October 2023].
[326] NSW Ministry of Health, 2021. Maternal & Child Health Primary Health Care Policy. [Accessed 20 October 2023].
[327] Bischofberger, A., Hegedüs, A. & Schürch, I., 2022. Implementing Buurtzorg-derived models in the home care setting: a Scoping Review. International Journal of Nursing Studies Advances, Volume 4, pp. 1 - 13.
[328] Buurtzorg, 2023. The Buurtzorg Model [Online] [Accessed 20 October 2023].

neighbourhood teams. A central tenet of the Buurtzorg model is 'humanity over bureaucracy', which is enacted in two key strategies. The first strategy is a holistic and person-cantered nursing practice ethos founded on advocating patients' autonomy and empowerment. Core principles are continuity of care, building trusting relationships, developing networks in the neighbourhoods, and linking patients to community resources. The second strategy is to establish independent, self-managing teams of up to 12 nurses, of whom 70% are registered nurses. The Buurtzog model enables people to stay living in their homes and has been found to afford cost savings to the health budget as a result.

Telehealth and Virtual Hubs

During the COVID-19 pandemic, the use of telehealth and virtual hubs increased substantially. Nurses and midwives were at the centre of effective utilisation of these virtual services. Prior to COVID-19, the use of telehealth in Australia was limited however, its use was expanded during the pandemic to reducing face-to-face consultations, and to offer continuity of health service delivery.[329] Utilising telehealth that includes video conferencing and telephone support has been identified as an effective method to bridge the gap between client demand and provider availability.[330] To address workforce shortages and improve access to healthcare in remote areas, the implementation of additional telehealth systems and virtual hubs should be considered. These technologies can help connect healthcare providers and patients in remote areas, allowing for virtual consultations and access to medical expertise without the need for travel. There is overwhelming support from consumers for the continuation of telehealth models of care. With guaranteed ongoing funding improvements can be made to support increased accessibility of this service across NSW.

To ensure equitable access to healthcare in remote areas, there is a need to expand telehealth systems and virtual hubs. These innovative technologies can bridge the gap between healthcare providers and patients, allowing remote populations to access medical services and consultations without the need for extensive travel. It should be noted though, that virtual and telehealth services should be an adjunct to face to face care, not a replacement.[331] Nurses and midwives and communities should be involved in ongoing consultation of implementation and review of telehealth and virtual health services.

Telehealth is not an adequate model of care in acute emergency settings, for example, when there is no doctor present in a rural or remote health facility and only a nurse available to provide clinical care. The nurse must perform their clinical role while simultaneously acting as the eyes, ears and hands of the doctor. This creates an unreasonable level of pressure for the nursing staff. In response, the NSWNMA strongly advocates for a minimum of three nurses on every shift in multi-purpose services, where the emergency department is open 24/7.

Digital Health Infrastructure

Across Australia and within NSW there exists disparate digital systems that do not communicate with each other. The National Infrastructure Modernisation ('NIM') program has been developed with feedback from stakeholders with the aim to:[332]

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[329] Halcomb, E. et al., 2022. Telehealth use in Australian primary healthcare during COVID- 19: a cross- sectional descriptive survey. BMJ Open, Volume 13, pp. 1-8. [Accessed 20 October 2023].

[330] Parker, J., 2022. How COVID-19 shaped new models of care for a child and family health nursing service. Australian Journal of Child and Family Health Nursing, 19(1), pp. 6-14.

[331] Schulte, A., Majerol, M. & Dr Nadler, J., 2019. Narrowing the rural-urban health divide. [Online] [Accessed 20 October 2023].

[332] Australian Digital Health Agency, 2020. Modernisation of national digital health capabilities to drive innovation. [Online] [Accessed 20 October 2023].

- deliver a secure and sustainable digital infrastructure with improved ability to innovate and expand future capabilities and services nationally;
- ensure digital health needs for all users are further progressed through a modern, future-proofed seamless digital platform; and
- ensure the benefits of digital health technologies and services supported by the national infrastructure are realised for consumers and clinicians, leading to improved health and well-being for all Australians.

From a state perspective, there is the eHealth Strategy for NSW Health 2016-2026.[333] This strategy includes streamlining of Electronic Medical Records ('eMRs'), HealtheNet information flow systems and HETI Online web-based learning systems. The NSW government and NSW Health need to continue working towards ensuring cohesive eMR systems across LHDs/specialty networks, primary health networks and both public and private systems to ensure that systems work together.

Nurses and midwives and other key stakeholders, including the NSWNMA should be consulted in the development of cohesive, streamlined systems. In Australia alone, the potential economic benefit of transitioning to an eMR system in all public acute and private hospitals equates to approximately $1.76 billion annually (Schofield, et al., 2019).[334]

Recommendations

- NSW Health amend settings to facilitate the delivery of low carbon models of care (e.g. 'hospital in the home' and virtual care programs, decreased reliance on centralised facilities through investment in health promotion, prevention and primary health care).
- Increased funding of primary healthcare and health promotion must occur, with nurses and midwives central to this workforce, to improve health outcomes of the population and thereby reduce the burden of cost of healthcare in the acute care sector.
- Maintain and expand universal services, such as UHHV, alongside targeted services, to ensure population broad interventions occur to improve outcomes in the community and reduce burdens on acute care services.
- NSW Health investigate and trial new nurse-led models of community based care, such as the Buurtzorg model, to reduce the costs to the health budget while keeping more people in their own homes and communities.
- Telehealth and virtual health services continue to be funded by NSW Health as a means to improve access to health services.
- Nurses, midwives, their unions, and consumers be involved in ongoing consultation to ongoing development of telehealth and virtual services.
- Telehealth and virtual services provide an adjunct to face to face services and not a replacement. Where a doctor is not available for emergency care in rural and remote settings, a minimum of three nurses should be on shift, two of whom are appropriately trained in emergency care.

[333] NSW Ministry of Health, (2016) eHealth Strategy for NSW Health 2016-2026. [Online] [Accessed 20 October 2023]
[334] Schofield, P., Shaw, T. & Pascoe, M., (2019) Toward Comprehensive Patient-Centric Care by Integrating Digital Health Technology with Direct Clinical Contact in Australia, National Library of Medicine. [Online] [Accessed 20 October 2023].

- The NSW government and NSW Health continue to invest in digital infrastructure to improve cost efficiencies and to ensure the various systems that currently exist in public and private health sectors can communicate with each other.

- NSW Health ensure key stakeholders, including the NSWNMA, nurses and midwives, health care consumers are involved and consulted throughout the process to ensure that digital systems are fit for purpose.

- NSW Health and other employers provide timely ongoing education to staff in the use of digital technologies.

I: Any other matters

The economic impact of systemic racism and cultural safety within NSW Health

Aboriginal and Torres Strait Islander nurses and midwives remain underrepresented amongst the nursing and midwifery workforce at approximately 1.4%[335], despite their pivotal role in delivering the culturally safe care that will improve health outcomes and equitable access to healthcare for Aboriginal and Torres Strait Islander consumers of healthcare throughout NSW. Their cultural knowledge, coupled with their professional expertise, is vital to ensuring that healthcare policy, education and practice in NSW Health delivers on its Closing the Gap objectives. However, members of the NSWNMA's Aboriginal and Torres Strait Islander Members Circle report experiencing disturbing levels of racism within NSW Health.

According to NSW Treasury, estimated Health expenditure on First Nations patients was $1.1 billion in 2020–21, concentrated in General Hospital Services ($837 million).[336] This spending is undermined if the system is not safe for Aboriginal and Torres Strait Islander staff and midwives.

Culturally and linguistically diverse ('CALD') nurses, midwives and AINs make up an increasingly significant part of the NSW Health nursing and midwifery workforce. 2021 workforce census data337 identified around 25% of NSW nurses, midwives and AINs are from the Philippines, India, Nepal, China, Korea, Fiji or Zimbabwe and this is likely to underrepresent the total diversity of the workforce. Their experience as employees and impact on heath funding must be considered.

The NSWNMA conducted a survey on the experience of its members from CALD backgrounds in 2018 and received responses from almost 700 nurses, midwives and AIN/AIMs employed in NSW Health.[338] The report found fewer than 9% had programs to access support in their workplace, yet around half of those reported they had been discriminated against because of their cultural background and/or ethnicity whilst at work.

Barriers to career advancement was a theme throughout however, stereotyping, name calling, use of culturally offensive language, refusal of patients/clients to be cared for by them and isolation were top areas of concern. 3% reported having been subject to racially motivated physical abuse. Many more nurses and midwives, not necessarily from CALD backgrounds would be affected vicariously as bystanders. A significant number of nurses and midwives lacked the knowledge of, or confidence in, the system to report the issue. Over a third experienced some form of discrimination at least once a month and almost 9% said this occurred every time they turned up for work.

> *"My clinical manager put me into trouble intentionally. I felt that the workplace was not safe to continue to practice. I was happy to leave the workplace." NSWNMA member, NSW Health employee*

[335] Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, 2022, 'gettin em n keepin em n growin em': Strategies for Aboriginal and Torres Strait Islander nursing and midwifery education reform, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Brisbane, available at: www.catsinam.org.au

[336] NSW Treasury, 2022, Comprehensive Indigenous Expenditure Report 2021-22, https://www.treasury.nsw.gov.au/sites/default/files/2022-10/20221021-comprehensive-indigenous-expenditure-report.pdf, accessed 14 November 2023

[337] Australian Bureau of Statistics (2021), 2021 *Census – employment, income and education* [Census TableBuilder], accessed 21 September 2023.

[338] NSW Nurses and Midwives' Association (2019) The Cultural Safety Gap. Accessed 14 November 2023

"I have been sidelined and bullied. Another person from a different cultural background went through a very similar situation in that department, and then another person, and I realised it was not just me but the toxic culture in that department. I changed departments because I thought I was not good enough at that time and suffered a blow to my self-confidence and doubted my skills and abilities. Once I changed departments and eventually changed organisations, I did very well in a supportive, accepting environment and have moved from strength to strength in my professional life." NSWNMA member, NSW Health employee

"I resigned as the other person continued the bullying." NSWNMA member, NSW Health employee

"I was abused by patients and staff as well. My manager said we get paid to be abused." NSWNMA member, NSW Health employee

"It has affected so much to the point of wanting to quit working in the health system." NSWNMA member, NSW Health employee

"When it comes to promotions, training and chances to get the position our chance as foreigner with dark skin are less than the rest of the staff." NSWNMA member, NSW Health employee

"In theory my workplace are against discrimination but they don't police it or implement." NSWNMA member, NSW Health employee

"It can be difficult to articulate an interview when the panel members have no consideration or idea of the challenges faced for a young indigenous women to attempt to go for a job for a start let alone taking in a public place under stress." NSWNMA member, NSW Health employee

"Culture awareness and diversity has to be a key plan from Ministry of Health. A policy doesn't necessarily drive change, it's all the systems and processes put in place to ensure that we all feel respected at work. My experience is that organisation's claim to be culture aware but what they actually do to prove this doesnt quiet correlate." NSWNMA member, NSW Health employee

A 2011 study calculated the costs to the Australian economy arising from racial discrimination was 235,452 in disability adjusted life years lost, equivalent to $37.9 billion per annum, roughly 3.02% of annual gross domestic product (GDP) over the period 2001–11, indicating a sizeable loss for the economy.[339] The negative impact of racism on victims, perpetrators and bystanders is far reaching and is known to cause physical and mental ill health and in some cases, death.[340] Workers from CALD

[339] Elias, A., and Paradies, Y. (2016) Estimating the mental health costs of racial discrimination. *BMC Public Health,* 16, 1205.

[340]Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019) Racism and Health: Evidence and Needed Research. Annual review of public health, 40**.** pp105–125.

backgrounds have higher rates of work related compensation claims across all industries and occupational status.[341]

The Australian Human Rights Commission's ('AHRC') *Concept Paper: a national anti-racism framework,*[342] released in March 2021, flagged a need for greater community understanding of the different dimensions of racism and racial inequality in Australia acknowledging racism is a significant economic, social and national security threat to Australia.

Racism also creates poor work conditions. Discrimination, and hostility in the workplace, impact on job satisfaction, well-being, and job security.[343] The Diversity Council of Australia recently found employees who feel excluded at work are five times less likely to be satisfied with their jobs, three times more likely to feel work negatively impacts their mental health and three and a half times more likely to leave their employer[344]. The psycho-social impact of discrimination in the workplace and the financial implications to NSW Health, although not reported on, are likely to be significant as nurses and midwives exit the sector and seek compensatory pathways.

NSW Health has historically focused on the important issue of cultural safety through the delivery of services, but less on the safety of its CALD workforce. However, both the financial and human cost of inaction around safety of workers has the potential to affect all aspects of health funding and service provision. Despite the negative economic impacts of structural racism, sourcing data on the impact in NSW health settings is highly problematic and suggests this is an area requiring attention.

> *"There is a crucial role for better and more robust data to identify the prevalence, severity, and impact of racism. Data will bring nuance to a collective understanding of racism that is necessary for creating and sustaining anti-racist action. Taking action is not just about raising awareness, but also looking to what laws, regulations, standards, and mechanisms our country has, or does not have, in place to protect against the harm of racism and to ensure accountability for its elimination"*[345].

Whilst the NSW government is listed as a supporter of the AHRC '*Racism – it stops with me*' campaign, there is no specific commitment from the MoH, despite this being an option open to them. Similarly, despite the AHRC inviting submissions from representatives of state agencies[346] the MoH was absent from mention in any of their feedback. A space that was ultimately filled through feedback from the NSWNMA and QNMU in their submissions. The AHRC concluding report[347] should serve as a reminder of the work left to do.

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[341] Smith CK., Wuellner S., & Marcum, J. (2023) Racial and ethnic disparities in workers' compensation claims rates. PLoS ONE 18(1): e0280307. https://doi.org/10.1371/journal.pone.0280307.

[342] Australian Human Rights Commission (2021) Concept Paper:a national anti-racism framework. Available at: https://humanrights.gov.au/sites/default/files/document/publication/ahrc_cp_national_anti-racism_framework_2021_.pdf

[343] Debbie Bargallie, Unmasking the Racial Contract: Indigenous voices on racism in the Australian Public Service (Aboriginal Press Studies, 2020) 103. See also Women of Colour Australia, Workplace Survey Report 2021 (Report, 2021) <https://womenofcolour.org.au/wp-content/uploads/2022/02/WOMEN-OFCOLOUR-AUSTRALIA-WORKPLACE-SURVEY-REPORT-2020-2021.pdf>.

[344] Diversity Council Australia, Inclusion@Work Index 2021-2022: Mapping the state of inclusion in the Australian workforce (Synopsis Report, 2021) 14 <https://www.dca.org.au/sites/default/files/synopsis_2021-22_inclusionwork.pdf>.

[345] Australian Human Rights Commission (2022) National-anti-racism-framework-scoping-report. Available at: https://humanrights.gov.au/our-work/race-discrimination/publications/national-anti-racism-framework-scoping-report

[346] https://humanrights.gov.au/our-work/race-discrimination/projects/national-anti-racism-framework

[347] Australian Human Rights Commission (2021) National-anti-racism-framework-scoping-report. Available at: https://humanrights.gov.au/our-work/race-discrimination/publications/national-anti-racism-framework-scoping-report

"Cultural safety was also offered as a solution to what was described as the ineffectiveness of workplace diversity and inclusion initiatives. Participants told the Commission that, to date, these initiatives have generally not adequately centred the needs of diverse staff and their safety, nor have they taken a strengths-based approach to diversity and inclusion. Project participants also identified that such initiatives also fail to be accountable to the employees they are stated to support".

"Cultural safety was identified by many participants as a best-practice approach to addressing race-based barriers and harms experienced in relation to job-seeking, and especially within the workplace. Cultural safety was also offered as a solution to what was described as the ineffectiveness and limits of workplace diversity and inclusion initiatives. Cultural awareness and cultural competence training for staff was recommended as being essential to building a respectful and inclusive workplace. Participants described how culturally safe workplaces provide a foundation for culturally safe service provision and identified community-controlled service provision, trauma-informed and healing approaches to service delivery, anti-racist competencies that underpin service delivery, and accountability mechanisms to protect these principles as strategies to build upon this foundation."

From the limited data collection undertaken through the NSW Health 'People Matter' employee survey,[348] it is clear nurses and midwives continue to experience negative impacts arising from bullying and racism in workplaces. Accountable data collection on the economic and personal impact of systemic racism in NSW Health must be implemented as priority accompanied by a whole of system governance strategy to both identify and eliminate the triple personal and economic threat caused by racism, bullying and discrimination.

Recommendations

- NSW Health implement cultural safety and awareness training for all staff pertaining to all Aboriginal and Torres Strait Islander health workers. This is to address how staff treat one another in the workplace.
- NSW Health implement a whole of system governance strategy to identify and eliminate structural racism. This must include the design and implementation of a strategy to collect data on the economic and social cost of systemic racism in NSW Health.

[348] NSW Health People Matter Survey Data. Available at: https://www.health.nsw.gov.au/employeesurveys/Pages/default.aspx

Appendix 1: List of failed privatisations

Hospital: **Port Macquarie Base Hospital** (New South Wales)
Period: 1994 - 2004
Key points:

- By 1998 elective surgery time was double the State average
- By 2003 there were 333 people having to wait more than a year for elective surgery compared to seven at Coffs Harbour and five at Taree hospitals. An inference to draw here is that more profitable private patients were possibly prioritised over public patients.
- In a submission to the inquiry that led to the report it was stated that staffing numbers in key areas were lower than comparable facilities, and that there is a lasting legacy of this in the renationalised service[349].

Hospital: La Trobe Valley Hospital[350] (Victoria)
Period: 1996 - 1999
Key points:

- Two local hospitals were merged into one privatised site. Within six months of operation the private provider approached government for more funding
- Following renationalisation, the company reported a loss of $6.2million
- The privatisation was said to be hampering the expansion of services available to the local community which occurred once the State Government took back control
- A lack of transparency is noted given the then Kennett Government refused to release the contract, citing commercial-in-confidence, despite the Victorian Civil and Administrative Appeals Tribunal ordering them to do so.

Hospital: **Modbury Hospital** (South Australia)
Period: 1995 – 2007 (despite a 20-year option)
Key points:

- Within two years the SA Government agreed to an increase in the contract price following the company's lobbying on the back of financial losses
- The private provider handed back the service in 2007 at a cost of $17.5million (2018 cost)[351]
- According to a McKell report there were ongoing concerns about the level, variety and quality of services provided, leading to the handover[352]

Hospital: **Robina Hospital** (Queensland)
Period: 2000 - 2002
Key points:

- Service was renationalised as the not-for-profit organisation struggled financially

Hospital: **Fiona Stanley Hospital** (Western Australia) Non-essential Services
Period: 2014 - 2015

[349] https://publicservices.international/resources/publications/peoples-inquiry-into-privatisation-full-report-taking-back-control-2017?id=11986&lang=en.
[350] Note that this example is of two smaller hospitals being merged into one service, similar to the Manly/Mona Vale merger into the Northern Beaches Hospital scenario
[351] The McKell Institute. (2014). Risky Business: The pitfalls and missteps of hospital privatisation.
[352] ibid

Key points:

- Serco was awarded a $4.3billion contract to run "non-essential" services including sterilisation.
- The WA Government ended the contract in 2015 following failures in the sterilisation of surgical equipment, including human tissue being left in sterilised equipment

Hospital: North West Regional Hospital (Mersey + Burnie) Hospitals (Tasmania)
Period: 1995 - 2004
Key points:

- Mayne Nickless (Mayne Health) won the tender, but sold the business in 2003 to Healthscope
- A downscaling of services at the site led to community anger which the then Howard Government capitalised on during the Federal election in a then marginal seat
- The Federal Government subsequently returned the facility to Tasmanian State Government control

Hospital: **Royal North Shore Hospital** ("Soft" Services including cleaning, porters, security, & catering) (New South Wales)
Period: 2008 - 2017
Key points:

- The private provider of the car park put a cap on the number of staff parking spots leading to a waiting list of over 500 staff to access parking rights
- A number of concerns were raised with regard to the quality of the services and staffing levels which were reduced in 2012 by 20%
- The subsequent lack of porters saw nurses and medical staff having to fill the gaps, delays in cleaning of beds at one stage reached six hours contributing to bed block in the emergency department
- The company reportedly sought more funding to maintain staffing levels, however this was refused by government
- Rather than renegotiate the contract the government returned services to the government owned operator

Hospital: **Royal Perth Hospital** (Cleaning Services) (Western Australia)
Key points:

- Reduction in staffing (from 110 orderlies to just 56) led to an outbreak of vancomycin-resistant enterococcus faecium (VRE) resulting in 172 patients contracting hospital acquired infections at a cost of $2.7million[353]

Hospital: **Sir Charles Gairdner Hospital** (wardspersons) (Western Australia)
Key points:

- The private provider decreased staffing by 50%[354]
- Costs decreased and quality increased once the service was brought back in-house

Hospital: **Perth Children's Hospital** (PPP for construction) (Western Australia)
Key points:

[353] Hansard WA Parliament; Mr R.H. Cook (2010). Available at: http://www.parliament.wa.gov.au/Hansard%5Chansard.nsf/0/9f4ecd3a6fbce11c482577120022c5d4/%24FILE/A38%20S1%2020100421%20p1965b-1968a.pdf

[354] ibid

- Opening was delayed and costs blew out as controversy hit the construction process, including flooding and the illegal use of asbestos products, linked to poor public oversight

Hospital: Mildura Hospital
Period: 1998 – 2020
Key points:

- The initial consortium[355] who won the contract sold the business to Ramsay Healthcare in 2000
- Following a concerted community campaign, the Andrews Government sought community consultation about the future operation of the hospital. 90% of people responding to the consultation process, which included staff, stated that they would prefer the site was publicly-run.[356] The contract expired in 2020 and the government resumed ownership and operation.

Hospital: **Midland Public Hospital** (Western Australia)
Key Points:

- Public services were reduced when the non-government St John of God Healthcare provider took control. This included access to reproductive health services. This led to further privatisation when the government sourced these services from a third-party provider.
- A lack of transparency has been noted as key contractual performance measures have been kept from public view due to commercial-in-confidence.

Hospital: **Juvenile Detention** (Northern Territory)
Key Points:

- Exposure of a lack of services led to the government taking back control of healthcare provision at the facility. Examples included weekly access only to a psychiatrist, half the number of nurses thought of as a minimum resulting in guards distributing medications, no policies or protocols. Once to State resumed control policies and procedures were put in place, Aboriginal health practitioners were employed for primary healthcare.

Hospital: Calvary Public Hospital / Northside Hospital (ACT)
Key Points:

- The ACT Government took over the site in July 2023 following what the government described as unsuccessful negotiations in obtaining '*outcomes consistent with the evolving needs of the community*'.[357] The reasoning being that; 'consolidating our public hospitals to create a single network will allow us to better coordinate our health services, distribute resources effectively, strengthen the capacity of our workforce, plan infrastructure on a Territory-wide basis, and improve health outcomes for all Canberrans'[358].

[355] This included a company, Sun Healthcare Group who were named in the Victorian Parliament for having been accused of "submitting false and misleading information to obtain Medicaid payments totalling $15million over 2 years including more than $1million in travel and entertainment expenses". https://www.parliament.vic.gov.au/images/stories/volume-hansard/smaller/Hansard%2053%20LC%20V441%20Oct-Nov1998/VicHansard_19981110_19981111.pdf

[356] https://www.premier.vic.gov.au/mildura-has-its-say-on-hospitals-future/

[357] https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/barr/2023/building-a-new-northside-hospital-and-a-more-efficient-health-system

[358] ibid

Appendix 2: Northern Beaches Hospital

NSWNMA submission to the NSW Legislative Council Parliamentary Inquiry into the operation and management of the Northern Beaches Hospital.

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
AUSTRALIAN NURSING AND MIDWIFERY FEDERATION NEW SOUTH WALES BRANCH

Submission by the New South Wales Nurses and Midwives' Association (in conjunction with the Australian Nursing and Midwifery Federation NSW Branch)

NSW Legislative Council, Portfolio Committee No 2

Inquiry into the operation and management of the Northern Beaches Hospital

26 July 2019

Our ref: EF/15/0009

The Hon Greg Donnelly MLC
Committee Chair
Legislative Council Portfolio Committee No 2

Attention: Director, Portfolio Committee No 2 - Health and Community Services

Email: PortfolioCommittee2@parliament.nsw.gov.au

Re: Inquiry into the operation and management of the Northern Beaches Hospital

The New South Wales Nurses and Midwives' Association, along with the Australian Nursing and Midwifery Federation NSW Branch ('Association') are the registered unions (in both the state and federal workplace jurisdiction) for all employees working in nursing and midwifery classifications and roles.

The Association provides both industrial and professional support and representation to some 66,000 members in NSW. This ranges, for example, from the provision of information about workplace rights, providing direct support to members (and representation if necessary) with employers or before industrial or professional courts and tribunals, assistance with appearances before other courts and jurisdictions, as well as negotiating and bargaining on behalf of members with their employers for awards and enterprise agreements.

The above has meant that the Association provides membership and therefore such services to nurses and midwives working in either the government or non-government sectors, state and federal. In other words, the Association is the relevant industrial organisation of employees for nurses and midwives whether they work in the NSW Health Service (government sector) or in the Northern Beaches Hospital (private sector).

Certainly the Association would welcome the opportunity to provide further evidence, in addition to that contained in our following submission, at any hearing the Committee undertakes. This submission is authorised by the Elected Officers of the Association.

JUDITH KIEJDA
Acting General Secretary, NSW Nurses and Midwives' Association
Acting Branch Secretary, Australian Nursing and Midwifery Federation NSW Branch

Executive Summary

The Association and its members opposed the privatisation of public health services on the Northern Beaches. Not through some absolutist opposition to private health services being available to the public and the privately insured in a complementary way, but one based that the provision of public health service remains a core responsibility of governments that should not be sublet or contracted out.

Unfortunately, the feedback from members and the experiences of the community since the end of October 2018 only reinforces the concerns expressed at the time.

The level of care and services currently being provided at the Northern Beaches Hospital (NBH) are generally seen as being less than that provided previously at Manly and Mona Vale Hospitals, both qualitatively in the view of members and statistically based on data available from the Bureau of Health Information.

Staffing was and remains a critical issue. A lack of staffing, poor skills mix, and a disproportionate reliance on casual and agency staff is causing significant issues, impacting on clinical care and the provision of a safe working environment for nurses and midwives.

This is sadly not surprising. In any privatised model, staffing levels and labour costs are all too often the first and most substantial target of cost savings and profit maximisation.

This runs counter to the rhetoric at the time the privatisation was announced, that promised much but can now be seen as hollow and unrealised promises. Assurances provided repeatedly by Healthscope regarding its readiness, and that it was fully staffed, equally proved empty and not reflecting the reality.

Much was also made that the new privatised hospital would be an integral part of the public health system in Northern Sydney, but the outcomes to date prove otherwise. Sadly, the Local Health District has been reduced to the 'purchaser' of public health episodes of care, rather than being directly responsible for the provision of such services. It has become a *bystander*, waving public monies at Healthscope in an attempt to manage and improve services. Whilst one of the so-called claimed benefits of privatisation is that it shifts (financial and operational) risk to a third party, current experiences again demonstrate that it is ultimately the patients and staff who carry the burden of that risk.

Certainly a number of actions and changes are needed urgently to bring about the necessary rectification desperately required.

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Format of this submission

The following submission by the New South Wales Nurses and Midwives' Association, along with the Australian Nursing and Midwifery Federation NSW Branch ('Association') draws upon a myriad of experiences leading up to the transfer of services and staff from Manly and Mona Vale Hospitals to Northern Beaches Hospital ('NBH') and the now near nine months since the opening of NBH.

More specifically, the Association notified members of the inquiry to be undertaken by Portfolio Committee No 2 of the NSW Legislative Council and encouraged feedback via a survey asking questions targeted primarily towards two of the terms of reference ('ToR') announced - namely (d) *"standards of service provision and care at the hospital"* and (e) *"staffing arrangements and staffing changes at the hospital"*.

The Association has assembled its feedback in this submission as per the most relevant ToR, albeit some feedback would sit comfortably within several. Accordingly, the Association has not sought to unnecessarily repeat or replicate feedback that straddle several ToR. Rather, it has concentrated on ensuring relevant information and feedback has at least been marshalled once in the submission.

Equally, a number of members gave experiences or examples that were similar in nature, and the Association has adopted the view of ensuring these views are expressed via the statistical feedback presented from the survey questions or by providing one such anecdote or example, with duplication of similar experiences resisted. Accordingly, it should not be assumed as a result that the narratives or examples provided are isolated.

Finally, the Association has taken the view to provide these experiences or commentary without identifying the member. In this way privacy has been preserved, and it encouraged the participation and receipt of feedback from members who were fearful of making public comments.

(a) the contract and other arrangements establishing the hospital

THE ESTABLISHMENT OF THE NORTHERN BEACHES HOSPITAL

The announcement and what was promised …

Without any prior warning, the then Minister for Health, the Hon Jillian Skinner MP, announced on 2 May 2013 [1] that an expression of interest process was to be established for *"… the private sector to design, construct, operate and maintain a world class hospital on Sydney's northern beaches."* [2]

The Minister further claimed that the private provider would use *"… leading digital technologies to deliver the highest quality care … the operator will … deliver public services and the hospital will remain part of the clinical network of the Northern Sydney Local Health District."* [3]

> *"I am excited our outstanding staff will have the opportunity to work in a fabulous new facility, which will in turn attract new staff of the highest calibre."*
>
> Minister for Health, the Hon Jillian Skinner MP, 2 May 2013

The new operator, was announced as being Healthscope on 29 October 2014, [4] following a *"rigorous evaluation process"*.[5]

> *"I have long had a dream about a state-of-the-art hospital which uses the latest technology and attracts the best clinicians to deliver care for the people of the Northern Beaches … This will mean exciting opportunities for the current, hardworking staff of both hospitals … Public and private patients will both be winners under this model … As part of the contract, Healthscope will be required to meet stringent Australian quality and safety healthcare standards."*
>
> Minister for Health, the Hon Jillian Skinner MP, 29 October 2014

The Northern Sydney Local Health District ('NSLHD') would enter into arrangements with Healthscope to ensure the delivery of public patient services for the first 20 years of the contract. [6]

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1 *"World class hospital for Northern Beaches",* Media Release, Jillian Skinner MP, Minister for Health, Minister for Medical Research, 2 May 2013.

2 Ibid.

3 Ibid.

4 *"Transforming NSW: Operator chosen to build and run new Northern Beaches Hospital",* Media Release, Jillian Skinner MP, Minister for Health, Minister for Medical Research, 29 October 2014.

5 Ibid.

6 Ibid.

Key deliverables promised
The Association, along with its members, staff in general, along with the community, have been largely reliant on the above type comments to ascertain the key goals or deliverables for the community. Reliance on voluminous and legalistic contractual material which is heavily redacted is not a recipe for readily accessible material.

It would also be fair to say that over the preceding four or so years prior to the NBH opening, the Association and its workplace representatives were involved in a considerable number of meetings, primarily with the NSLHD, and to a lesser degree the Ministry of Health ('Ministry'). These were predominately regarding workforce and employment issues for those staff who may elect to transfer to the NBH.

However, from the perspective of our members, it also involved a significant concern as to the services to be provided and the clinical profile of nursing and midwifery staff to provide such services, especially in speciality areas.

It would be fair to say that the Association and its members at Manly and Mona Vale Hospitals found the level of information and certainty provided to be inversely proportionate to the large number of meetings held.

Nonetheless, what was promised to the community and staff alike can be usefully captured and tabulated as follows.

TABLE 1

The new hospital would:	
i.	be a state-of-the-art, purpose built facility
ii.	provide greater capacity to the people of the Northern Beaches
iii.	provide greater complexity of services to the people of the Northern Beaches
iv.	utilise leading digital technologies to deliver the highest quality care
v.	be part of (or somehow incorporated within) the clinical network of the Northern Sydney Local Health District
vi.	be held accountable to the highest clinical standards
vii.	provide better public health services
viii.	provide better private health services
ix.	provide a better working environment for hospital staff
x.	have certainty regarding the employment conditions of transferring staff from Manly and Mona Vale Hospitals

The mechanisms for delivering these promises/arrangements
The primary vehicle for delivering and ensuring compliance with the goals and arrangements set out in Table 1 was the Project Deed ('Deed'). The Deed was entered into between Healthscope and the State of NSW and set out the terms and conditions of its establishment and subsequent operation.

The *episodes* of public health care to be 'purchased' by the NSLHD on behalf of the Northern Beaches community is subject to such terms. Other requirements within the Deed pertaining to transferring staff and any requisite obligations are embedded within the Deed as well, albeit these have been subject of public dialogue and communication.

However, as previously noted, visibility and access to the full terms contained in the Deed is not surprisingly limited to these direct parties. It was also clear that those persons not party to the Deed had no legal capacity to seek enforcement of its terms.

The Association, other public health unions, along with Unions NSW, held and raised significant reservations regarding a reliance upon the Deed, essentially a commercial contract, to somehow be a mechanism for the enforcement of, for example, certain promised workplace rights. These concerns were continually and repeatedly rebuffed. The basis of the refusal to entertain some 'additional' mechanism of enforcement can be usefully and pithily summarised in the following response received by unions:

"In the unlikely event that Healthscope does not comply with any commitment or obligation in the Project Deed, NSW Health can enforce that agreement on behalf of employees." [7]

This remains an unsatisfactory arrangement for those matters that, from an employment perspective, fall outside of the copied State awards and the reach of the Fair Work Commission (via provisions contained in the *Fair Work Act 2009* pertaining to award terms and conditions for employees who transfer from a state government employer to a private employer via a transfer of business).

This essentially leaves the Ministry to be the *industrial cop on the beat* on behalf of transferring employees and/or their unions in relation to certain employment commitments.

It is presumed that any mechanism to enforce clinical or other service delivery obligations upon Healthscope would similarly be totally reliant on the Ministry to pursue, albeit what those mechanisms are or the penalties involved remain unknown to the Association.

Effectiveness of these mechanisms

Ample opportunity would seem to have arisen from the first nine months of the NBH being operational to test the robustness and effectiveness of the Deed and the approach described above. It is unclear as to whether the Ministry has indeed pursued Healthscope in the manner intended under the Deed, presuming that the Deed contained actual mechanisms for ensuring the achievement of gaols as set out in Table 1.

[7] Contained in an Attachment to correspondence from the Hon Brad Hazzard MP, Minister for Health, to the secretary, Unions NSW, dated 18 August 2018.

For example, patient volume/capacity at the NBH were originally anticipated (promised) to achieve full 'ramp-up' within three to four years of opening. This was subsequently modified by Healthscope so that full capacity would not be achieved until four to five years. How will this 'business' decision impact on the delivery of public and private services? Is such a variation to patient volumes anticipated in the Deed?

In any event, a significant failing of the current arrangements (and privatising public health services in general) is that the NSLHD has been reduced to the 'purchaser' of public health episodes of care, rather than being directly responsible for the provision of such services. It has become a *bystander*, attempting to vicariously manage events rather than being directly responsible for them. Perversely, whilst one of the so-called claimed benefits of this approach is that divorces or shifts (financial and operational) risk to a third party (and away from the State), it only serves to magnify that risk and leaves it to be borne by the community and patients.

Certainly there can be no remaining illusion that the NBH is somehow an integral aspect of or part of the public health system, regardless of the rhetoric from the then Minister for Health when this arrangement was first announced. Healthscope to their credit has not shied away from what it is, *"… a private hospital treating public and private patients …"* [8]

The buck stops with Healthscope … literally.

There is a world of difference between the way that public and private hospitals operate, a view reinforced by subsequent member feedback in this submission.

From a staffing perspective at the NBH, in discussions leading up to its opening, it was clear that Healthscope largely determined the number and profile of staff it wished to employ and have available on its opening. The following example is emblematic of the differences in approach and emphasis between what was utilised at Manly and Mona Vale Hospitals as opposed to the NBH.

Clinical Support Officers

During discussions upon the proposed expression of interest process to be utilised for staff wishing to transfer from Manly and Mona Vale Hospitals, it became evident that Healthscope had chosen not to 'carry over' the position and role of Clinical Support Officers ('CSO'). The Association on behalf of members made known to Healthscope and the NSLHD that this was a retrograde step.

The Association put its concerns to the NSLHD at that time in the following terms:

"In the view of members, these roles are essential to assist in the good management of wards and part of the staffing architecture to ensure that NUMs [Nurse Unit Managers] *and senior clinicians in general are appropriately supported to ensure they are able to spend the maximum time on clinical activities/management.*

[8] Contained in a response from Healthscope to the Australian Salaried Medical Officers' Federation, circa 2016/17.

The role of CSO arose from a recognition that "… a real need exists in times of a national health workforce shortage for clinical support staff to be employed to undertake tasks for which they are suitably qualified so as to allow senior clinicians, in particular, to be freed up to attend to those components of patient care which require their other skills." [Extract from the Special Commission of Inquiry Acute Care Services in NSW Public Hospitals, pp 19] It was found to be to the benefit of the patient, the relevant clinician, and the budgetary bottom line to have CSOs incorporated within the team based/staffing profile.

This was a key finding and recommendation of the Garling Report and should remain in any publicly funded hospital service. [9]

The Association also provided relevant extracts from the Garling Report to underpin its concerns regarding the impact arising from this erosion that would have a consequential impact upon clinical managers.

The response?

Essentially NSLHD and the Ministry could not in this instance 'require' Healthscope to maintain these positions, regardless of the weight and volume of evidence that led to their creation and continued use in the public health setting.

From the Association's view, this was a harbinger of the limitations that NSLHD and the Ministry would have over Healthscope and the public health services it procured.

[9] Correspondence from the Association to NSLHD, dated 2 November 2017.

(b) changes to the contract and other arrangements since the opening of the hospital

The Association and its members would have little ability to be aware of (or have access to in any event) changes to the contract, if this pertains to the Deed.

(c) ongoing arrangements for the operation and maintenance of the hospital

From an employment perspective, the ongoing arrangements for nursing and midwifery staff will be as follows: Healthscope and the NBH operate within the federal industrial relations jurisdiction. There is no dispute that NSW Award applicable to transferred staff from Manly and Mona Vale Hospitals, the *Public Health System Nurses' and Midwives' (State) Award* ('NSW Award'), follows such employees to the NBH and their employment by Healthscope as a ***copied State award*** - as per Part 6-3A of the *Fair Work Act 2009*.

This recognises that certain rights accrue to employees who transfer from a state government employer to a private employer via a transfer of business [as noted in ToR (a)].

In addition to the employment conditions set out in the now copied State award, additional commitments or guarantees on behalf of transferring Manly and Mona Vale Hospital employees were entered into by the NSW Government/Ministry with Healthscope, albeit most if not all of these were announced without any consultation with relevant staff.

Nonetheless, these included a two year employment guarantee period (if a permanent employee at the time of the transfer); maintenance of existing conditions during that period; and an undertaking that Healthscope cannot initiate the 'replacement' of the copied State award with a making of a federal enterprise agreement in relation to transferred staff for a period of two years.

These commitments did not extend as far as is known, to mandating the models of care or staffing skill mix to be utilised within the NBH. The only staffing arrangements that are likely to be mandated are those contained in the now copied State award. [10] [This will be further discussed in ToR (e)].

Those nurses and midwives employed directly by Healthscope (ie outside the transfer process involving Manly and Mona Vale Hospital staff) are employed under the terms and conditions of the *Healthscope Group - NSWNMA/ANMF - NSW Nurses and Midwives' - Enterprise Agreement 2015-2019* ('Federal EA').

The challenges of applying and utilising two differing sets of terms and conditions within a workplace is not without difficulty. It has at times required Healthscope and the Association to work collaboratively to reach outcomes that meld and yet comply with two industrial instruments covering the same cohort of nurses.

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[10] Clause 53, Staffing Arrangements, *Public Health System Nurses' and Midwives' (State) Award*. The intent of this provision is to establish reasonable workloads for nurses and midwives in certain designated wards and services across a number of public hospitals ie it does not exhaustively cover all areas or all public hospitals, despite attempts by the Association to vary and/or expand its scope. The clause utilises a methodology of Nursing Hours Per Patient Day ('NHPPD').

Of course a differing approach may have had Healthscope alternatively required to operate the NBH as an *"affiliated health organisation"* [11] (often referred to as Schedule 3 hospitals) - and not dissimilar to how St Vincent's Hospital Darlinghurst and others operate.

Whilst the non-government organisation is the employer of staff, it is more fully 'embedded' within the NSW Health Service and public hospital system. It also requires such providers to comply with and make available the same rates and conditions of employment for staff contained in NSW Awards, as well as complying with policy directives or other directions or policies issued by the Ministry. These are usually set out in a 'Conditions of Subsidy' arrangement with such providers (ie funding arrangements).

This would have been one way to truly ensure that the NBH remained *"… part of the clinical network of the Northern Sydney Local Health District."* [12]

Apart from keeping it in public hands in the first instance.

[11] *Health Services Act 1997*. The Act enables recognition of nominated non-profit, religious, charitable or other non-government organisations and institutions so they can be treated as part of the public health system where they control hospitals, health institutions, health services or health support services that significantly contribute to the operation of that system.

[12] As previously claimed by the former Minister for Health, *"World class hospital for Northern Beaches",* Media Release, Jillian Skinner MP, Minister for Health, Minister for Medical Research, 2 May 2013.

(d) standards of service provision and care at the hospital

The problems besetting the NBH on its opening are well documented and publicised. They continue to be the subject of regular media reporting and commentary. The Association does not for the purposes of this submission seek to replicate or dwell upon that reporting or some of the more notorious examples published in the media, other than to say that they have been confirmed by our members as being accurate.

However, it is an integral aspect and was a fundamental basis underpinning the new hospital that it would improve and enhance the services available to the community when compared to the then services available from Manly and Mona Vale Hospitals.

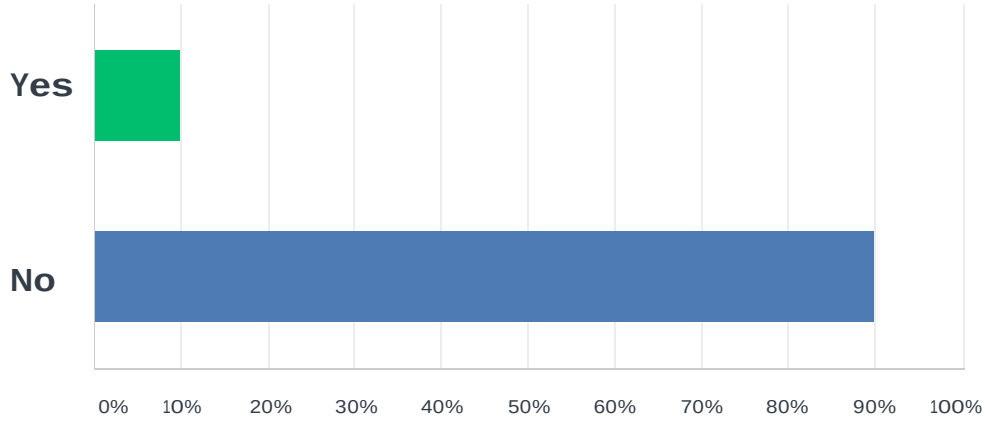
> *"I want the Northern Beaches Hospital to be a showcase to the world, attracting health professionals keen to see its high-tech facilities."*
>
> Minister for Health, the Hon Jillian Skinner MP, 29 October 2014

Sadly, this and other claims made then now seem all too hollow.

The Association asked the following questions of members working at the NBH regarding the standards of service provision and care:

TABLE 2

On <u>your commencement</u> at the NBH, was the hospital adequately prepared to provide acceptable levels of care and service to patients?



This is simply astonishing. Despite several years of preparation, and all the promises of not only an orderly transition and but indeed an improved span and scope of services, almost all members responding to this survey question indicated that the NBH was simply *not up to scratch* on commencement.

TABLE 3

If you found the NBH under-prepared on your commencement, what were the three biggest issues that prevented acceptable levels of care and service being provided to patients?

ISSUE	RESPONSE
Lack of equipment/medical-medication supplies	**98%**
Inadequate staffing (ie understaffed, poor skill mix, over reliance on agency/casual staff, lack of training for staff re the new hospital)	74%
No or inadequate policies and procedures in place	**44%**
IT system issues	16%

Perhaps not surprisingly, mindful of media commentary at the time, essentially all members responding to the survey listed lack of equipment and medical supplies as one of the three reasons for the NBH lack of preparedness on day one.

> *"Lack of basic stock ie IV fluids, syringes, delivery instruments …"*
>
> Association member responding to the survey

> *"Inadequate amounts of routinely used medication, IV antibiotics, fluids and stock to be able to prepare and administer these medications … inadequate amounts of regular ward stock such as pads …"*
>
> Association member responding to the survey

> *"… stock supplies inadequate, running out of basic supplies* [like] *10 ml syringes, normal saline IV bags …"*
>
> Association member responding to the survey

> *"… we ran out of IV cannula packs in emergency …"*
>
> Association member responding to the survey

> *"Massive lack of equipment … syringes, chest drains …"*
>
> Association member responding to the survey

"No basic equipment … no forceps in [the] *birthing unit …"*

Association member responding to the survey

"From the start of opening the hospital we were not given the triangular plastic pill counter … for four months we were counting drugs with our fingers … not being given pill cutters [so] *having to break medications with fingers or knife or scissors … no available blood sugar machines …"*

Association member responding to the survey

The next most common and pervading issue was staffing, or lack thereof, with three quarters of all respondents identifying this as one of the three issues leading to the dysfunction on opening.

"Staffing hugely understaffed, with poor skill mix further worsening things …"

Association member responding to the survey

"Lack of staff. Agency staff with no orientation and no access to EMR. Nurses being left with double to triple patient loads."

Association member responding to the survey

"Staffing with inexperienced agency nurses … sometimes 80% [of the] *shift was agency …"*

Association member responding to the survey

"Skill mix was non existent … Staff with little to no experience were expected to perform operations they had never seen …"

Association member responding to the survey

"The understaffing - the wards weren't open to its full potential … this made ED presentations hard to move to wards and led to bedblock in ED for a very long time …"

Association member responding to the survey

Almost half of all respondents indicated that IT system issues was one of the three issues impairing responsiveness and preparedness.

> *"Inadequate education on using computer systems …"*
>
> Association member responding to the survey

> *"EMR not working to electronically record patient notes."*
>
> Association member responding to the survey

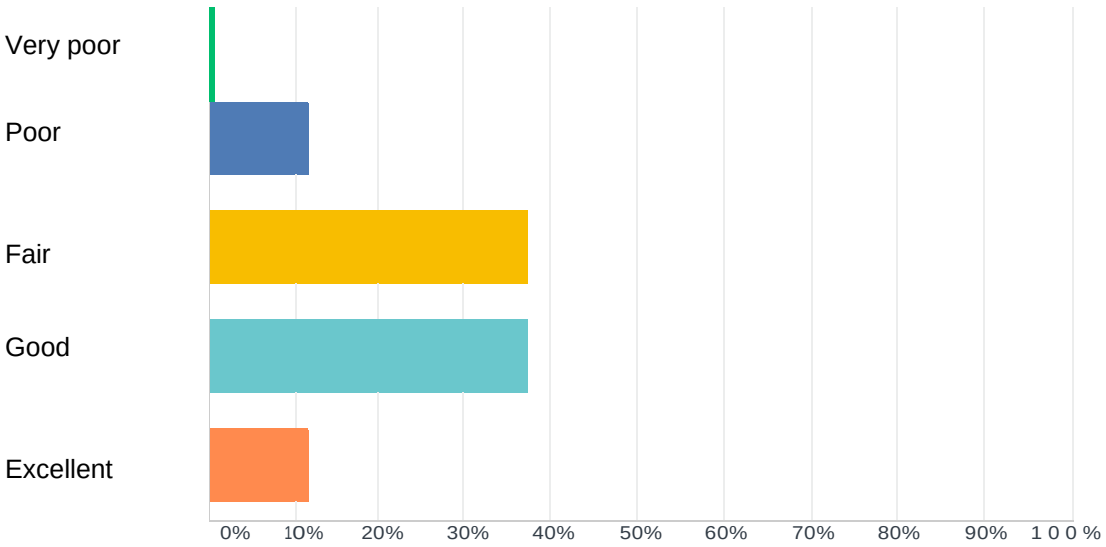
> *"No education with EMR system and no one to ask* [about] *ordering pathology, x-rays …"*
>
> Association member responding to the survey

> *"… no training in new IT system …"*
>
> Association member responding to the survey

Have things improved?

TABLE 4

How do you rate the levels of care and service <u>currently provided</u> to patients?



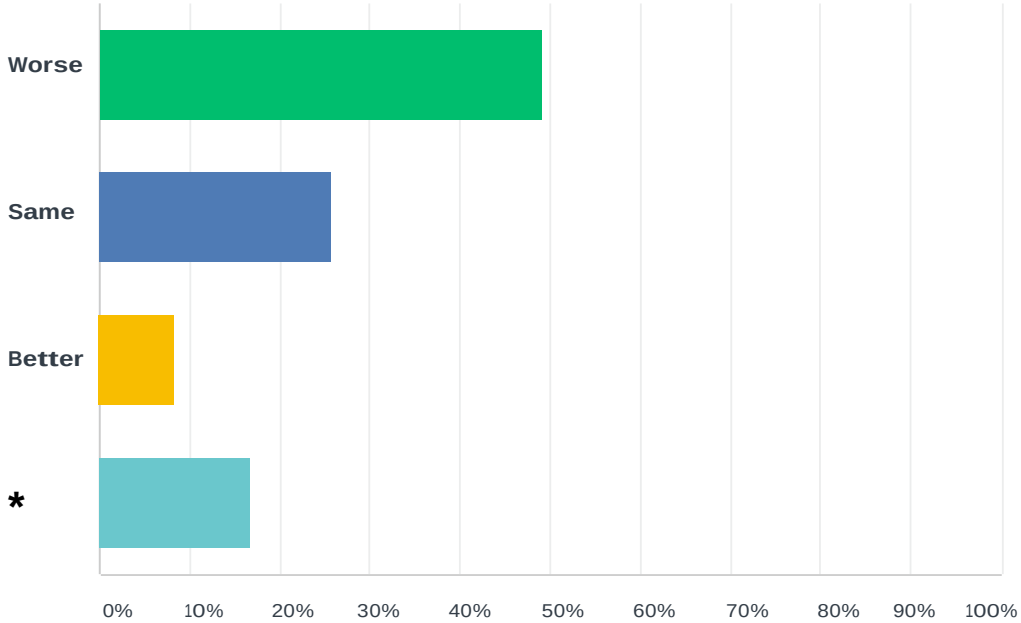
So progress has been made, but from the responses received from members, this can largely be attributable to the persistence and resilience of staff, who on a daily basis rise above endemic problems and issues to provide the best possible care, despite the continuation of a number of adverse conditions and challenges.

> *"…we'll keep working hard to ensure the best and safest possible care is provided to all our patients (private or public, it really doesn't matter to us and we'll treat everyone with equal respect and care). Without the nurses presence here, things could've been a lot worse …"*
>
> Association member responding to the survey

But is it comparable to what was previously available to the community?

TABLE 5

If you previously worked at Manly or Mona Vale Hospitals, how do you compare the current level of care and service provided to patients at NBH?



* Had not worked previously at Manly or Mona Vale Hospitals.

Based on this feedback much work still needs to be done to achieve parity with the level of care and services provided by Manly and Mona Vale Hospitals previously.

So what needs to change to achieve greater improvement at the NBH?

TABLE 6

What three things (if any) need to change to improve the levels of care and service <u>currently provided</u> to patients?

CHANGE NEEDED	RESPONSE
Improve staffing (ie more staff, improve skill mix, decrease reliance on agency/casual staff, increase number of experienced staff)	**100%**
Improve support/education/policies available	80%

Overwhelming, all feedback indicated the need to improve staffing to achieve better levels of care and service.

> *"Staffing increase with more experienced staff members …"*
>
> Association member responding to the survey

> *"… more qualified staff employed to work at NBH … less agency* [staff] *…"*
>
> Association member responding to the survey

> *"We are constantly faced with the threat of budget cuts to staffing … constantly forced to advocate for safe staffing levels …"*
>
> Association member responding to the survey

> *"Stop taking on more patients and/or opening up more shifts until we have adequate levels of appropriately trained staff …"*
>
> Association member responding to the survey

> *"Stop cancelling nurses for an afternoon shift because the ward seems quiet, then Emergency fills up and the afternoon nurses are run ragged as they are short a nurse and have lots of new admissions."*
>
> Association member responding to the survey

It is also clear that significant work also needs to occur in a range of supportive mechanisms in the hospital, including education, clear policies and the like.

"Improve electronic medical record – cumbersome and too much time wasted away from the patient."

Association member responding to the survey

"Provide more Nurse Educators … education on speciality areas [needed] *…"*

Association member responding to the survey

"Staff support!!! - (solid experienced leadership with greater staff focus - improved communication & collaboration from management - more flexibility & compromise with rostering - better ratios less admin/cleaning work – a New less disjointed user friendly computer system – space & support to take entitled breaks)… no training in new IT system …"

Association member responding to the survey

"Complete policies and procedures and compile them in one resource to enable finding them much more efficient!"

Association member responding to the survey

"… need to encourage Healthscope to get rid of the incompetent EMR that we currently have to use and get them to purchase the same program (FIRST NET) that NSW Health is using."

Association member responding to the survey

Other responses on the necessary solution(s) were more pointed.

"The unit needs to run like a public unit. It needs to be care based not budget driven."

Association member responding to the survey

"Private hospital feel, money-based, patients seem to be just a number. Quick turnover is expected. It get[s] *overwhelming and you feel like things can easily get missed."*

Association member responding to the survey

Or put more simply.

> *"… return this hospital back to public health …"*
>
> Association member responding to the survey

Emergency Department

Member feedback indicated significant and continuing issues within the Emergency Department ('ED') at the NBH. These are illustrated by the following examples of more specific comments and feedback - excluding those relating to staffing issues, which are dealt with in more detail under ToR (e).

> *"Actual Emergency dept set up is shit, ie you can't see the whole waiting room from triage, and it's still not fixed and it's dangerous."*
>
> Association member responding to the survey

> *"There is no drop off and pick up zone for ED, I had a lady … she was unable to park out the front* [with ill partner], *parked in the car park and then couldn't get* [them] *over to ED …"*
>
> Association member responding to the survey

> *"Only 168 beds fully open in the hospital to service a 55 bed ED - wait times for a bed unacceptable because of this."* [on opening]
>
> Association member responding to the survey

> *"… there's no treatment room in the ED paed area for cannula, nitrous suturing etc, poorly set up, there's not enough mental health rooms in ED ie able to lock the door …"*
>
> Association member responding to the survey

> *"…2 different computer systems which is another thing as well, you have to triage in one program but to put obs in or look at the patients notes, you need to go into another screen, it's time consuming and poorly set up."*
>
> Association member responding to the survey

"Fully operating ED with hardly any beds upstairs to offload to …"

Association member responding to the survey

"More than one registrar so they don't have to go between OT and ED, leaving patients waiting for hours in ED …"

Association member responding to the survey

"… hav[e] *firstnet* [NSW Health IT system], *instead of a shit program that won't allow triage obs and only 6 lines to* [record] *triage …"*

Association member responding to the survey

This feedback is also validated in the results thus far for ED performance at NBH.

TABLE 7 [13]

Emergency department performance		Manly Hospital Jan-Mar 2018	Mona Vale Hospital Jan-Mar 2018	NBH Jan-Mar 2019
Time to treatment by triage category				
T2: Emergency	**Median time to treatment**	**6m**	**7m**	**8m**
	90th percentile time to treatment	10m	11m	32m
	% started treatment on time	**91.7%**	**88.4%**	**58.5%**
T3: Urgent	Median time to treatment	12m	16m	28m
	90th percentile time to treatment	**33m**	**41m**	**1h 39m**
	% started treatment on time	88.1%	82.8%	53.4%
T4: Semi-urgent	**Median time to treatment**	**13m**	**15m**	**39m**
	90th percentile time to treatment	1h 01m	1h 19m	2h 00m
	% started treatment on time	**89.9%**	**85.2%**	**65.1%**
T5: Non-urgent	Median time to treatment	14m	16m	37m
	90th percentile time to treatment	**1h 20m**	**1h 40m**	**2h 01m**
	% started treatment on time	96%	94.9%	89.6%
Patients starting treatment on time %		**89.8%**	**85.8%**	**59.7%**
Median time to leave the ED		2h 31m	2h 36m	3h 22m
90th percentile time to leave the ED		**4h 37m**	**4h 51m**	**7h 00m**
Patients leaving the ED within four hours of presentation		87.1%	85.6%	72.3%

[13] This data has been extracted by the Association from relevant data for 2018 and 2019 contained in 'Healthcare Quarterly' produced by the Bureau of Health Information. Any accidental errors or omissions are those of the Association.

On almost every measure, the NBH has fallen short (at times significantly so) when compared to the exceptionally high standards previously achieved by Manly and Mona Vale Hospitals in ED performance.

And more

Mental Health and Maternity Services also received significant feedback regarding problems in delivering services (in addition to staffing concerns).

> *"On all of level 3 mental health there is not one wash basin for a nurse to wash* [their] *hands, on each ward on level 3 mental health the wash basin is in the office, or medication room, so if you are changing beds, doing dressings etc you cannot wash your hands anywhere outside any room on level 3 you have to go back into the office/medication room, I have and many other nurses put this into riskman online reporting but we all have been informed you won't be getting hand wash basins."*
>
> Association member responding to the survey

> *"… only just now they have supplied a torch for night staff …* [we] *have been using the torch on* [our] *mobile phone …"*
>
> Association member responding to the survey

> *"From the start of opening the hospital we were not given the triangular plastic pill counter … for four months we were counting drugs with our fingers … not being given pill cutters* [so] *having to break medications with fingers or knife or scissors … no available blood sugar machines …"* [Mental Health]
>
> Association member responding to the survey

> *"… whoever is doing this investigation to please have access to the RISKMAN reporting system so you can access all the incidents that have …"*
>
> Association member responding to the survey

> *"Mona Vale and Manly each had an O and G reg on weekends and nights, this was cut to one doctor to cover Birth Unit, Postnatal, Emergency and Antenatal resulting in lengthy delays in getting medical care for women …"*
>
> Association member responding to the survey

The uncertainty regarding Maternity Services extends to compliance with staffing arrangements in the copied State award for maternity (referred to as Birthrate Plus). This is designed to ensure that appropriate levels of care can be provided to birthing mothers and their babies.

As recently as June this year, in response to Association representations and concerns on behalf of midwifery members working at the NBH, Healthscope confirmed it was continuing to liaise with NSLHD and the Ministry to establish the best way it could achieve compliance with Birthrate Plus. [14]

It is hard to fathom or contemplate that this level of uncertainty or unpreparedness could be evident following years of preparation. Non-compliance with mandatory staffing obligations are hardly *teething problems* and it questions the vigilance and any probity checks undertaken by the NSLHD and Ministry to ensure that Healthscope was aware and fully understood the level of care required and staffing requirements to be met.

[14] Correspondence to the Association from Healthscope, dated 7 June 2019.

(e) staffing arrangements and staffing changes at the hospital

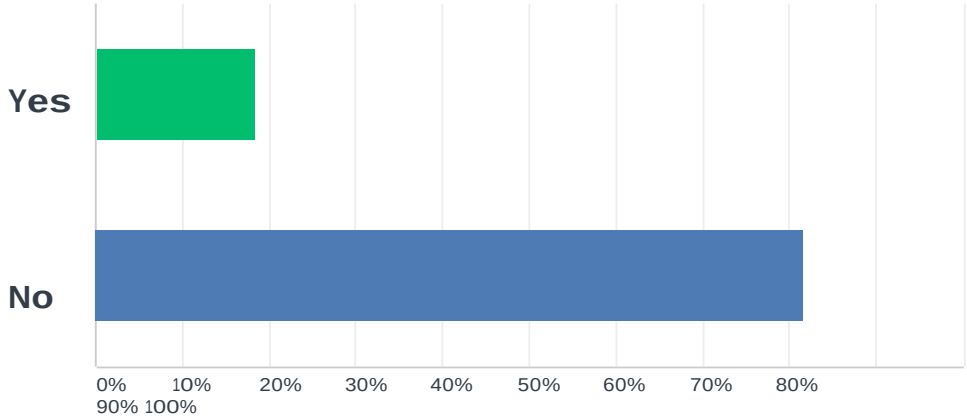
It would already be clear from previous responses that staffing was and remains an issue and a significant impediment to improve services.

This is diametrically opposite to the emphatic assurances made by Healthscope just prior to the NBH opening when it was reassuring the marketplace.

> *"Mr Ballantyne said 550 staff would be transferred from two nearby hospitals and **there was no shortage of staff in any unit** … "**There is no staff shortage** because if there were, we would not have reached this milestone.""* [15] [emphasis added]

TABLE 8

Were the staffing arrangements on <u>your commencement</u> at the NBH adequate to provide acceptable levels of care and service to patients?



This validates experiences identified in Table 3 and Table 6.

Members were then further asked to identify what the single most important impediment was for acceptable staffing arrangements at the commencement of the NBH.

[15] Comments attributed to the Chief Executive Officer of Healthscope in *"Healthscope says it has not lost investor support"*, Australian Financial Review, 24 October 2018.

TABLE 9

If not, what was the single biggest problem with the staffing arrangements?

ISSUE	RESPONSE
Not enough staff	**54%**
Over-reliance on agency/casual staff	20%
Poor skill mix	**16%**

Without replicating previous examples, the following feedback further crystallises how ill-prepared and potentially unsafe staffing was on the opening of the NBH.

"… nurse patient ratio unsafe level. In the Emergency Department it was very unsafe and unacceptable to the workload that was expected with the lack of staff and lack of medical supplies and to top it off, the ridiculous computer program that Healthscope decided to use.…"

Association member responding to the survey

"… they only staffed one emergency theatre (for the whole weekend) which in itself is outrageous when you've closed two hospitals that offered emergency services with a theatre each all weekend long. I believe all staff stayed and did hugely long and dangerous hours that weekend in order to get through the mountain of cases that needed to be done. This stress and dysfunction/mismanagement/poor communication from senior members has stayed with me ever since."

Association member responding to the survey

"At least half the staff in ED and a higher ratio on wards were agency nurses most of whom were new to the area they were working in.…"

Association member responding to the survey

"… inexperienced agency staff, 60-80% agency most shifts 1st 6mths…"

Association member responding to the survey

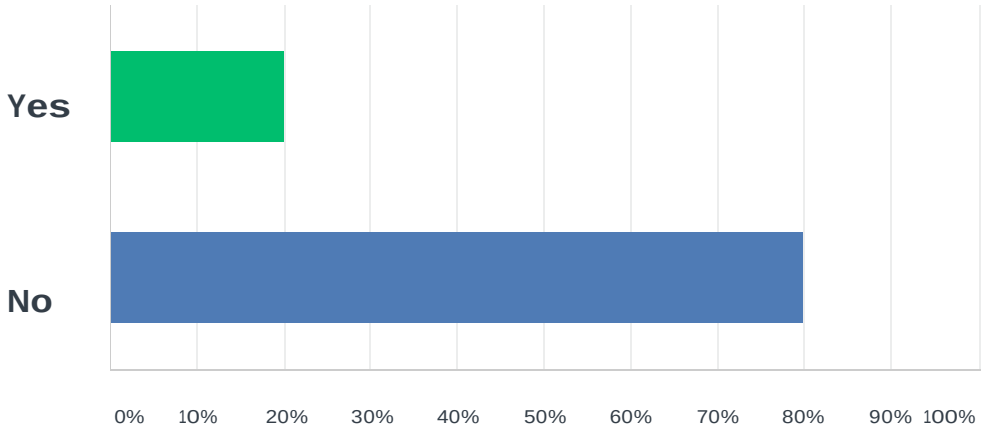
"… 50 bed ED fully functioning with only some wards opened upstairs."

Association member responding to the survey

And it wasn't only the safety of patients in question.

TABLE 10

On <u>your commencement</u> at the NBH, were staffing arrangements adequate to provide a safe place of work for nurses and midwives?



Inevitably, staffing arrangements that impacted or impaired service delivery to patients also created an unsafe place of work for nursing and midwifery staff.

The reasons offered by members are entirely consistent with results from Table 3, Table 6 and Table 9.

TABLE 11

If you answered no, what was the problem?

ISSUE	RESPONSE
Not enough staff	**60%**
Poor skill mix	20%

One or two additional comments complement those previously provided.

"It was a very unsafe environment The influx of patients that attended the ED was way over what was expected, staffing was inadequate. Staff were stressed, it was very unfair to expect staff to work under those conditions. It was appalling what we had to go through. Healthscope should NOT have opened up until ALL areas had sufficient staffing to meet the demands. Healthscope placed staff under great pressure and this is unacceptable."

Association member responding to the survey

"Often missed meal and toilet breaks due to work load."

Association member responding to the survey

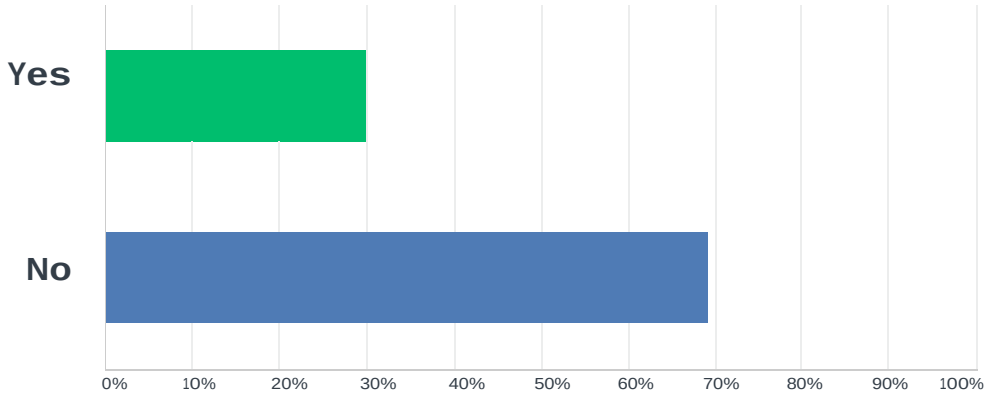
"… I would leave every shift deeply upset because of not having the stock, assistance and safe workload that I previously had to be able to provide the high standard of care I have provided my whole career … This job has taken an unmeasurable toll on every aspect of my life."

Association member responding to the survey

Have things improved?

TABLE 12

Are <u>current</u> staffing arrangements adequate to provide acceptable levels of care and service to patients?



This again only reiterates previous feedback regarding the criticality of getting staffing right.

TABLE 13

If you answered no, what needs to change?

WHAT'S NEEDED	RESPONSE
More staff	**70%**
Improve skill mix	20%

These additional comments complement those previously provided.

"Better ratios - less use of transient agency staff - more experienced staff having greater value - a patient free team leader on every shift to monitor and educate until more solid structure is established - less emphasis on minimising staff budget until basic processes are established sufficient Staff to support breaks and getting off on time."

Association member responding to the survey

"Having wards staffed with masses of agency nurses has not helped! Supporting the Nurses who have shown great dedication through this extremely tumultuous first 9 months will hopefully improve morale. Not "Taco day", but real support. Educators who are on the floor to relieve for breaks, to help Nurses understand the different specialties they are thrown into with no regard for the stress that involves."

Association member responding to the survey

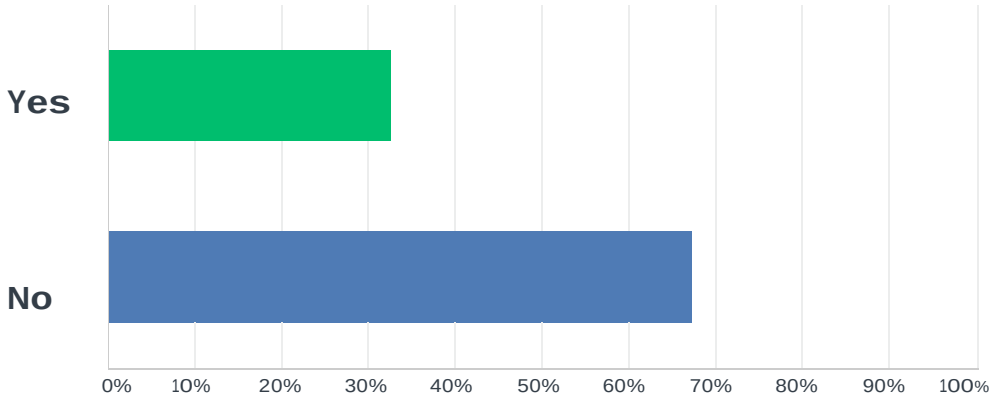
"… the best solution is to give this hospital back to NSW Health …"

Association member responding to the survey

And is the NBH any safer for staff?

TABLE 14

Are current staffing arrangements adequate to provide a safe place of work for nurses and midwives?



Not surprisingly, feedback reflected common themes.

"… get rid of Healthscope and get NSW Health to buy this facility back relying on agency staff to fill in the gaps is only a bandaid solution. It is unsafe because many times staff are inexperienced. For example in ED many time due to lack of staff an agency AIN will fill a gap. This is very unsafe as an AIN cannot do what an RN can in ED This causes the RN on shift having to increase their workload making it unsafe and very unfair…"

Association member responding to the survey

"More staff at the bedside to support favourable patient care with the level of documentation and clerical accountability required so that work can be completed on time - flexibility with 8 - 10 – 12 hour shift rostering to support fatigue levels & staff health - enough staff to cover for breaks."

Association member responding to the survey

"Better midwife to patient ratios."

Association member responding to the survey

"Improve nurse to patient ratios. 1:3 in Emergency and 1:4 on the ward. Increase number of nurses and employ more senior nurses."

Association member responding to the survey

Award versus federal agreement

As previously noted in ToR (c), from an employment perspective, nurses and midwives employed by Healthscope are under either:

(i) the copied State award (transferring nurses and midwives from Manly and Mona Vale Hospitals); or

(ii) the Federal EA (nurses and midwives employed directly be Healthscope).

Agency staff would alternatively be engaged and paid via contractual arrangements entered into by Healthscope and the agency involved.

The copied State award requires Healthscope to comply with staffing provisions for employees so covered (transferred nurses and midwives) - at least in certain prescribed areas of the hospital as set out in the copied State award. However, no staffing provision is contained within the Federal EA and therefore none is mandatorily applicable to those nurses and midwives.

This gives cause to a number of issues.

- Firstly, there are differing obligatory staffing arrangements dependent on how you were engaged by Healthscope (and what industrial instrument applies);

- The copied State award (and its staffing arrangements) would not apply to agency staff;

- Accordingly, as wards or services become increasingly staffed by Federal EA and/or agency staff, the impact of the staffing arrangements contained in the copied State award (which in certain areas seek to maintain a minimum nurse to patient ratio) lessens;

- With the effluxion of two years from opening, it will be open to Healthscope to seek to have the copied State award superseded by the Federal EA via processes under the *Fair Work Act 2009*, something 'permitted' by the Deed;

- The net consequence of this outcome would be the removal of any prescribed and obligatory staffing arrangements upon Healthscope; and

- In an environment whereby the lack of staffing has and remains the number one issue for nurses and midwives to facilitate a safe workplace that can deliver the best possible care, one is entitled to wonder what staffing arrangements may arise in an environment whereby Healthscope is unencumbered by any award based requirements.

The feedback received from members suggest that staffing is equated as a cost, and a cost that Healthscope is all too ready to trim back on.

Paradoxically this seems to be demonstrated based on member feedback in those parts of the NBH dedicated to patients with private health insurance, often staffed by nurses not covered by the copied State award. Whilst these patients would no doubt be expecting a superior level of service, it is these wards that are often operating with a staffing ratio of one nurse caring for up to eight plus patients (1:8+).

> *"I have been told, 1:8 … get used to it …"*
>
> Association member responding to the survey

Perversely, patients in the public health system who exercise the use of private health insurance would access as a minimum any prescribed staffing arrangement in the State award. For example, in a medical or surgical ward in metropolitan Sydney, they would be subject to a far better ratio of nurse to patient care.

Poor management or a business model?

It is clear a heavy reliance upon agency and casual staff is evident. In part this reflects that the NBH remains anything but fully staffed. This has its obvious difficulties. As member feedback details, agency staff are often thrown in the deep end, in areas or specialties that they are unfamiliar with, all of which creates greater stress and pressure on permanent, experienced nursing staff.

Having a *melting pot* approach to staffing, whereby there is no consistent nursing workforce familiar with the nuances of the services to be provided and the framework they operate within, is undesirable and ultimately unsafe.

No doubt it is increasingly difficult to attract and retain experienced nursing and midwifery staff to the NBH. But there is no point in blaming poor publicity. This is a failing that must be sheeted home to Healthscope, and ultimately also to the NSLHD and Ministry who entered this arrangement and are now paying the bill on behalf of the community for public health services rendered. It was they, along with then NSW Government decision makers, who promised that there was no staffing shortages.

Passing curious then that despite the confidence and the bravado exuded by the CEO of Healthscope in the marketplace and by others elsewhere, it was Healthscope who continually refused to provide any assurance to the Association and its members in relation to specific details on the staffing and clinical profile to be provided for wards and services. This information was persistently sought over several months, as exampled below:

"Firstly, the Association formally acknowledges receipt of this further information and confirms that it has been distributed to members at Manly and Mona Vale Hospitals ('Hospitals'). The Association is aware that the information has been actively reviewed and discussed by members, and has recently been subject of Association Branch meetings. The overwhelming consensus is that members working at the Hospitals would still seek to have provided, as part of the further tranche of information promised following the conclusion of Round 3, information that provides a breakdown of nursing classifications and FTEs that will be intended (based on assumptions regarding occupancy and demand) to be utilised in wards and services at NBH on its opening at end of October 2018." **16**

The concerns of members were obvious. They were suspicious that staffing levels and/or the skill profile of nursing and midwifery staff would be eroded and less than that provided at Manly and Mona Vale Hospitals. They were concerned that this would mean a lesser capacity to care and the potential for placing themselves in an unsafe workplace.

Healthscope refused to provide the detail as requested. NSLHD and the Ministry conceded they had no authority or capacity to compel Healthscope to do so.

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16 Extract from correspondence to both the CE of NSLHD (Ms Deborah Willcox) and CEO of the NBH (Ms Deborah Latta) from the Association, 5 June 2018.

One is left to speculate did Healthscope believe their own rhetoric. Did they know or realise the poor state of staffing that would be in evidence from day one? If not, why not? Did the NSLHD and Ministry harbour similar suspicions as that of our members?

What was or is going on here?

Unless, part of the business model determined to be utilised by Healthscope is to retain a significant reliance on agency and casual staff to enhance their 'flexibility' to change or cut shifts that would be more difficult with permanent staff. Member feedback has identified that Healthscope is not frightened to cut back on shifts if the (short-term) opportunity presents itself, regardless of the subsequent consequences if patient demand spikes.

This perhaps is the inevitable tension that arises in a privatised model of care.

Professional obligations

The matter of proper staffing levels (along with adequate education, training and supports) is critical to providing and enhancing safe clinical practice. Attempting to provide such care in an environment beset by shortages, also strikes at the heart on the obligations imposed upon registered health professionals, such as nurses and midwives.

A recent case [17] before the Victorian Civil and Administrative Tribunal grappled with a clinical error that occurred within an environment that was agreed was poor in general, and likely a contributing factor to the error. However, the conclusion drawn from this decision is that it is not enough for registered health professionals to make known their concerns and it is not an excuse for subsequent incompetent practice. The following extract is pertinent to the situation that nurses and midwives often confront:

"57 Poor working conditions do not excuse incompetence or dangerous practice.

58 Patients are entitled to assume that if they come through the doors of a hospital to give birth, they and their babies will receive safe and competent care.

59 And if midwives are unable to safely or competently care for patients because of conditions outside their control and have done all they can to bring the deficiencies to the attention of those responsible, they will need to make their own decision about whether they remain in that workplace. This case illustrates the risks not only to patients but also to professionals who work in such an environment.

[17] Nursing and Midwifery Board of Australia v Macrae (Review and Regulation) [2018] VCAT 1707

60 Dangerous conditions should be reported, documented and publicised. They should never be normalised …" [18]

The Tribunal would seem to be suggesting that despite the efforts of the registered health professional to make known the problems and have them rectified, it is a matter for them as to whether they 'choose' to remain in such a dysfunctional environment.

This latter aspect of this decision is concerning for any registered health professional who attempts in good faith to carry out their role in such an environment. If a genuine error or harm arises from the stress or strain of that environment, it will not necessarily mitigate the fact that their registration (and profession) may be placed in potential jeopardy.

No employer (public or private) should ever place a nurse or midwife in an untenable situation where they may compromise the level of care due to under resourcing and potentially lose their registration as a consequence.

The employer and provider of such services (in this case Healthscope) MUST be responsible and held accountable for providing the resources necessary to provide safe clinical care. And the NSLHD and Ministry should insist that this is the case.

[18] Ibid.

(f) the impact of the hospital on surrounding communities and health facilities, particularly Mona Vale Hospital, Manly Hospital and Royal North Shore Hospital

Mona Vale Hospital

On the initial announcement of the proposal to tender the construction and operation of the NBH, it was stated that whilst all acute services would be *stripped* from Mona Vale Hospital, the assessment and rehabilitation beds would remain, along with some form of Urgent Care Centre as a substitute for the Emergency Department. Reference was also made to the development of a master plan for the Mona Vale Hospital site.

Disappointingly for staff and the community, it was then not until June 2018 [19] (over four years later) that the services and staffing to remain at Mona Vale Hospital was more clearly articulated. This confirmed the retention of 56 beds, comprising assessment and rehabilitation services, community health centre, hydrotherapy pool, community palliative care, and a proposal to add an additional 20 beds for inpatient palliative care and geriatric evaluation and management.

It also confirmed that an Urgent Care Centre ('UCC') would be operational when Mona Vale Hospital acute services ceased from 31 October 2018. It was confirmed that the UCC would only be able to meet the needs of those with minor injury or minor illness (ailments similar to that which may have you attend your local GP), albeit some additional capacity has been introduced since opening, such as X-rays.

This would and has been a significant shift for the local community. An ED that previously averaged approximately 80 plus presentations per day (including a number of children), with approximately half of these presentations requiring some form of continued care and/or admission, to that of only having access to basic care or limited stabilisation prior to transfer to another hospital, is a seismic change.

Indeed the ongoing commitment to the UCC is also not locked in. The NSLHD made clear at that time that the *UCC "… will be 24/7 in the first 12 months with a plan to conduct an utilisation review to determine usage/demand."* [20]

This would be unfortunate for the community if even these limited services were further curtailed or had its hours of operation reduced. If anything, any review by NSLHD/Ministry should seriously contemplate whether further services may be needed to better complement those provided at NBH.

It is understood by the Association there would be no barrier to NSLHD expanding its range of public health services at Mona Vale Hospital. [21]

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19 Correspondence to the Association under the signature of the Chief Executive of the NSLHD dated 16 June 2018.

20 Ibid. Contained in a Consultation Paper attached to the Chief Executive correspondence.

21 Observation made during an address by the Hon Rob Stokes MP, then Minister for Education, at a 'Save Mona Vale Hospital' protest meeting, Pittwater RSL, 5 February 2019.

Manly Hospital

All services at Manly Hospital ceased with the opening of the NBH. Accordingly, the community is completely dependent on the NBH.

Royal North Shore Hospital

It is difficult for the Association to establish with any certainty what impact the closure of Manly and Mona Vale Hospitals and the opening of NBH has had on the services provided by Royal North Shore Hospital ('RNSH').

However, based on anecdotal feedback from members working at RNSH, there would appear to be an increased demand arising from those bypassing or refusing to be treated at the NBH. Indeed media reports [22] have suggested that local GPs were actively referring their patients to RNSH (rather than the NBH), at least in part to reduce out of pocket expenses for such patients that might be incurred at the NBH.

[22] *"GPs anger at patients out of pocket expenses",* Manly Daily, 10 April 2019

(g) the merits of public private partnership arrangements for the provision of health care

It will be no surprise to the Committee that the Association and its members have long taken a stance opposing the privatisation of public health services and assets. It vigorously campaigned against the decision to proceed with a privatised model for the NBH. Not because it is opposed to the provision of health services by NGO providers, the Association acknowledges and accepts that the private health system has long been a complementary part of the total health services provided to the community.

But the provision of public health services has long been and seen to be an integral responsibility of governments at both state and federal level. These are essential services that must remain in the hands of the community via their governments. As demonstrated time and time again, when governments have made decisions to contract out these essential services, they have largely failed in the Australian setting. The NBH appears, sadly to date, to validate those experiences.

The justification for privatising public health services generally rely upon the false assumption that such services can be commodified and dealt with as a financial equation - searching for supposed increased efficiency and effectiveness ie providing a service at a lower cost than would otherwise have been the case if these services had remained in public hands.

There are major flaws in this approach and view of the world. Firstly, the provision of health services cannot simply be reduced to, and tested on, achieving some notional lowest possible price for providing it. The ultimate test for such services are about their adequacy, the timeliness of their provision, and the quality of such services. It is a false economy to provide a (cheaper) episode of care first time round, and deal with the subsequent consequences for the patient when they need to be readmitted or have complications arising from such care or are left with a poor experience.

Further, if the privatisation leads to an alleged lower payment for episodes of public health care, a private provider will need to drive that service delivery at even a lower cost to achieve a profit ie it must reduce the cost of providing such care, and inevitably this results in poorer service delivery, a lack of timeliness and, all too predictably, a reduction in staffing (and labour costs). It is the latter reduction that only adds and fuels poorer performance and clinical outcomes.

This approach is already evident at the NBH, and is an everyday consequence that the Association and its members confront in the Aged Care (residential) setting for example, where despite the paucity of care available, staffing levels are often the first to feel the efficiency axe (often straight after accreditation is achieved).

The Australian experience with public hospitals clearly demonstrates as much. [23]

[23] The following summary of the experiences at Port Macquarie Hospital, La Trobe Hospital, and Robina Hospital is based on previous research undertaken by and for the Association.

Port Macquarie Base Hospital

This privatisation was initiated by the then NSW Government as part of its so-called reforms of the public sector. In December 1992, the Department of Health ('DoH') entered into a 20-year contract with Mayne Nickless for the construction and operation of the Port Macquarie Base Hospital ('PMBH').

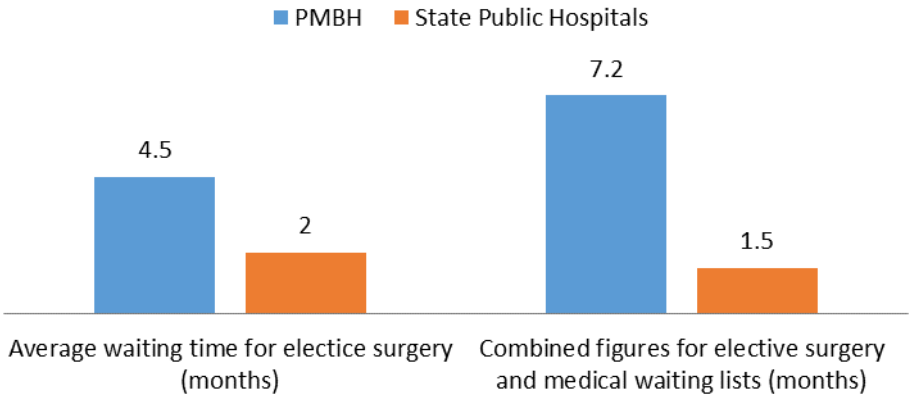
A subsidiary of Mayne Nickless, Health Care of Australia ('HCoA'), managed the hospital. The hospital was contracted to treat a mix of 80 per cent public and 20 per cent private patients. The PMBH commenced operations in November 1994.

Following ten years of operation, in October 2003 the Mayne Group proposed selling its entire Australian hospital portfolio, including the PMBH, to another private consortium. Consequently, the NSW Government commenced legal proceedings in April 2004 against the Mayne Group. On 31 January 2005, after 10 years of contracting public hospital services from Mayne Nickless, the NSW Government bought back the PMBH for $35 million, at which point the hospital reverted to public ownership.

While the most obvious outcome of the PMBH was contract failure, it is worthwhile to examine the performance of the PMBH on the criteria of quality of services and value for money (the said benefits of privatisation). A number of performance indicators for the PMBH had been set, which included elective surgery waiting times, and comparisons with peer hospitals. The privatisation quickly was seen as a gross failure on those parameters. [24]

TABLE 15

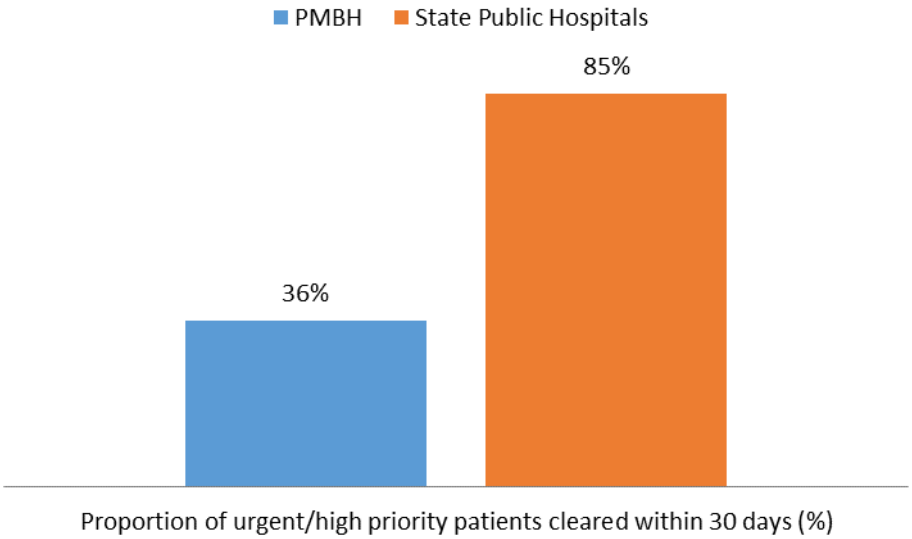
Performance Indicators of PMBH as of April 1998



[24] See for example *"Developing an analytical framework for analysing and assessing public-private partnerships: a hospital case study."* The Economic and Labour Relations Review, 19(2), 69-90, Chung, D.

TABLE 16

Performance Indicators of PMBH as of April 1998



The assumption that the privatisation would result in lower cost turned out to be false, despite the cost assessment being presented at its initiation with claims it would lead to significant cost savings. Rather, the PMBH cost the NSW Government 30% more to run than its public sector hospital comparators. Widely reported at the time and since, the exercise was labelled as being equivalent to the PMBH being *"…paid for twice over by the taxpayer …"* [25] following its collapse and return to public ownership.

La Trobe Regional Hospital

While the outcome of the PMBH was contract failure, it is not the only contact failure. La Trobe Regional Hospital was initiated in 1997 when the Victorian Government entered into a 20-year contract with Australian Hospital Care for the design, construction and operation of the La Trobe Regional Hospital. It commenced operations in October 1998. After 6 months of operation, Australian Health Care approached the Victorian Government for more funding following significant operating losses. The Government refused. In November 2001, the staff of Latrobe Regional Hospital transferred back into public employment and in 2002, the ownership of the hospital reverted back into public hands.

[25] For example, comments attributed to the then Premier, the Hon Morris Iemma MP, ABC Television, 2006.

Robina Hospital

The experience for Robina Hospital was almost identical to that of La Trobe Regional Hospital: the hospital operator, Sisters of Charity, approached the Queensland Government in the first six months of operation to alleviate operating losses and to seek more favourable contract provisions. The assumption that greater operating efficiencies would be achieved proved false. The Queensland Government did not assist and the operator continued to make operating losses. After just two years of operation, Robina Hospital reverted to public ownership.

Northern Beaches Hospital

As amply demonstrated in this submission and feedback from our members, significant issues are still plaguing the NBH. We will not seek to replicate these concerns here.

What is unclear is how the NSW Government, along with NSLHD and the Ministry, exert effective control over the episodes of public health care delivered by Healthscope at the NBH. As previously noted in this submission [ToR (a)], from observations and experiences to date, the Association believes:

"… that the NSLHD has been reduced to the 'purchaser' of public health episodes of care, rather than being directly responsible for the provision of such services. It has become a bystander, attempting to vicariously manage events rather than being directly responsible for them. Perversely, whilst one of the so-called claimed benefits of this approach is that divorces or shifts (financial and operational) risk to a third party (and away from the State), it only serves to magnify that risk and leaves it to be borne by the community and patients."

(h) any other related matter

The Association has never supported the decision of the NSW Government to privatise the public health services via the NBH for the community of the Northern Beaches. It has however, diligently and professionally participated in every forum, every consultation process, every meeting, along with providing copious feedback and suggestions regarding processes relating to employment and 'migration' of staff to ensure the best possible outcome for both patients and its members, the professions of nursing and midwifery.

Any success attributable to the NBH is a validation of the staff and the exceptional work being undertaken by nurses and midwives in the most trying of circumstances. Their story needs to be told and yet with each 'bad news story', it becomes harder to attract and retain experienced (in fact any) nursing and midwifery staff to work there at all, let alone permanently.

Based on the feedback received by the Association, and the experiences of our members along with the community, the report card for the NBH is less than glowing.

TABLE 17

Report card

The new hospital would:		Pass/Fail
i.	be a state-of-the-art, purpose built facility	Certainly new, but design faults are evident.
ii.	provide greater capacity to the people of the Northern Beaches	Fail. It appears to be providing a lesser level of service and performance than Manly and Mona Vale Hospitals.
iii.	provide greater complexity of services to the people of the Northern Beaches	Uncertain.
iv.	utilise leading digital technologies to deliver the highest quality care	Fail in relation to the IT platforms and EMR system being used.
v.	be part of (or somehow incorporated within) the clinical network of the Northern Sydney Local Health District	Based on experiences to date, fail.
vi.	be held accountable to the highest clinical standards	Experience suggests otherwise.
vii.	provide better public health services	Fail.
viii.	provide better private health services	Fail.
ix.	provide a better working environment for hospital staff	Fail.
x.	have certainty regarding the employment conditions of transferring staff from Manly and Mona Vale Hospitals	Pass, setting aside those guarantees fall well short of what staff sought.

What is needed?

Whilst the actions that may practically (and legally) be possible under the Deed between Healthscope and the NSW Government is likely to be limited, the following steps or actions are respectfully suggested by the Association to be strongly considered by the Committee as part of its Final Report and recommendations:

1. Resume public ownership of the NBH or at the very least have the NBH become an affiliated health organisation (Schedule 3 Hospital) so greater control can be exerted, and the NBH can truly be 'integrated' within the public health system of NSW.

2. Immediate intervention to review and increase permanent nursing and midwifery staffing levels.

3. Apply a hospital wide nurse/midwife to patient staffing ratio relevant to the speciality and service being delivered, which enables safe care to be provided and encourage the attraction and retention of staff, with these to remain in place indefinitely and certainly during the tenure of Healthscope.

4. As part of this intervention, ensure that appropriate skill mix levels are set for and included within staffing ratios that are relevant to the speciality and service being delivered.

5. Review the Emergency Department as to the number of beds that can be kept open safely and the number of permanent and experienced staff required.

6. Increase the numbers of Nurse/Midwife Educators and Clinical Nurse/Midwife Educators to provide necessary support and education.

7. Consider providing staff with access to HETI/NSW Health online education.

8. Increase additional support staff (and reintroduce Clinical Support Officers) to assist clinical managers (such as Nurse Unit Managers) to allow a greater emphasis on clinical leadership and oversight, and not administrative duties. Additional support is also required at ward level to allow nurses to cease undertaking unnecessary non-clinical duties, especially after hours and on weekends.

9. Urgently review IT platforms and electronic medical record systems and seek consistency with NSW Health.

10. Make known to the public what obligations and public health services are expected and required to be provided by Healthscope.

11. Reveal what KPIs are specifically established for Healthscope by the Project Deed and how these are tracked and make known the current report card.

12. Consider expanding services at Mona Vale Hospital and/or establish Mona Vale Hospital as a clinical centre of excellence for old age - geriatric care.

Survey Methodology

The Association established a series of questions to elicit feedback from members (with those outcomes tabulated and appearing in this submission).

Questions included providing specific answer options to select from and alternatively those that enabled free text responses so that members could further expand on their responses.

The survey (via email) was sent to 353 members. Of these, 250 members opened the email and survey, with 164 subsequently completing the survey.

Accordingly, this constitutes a 46% response rate, which from the experience and knowledge of the Association is an outstanding response rate for online surveys.

It is also of note that of those responding, some 60% did so within the first 24 hours of the survey being made available.

Submission feedback in general of course is also predicated upon the experiences of Association officers and members involved in this privatisation process, and the continued support and representation provided to members working at the NBH.

Appendix 3: QNMU report

Queensland Nurses and Midwives' Union submission to the Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

Queensland Nurses & Midwives' Union

Submission to

Health and Environment Committee

Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

December 2021

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Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Health and Environment Committee (the Committee) for the opportunity to comment on *the Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system*.

Nursing and midwifery is the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all classifications of workers that make up the nursing and midwifery workforce including registered nurses (RN), registered midwives, enrolled nurses (EN) and assistants in nursing (AIN) and students who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 66,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses and midwives in Queensland are members of the QNMU. As the Queensland state branch of the Australian Nursing and Midwifery Federation, the QNMU is the peak professional body for nurses and midwives in Queensland.

The QNMU supports this inquiry into the provision of primary and allied health care, aged and NDIS care and private health and its impact on the public health system. Taking a broad view, Queensland's health care system sits within Australia's health system which is complex and disjointed - federal and state governments and private sector providers including primary health and aged and disability care providers all play different roles. Responsibility for health service planning and delivery is divided and collaboration is not incentivized. As a result, care is fragmented and costs are shifted, contributing further to system dysfunctionality. In addition to this fragmentation is the added complexity on how to navigate care, particularly for those with complex health care needs. We believe there is a need for a greater focus on joint planning and funding between the state and federal governments to meet the population's health care needs and to deliver safe and quality health care for all. The QNMU is calling on both the federal and state governments to address the health care system to meet the needs of Queenslanders in the short, medium and long-term.

In our submission to Queensland Health on expanding health care quality and patient safety reporting across Queensland's health care system (2017) we first raised the concept of establishing a Health Performance Commission. We see this as an overarching, independent body to gather, analyse and report on data that enables value-based health care. It would be well placed to link hospital and health data with other economic and social data as an evidence base for value-based health care and new health programs. Given the divided roles and responsibilities for health and health care that involve different levels of government we

suggest that if the Health Performance Commission was established, it could facilitate greater integration and coordination of health care services and resources between government sectors.

This inquiry comes at a time when the demand for health services in Queensland is exceeding supply with an urgent need for additional investment in Queensland's health system. In response to this need, the QNMU, together with other health workers and their unions, launched the campaign – *Health Needs Urgent Care*, (2021a) (the campaign) calling for immediate and long-term solutions to fix the problems of Queensland's health care system. Even before the COVID-19 pandemic, there were increasing demands on already stretched health services and beds that were impacting QNMU members and other health staff. With the Queensland border re-opened and with the potential Omicron strain being more virulent than Delta we fear the anticipated surge in Queensland of COVID-19 cases will have enormous impacts on an already understaffed and under resourced workforce – and our ability to provide quality care. We see the disruption caused by COVID-19 to the health care system as a chance to reset and enact different models of care that increase a patient's access to healthcare, provides more choice and meets the needs of all who need to access it.

It is our view that health equity for all Queenslanders, where they have the opportunity to live their healthiest lives, is foundational to this inquiry. Equity not only in health but in health care. The social determinants of health, the conditions in which people are born, grow, live, work and age, influence health and wellbeing outcomes and quality of life. To achieve health equity, we believe greater coordination of federal and state government health services and programs is imperative. Aligning action through whole-of-government approaches will assist in making Australia more equitable. We acknowledge the work Queensland Health is already undertaking in this area, particularly with the First Nations Health Equity framework and we support more of this understanding of local, community health needs.

In framing our response, the QNMU will address the terms of reference and have included a number of case studies. We have also chosen to focus on several areas within Queensland's health care that are currently impacting health care delivery and/or are areas of the health care system we wish to address. They are:

- workforce planning;
- ambulance ramping;
- demand on emergency departments;
- mental health care;
- palliative care.

Recommendations

The QNMU recommends the Queensland Government:

- Support growth of innovative nursing and midwifery models that will enhance the ongoing sustainability and safety of our public health system.
- Review and extend new and/or improved models of care that were successfully implemented in response to COVID-19.
- Address nursing and midwifery workforce shortages through the development of a comprehensive health workforce plan for Queensland.
- Consult and include First Nations people in every stage of health care and delivery.
- Continue to support the use of multi-disciplinary teams within primary health care.
- Continue to implement models of care that focus on preventing illness and disease and promoting health and wellbeing.
- Trial and evaluate new models of funding that would complement activity-based funding.
- Review current funding and contracting arrangements of community organisations to ensure continuity of care and service.
- Support the federal government in implementing and achieving the recommendations from the Royal Commission into Aged Care Quality and Safety.
- Investigate funding for additional mental health community-based extended-services.
- When allocating funding for mental health services, provide a commitment that this funding will continue, ensuring continuity of mental health services and care.

1.a. The provision of primary and allied health care and any impacts the availability and accessibility of these services have on the Queensland public health system

Ensuring access to primary and allied health care is key to improving health outcomes, so in addressing this term of reference, the QNMU has chosen to focus on:

- state-specific considerations;
- innovative health care;
- multidisciplinary collaboration;
- funding reform;
- nurse-led models of care;
- midwife-led models of care;
- examples of initiatives supported by the QNMU.

One arm of Queensland's health care system are the services provided by the primary and allied health sectors. The QNMU takes the position that primary health care is a broad range

of health services that includes services provided by nurses and midwives and allied health practitioners. The Alma-Ata Declaration of 1978 identified primary health care as the key to the attainment of the goal of health for all and is the first element of a continuing health care process that brings health care as close as possible to where people live and work (World Health Organization, 1978). We strongly support this view and believe that quality primary health care is associated with increased access to services, better problem recognition and diagnostic accuracy, a reduction in avoidable hospitalization, better health outcomes, lower suicide rates, and a higher life expectancy (World Health Organization, 2018).

State-specific considerations

When discussing the accessibility to health care in Queensland, the state's demographics and geographically diverse population is an obvious consideration. Covering just over 95% of the state's land mass, rural and remote Queensland is home to over 1.65 million people (Queensland Government, 2016). Due to their geographic location, low population density, limited infrastructure, and higher costs for delivering health care in rural and remote areas, people living in rural and remote areas experience challenges in accessing health care more so than those who live in urban centres (Australian Institute of Health and Welfare, 2018). Many must travel significant distances, often at great cost and inconvenience to seek health care.

Another state-specific consideration is that for some, primary and allied health care is not easily available or accessible. This is evident for First Nations people where barriers to accessing health care include cost, experiences of discrimination, and poor communication with health care practitioners. This has impacted the health and life expectancy of First Nations people identified in the *Closing the Gap Report 2020* where there has been limited progress against the life expectancy target[1]. Delivering culturally sensitive primary health care must be appropriate to the unique culture, language and circumstances of First Nations people.

A recent example of poor accessibility was the initial slow COVID-19 vaccination programs rolled out to First Nations people in rural and remote parts of Queensland leading to low vaccination rates in these communities. Initial criticism was levelled at the low number of Indigenous-specific outreach programs to undertake this work. To ensue clinics are culturally welcoming, First Nations people must be engaged with to ensure culturally sensitive health care provision. This is not only imperative for the vaccination programs in rural and remote areas but health care as a whole.

[1] The target to close the gap in life expectancy by 2031 is not on track. In 2015–2017, life expectancy at birth was 71.6 years for Indigenous males (8.6 years less than non-Indigenous males) and 75.6 years for Indigenous females (7.8 years less than non-Indigenous females). Over the period 2006 to 2018, there was an improvement of almost 10 per cent in Indigenous age-standardised mortality rates. However, non-Indigenous mortality rates improved at a similar rate, so the gap has not narrowed.

Equity of health outcomes for Queensland's First Nations people is a priority. It can only be achieved when First Nations people are consulted and considered in every stage of health care and delivery to ensure it is culturally safe, responsive and is evidence-based. A step to achieve this may be to improve the cultural safety of mainstream services to First Nations people by providing cultural safety training for health staff. Research shows when health care systems improve cultural safety practice, patient experiences of communication, patient satisfaction and trust improve (De Zilva, Walker, Palermo & Brimblecombe, 2021).

Innovative health care

In addressing ways to access primary health care, we need look no further than the federal and state government's response to the outbreak of the COVID-19 virus. These events have highlighted there is very little excess capacity in the health care system to meet the needs of an ageing population, an increasing prevalence of illness and disease alongside chronic conditions when emergent events such as a pandemic, occur. COVID-19 has prompted a welcomed review of the broader health care system, how it is accessed, the health care workforce and the roles each health practitioner plays. The COVID-19 crisis has been a stark reminder that our health care system must meet patient needs, be responsive as well as being sustainable.

The pandemic has forced governments and health care providers to consider alternative ways in delivering health care and adapt and develop strategies in surge capability. Changes to state legislation, as well as regulatory and policy frameworks have enabled an agile response in introducing and adapting models of care and service provisions. The following innovative models have been either implemented or further developed during the pandemic response:

- virtual care which improves access and convenience for patients. E.g., virtual diabetes clinics;
- hospital in the home (HITH) - a hospital avoidance strategy implemented to treat and monitor patients in the home;
- triaging models and assessment tools such as in-car triage/fever clinics and open-air consultations where patients arrive in their car, drive-through to where nurses take swabs, from which the sample is sent for COVID-19 testing;
- telehealth;
- 13Health – health advice provided by RNs over the phone; and
- testing and fever and vaccination pop-up clinics.

These strategies demonstrate that by challenging the status quo of how primary health care is delivered, alternatives to service delivery can be found that increase accessibility, are patient-centred, effective, lower-cost, and reduce the demand on hospitals. We urge the state government to urgently evaluate the value and outcomes of changes adopted during the pandemic with the view that those practices that work effectively be retained as regular practice.

We believe this aligns with a recommendation made by the Queensland Audit Office (2021b, p.3) where they identified that to improve access to specialist outpatient services, Queensland Health must 'work with hospital and health services to embed proven, innovative models of care and more integrated health solutions across the state to help increase capacity and optimise benefits more broadly'. The QNMU supports the rigorous evaluation of these models of care to provide evidence of their effectiveness for the patient and the greater health care system.

In addition, it is the view of the QNMU that a shift is required in the dominant short-term focus of treating illness and disease, which contributes to the undermining of the long-term sustainability of the health care system. The QNMU believes there is insufficient attention paid by governments to advancing innovative models of care that focus on what matters most – protecting and preventing illness and disease and keeping people out of expensive acute care hospitals. Chronic conditions make up roughly half of all potentially preventable hospitalisations (46%) which in 2015-16 cost the Australian health care system over $2.3 billion (Australian Institute of Health and Welfare, 2020). Further approaches need to be developed that look at health promotion and wellbeing and secondary prevention activities such as social prescribing. Prevention and intervention will not only reduce the pressure on the health budget, but it will also increase workforce participation and productivity and improve the health of future generations.

Multidisciplinary collaboration

The QNMU believes that an essential component in delivering primary health care is through multidisciplinary teams, working together to improve health outcomes for patients and reduce the strain on the wider health care system. Health practitioners from a range of health disciplines and with varied skill mixes deliver comprehensive, coordinated primary health care with significant benefits that include:

- reduced emergency department visits;
- reduced hospital admissions and readmissions;
- reduced inappropriate healthcare interventions;
- reduced duplication of services;
- care that is better aligned to patient and family needs;
- care that is collaborative;
- decreased total health spending;
- a healthier, more supported population (Agency for Clinical Innovation, 2021).

Multidisciplinary teams that include nurses and midwives, are a critical component in Queensland's broader health care system as these multidisciplinary teams are able to support patients in their health care and prioritise and identify care goals, take into consideration the patient's cultural preferences and stage of life, across a wide range of concerns such as mental

and physical, chronic and acute, intervention and prevention, rehabilitation and palliative care (World Health Organization, 2018).

We acknowledge, however, that there is no one-size-fits-all approach as to the occupations of health practitioners that form the multidisciplinary team. The makeup of the multidisciplinary team is determined by workforce planning, retention, recruitment and availability of health practitioners, patient complexity and needs, funding models and the geographic location of the primary health care facility. Some of these issues we will address later in our submission.

To support multidisciplinary teams in becoming highly functioning and effective, there are internal and external mechanisms that can shape the practice of these primary health care teams. Internal factors such as a culture of support, a shared purpose and recognition of the important role each health practitioner plays, support for power sharing, joint problem-solving and building mutual respect are integral to multidisciplinary teams working effectively and providing safe and quality care.

Funding reform

Another impact that effects the availability and accessibility to primary health care is how it is funded. The QNMU believes there is an urgent need to reframe funding by focusing on the value of the provision of health care rather than on activity undertaken. The QNMU strongly believes that if primary health care is provided by nurses and midwives and allied health practitioners within their scope of practice, then this must be reflected in funding. That the Medicare Benefits Schedule (MBS) funding model continues to prescribe that health practitioners within the multidisciplinary team are deemed to have provided care 'for and on behalf' of a medical practitioner, diminishes and limits the important role they play in delivering primary health care.

Nurse-led models of care

Research shows that nurse-led and midwife-led models of care do not dilute access to or quality of primary health care services but strengthens the provision and access to primary health care and have:

- improved access to healthcare services, particularly in rural and remote areas;
- provided co-ordinated care across acute and community boundaries;
- improved continuity of care by acting as a link between primary health care services and other health service providers;
- increased early intervention of health issues through building a rapport with the patient and community;
- reduced avoidable emergency department/hospital admissions and ambulance trips, (Douglas, Schmalkuche, Nizette, Yates & Bonner, 2018 & KPMG, 2018).

There are many roles and models of care occupied by ENs, RNs and nurse practitioners (NPs) working in primary health care. They include:

- immunisation services where RNs administer vaccines with a medical practitioner's written or oral order;
- providing mental health care for people experiencing mental health issues;
- diabetes nurse educators who support patients in the management of their diabetes;
- sexual and reproductive health care that includes taking sexual and reproductive histories, screening for sexually transmitted infections, contact tracing, and providing information and education to patients;
- nurse clinics where nurses within their scope of practice are the primary provider of care and examples of these clinics include:
    - women's health;
    - lifestyle medication (e.g., weight loss, smoking cessation); and
    - wound management (Australian College of Nursing, 2015).

And yet, some nurse-led and midwife-led services continue to be contested in a medically dominated healthcare system. These models of care are often only supported when under the direction and supervision of medical practitioners with the level of autonomy in clinical practice often controlled by medical colleagues, thereby diminishing the critical role nurses and midwives play (Douglas, Schmalkuche, Nizette, Yates & Bonner, 2018).

However, there are also many success stories where nurses and midwives have been supported in developing and implementing innovative models of care in particular nurse navigators and nurse practitioners.

Nurse navigators

Nurse navigators are advanced practice RNs who deliver nurse-led models of care. Nurse navigation models deliver person-centred care co-ordination, create partnerships with patients and with and between stakeholders in patient care, improve patient outcomes and facilitate system improvements. (Hannan-Jones, Mitchell & Mutch, 2021). Queensland Health introduced nurse navigation in 2016 as part of a wider health care reform agenda to address the fragmentation of the health care being delivered, to assist patients with co-ordinating their care and to keep them well and out of hospital. Their boundary-spanning role enables them to engage across and beyond primary and secondary health care settings (Hannan-Jones, Young, Mitchell & Mutch, 2019).

Preliminary reports of the benefits of the nurse navigator in Queensland are extremely encouraging with the Torres and Cape Hospital and Health Service (TCHHS) showing a 61% decrease in visits to emergency departments (ED), a 77% decrease in unplanned re-admissions to ED, a 58% decrease in hospital bed days per month and a 61% decrease in total

hospital bed days. In two months alone in 2018, $86,000 was saved in patients' travel costs. (Queensland Government, 2019b).

The disability nurse navigator was also rolled out at this time and provides a person-centred approach for those living with a disability and frequently intersects with the National Disability Insurance Scheme (NDIA) in an advocacy capacity. These nurses were particularly important when there was rapid service change due to COVID-19 which saw those with disability having to use telehealth. The disability nurse navigator was able to stabilise the relationships between changed service provision and the capacity of people with disability to use this technology (Brunelli, Beggs & Ehrlich, 2021).

Nurse practitioners

NPs are experienced RNs educated to Masters level and competent to function autonomously and collaboratively in an expanded clinical position. NPs have access to the MBS and Pharmaceutical Benefits Scheme (PBS) and provide high levels of clinically focused autonomous nursing care. KPMG (2018) for the Department of Health, conducted a cost benefit analysis of NP models of care in aged care and primary health care in Australia. They identified that for NPs to be effective they should not be regarded as a substitute for general practitioners (GPs) but rather as an opportunity for meeting unmet needs and were seen as valuable particularly in rural and remote areas and residential aged care facilities.

One example of a nurse-led model of care that gained the support from hospital executive and other health practitioners is the *Nurse Practitioner (NP) in Breast Oncology* (2021b). The NP helped establish this service that provides breast care services as part of a multi-disciplinary team for those patients being treated for breast cancer. Anecdotal evidence is already showing the service is receiving positive feedback and patient numbers increasing.

In a recent Australian study (Wilson, Hanson, Tori & Perrin, 2021) one successful NP-led model of care saw NPs provide after-hours urgent care for rural communities. The after-hours NP roles emerged as multi-faceted, able to use their advanced clinical skills and provide holistic care in rural communities. Utilising NPs in primary health care in rural communities will alleviate the burden on GPs and hospital services and contribute to primary health care access for all.

Furthermore, is the successful and cost-effective NP/advanced practice nurses' model in the Australian Capital Territory (ACT) called *Walk-in Centres* which is a network of nurse-led clinics. Nurses provide free health care advice and treatment for non-life threatening injuries or illnesses thereby taking the pressure off emergency departments. These nurse-led models of care undertake comprehensive assessment, provide timely person-centred care, opportunistic education and support, continuity of care and link patients to other health professionals and services.

Midwife-led models of care

The QNMU believes women should have access to professional midwifery care, regardless of where they live in Queensland. Midwife-led models of care are an important part of primary health care. The World Health Organization (2013) has strongly supported midwife-led continuity of care models for pregnant women and view these models as being beneficial for the woman and her family. These midwifery services need to be adequately funded, staffed and supported. We encourage the government to incentivise maternity service models in which women receive continuity of care from a known midwife throughout their pregnancy, during birth and after the birth. These models have been shown to produce physical benefits for mothers and babies and are cost effective (Callander, Slavin, Gamble, Creedy & Brittain, 2021).

The QNMU's *Count the Babies* campaign continues to highlight the very real concerns that under commonwealth legislation (the *National Health Act 1953* and the *Health Insurance Act 1973*) mothers, and babies under 9 days, are considered one person despite the level of care and documentation specific to the newborn. (Babies younger than 9 days of age are considered "unqualified neonates" for Commonwealth funding, including not be recognised under the activity based funding (ABF) regime.) This impacts a midwife's workload dramatically and their ability to provide safe, quality care.

We also strongly assert that birth on country models are examples of best practice. An example is the *Waijungbah – Innovation: Integration of birthing on country and first 1000 days Australia models of care*. The Gold Coast HHS in collaboration with the Gold Coast Aboriginal and Torres Strait Islander community, provide continuity of care by a First Nations midwife and child health nurse from conception to the first 1000 days. Birthing on Country and the First 1000 Days Australia principles are both aimed at providing Aboriginal and Torres Strait Islander babies with the best possible start in life. An evaluation of the outcomes of the model of care has shown that most mothers have had a culturally safe experience and had better clinical outcomes than women in standard care. Further, mothers were reporting the interaction, engagement and relationship between them and the midwife was a valuable and important aspect of the model (Queensland Health, 2020).

Another example of a midwifery-led model of care is the *Midwifery Community Access Program* at the Townsville HHS. This program is about ensuring pregnant women in the community can access antenatal care early and regularly, rather than just when they give birth. It provides culturally safe care and increases access for First Nations women to a Clinical Midwife Consultant It aims to reduce discharge against medical advice, failure to attend antenatal appointments and reduce high levels of smoking during pregnancy. This improves health outcomes for First Nations women and their families. (Queensland Nurses and Midwives' Union, 2020).

The QNMU also supports the permanent amendment of Section 19(2) of the *Health Insurance Act 1973.* (This section prohibits the payment of Medicare benefits where other government funding is provided to that service. In the past, the Council of Australian Governments (COAG) has approved the introduction of a Section 19(2) exemption initiative that has been extended over time to enable exempted eligible sites (most in Queensland being in regional or remote areas) to claim against the MBS for non-admitted, non-referred professional services (including nursing, midwifery, allied health and dental services). We believe this exemption should be extended to include other regional and metropolitan sites to support the delivery of innovative models of care. We see this as critical in increasing access to primary health care for all small rural and remote communities' and enhancing service delivery to these areas. We would also like to see any extension of the 19(2) exemptions for primary health services, includes midwives which would enable midwives with an endorsement to work in primary health centres to provide community-based midwifery care.

Examples of initiatives supported by the QNMU

When discussing nurse-led and midwife-led models of care, it is with pride that the QNMU promotes the often-unnoticed work that nurses and midwives are undertaking in reshaping health care services to improve patient experience and address gaps in health services. We strongly assert that expanding nurse and midwife-led services has the potential to create a more accessible, productive, and safe healthcare system in Queensland.

The QNMU takes the opportunity to acknowledge the benefits of the establishment of the $10 million Innovation Fund under the *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10)*. This has meant that Queensland Health has made this money available through EB10 with the support of the QNMU. In September 2019, 19 projects were funded. They are:

- *Waijungbah - Innovation: Integration of birthing on Country and first 1000 days Australia models of care*;
    - discussed previously in our submission.
- *Gold Coast Mental Health and Specialist Service (GCMHSS) and Gold Coast Local Ambulance Service Network (GCLASN) Co Responder Model of Service*
    - the project has enhanced two existing models in the GCHHS, the *Coordination Hub Initiative* and the *Gold Coast Mental Health and Specialist Service/QPS Co Responder*. Early findings show hospital avoidance between 45-58%, reduced length of stay for those that required hospital intervention via the emergency department and less use of restrictive practices e.g., use of *Public Health Act (2005)* and *Mental Health Act (2016).*
- *Maximising scope of practice: Mental Health Nurse Practitioners addressing community clinical complexity and unmet customer need*
    - the project expanded the Sunshine Coast University Hospital Mental Health Nurse Practitioner (MHNP) Emergency Department model of care into MHNP

community roles. Early findings show 41% of hospital avoidance interventions occurred after-hours and 460 interventions specifically for clinical deterioration, secondary consultation and medication intervention for mental health patients.

- *Nurse Practitioner Innovation Project*
    - the project created two NP positions within the Outer Islands of the Torres and Cape Hospital and Health Service. The NPs are responsible for providing support, leadership and clinical expertise in remote area nursing practices complementing existing services. Early findings show remote area nurses are feeling valued and supported.
- *Community Maternity Hubs Model*
    - targets the social determinants of health in the Logan community and addresses the needs of mothers, babies and children. Early findings show an increase in antenatal attendance and higher breast feeding rates.
- *Shared Care for Opioid Treatment (SCOT) Project*
    - the project increases access to opioid treatment programs for the vulnerable and complex population moving in and out of correctional facilities and other people experiencing opioid dependence in the community. Early findings show engaging nurses in developing the shared care model has increased the focus on client recovery.
- *Child Development Clinical Nurse Consultant (CNC)*
    - introduced in the Darling Downs district to address the large cohort of triage category three patients on the paediatric or child development service waiting list with behavioural concerns. Early findings from the trial saw more timely care (including early access to specialised services for rural clients and improved access for vulnerable patients on a medical waitlist) and high engagement from many eligible patients across the four centres.
- *Trauma Informed Care*
    - aims to provide the mental health nursing profession with a model of care to complement current practice and reinforce a person-centred approach and acknowledging the prevalence of trauma. Early findings show that a 4 hour education package was delivered to 416 health practitioners across Metro North mental health with feedback indicating it was informative and relevant.
- *Enhanced General Practice STI Testing Initiative*;
    - the project was a collaboration with multiple high Aboriginal and Torres Strait Islander caseload General Practitioner (GP) services in Townsville HHS to build capacity to increase opportunistic Sexually Transmitted Infections (STI) testing rates in response to the current syphilis outbreak amongst the population. Early findings show one GP service has shown sustained, above average syphilis testing.
- *Pregnancy on Palm* (PoP)

  - this project implemented and evaluated a phone application (app) to provide information to women and increase communication between maternity service staff and pregnant and post-natal women within the Palm Island community. Early findings show strong community engagement with the app.
- *Transition framework from paediatric to adult health care*
  - the aim of this project is to develop a framework that is transferable across Queensland to guide the timely, planned process of transition for adolescents and young adults with chronic conditions from the paediatric to adult healthcare setting. Early findings show improved patient experience and greater continuity of care.
- *Healing Wounds - Building Lives - a collaborative wound care capacity building project*
  - the project has developed and implemented a nurse-led model of wound care that can be applied across all health settings. Early findings show that staff have reported an increase in their wound care knowledge.
- *Routine Preventative Cancer Screening – Prison Health Services*
  - the program was about ensuring incarcerated men and women received access to preventative screenings for bowel and breast cancer. Early findings show an increase in bowel cancer screening participation.
- *Enhanced Aboriginal and Torres Strait Islander Infant and Maternal Care*
  - the vision for the project was to prevent adverse outcomes for mothers and babies that were disengaging from obstetric clinics and clinically at higher risk of morbidity and mortality. Early results from the project saw mothers consistently attending antenatal visits.
- *ReViving Rural Dementia Care*
  - the project aimed to empower the Cairns and Hinterland HHS rural facilities with knowledge, improved environments and additional resources to provide best practice care to dementia in the local community. Early findings show that the development of dementia resources has increased understanding of dementia.
- *Improving Access for Displaced Patients*
  - the aim of this project is for NPs to improve service access and efficiency for acute care patients with a prolonged time to be seen by a treating clinician in the emergency department. Early findings show that median wait time was reduced, and increased discharge rates.
- *Digital Back to Country*
  - this project saw health practitioners and patients connected by means of a wearable device to wear at home. Early findings show that this model of care has enabled patients to receive care in the home which reduces costs and frees up hospital beds.
- *Midwifery Community Access Program*
  - discussed previously in our submission.

- *Nurse Navigator Refugee Health*
    - the Nurse Navigator role acts as a central contact for hospital staff and general practices to coordinate care, liaise and assist with language and cultural barriers when refugees access Toowoomba Hospital services and provide education on refugee health. From October 2019 - August 2020, the Nurse Navigator was contacted 1110 times for both patient related assistance and for general enquiries regarding refugee health.

These projects were funded for one year and have produced tangible results that not only improved clinical outcomes and patient experiences but positively addressed the social determinants of health. These projects also highlight the significant gaps that currently exist between acute care services and community based non-acute care services and the role that nurses' and midwives are so well positioned to play in bridging these gap. These gaps exist in large part because of the fragmented funding and policy frameworks that exist at the federal and state levels of government.

1.b. The provision of aged and NDIS care and any impacts the availability and accessibility of these services have on the Queensland public health system

It should go without saying that any person with a disability and those who require aged care, must have comparable access to health care as in the acute health care sector. This would ensure residents and/or patients can receive care that is convenient for them and would greatly reduce the impact on Queensland's public health system as those receiving disability and aged care, would do so in the place of their care rather than in acute care settings. And yet, sadly, this has not always been the case. The stark findings from the recent *Royal Commission into Aged Care Quality and Safety* (Aged Care Royal Commission) and the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Disability Royal Commission) have shown that for many who are seeking support from the disability and aged care sectors, they have received poor, substandard health care and experienced neglect. We believe the opportunity is overdue in providing the care that is needed in the disability and aged care sectors.

In supporting the ongoing provision and sustainability of aged care and NDIS care in Queensland, it is particularly important to address the key issues and drivers of the current systems. We acknowledge there are strong parallels between the disability sector and the aged care sector, in terms of service quality and delivery, workforce and market forces and funding. We will now address aspects of aged care and the NDIS and the role they play in Queensland's health care system.

Aged care

We applaud the state governments' commitment to minimum nurse to patient/resident staffing ratios which has seen legislation passed making nurse-to-resident ratios law in

Queensland's government-run aged care facilities. This maintains minimum aged care staffing and skill mix and reduces unwarranted variation in service safety and quality in aged care. The benefits of ratios are many with research within the aged sector and beyond the sector showing minimum staffing levels and skill mix are critical in delivering safe, quality care (Peters, Marnie & Butler, 2021 & McHugh, Aitken, Windsor, Douglas & Yates, 2020). The QNMU has been working with the Office of the Chief Nursing and Midwifery Officer (OCNMO) in undertaking the evaluation of Queensland's public aged care sector with the outcomes of this work yet to be completed.

Whilst ratios are a great achievement for Queensland's public aged care sector and recipients of that care, the QNMU continues to advocate for nurse-to-resident ratios in private aged care facilities. That privately owned aged care facilities do not have mandated minimum ratios in place, continues to diminish and deny the health care needs of those who live in these facilities.

The QNMU believes the current residential aged care workforce, comprised primarily of unregulated care workers, lacks the training and skills needed to adequately meet the care needs of this special needs group. The situation is compounded by the overall decreasing number of RNs and ENs employed in aged care which is resulting in the de-skilling of the workforce. Missed care due to inadequate staffing and skill mix means that residents are not receiving basic care needs in a timely manner putting them at greater risk of falls, pressure injuries and nutrition deficits. A distressing example is the coronial inquest into the deaths of 50 residents at St Basil's aged are facility in Melbourne where 45 residents died from COVID-19 while a further 5 dying from neglect. Gaps in infection control were revealed when the entire St Basil's staff were classified as close contacts and told to quarantine and an agency relief workforce brought in. The inquest has heard that the federal government struggled to find replacement workers due to other COVID-19 outbreaks with residents reportedly missing meals, medications and activities of daily living care, leading to neglect and deaths. This highlights not only the workforce shortage issues in health and aged care but the importance of the right skill mix of the staff who work in residential aged care facilities.

The QNMU also has significant concern with the new Queensland regulatory framework for medicines and poisons that came into effect at the end of September 2021. This new framework, *Medicines and Poisons (Medicines) Regulation 2021,* replaces the *Health (Drugs and Poisons) Regulation 1996 (Qld*). It is extremely disappointing that the new framework does not address the ambiguity around what constitutes medication assistance and how unregulated care workers are regulated under this framework. For the safety of those receiving medications we believe medication management and medication administration is a role for nurses and midwives, with unregulated care workers restricted to medication assistance.

The recent federal government announcement of the membership of the new *National Aged Care Advisory Council*, tasked with providing expert advice and guidance on aged care, has been formed without any nursing groups represented. This blatant oversight is mystifying and goes against the findings and recommendations of the Aged Care Royal Commission and the need for high quality aged care. It begs the question, how can high quality aged care be developed and planned if nurses aren't represented? This short-sightedness impacts not only the type of care delivered to those who live in aged care facilities, it places a strain on an already crowded health care system. While this is a federal government decision, it highlights how the federal and states systems are intertwined with decisions made at one level of government, having significant impacts at local levels.

There appears to be a widespread view that aged care, particularly residential care, is not health care despite the significant, and increasing, health care needs of residents. The QNMU believes all residential aged care services should be classified as health services, irrespective of how else they are categorised. Residential aged care facilities must be able to provide acute care to those residents who need it and be able to access services such as telehealth and virtual care to avoid unnecessary transfers of residents to hospitals. This lack of acknowledgement of aged care as a health service means aged care providers have little incentive to invest in hospital avoidance processes such as primary care and on-site clinical (nursing, medical and allied health) interventions. We believe hospital avoidance is best achieved by having the right staff with the right skills and the right support to ensure timely treatment can be provided in the residential aged care facility. This will then have the potential to reduce unnecessary harm and distress caused to residents by avoidable hospitalisation.

The QNMU believes the state government has a critical role to play in holding the federal government to account for the timely implementation of all recommendations from the Aged Care Royal Commission. If the federal government does not accept this responsibility, then it will fall to state and territory governments to "fill the gap". We need look no further than the experience a few years ago with the Queensland government being forced to take over the running of the Earle Haven aged care facility on the Gold Coast. It is our belief that other residential aged care facilities are experiencing financial and or staffing shortages and as a result the Queensland government will be called upon to act to provide these services in the local affected communities. It is not technically their responsibility to do so, but such systems failures demand urgent action and unfortunately given Queensland Health is all too often the major health service provided in many communities in Queensland, it will fall to Queensland Health to fill the void.

If the federal government, as funder and regulator, continues to fail to take responsibility, the impact on Queensland's public health system will be immense as it tries to deal with an increasing and ageing population, coupled with growing health care needs. Therefore, states

and territories must support the federal government to achieve the recommendations proposed by the Aged Care Royal Commission to:

- look beyond individual programs and arrangements of integrated long-term support to focus on what older people want and need;
- integrate health and aged care systems, thereby delivering the best outcomes for older people;
- ensure the care finders employed to support the navigation of aged care are suitability trained and qualified;
- ensure aids and equipment programs are adequate and accessible for all who need it;
- publicly report, each quarter, the status of the waiting list to receive the Home Care Package;
- share data about the different types of services across Australia, potentially establishing benchmarks or standards for particular areas across both public and private aged care providers;
- establish culturally appropriate documents such as advance care directive processes;
- make available vocational educational training facilities, teachers and courses in urban, rural, regional and remote Australia to assist in the employment and training for First Nations people in aged care (Royal Commission into Aged Care Quality and Safety, 2021a);
- mandate that a RN must be available 24/7 in nursing homes to prevent adverse outcomes and costly hospital interventions;
- grow the skilled workforce required in aged care through the vocational education and training sector.

This is by no means an exhaustive list, but it illustrates the work states and territories need to undertake in the aged care sector as identified by the Aged Care Royal Commission.

It is our view, providers of aged care must not only be held accountable for the health, wellbeing, and safety of those in their care but how they spend government funding. Currently, the federal government does not require aged care providers to report on care needs and the care expenditure. There is no obligation or regulation that requires them to do so. The QNMU believes this must change to provide an oversight of how the financial arrangements of aged care providers and home care providers are structured and how the bulk of their funding, which comes from the public purse, is spent.

We provide two examples to illustrate how poor regulation of financial arrangements leads to unaccounted funds and unaccounted care. One is related to residential aged care providers and another concerns home care providers:

- In the financial year (2016-2017) six for-profit aged care companies combined received over $2.17 billion in government subsidies. This made up 72% of their combined total revenue of over $3 billion (Tax Justice Network, 2018).

- Home care providers can charge high management and administration fees thereby reducing what participants can spend on actual care. These providers can set their own prices, service levels and schedules with recent analysis showing that providers spend about $1 billion a year on administration costs. This is about a quarter of the total allocated for a home care package, regardless of the level of service delivered. This is due to Australia's home care system being poorly regulated with no stewardship to develop, monitor, and manage home care providers on behalf of older people. (Daniel, 2021).

These examples highlight the need for more comprehensive financial standards and greater regular and timely reporting and transparency that holds private aged care providers publicly accountable to protect this vulnerable cohort. The same standards of care and reporting mechanisms operating in the acute sector must also apply in aged care. That profit-making is a driving factor in the aged care sector with no link to the quality of care, is unacceptable and fundamentally flawed.

The QNMU contends that the current dire situation in the provision of aged care, which has been clearly identified over several years, and most comprehensively in the final report of the Aged Care Royal Commission, has resulted in large part because of a market-based approach to an area of essential health service provision. It is the experience of the QNMU that the predominately privatised and marketised aged care sector has largely put funding and cost foremost at the expense of care, safety and quality. We believe the current arrangements have led to the many structural issues apparent in the private aged care sector including:

- almost universally inadequate staffing and skill mix to meet the care and safety needs of those accessing aged care services both community-based and in residential aged care facilities;
- providers operating without guidance and in some instances, the clinical knowledge, to match staffing levels to care needs;
- providers making staffing decisions driven by budgetary considerations, rather than ensuring delivery of safe, quality care;
- inadequate accountability or transparency of how government subsidies are spent;
- lack of primary care and clinical capacity to meet the often complex care needs of older Australians, where the numbers of RNs and ENs have significantly declined and have been replaced by a far less capable, though cheaper, unregulated care worker labour force;
- development of a compliant, low cost, tenuously employed workforce, often on minimum hours contracts that could well be described as the "working poor" of aged care.

The QNMU agrees that the public hospital system should be equipped to handle any increase in hospitalisations, and this includes presentations of patients from aged care facilities. However, it is apparent that many residential aged care providers default to sending their

residents to hospital when the care they need is something you would expect to receive from an RN or GP in an aged care facility. Research shows nearly 37% of Australian aged care residents over 65 were taken to an emergency department for treatment at least once during 2018–19 (Royal Commission into Aged Care Quality and Safety, 2021b). We know from our members that aged care residents are being sent to emergency departments for procedures such as a catheter change, intravenous fluids (IV), basic wound reviews and urinary tract infections which if there was the right skill mix and number of RNs employed at residential aged care facilities these could be addressed within the facility. With a mandated number of nurses on shift in all residential aged care facilities, we believe this could be prevented, therefore decreasing the impact on the health care system.

NDIS

Access to safe, effective and high-quality healthcare is a basic human right. This right recognises that every person has the right to the highest attainable standard of health without discrimination on the basis of disability (Convention on the Rights of Persons with Disabilities, 2008). Unfortunately, the recent Disability Royal Commission has heard from those with a disability and their advocates, with many reporting insufficient care and access to health care and services. That both the Aged Care and Disability Royal Commissions have had similar issues presented is profoundly distressing with reform in these health care sectors glaringly overdue.

Much like the aged care sector, we believe there is potential for increased collaboration and integration between disability and health care, such as community health services and Primary Health Networks (PHNs). In our view this will lower the impact on Queensland's public health system as the right care at the right time will be delivered and not be transferred to the hospital system. Nurses are critical to this work. Nurses have the skills, expertise, and qualifications to perform roles that support NDIS participant empowerment and self-sufficiency. The NDIS must enable nurses to work to their full scope of practice and recognise the specialised and vital role of nurses in the assessment, education, and capacity building of participants with complex disability needs.

The QNMU also asks the Committee to consider the prevalence of clients with intellectual disability being detained in mental health units because of challenging behaviours. This situation is offensive to those suffering a disability without any comorbid mental illness and serves to perpetuate the community stigma associated with both mental illness and intellectual disability. It also occupies valuable mental health clinical and administrative services, as well as occupying beds and thereby reducing the availability of acute mental health beds for those that really need them. As an example, the QNMU presents the following case study:

Case study 1 – Mental health unit

A young man with a severe disability was admitted to a mental health unit for over 12 months despite no mental health diagnosis or history, due to his complex challenging behaviours related to his disability. The treating team concluded that he required 24/7 care from experienced clinicians with a specialist qualification in his area of disability. While he has an NDIS package, it was insufficient to cover the cost of providing specialist home support services for the management of his behaviours.

QNMU members have also raised concerns regarding delays in discharging patients to NDIS-funded accommodation, citing the scarcity of facilities who employ a specialised clinical workforce capable of meeting the complex support needs of patients with specific disabilities. As an example, the QNMU presents the following case study:

Case study 2 – Medical unit

A young woman receiving NDIS support was admitted to an acute care medical ward, where she was successfully treated for a medical issue. However, the lack of appropriate post-discharge accommodation options suitable for her disability needs resulted in an inappropriately long length of stay on the ward, effectively "trapping" her in the acute care sector. The experience on an acute ward led to significant distress and agitation for the patient. Additional nursing staff were required to be rostered on to manage the increased acuity of the patient and disruption to the ward as a result.

The QNMU believes there is an urgent need for a specialist clinical workforce with the skills, training, and education to manage specific types of disability. The absence of such a workforce may be a contributing factor to the supply gaps for supports and services for NDIS participants particularly those with complex needs which may be contributing to people with disability remaining in hospital for longer than is medically necessary. The Queensland Government (2020a), in their submission to the *Inquiry into the NDIS Market in Queensland*, stated that (**bold** emphasis added): "The quality of providers in the market is not able to meet the complex needs of many patients being discharged from hospital. They **often do not have a sufficiently skilled workforce** to accept referrals immediately or to sustain the levels of care that are required within the community." This is extremely problematic as NDIS participants may become inappropriately held in the acute hospital sector due to a lack of disability support options post-discharge, placing a strain on the patient and the health care system. As an example, the QNMU presents the following case study:

Case study 3 – Rehabilitation unit

A random workload monitoring audit by the QNMU of a single day in a specialised rehabilitation unit in a tertiary hospital revealed that on that day, there were at least 15 patients who were experiencing delayed discharges from hospital due to the lack of appropriate NDIS community-based services. Sourcing adequate in-house clinical care was challenging for the level of disability support and assistance required.

In our view, the Queensland government has a role to play in ensuring the NDIS is working to the benefit of its recipients by:

- taking a proactive and central role in workforce planning, specifically in facilitating and driving the training and development of a qualified and work-ready workforce;
- planning of this workforce should be at both the commonwealth and state and territory level to account for localised issues in Queensland such as the large disparity of service access across regionality (Joint Standing Committee on the National Disability Insurance Scheme, 2020);
- ensuring NDIS funding is inclusive of RNs as they are an important part of the NDIS workforce where they can provide supervision to unregulated carers where nursing tasks are being performed with NDIS participants to minimise risk and improve outcomes;
- investing in robust research into the impact of job quality on service quality in the NDIS. The QNMU welcomes the establishment of the National Disability Research Partnership (NDIS, 2020a) and anticipates further insight into the impact of job quality of disability workers on the quality of service provided;
- funding and financial incentives that take a targeted approach to the provision of disability care to accurately reflect the regionality-based needs of the state;
- working with the *National Disability Strategy 2021-2031* (Commonwealth of Australia, 2021) in ensuring the rollout of the strategy delivers the outcome areas for those with disability and those seeking supports and services like the NDIS.

Rapid growth in technology is changing traditional models of healthcare with digital platforms shifting how healthcare is delivered. Technology has evolved to enable the 'uberisation' of work in disability and aged care. The development of digital platforms has coincided with the change and growth in the disability sector where once consumers received support from generally one organization to a now more fragmented approach to support programs. Data shows that since the introduction of the NDIS in March 2013, there has been continual growth in participant numbers with almost 400,000 people with disability being supported by the NDIS. The active providers have also grown by almost four times since 2017 from 4,005 to 14,882 in June 2020 (NDIS, 2020b). This NDIS delivery model has propelled the rapid emergence of gig-type arrangements. These digital platform brokers operate under a

business model. They are not service providers, they are not covered by labour hire licensing regulation, they do not provide oversight or supervision of care workers and they have no responsibilities for employment or care (Baines, MacDonald, Standford and Moore, 2019).

To that end, the QNMU unequivocally supports a safe and competent NDIS workforce through the registration of NDIS providers. The regulatory requirements for these providers will ensure a skilled and safe workforce of AINs, ENs and RNs who have relevant qualifications and/or licenses.

As a publicly funded institution that supports some of the most vulnerable people within our community, the NDIS must be open to public scrutiny and regulatory oversight and administration. The QNMU is concerned that self-regulation of the market has clearly failed in the case of the aged care sector; it appears that the disability sector may be falling prey to some of the same predatory business models and practices that take advantage of a complex, confusing NDIS system to financially exploit participants. As it currently stands, the NDIS is provider-driven and not participant-driven. This approach must change. Support provision must be responsive to the needs of the person accessing it and acknowledge that the participant is the expert on their needs. This value-based approach aligns disability health care service delivery with patient-centred care.

1.c. The provision of the private health care system and any impacts the availability and accessibility of these services have on the Queensland public health system

Queensland's health care system is a blend of private and public services which are delivered by a range of health practitioners in a variety of settings. The COVID-19 pandemic has seen the public and private health care sectors in Queensland working together to meet the health care needs of the state and respond to COVID-19. This was evident in the early stages of the pandemic where the National Cabinet temporarily suspended all non-urgent elective surgery in both the public and private hospital systems to ensure the healthcare system could cope with an influx of potential patients and to preserve stocks of personal protective equipment (PPE). It was during this time the Queensland Government signed a *National Partnership Agreement* with the federal government ensuring private hospitals remain financially viable over the COVID-19 pandemic, in return for agreeing to provide their facilities, staff and supplies to support the COVID-19 response. Twenty-eight private hospital operators signed the agreement with the Queensland Department of Health, illustrating how the public and private sectors can work together for the health of the state (Queensland Audit Office, 2021a).

The private health care system plays a significant complementary role in Australia's provision of health care. Over 40% of Australians have private health insurance, encouraging patients to access the private health sector (Duckett & Moran, 2021). This is reasonable given private patients generally have shorter waiting time for treatments, the ability to choose their health

practitioners and enjoy better amenities such as a private hospital room (Rana, Alam & Gow, 2020). The belief that there are longer waiting times in the public health system is a determinant of a patient taking out private health insurance and using the private health care system. So too are the tax incentives provided to individuals who hold appropriate levels of private hospital health insurance coverage. And yet, some patients continue to use the public health care system regardless of having private health insurance. This may indicate a lack of coherence in the insurance policy, excessive medical fees not covered by insurance arrangements, or a perceived higher quality and specialisation of public hospitals compared to private hospitals. Proximity may be another reason for choosing public health services (Rana, Alam & Gow, 2020).

With private health insurance premiums continuing to rise, out-of-pocket costs increasing and dissatisfied consumers dropping their private health insurance cover, this raises many questions as to the sustainability of the private health care sector and private health insurance, with calls for the federal government to clarify the purposes of private health insurance (Duckett & Nemet, 2019). Questions such as does private health care save costs overall? Is it to reduce the total spending on health even if government spending were higher because there were more public and fewer private health care services? If private hospitals are more efficient overall than public hospitals, then encouraging people to use private hospitals would contribute to the overall efficiency of the health system?

We recognize there are differences between public and private health services which can make it difficult to compare the efficiency of these health systems, such as:

- case-mix and treatment complexity;
- workforce;
- differing standards and regulations;
- reporting and accountability.

A joint interest in the sustainability of the private and public health care systems is imperative for both systems to continue. Ensuring the provision of health care is available and accessible is dependent on both the private health care sector and the public health care sector. Key stakeholders of both industries must be engaged with the goal of creating sustainability of these health care sectors.

To that end, the QNMU seeks the state and federal governments to commit to keeping our health system in public hands, not privatising services or beds. We submit that the level of care and service provision and access is at risk when profit is a central driver.

2.a. In conducting this inquiry, the Committee should consider the current state of those services (outlined in 1) in Queensland

The COVID-19 pandemic has exposed issues in public health systems world-wide, and Queensland is no different. In our view, it is time for the swift and serious re-evaluation of how Queensland's public hospitals and health services are funded, designed, staffed and operated. This must occur now to ensure demand surges are met safely and government funding is best spent. The lack of proper public health service planning has created short-term crisis management that adversely impacts the public system and puts patients at risk and causes invaluable frontline health workers to experience extreme stress and burn out. This situation is now untenable and unsustainable for both patients and health workers. Identified solutions include better health system design, enhanced connection between services, the improved management and prioritisation of health services and new fit for purpose federal and state government health care funding frameworks. We believe the planning and management of the surge in COVID-19 patients needs a co-ordinated response to deal with this crisis and the subsequent pressure on the Queensland public health system.

As part of this inquiry, the QNMU believes the Committee must consider the variability that exists across Queensland Health due to the devolved governance arrangements that currently exist. Although we support the ability of HHSs to be responsive to the needs of their particular communities, this should be done in the context of ensuring transparency and consistency of approach with respect to the implementation of government policy priorities and ensuring compliance with legislative and industrial requirements.

We respectfully acknowledge the work being undertaken by the Queensland government in the implementation of the recommendations from the 2019 review into Queensland Health's governance framework (McGowan, Philip & Tiernan, 2019). We are hopeful this work will see a decrease in variability across the HHSs and eagerly await to see the outcomes.

2.b. In conducting this inquiry, the Committee should consider bulk billing policies, including the Commonwealth Government's Medicare rebate freeze

The QNMU believes the current health funding model is fragmented and needs an urgent review as it does little to support integrated care and focuses funding predominately on activity and not outcomes. In addressing this term of reference, we will briefly look at the Medicare rebate freeze, bulk billing, funding restraints and how to achieve a financially sustainable health care system. We again reiterate our *Health Needs Urgent Care* (2021a) campaign where we are urging federal and state governments to:

- invest in the health system by committing to working with health workers on a joint, immediate solution;
- work with health workers to identify long term solutions for a sustainable health system and economy;
- commit to smarter funding that is in the best interests of patient care and staff safety;

- commit to keeping our health system in public hands, not privatising services or beds.

As part of the campaign, we have outlined that in order to achieve a financially sustainable health care system, the QNMU supports:

- the introduction of a permanent shared 50-50 commonwealth-state funding model for public hospitals and remove the 6.5% per annum cap on the efficient growth of activity based services for 2022-2023 to 2024-2025 financial years;
- the establishment of an innovation fund to trial and evaluate new models of funding which would complement the current ABF model in order to:
    - address demand;
    - improve performance, capacity and innovation;
    - support integrated care; and
    - provide greater access to health resources and better weighted funding models to First Nations people and other disadvantaged groups to improve non-medical and medical conditions which influence health outcomes.
- the establishment of a transition fund to move to new funding arrangements after successful evaluation of such trials;
- evaluation being Incorporated as a standard component of all new funding arrangements in order to provide assurance of both quality health outcomes and efficiency in the health system;
- clinically integrated acute, primary, disability and aged care health systems to improve physical, mental and social health and wellbeing;
- removal of fee-for-service arrangements for GPs which drive increases in costs and move to a per capitation model which drives innovation, efficiency and better health outcomes.; and
- investment in community education to shift patients away from hospital and into care in the community.

The QNMU takes this opportunity to discuss the current funding restraints for nurses and midwives in their ability to work to their full scope of practice and their unequal access to the MBS. In many instances' nurses are limited in the MBS items they can utilise (Australian College of Nursing, 2020). To overcome these funding barriers, we suggest:

- increasing access to the MBS, recognising nurses and midwives are equal and valued members of the health care team and to cover the delivery of all nursing and midwifery services;
- implementing the recommendations made by the *Nurse Practitioner Reference Group* (NPRG) to the *MBS Taskforce* related to NP services. The NPRG was formed to provide recommendations to the *MBS Taskforce* related to NP services. The NPRG offered 14 recommendations all of which were for funding of services that NPs already provide. The MBS Taskforce did not accept any of these recommendations and offered three alternative recommendations which showed a distinct lack of understanding of the

role of NPs, were not evidence-based, and would impose additional restrictions on services provided by NPs (Chiarella & Currie, 2020);

- increasing funding to support midwifery primary health care models as most pregnant women achieve better outcomes with primary health care by a known midwife. During health crises, hospitals are known to be areas of higher clinical risk; primary health care enables safe care for a well population who have specific fears and anxieties (Bradfield, et al., 2021);
- developing funding mechanisms that support teams of nurses; and
- uncoupling Work Incentive Program (WIP) block funding of nurses in general practice from being tied to GP numbers (Australian College of Nursing, 2020).

Ensuring nurses and midwives can work to their full scope of practice improves patient outcomes, enhances productivity and is better value for money for health services (Australian College of Nursing, 2020).

The QNMU is also concerned with short funding cycles of community-based organisations and services. We have previously addressed this issue in our recent submission to the Community Support and Services Committee for the inquiry into social isolation and loneliness in Queensland. Short funding cycles, at times contracting services for only one year, results in organisations facing deep uncertainty over the sustainability of their service. This is compounded by short notice periods regarding whether funding will be renewed, at times only weeks prior to the contracted term. Insecure funding causes disruption, anxiety, and distress among participants and staff. This can further impact on the following issues:

- *Job insecurity and workforce issues*:
    - Short funding cycles result in limited ability for community organisations to offer staff anything other than temporary or casual contracts, leading to increased job insecurity in the sector. The limited prospects of permanent positions in community services may act as a deterrent for qualified staff to apply for such positions, resulting in difficulties in recruiting and retaining staff. For an industry that relies heavily on fostering and developing relationships with participants, a 'rotating roster' of staff can have a detrimental impact on the ability to support the community (Blaxland & Cortis, 2021).
- *Limitations on long-term planning:*
    - Uncertainty over funding can also impact on an organisation's ability to form or sustain long-term relationships with the community (Blaxland & Cortis, 2021). Moreover, predictability of funding is necessary for organisations to plan long-term community goals and programs and to enable ongoing change within communities.
- *Poorer outcomes for participants*:
    - Short funding cycles can impact the ability for people who access community programs and services to forge meaningful relationships with others in the

community. For some, community programs such as neighbourhood centres may be their only opportunity for social interaction with peers. With many programs focusing on independent living skills and social connection, disruption or uncertainty regarding such programs can lead to significant distress, especially among demographics that already face stigma and ostracization.

As an example, the QNMU presents the following case study:

Case study 4 – Children's Health

The right@home program (Children's Health HHS) and the Home Visiting program (Gold Coast HHS) were earlier this year informed by the Department of Children, Youth Justice and Multicultural that their funding was to be cut after the program had been successfully running for over 10 years. These programs see child health nurses deliver crucial support to hundreds of vulnerable new and expecting families and have been shown to improve parental bonding, maternal mental health and children's literacy. After lobbying from the community, nurses, other health care staff and the QNMU, funding was reinstated for one more year ensuring vulnerable families receive the support they need.

The QNMU recommends the government reviews the current funding and contracting arrangements with community organisations to promote and enable longer and secure funding cycles and flexible contracting terms.

In addition, we would support the review of the Medicare rebate freeze as it is having a flow-on effect on the rest of the healthcare system. We are seeing non-urgent patients presenting to emergency departments as they are either not wanting to pay out-of-pocket costs to see a GP who charges higher than the Medicare rebate or cannot get into a bulk-billed medical centre in a convenient timeframe.

2.c. In conducting this inquiry, the Committee should consider the Commonwealth Government's definition of the Commonwealth Distribution Priority Areas

The QNMU has no comment.

2d. In conducting this inquiry, the Committee should consider the availability of medical training places at Queensland universities, compared to other jurisdictions

The QNMU suggests the Committee not only considers the availability of medical training places at Queensland universities but also places for other health practitioners, including nurses and midwives.

As of the end of March 2021, Queensland had:

- almost 69,000 RNs and almost over 15,500 ENs;
- approximately 6,000 midwives registered (Nursing and Midwifery Board of Australia, 2021);
- just over 26,000 medical practitioners registered (Medical Board of Australia, 2021);
- almost 7,500 physiotherapists registered (Physiotherapy Board of Australia, 2021); and
- over 5,100 occupational therapists registered (Occupational Therapy Board of Australia).

Given the large number of health practitioners other than medical doctors who are registered to work in Queensland, we believe the availability of training places at Queensland universities should be extended to be inclusive of all health practitioners to assist in addressing future skills shortages in the health sector. Any increase in graduate numbers must then be supported with increased clinical educators and graduate program places to support the transition.

We also draw comparison to the differences in graduate programs between medical practitioners and nurses and midwives. The transition from student to RN or midwife involves many changes in roles and responsibilities. And yet, nurses and midwives are not required to undertake transition programs, nor are there coordinated, formalised graduate programs, unlike their medical colleagues. The QNMU believes that new graduates need support and a period of structured transition when first employed as a nurse or midwife, in order to progressively develop their clinical skills and confidence.

We also note federal Labor's recent announcement that if they win the next federal election, they will provide free TAFE places in nominated areas of skills shortage that includes aged care, disability care, nursing and community services. It is proposed that this will be a shared funding arrangement between a future Labor government with states and territories. The aim of the package is to meet current and future needs in the health and care environment. Given the National Disability Insurance Agency (NDIA) forecasts a substantial increase of employment in the disability sector and the NDIS and one of the recommendations from the Aged Care Royal Commission was the aged care workforce and their training, the QNMU is supportive of these measures (McKell Institute, 2021).

As stated in our introduction the QNMU will now address a number of key elements of Queensland's health care system: workforce planning, ambulance ramping, the demand on emergency departments, mental health and palliative care.

Workforce planning

To sustainably manage Queensland's health care system, the QNMU supports a strong preventative approach to health care, with all health disciplines using their full skill sets. As part of this approach are nurses and midwives working to their full scope of practice where they are able to improve the health of the community through preventive health and chronic and complex disease management which keep people well and out of hospital (Booth, 2019).

Nationally, policy concern about the increasing demand for health care coupled with an inadequate workforce to meet projected needs resulted in the establishment of Health Workforce Australia (HWA). The federal government established HWA to deliver a national, coordinated approach to workforce reform with an overall goal of building a sustainable health workforce for Australia (HWA 2013a cited in Buchan, Twigg et al., 2015). While HWA was able to gather national data and develop policy levers for managing the health workforce, in 2015, the federal coalition government closed it down. Thus, although its projections and responses may have been different over time, its focus on the health workforce was a welcome insight into an area of growing concern in an ageing population. The HWA predicted that population health trends, combined with an ageing nursing workforce and poor retention rates, will lead to an imminent and acute nursing shortfall of 85,000 nurses by 2025 and 123,00 nurses by 2030.

Increasing workloads, understaffed shifts, double shifts and regular overtime are becoming normalised and are leading to staff burning out. Workforce planning is desperately needed to support exhausted nurses and midwives and other health practitioners. For many, their existing workload has been on top of the COVID-19 response which has involved testing, tracing, screening, isolating, vaccinating and treating the disease. These workload problems aren't new, but they have been exposed and exacerbated by the COVID-19 pandemic.

We urge the state government to focus on five priority areas that would make a difference right now to staff and patients:

1. *Address current excessive demands on the workforce*:
    a. Prioritise the prompt resolution of workload concerns.
    b. Focus on safety first – make keeping health workers physically, psychologically and culturally safe a system priority.
    c. Place a limit on excessive overtime and implement strategies to enable staff to take leave.
    d. Promote job security through permanent employment within Queensland Health by prioritising the implementation of existing government policy.
    e. Prioritise effective, co-ordinated and responsive workforce planning at the central and local levels, including introducing strategies to maximize the existing workforce including increasing hours for any staff member seeking more hours and flexible working options.

2. *Review the demand drivers*:
    a. Urgently review and amend the drivers of current demand, including the funding model, so that innovative value-adding models of care that will better manage demand are prioritised and funded accordingly.
3. *Planning and accountability for delivery*:
    a. Establish clear system priorities through effective and inclusive planning and robust accountability mechanisms for the delivery of objectives across the health system.
4. *Devolve necessary authority*:
    a. Immediately implement strategies to ensure all health workers can work to their full scope of practice in order to support the growth of new models of care. This must also be linked to ensuring the necessary budgetary and other authority exists to drive the necessary system reform and enhance the delivery of responsive quality care.
5. *Moratorium on business cases for change*:
    a. Halt current business cases for change processes related to significant organisational change and restructuring and undertake a fundamental re-thinking of the purpose of the negative consequences of focusing on short term efficiencies rather than long term whole of health system sustainability.

In Queensland, there is a fear that the anticipated COVID-19 surge (which we are already seeing) will have enormous impacts on this already understaffed and under resourced workforce and their ability to provide quality care. Queensland Health workers are calling for a coordinated response to the planning and management of the impending surge in COVID-19 cases and associated expected increase in pressure on Queensland's public health system. While we understand the need to respond quickly to a crisis, there have been significant issues with personal protective equipment (PPE), staff vaccination rollouts and access to resources. These issues have only been resolved because of the involvement and engagement of workers via their unions. We urge the state government to meet with unions about the planning and management of the impending surge of COVID-19 cases and subsequent pressure on the health care system.

While the pandemic has brought to light the contribution and value of the nursing and midwifery workforces, it has also shown the health, wellbeing and safety of these workers must be protected. Strategies that include psychological support, investment in training and education, and recruitment and retention approaches are imperative. We must learn from the experiences of the nurses and midwives in New South Wales and Victoria as well as internationally, and the trauma they have experienced during the pandemic and the potential impact this will have on nurses burning out and potentially leaving the profession.

The International Council of Nurses (ICN) (2020) suggests one way to fill the impending nurse shortage gap is to increase the number of nursing and midwifery students. We acknowledge

this as one solution and add, however, that this does not address the problem of the three year gap before new graduate nurses are ready to enter the workforce, during which time experienced nurses may leave the profession. This shortage of experienced nurses and underemployment of graduate nurses sits alongside the ever-increasing demand for health care with shifts in the burden of disease and an ageing population.

In addressing the need for workforce planning, the QNMU sees several steps the state government can take:

- conduct research on the future health needs and patient preferences, based on current health and disease trends, demographics, population growth and ageing to determine where health care needs will be and the scope of practice of the health practitioners required to meet those needs. The Queensland government already has data showing that Queensland's population is ageing, and that it is anticipated that this will not be experienced in a uniform manner across the state, with HHS regions such as the Metro-North, Metro-South, Gold and Sunshine Coasts expecting to be greatly impacted by an ageing population while Torres and Cape and Central Queensland are less likely to see this growth (Queensland Government, 2019a);
- support growth of innovative nursing and midwifery models of care and other health practitioners that will enhance the ongoing sustainability and safety of our public health system. For example, the state government recently announced that GPs will be based at 50 schools throughout Queensland as part of a pilot program and the government's student wellbeing program. Given there are already school nurses in Queensland schools, we assert that school nurses already provide mental health services and support to school-aged children within the school environment. We would support expanding this initiative to include nurses;
- address nursing and midwifery workforce shortages through the development of a comprehensive workforce plan for Queensland, with a particular emphasis on the provision of scholarships and other support mechanisms;
- once the workforce needs are determined, assist in developing nationally consistent vocational education and training (VET) tertiary courses that will meet health care needs, in partnership with education providers, so that student intake and completion rates can be commensurate with anticipated need;
- provide incentives and supports and targeted recruitment for health workers to practice/work in regional, rural, and remote areas and continue to monitor the effectiveness of these strategies for a longer-term rural health workforce. This must include an emphasis on growing local health workforces in community, including a particular focus on increasing the growth of local First Nations nurses and midwives[2]. The QNMU asks that in the planning for health care in rural and remote areas,

[2] We note and welcome the federal government's recent announcement of a new incentive scheme that will remove the university debts for doctors and nurse practitioners who work in rural, regional, and remote areas. This incentive is aimed at attracting more health practitioners to these areas.

adequate, safe and timely accommodation for those who work in health care services be included. We recognise the wider economic and social impact that accommodation has in rural and remote areas as accommodation plays a major role in the attraction and retention of the health care workforce in rural and remote areas. Addressing the barriers to health practitioners working in a rural and remote area must be a priority, to ensure that the population living in rural and remote areas have equity of access to healthcare;

- growing the workforce in non-acute health settings including mental health, midwifery and aged care to shift health care out of acute hospitals;
- lobby the federal government to ensure private sector minimum wages and conditions are adequate and appropriate in order to attract and retain nurses and midwives.

The QNMU also wishes to draw to the Committee's attention the increasing risk our members face in being assaulted while at work. We know that acts of aggression towards individual staff members in HHSs has been rising. In the 2015/16 financial year there 3,719 serious assaults reported which has jumped to 6,321 in the financial year 2018/19 (Queensland Government, 2019c). No level of violence is tolerable in any workplace and for our members this means that there must be no violence in their workplaces which are our hospitals and health services. Increasingly, health and aged care services are being delivered in the community including in people's homes, so strategies must be developed to ensure the safety of workers in all these settings.

Ambulance ramping

Ambulance ramping occurs when hospitals are at capacity and is a symptom of a health system under stress. Direct action to address the root cause of the problem is needed and not merely to treat the symptoms. Patients waiting in ambulances on the hospital ramp to receive treatment is a major problem for Queensland's health care system. While making more beds available and boosting primary health care are some approaches there are other models too. One approach being successfully used in addressing the needs of people with mental health concerns is an early intervention model of care where RNs deliver mental health treatment and care in Ipswich, Queensland. The *Co-responder Mental Health Program* sees RNs picked up from the Ipswich hospital by a police car responding to an emergency call relating to mental health and attends the incident with the police service (Clinical Excellence Queensland, 2019). This program has reduced ambulance ramping and hospital patient numbers as these people are seen by the nurses and treated at home avoiding the need for assessment in emergency departments (Murray, 2018).

Demand on emergency departments

Patient demand for health care services in Queensland has been brought to light by the COVID-19 pandemic. And yet, Queensland's emergency departments and hospitals were

already experiencing heightened demand even before the virus hit Australia. This is due to insufficient hospital beds and/or staff to cope with the workload. There is also a lack of alternative community-based health services, for people to go to so they present to emergency departments. It is our great fear that demand will only increase with Queensland's projected population boom from interstate migration in the foreseeable future.

The volume of emergency department presentations in Queensland public hospitals is growing at a faster rate than population growth and more people are presenting at emergency departments with complex issues. In 2019/20, there were more than 1.6 million presentations to public hospital emergency departments in Queensland - a third arrived by ambulance (Queensland Audit Office, 2021c). The reasons for this increase in presentations is complex and varied. We need better data to inform enhanced planning and response.

The recent auditor-general's report (2021c) stated that controls over Queensland emergency department data must be improved so the data is complete, accurate and validated in a timely manner, making several recommendations to achieve this:

1. Data reliability
    a. Improving the accuracy of data recorded.
    b. Improving how patient off stretcher time is recorded and reported.
2. Performance measures
    a. Initiatives to promote measures of performance and outcomes in all parts of care.
    b. Develop and implement guidelines to identify measure so success.
3. Short term treatment areas
    a. Monitor and report on the use of short-term treatment areas such as short stay units.

The QNMU supports Queensland Health in working with HHSs to implement these recommendations to assist with the increased demand in emergency departments. We also acknowledge the hundreds of beds being occupied by aged care and disability care patients in Queensland's public hospitals and support the state government in continuing to lobby the federal government for alternative care arrangements for these patients.

Prior to the last Queensland election, the QNMU successfully lobbied for the establishment of a project to examine nursing workloads and models of care in emergency departments, and we look forward to this project officer starting in the New Year.

Mental health care

Investigating the provision of Queensland's health care system must include the increasing need for mental health care and the link between mental health and physical health and how this impacts overall wellbeing. Statistics show that in Queensland 23% of adults self-reported

a long-term mental or behavioural problem in 2017-2018 and mental health-related presentations to public emergency departments was 4.1% in 2019-20 and has been steadily rising over a number of years (Queensland Government, 2020b & Australian Institute of Health and Welfare, 2021). These figures show the large number of people who experience a mental health condition as well as needing mental health care and highlight the urgent need to undertake structural reforms in the service delivery of mental health care and funding arrangements.

We note the complexity of the current mental health system. Services are delivered by public and private systems and policies are developed by state and federal governments. Regulating and funding is also shared between the Australian and state and territory governments. This disjointed system inevitably leads to unclear responsibility and accountability and poor service provision and continuity of care. The QNMU's position continues to support the need for governments to give a commitment to mental health programs and services to ensure certainty of funding for the continuity of mental health services.

We believe nurses have a pivotal role to play in this health care service. The QNMU continues to seek the reinstatement of the Nursing and Midwifery Board of Australia (NMBA) endorsement for nurses with mental health qualifications to recognise mental health as a specialty area of practice, as do other National Boards such as the Psychology and Medical Boards. ENs, AINs and personal care workers (however so named) also play an important role in the mental health workforce. Given their essential role, ENs should be afforded the opportunity to complete additional training in mental health and suicide prevention, whether that be in the tertiary education sector or the vocational education and training (VET) sector.

The QNMU continues to advocate for specific funding that addresses the need for mental health nurses and the models of care they provide. Previous programmes and services such as the commonwealth funded *Mental Health Nurse Incentive Program* (MHNIP) was a collaborative program that supported mental health care nurses in Primary Health Networks (PHNs). Unfortunately, the responsibility of this funding has since been given to the PHN flexible funding pool. This has meant that mental health services are now commissioned to local providers by the PHNs to provide mental health care services which may not necessarily be provided by mental health nurses or other health practitioners with mental health training or qualifications. This has resulted in significant changes as to how mental health nursing services are delivered across PHNs.

Queensland's Mental Health Commissioner has recently put forward that counsellors and mental health nurses should qualify for MBS funding to assist with the major workforce shortages that are seeing people waiting between three and 12 months for an appointment with a psychologist or psychiatrist. The QNMU has long campaigned for increased access to mental health care and expanding who can provide mental health care. We believe mental

health nurses should be involved in every step of the *Stepped care model in primary mental health care clinical service delivery* (Australian Government, 2019). Currently, workforce requirements in the model only have mental health nurses working in the highest end of the spectrum which is dealing with patients with severe mental illness. We would suggest PHNs could make better use of the mental health nursing workforce and use this workforce at all stages of the stepped care model. Mental health nurses have the skills, qualifications and experience to work across the whole spectrum of care including those patients with episodic mental ill health and those with high needs (Australian College of Mental Health Nurses, 2018).

To inform the future approach to mental health care, we believe there is the need for data collection that includes the number of patients in mental health crisis who present to a hospital emergency department:

- with a mental illness or disorder and who are being refused admission;
- the reason for not admitting the person is due to the shortage of beds, or their condition is not severe enough, or hospital/medical policy;
- what are the consequences for people with mental health concerns who are not admitted, or are not being seen in the emergency department in a timely manner?
- or leaving due to lengthy delays in assessment;
- if covered by private health insurance, referred to a private mental health unit. If the cost of treating mental illness is being shifted to the private sector, is this resulting in additional costs for health insurance companies and subsequent increases in premiums?

We suggest one solution in providing additional mental health care is the funding for more community-based extended-hours services. This would provide an alternative for people with a mental illness or disorder or suicide ideation having to present to hospital emergency departments, thereby avoiding hospital admissions and freeing up hospital beds. The QNMU acknowledges that boosting the number of community-based mental health facilities is just one part of the mental health system and sits alongside other measures that shift expenditure from acute, hospital-based and late-intervention health services to prevention focused, early intervention and recovery.

We also support further investment in crucial mental health support for adolescents. Recent data shows that there has been a 12% increase in mental health triple-0 calls to the Queensland Ambulance Service in three years, with 52,000 in 2019 and 59,000 in 2020, with an alarming rise in call-outs for children (Chamberlin, 2021). We believe both the state and federal governments have a responsibility to make sure that mental health care is provided for all age groups. We acknowledge that there is no 'one-size-fits-all' approach for adolescents and that care often falls between child and adult mental health services. Yet, this must not prevent an ongoing strategy for mental health support and services for adolescents.

Palliative care

We believe that a review that addresses access and funding of palliative care services should be included in this inquiry. As part of the palliative care strategy must be the commitment to ensuring palliative care services are delivered in a range of settings with equitable access to high quality palliative care, not only in the south-east corner of Queensland but extending to regional, rural, and remote areas of the state. Palliative care must also have adequate resourcing with suitably qualified and adequate numbers of nurses for those requesting and/or requiring palliation.

In addition, when the voluntary assisted dying scheme begins in Queensland this must not divert resources and/or funding from palliative care.

We recognize the state government's ongoing investment in Queensland's palliative care system and the work of the *Palliative Care Reform Package*. We are supportive of the government's focus on growing and investing in a specialist palliative care workforce and developing a workforce plan that is inclusive of the important role of nurses.

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Appendix 4: Ratios research

Ratios Saves Lives – Supporting Research.

NSW NURSES & MIDWIVES' ASSOCIATION

Ratios save lives

SUPPORTING RESEARCH

Foreword

Shaye Candish, General Secretary

Nurses and midwives have a professional responsibility to stand up for patient safety and advocate for a better healthcare system.

Growing international and Australian research proves safe nurse to patient ratios save lives and money. This booklet summarises the compelling evidence supporting the need for a nursing and midwifery ratios system in NSW.

Put simply, the research shows unsafe ratios increase the risk of dying. More nursing care hours provided to patients by highly skilled clinicians improves patient outcomes, while reducing costs and pressures on the health system over the longer term.

NSW nurses and midwives share a vision for safe patient ratios in all health settings across the state. The people of NSW deserve nurse to patient ratios, no matter where they live.

Shaye Candish
General Secretary
NSWNMA

August 2022

Academic research shows better nurse-to-patient ratios save lives

Over 16 years of academic research has now provided an extensive body of research to show almost 20 common "adverse patient events" are significantly related to the number and education level of the nurses who care for those patients.

Unsafe levels of nurse to patient ratios are now academically proven to increase the risk of the following adverse events or complications:

- Urinary tract infection
- Pressure ulcers (commonly known as "bed sores")
- Hospital-acquired pneumonia
- Shock or cardiac arrest
- In-hospital mortality
- Failure to rescue
- Upper gastro-intestinal bleeding
- Hospital-acquired sepsis (life threatening infection)
- Deep vein thrombosis ("DVT")
- Central nervous system complications
- Pulmonary failure post-surgery (heart/lung)
- Metabolic derangement post-surgery (abnormal biochemical functioning)
- Adverse drug events (missed, delayed or incorrect medication)
- In-hospital falls.

Nurses are the only health professionals who provide a 24/7 presence at the patient's bedside. Therefore, the nurse is the member of the healthcare team most likely to pick up deterioration in a patient's condition, and initiate interventions to minimise the impact of adverse events, which can prevent negative patient outcomes.

In this booklet

The following tables summarise studies that demonstrate the benefit of improved nurse-to-patient ratios. By employing a high proportion of university-qualified Registered Nurses (RNs), there are better patient outcomes for a range of hospital treatments and surgical procedures.

Studies estimating the economic cost savings through funding increased nurse staffing levels are also presented.

STUDY	FINDING
Lasater *et al.* (2021)	Each additional patient per nurse is associated with 12% higher odds of in-hospital mortality, 7% higher odds of 60 day mortality, 7% higher odds of 60-day readmission, and longer lengths of stay, even after accounting for patient and hospital covariate including hospital adherence to SEP-1 bundles. Adherence to SEP-1 bundles is associated with lower in-hospital mortality and shorter lengths of stay; however, the effects are markedly smaller than those observed for staffing.
McHugh *et al.* (2021)	For this prospective panel study, we compared Queensland hospitals subject to the ratio policy (27 intervention hospitals) and those that discharged similar patients but were not subject to ratios (28 comparison hospitals) at two timepoints: before implementation of ratios (baseline) and 2 years after implementation (post-implementation). The majority of change was at intervention hospitals, and staffing improvements by one patient per nurse produced reductions in mortality (OR 0·93, 95% CI 0·86–0·99, p=0·045), readmissions (0·93, 0·89–0·97, p<0·0001), and LOS (IRR 0·97, 0·94–0·99, p=0·035). In addition to producing better outcomes, the costs avoided due to fewer readmissions and shorter LOS were more than twice the cost of the additional nurse staffing.
Nijkamp *et al.* (2021)	The review demonstrated that empirical data surrounding perioperative nursing staffing is widely available. Fatigue, perioperative nurse education and nurse-to-patient ratios have a significant impact on the safety of patients undergoing invasive procedures. However, there is a lack of quantitative data surrounding these staffing factors.

STUDY	FINDING
Winter *et al.* (2021)	For all three dimensions of patient-perceived quality of nursing care, we found that they significantly decreased as (1) nurse staffing levels decreased (with decreasing marginal effects) and (2) the proportion of assistant nurses in a hospital unit increased. The association between nurse staffing levels and quality of nursing care was more pronounced among patients who were less clinically complex, were admitted to smaller hospitals or were admitted to medical units. The results indicate that, in addition to nurse staffing levels, nursing skill mix is crucial for providing the best possible quality of nursing care from the patient perspective and both should be considered when designing policies such as minimum staffing regulations to improve the quality of nursing care in hospitals.
Griffiths *et al.* (2020)	The recommended minimum sample of 20 days allowed the required number to employ (the establishment) to be estimated with a mean precision (defined as half the width of the CI as a percentage of the mean) of 4.1%. For most units, much larger samples were required to estimate establishments within ±1 whole time equivalent staff member. When staffing was lower than that required according to the SNCT, for each hour per patient day of registered nurse staffing below the required staffing level, the odds of nurses reporting that there were enough staff to provide quality care were reduced by 11%. Correspondingly, the odds of nurses reporting that necessary nursing care was left undone were increased by 14%. No threshold indicating an optimal staffing level was observed. Surgical specialty, patient turnover and more single rooms were associated with lower odds of staffing adequacy.

STUDY	FINDING
Thomas-Hawkins *et al.* (2020)	The purpose of this study was to examine interrelationships among registered nurse (RN) staffing, workload, nursing care left undone, and patient safety outcomes in hemodialysis settings. The sample consisted of 104 staff nurses who worked in hemodialysis facilities and completed a mailed survey. Low RN staffing, high RN workloads, and RN nursing care left undone were significantly associated with unsafe patient shift change periods and low safety ratings. Care left undone was an indirect pathway through which low RN staffing and high workloads impacted safety. Patient safety in hemodialysis units can be enhanced by ensuring adequate RN staffing and reasonable RN workloads, as well as redesigning responsibilities so RNs can complete necessary care activities.
Driscoll *et al.* (2018)	Nurse-to-patient ratios influence many patient outcomes, most markedly in-hospital mortality. More studies need to be conducted on the association of nurse-to-patient ratios with nurse-sensitive patient outcomes to offset the paucity and weaknesses of research in this area. This would provide further evidence for recommendations of optimal nurse-to-patient ratios in acute specialist units.
Altares Sarik *et al.* (2016)	Across 1,267,516 patients in 665 hospitals, logistic regression models showed that each 10% increase in proportion of RNs to total nursing staff was associated with a 7% decrease in the odds of 30-day mortality and FTR in the surgical patient population.
Ball *et al.* (2016)	Lower registered nurse staffing levels are associated with higher levels of care left undone and with an increased risk of patient death, even when other factors are controlled for.

STUDY	FINDING
Kim *et al.* (2016)	The aim of this study was to evaluate the effects of nurse staffing on hospital readmissions of COPD patients. A total of 1,070 hospitals and 339,379 hospitalization cases were included in the analysis. A higher number of RNs was associated with lower readmission rates of 8.9% and 7.9% respectively. A similar effect was observed as the proportion of RNs among the total nursing staff gradually increased, resulting in lower readmission rates of 7.7% and 8.3%. There were notable positive effects of nurse staffing by RNs on patient outcomes. In addition, the magnitude of impact differed between different sizes of hospitals. Thus, human resource planning to solve staffing shortages should carefully consider the qualitative aspects of the nursing staff composition.
Ozdemir *et al.* (2016)	There were 294 602 emergency admissions to 156 NHS Trusts (hospital systems) with a 30-day mortality of 4.2%. Trust-level mortality rates for this cohort ranged from 1.6 to 8.0%. The lowest mortality rates were observed in Trusts with higher levels of medical and nursing staffing, and a greater number of operating theatres and critical care beds relative to provider size. Higher mortality rates were seen in patients admitted to hospitals with lower nursing staff ratios.
Silber *et al.* (2016)	This study included 25 752 elderly Medicare general surgery patients treated at focal hospitals and 62 882 patients treated at control hospitals during 2004-2006 in Illinois, New York, and Texas. Hospitals with better nursing environments and above-average staffing levels were associated with better value (lower mortality with similar costs) compared with hospitals without nursing environment recognition and with below-average staffing, especially for higher-risk patients. These results show that patients undergoing general surgery at hospitals with better nursing environments generally receive care of higher value.

STUDY	FINDING
Bruyneel *et al.* (2015)	In 217 hospitals in 8 European countries, higher proportions of nurses with a bachelor's degree reduce the effect of worse nurse staffing on more clinical care left undone.
Eunhee *et al.* (2015)	This study analysed 76,036 instances of surgical discharges and found that each additional patient per nurse is associated with an 5% increase in the odds of patient death within 30 days of admission and that each 10% increase in nurses with a degree level qualification is associated with a 9% decrease in patient deaths.
Twigg *et al.* (2015)	The sample included 36,529 patient admissions over a two-year period from October 2004 – November 2006. The prevalence ratio showed that for each of the nurse-sensitive outcomes there was an increase in prevalence for those who were exposed to an understaffed shift, with all ratios being greater than one. After adjusting for patient characteristics, nurse-sensitive outcomes found to have the understaffed variable significant in the logistic regression model were surgical wound infection, urinary tract infection, pressure injury, pneumonia, deep vein thrombosis, upper gastrointestinal bleed, sepsis and physiological metabolic derangement.
Aiken *et al.* (2014)	Discharge data for 422 730 patients aged 50 years +, who had common surgeries in 300 hospitals in nine European countries was studied. An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% and every 10% increase in bachelor's degree nurses was associated with a decrease in this likelihood by 7%.
Ausserhofer *et al.* (2014)	In 488 hospitals across 12 European countries, better nurse to patient ratios resulted in fewer instances of care left undone, especially 'comfort/talk with patients', 'Developing or updating nursing care plans/care pathways' and 'Educating patients and families'.

STUDY	FINDING
Ball *et al.* (2014)	In 401 NHS general wards of 46 acute hospitals, the number of patients per registered nurse was significantly associated with 'missed [elements of] care', most often comforting or talking with patients, educating patients and developing/updating nursing care plans.
Ausserhofer *et al.* (2013)	Higher levels of implicit 'rationing' of nursing care in 35 Swiss acute hospitals resulted in significant increase in the odds of nurse-reported medication errors, bloodstream infections and pneumonia.
Griffiths *et al.* (2013)	Discharge data from 66,100,672 surgical admissions to 146 general acute hospital trusts in England showed that lower rates of failure to rescue were associated with a greater number of nurses per bed.
Jianghua *et al.* (2013)	For 284,097 patients discharged from 446 acute care nursing units at 128 acute hospitals, higher RN skill mix was associated with lower 30-day mortality across all three levels of risk adjustment.
Kutney-Lee *et al.* (2013)	This Pennsylvania study found that every 10% increase in nurses holding a baccalaureate degree within a hospital was associated with an average reduction of 2.12 deaths for every 1,000 patients—and for a subset of patients with complications, an average reduction of 7.47 deaths per 1,000 patients.
Twigg *et al.* (2013)	Hospital morbidity and staffing data were used to analyse nursing-sensitive outcomes and showed cost per 'life year' gained due to prevention of FTR events was AUD$8,907 (in 2013 dollars).
Wiltse *et al.* (2013)	This study found that of 20,409 patients in 517 hospitals studied, each additional patient per nurse increased the odds on patients dying and being involved in a failure to rescue, by factors of 1.12 and 1.08 respectively.

STUDY	FINDING
Esparza *et al.* (2012)	A study of 235 Californian hospitals found (1) that with increased nursing hours per patient day (NHPPD) the odds of UTI decreased 1.013 times, and (2) as the RN proportion of skill mix increased, the odds of a UTI decreased by 4.25 times. The higher the proportion of RN skill mix, the shorter the LOS according to two separate studies conducted a decade apart.
Frith *et al.* (2012)	From 31,080 patient observations, this study shows that increasing the number of RN hours and decreasing/ eliminating LPN (non-degree qualified nurse) hours can be a strategy to reduce medication errors.
Park *et al.* (2012)	Data from 42 hospitals (759 wards), and approx. 1 million inpatients showed that higher RN staffing was associated with lower FTR.
Rochman (2012)	This US study of 299 patients in 22 units in one US hospital found that one additional hour per patient day of RN care resulted in 28% greater odds of surviving to discharge post in-hospital cardiac arrest.
Roche *et al.* (2012)	The study sought to determine the rate of occurrence of several NSOs, the relationship of skill-mix to that rate, and the number of patients affected per annum. It was found that the current rate of NSOs across wards ranged from 0.17% to 1.05%, and that there was an inverse relationship between the proportion of hours worked by RNs and NSO rates: an increase of 10% in the proportion of hours worked by RNs was linked to a decrease in NSO rates by between 11% and 45%. It was estimated that increasing the RN staffing percentage by10% would mean 160 fewer adverse outcomes for patients per year across these two hospitals.

STUDY	FINDING
Wiltse Nicely *et al.* (2012)	This US study had a sample of 25,625 nurses and 20,409 patients from 517 hospitals and found that when the Patient to Nurse ratio was changed from 8:1 to 6:1 there was a significantly lower rate of failure to rescue for patients undergoing Abdominal Aortic Aneurysm repair. This was more pronounced when the Patient to Nurse ratio was further changed to 4:1. Hospitals with higher NTPR have lower rates of mortality for patients undergoing Abdominal Aortic Aneurysm repair, according to this US study.
Blegen *et al.* (2011)	This study, using data from 1.1 million adult discharges in the US and staffing for 872 wards in 54 hospitals, found that: • an increase in NHPPD was associated with lower rates of pressure ulcers in intensive care. • an increase in RNs as proportion of skill mix was associated with fewer cases of sepsis. • increased NHPPD is associated with lower rates of failure to rescue. • higher nursing staffing was associated with lower rates of congestive heart failure mortality in general wards. • increased NHPPD was associated with decreased LOS.
Bobay *et al.* (2011)	In this US study researchers examined the impact of unit-level nurse staffing on unplanned readmissions and ED visits within 30 days of discharge from 16 adult medical-surgical units (1,660 patients). They found that the odds of an unplanned (related to initial admission) ED visit decreased by 45% with a 0.71 hours increase of RN NHPPD and by 32% with a 0.66 hours increase in non-RN NHPPD. Additionally, it was found that a 0.88 hour/RN increase in overtime worked increased the odds of an unplanned ED visit by 33%.

STUDY	FINDING
Duffield *et al.* (2011)	This study, using data from 80 units in 19 NSW hospitals, found increased RN/CNS (Clinical Nurse Specialist) staff is associated with significantly decreased rates of pressure ulcers, sepsis and pneumonia. It also found increased RN/CNS (Clinical Nurse Specialist) staff as a proportion of nursing hours was associated with significantly decreased rates of pressure ulcers, GI bleeding, sepsis, shock, pulmonary failure and physiological/metabolic derangement.
Hinno *et al.* (2011)	A survey of 535 Finnish RNs and 334 RNs from the Netherlands found that lower nurse staffing is associated with an increased number of patient falls.
Chan et al. (2010)	Increased Length of Stay (LOS) = 2.39 days/fall Cost per fall = $6,919
Twigg *et al.* (2010)	This retrospective study of three adult tertiary hospitals in Perth utilised 236,454 patient records and 150,925 nurse staffing records and found that increased NHPPD: • lead to a 17% decrease in pneumonia. • lead to a 54% decrease in CNS complications in surgical patients. • lead to a 37% decrease in ulcer/gastritis/upper GI bleeds. • was significantly associated with a 25-26% decrease in mortality rates.

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Ratios save lives

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Appendix 5: RRR report

NSWNMA submission to the NSW parliamentary Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

NSW NURSES & MIDWIVES' ASSOCIATION

Submission to Health outcomes and access to health and hospital services in rural, regional and remote NSW

DECEMBER 2020

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Foreword

The New South Wales Nurses and Midwives' Association (NSWNMA) is the industrial and professional body for nurses and midwives in New South Wales, representing over 70,000 members across the full spectrum of health care services in NSW in facilities including public and private hospitals, corrective services, aged care, disability and community settings. Approximately half our members work in Local Health Districts that cover regional, rural and remote parts of NSW.

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.

This response is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association.

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“I am Clinical Nurse Specialist / RN working in a rural ED. I'd like to share a story about a recent shift, and the challenges faced as a rural hospital with less resources than our metro counterparts.

Recently I was in charge of the Emergency Dept. on an evening shift, 1300-2130. Our 12 bed ED is staffed with 3 nurses on the evening shift and a triage nurse that goes home at 1830.

The dept. was heaving when we arrived, every bed was occupied and we hit the ground running. It's often like this for the handover period, but mostly we have it back under control by the time the morning shift leave. This shift however, just got busier and busier. Patients kept coming, and they had serious and complicated conditions that required lots of nursing attention.

After 1600 there is no clerk, so the triage nurse does the clerical registration of the patients as well as the clinical triage. After 1830 there were just 3 of us to care for a full department of acutely unwell patients. As coordinator I clerked, triaged and treated patients, liaised with the hospital supervisor, booked beds, arranged transfers, booked ambulances and coordinated patient flow with the doctors.

At about 7pm, we were still flat out and had patients in every bed, when we called by a wardsman (the only one in the hospital) to an "unconscious woman in the carpark". Two of us nurses went out to perform a car extraction (getting an unconscious patient safely from a car is no easy feat). Luckily for us the patient was able to get herself from the car to stretcher bed, which we wheeled into the ED, moving patients like deck chairs on the Titanic to fit her into a bed bay with cardiac monitoring.

Not so lucky for us, our patient was experiencing a mental health crisis and her behaviour very quickly escalated to very loud and aggressive. While 2 of us tried to calm her, our remaining nurse and doctor tried to reassure the other patients that they were safe.

Behind the flimsiest of curtains was an unstable and extremely angry young woman. Sharing the ED, and in beds beside her, were a 3yr old with a fractured leg and her mum, a 6yr old girl needing stitches in her face and her mum, 10yr and 16yr old brothers who'd crashed their skateboards at speed and needed extensive dressings, an

elderly woman with a hip fracture and dementia, who needed constant supervision not to climb over the bed rails, a man in his 70's with chest pain, a young woman with severe abdominal pain who was sobbing and vomiting, a man in his early 20s with a fracture dislocation of his elbow, a young man waiting for burns dressing to both of his legs, and a 4yr old with a cough and fever, which despite being asthma, required full covid infection control precautions, and all of the family members who were with them.

With no security on site on weekends, only 1 wardsman and clinical staff already stretched beyond capacity we were unable to restrain the patient with a mental health disturbance, something that was needed to keep her, our patients and ourselves safe. Without the ability to restrain her safely, our patient left the ED and started roaming the hospital. She smashed a glass cabinet and was brandishing a large piece of glass as a knife, threatening to kill herself and others.

Our rural town has a police station that is often unstaffed, police are dispatched from 30 mins away. So, no security, minimal staffing and unreliable police presence. We are vulnerable. Thankfully, on this occasion police responded quickly and were able to safely get our patient to comply with handcuffs, which allowed us to safely assist in transferring her to the specialist care she needed.

Rural sites so often run on minimal staffing, there aren't the extra people that can be called upon to help in a crisis. We had no clerk, so I made the call to the police, taking valuable time when I needed to be assisting. We had no security, perhaps the situation might have been averted if we could have restrained her appropriately earlier. We were already at capacity and when forced to prioritise the treatment of our other patients was compromised.

I'm proud to say all our patients, including the distressed young woman, had good outcomes - because we worked hard to make it so. But the system did not support us. Even after this, our senior LHD management want to cut the staffing in our ED. We are determined to fight any reduction in staffing, but how much effort can we keep directing to keeping safe staffing when we are using all our energy keeping our patients safe?"

The Association welcomes this renewed interest into health outcomes and access to health and hospital services in rural, regional and remote parts of NSW. As illustrated by the testimony above, the situation is dire for people outside of Sydney, with health outcomes substantially poorer than their Sydney counterparts. This needs to change. It is not acceptable that residents in the rest of NSW are provided with an inadequately resourced, substandard system of healthcare while metropolitan Sydney residents enjoy far superior access and outcomes. Regional, rural and remote citizens of NSW are entitled to the same standard of healthcare as every other member of the NSW community.

This interest in healthcare delivery is also good news for the nurses and midwives who are the backbone of healthcare in rural, regional and remote parts of NSW. While the supply of nurses and midwives varies across remote areas, the nursing profession stands out as the best distributed health workforce in comparison to other professions[1]. The Association represents 35,000 nurses and midwives employed in Local Health Districts (LHDs) outside Sydney. The members we consulted in preparation for this submission universally expressed their concerns about poor healthcare, not only from a professional perspective, but also in terms of their deep commitment to their community and the reality that they and their families are also reliant on a system they know is under-resourced.

People living in regional, rural and remote parts of NSW have greater and more complex needs for health services but less access. They have higher rates of coronary heart disease, stroke, chronic kidney disease, mental ill-health and diabetes. The burden of chronic disease is increasing in Australia and there is a strong gradient in burden across remoteness areas.[2] However, in response to this increased demand we see poor staffing and skill mix, nurses and midwives routinely working in isolation, limited access to continuing education, reliance on colleagues to provide unpaid on-call support, skill shortages, inadequate security and transport services and lack of medical cover.

[1] National Rural Health Alliance, 2019, https://www.ruralhealth.org.au/sites/default/files/publications/fact-sheet-nurses.pdf, accessed 11/11/2020

[2] Australian Institute of Health and Welfare 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. https://www.aihw.gov.au/reports/burden-of-disease/burden-disease-study-illness-death-2015/, accessed 11/11/2020

We are not an Indigenous organisation so we defer to the expertise of the many First Nations organisations that are the experts in healthcare and health outcomes of Aboriginal and Torres Strait Islander peoples. In more general terms, we know that the health of Aboriginal and Torres Strait Islander people is poorer than other people in NSW and that First Nations people frequently do not have access to culturally sensitive healthcare, appropriate drug and alcohol support, education, housing services, mental health interventions or support for cognitive disabilities. The interests of First Nations people must be addressed in the final recommendations of this Inquiry.

The NSWNMA is committed to working to address the inequalities experienced by many Aboriginal and Torres Strait Islander peoples and achieve health equality for First Nations peoples. NSWNMA is also committed to supporting the principle of self-determination for First Nations people. Self-determination must be a key characteristic of measures aimed at improving the health of Aboriginal and Torres Strait Islander peoples and therefore we support Aboriginal and Torres Strait Islander community controlled health services in regional, rural and remote areas as a key means of reducing health inequalities. Aboriginal Community Controlled Health Organisations are well known to enhance equitable access to healthcare and effectively manage chronic diseases. First Nations people in regional, rural and remote parts of NSW should have access to their services.

Every member of the NSW community regardless of where they live, should have access to comprehensive, high quality healthcare. However, we know that people in rural, regional and remote communities are dying prematurely because of inequitable access to healthcare and a lack of investment in rural, regional and remote communities. There have been multiple well publicised failures of care that have had devastating impacts, not just on the patients and their families, but also the nurses and midwives who are doing their best.

It is true that most of the time, largely due to the good will, hard work and sacrifice of staff, services are being delivered. However there is growing awareness among people outside Sydney that their healthcare needs are being neglected. We see growing media interest in the catastrophic failures of care that once went unnoticed. Certainly this organisation is working hard to ensure affected communities understand that their limited access and subsequent poor health outcomes are attributable to choices that are made by the NSW Government.

We believe that the current situation in many parts of regional, rural and remote NSW contravenes NSW Health's statutory obligations to provide a safe work environment for nurses and midwives and to ensure so far as reasonably practical the safety of staff and patients in terms of the way work is carried out.

To accurately capture the views and perspectives of our members, we invited them to provide us with reports of their experiences and these are included in this submission. We have also included submissions from members that were collected for an earlier project that looked specifically at violence in the workplace. Their testimony is compelling and paints a stark picture of the range of issues that sooner or later cascade into the terrible tragedies and catastrophic failures of care that precipitated this Inquiry.

It should be noted that many contributors were concerned about potential repercussions if they raised their concerns in this context. This was despite our assurances that advocacy is included in both the nursing and midwifery codes of conduct[3]. Many expressed fears that raising their concerns would result in a punitive response from their management. For this reason, individuals, services and localities are not identified in this submission.

> *"Nurses cannot speak up about the issues due to the potential for reprisals. This is the only employer in the town for nurses. The fear is that if they are targeted there is nowhere else to go for work."*

This is a matter that should be of great concern. It is a fundamental principle of safety and quality in healthcare that individuals feel empowered to raise concerns about issues that impact on patient safety.

These firsthand reports from our members move beyond the official government statements and statistics by capturing the experiences of the people on the ground. Their testimony is deeply concerning although frankly, not unexpected considering the well-documented poor health outcomes in regional, rural and remote NSW.

Staffing is the number one issue raised by our members trying to deliver care in regional, rural and remote parts of NSW. On a routine shift they are expected to care for more patients than they have capacity to attend to safely, and when emergencies arise, they are woefully unsupported. There is also limited access to a casual workforce which means that it is difficult to replace nurses and midwives who require short term leave.

[3] Nursing and Midwifery Board of Australia, https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx, accessed 23/11/2020

"Night shift 1 – on COSOP (remote medical consultation process, Critical Operations Standard Operating Procedures). We have 1 midwife (MW), 1 registered nurse (who is allocated to ED on nightshift even though they are the ward RN) and 1 enrolled nurse. This is a district hospital with 3 bay emergency dept (ED) and 28 bed acute med/surg ward that includes maternity, high dependency unit, paediatrics and palliative care. Our ED is located over 60m from the acute ward. The hospital is in a town approximately 1 hr away from a base hospital. We are generally on COSOPs at least 70% of the time (sometimes a Dr available for triage 1-2).

Elderly gentleman brought in by ambulance with sepsis, decreased GCS (5), very sick – family wanting no CPR but full treatment otherwise. History of CVA a few months prior. Unstable – hypotension, tachycardia, hypoxia. MW & RN go to ED as it is unsafe for 1 staff to attend ED alone. This left the EN alone on the ward with 12 acute patients.

Rural and Remote Dr (RaRMs) was contacted by the MW whist the RN was treating the patient - IVC, ECG, point of care (PoCT) pathology as per sepsis pathway. Inotropes were given to maintain BP even with no Dr on site. Dr wasn't happy to arrange retrieval but was insistent that MW should discuss the intervention and management plan with the family. Dr would not talk to the family himself as he didn't think that would be 'fair' as he hadn't physically seen the patient. It was a very difficult situation to be in as a nurse. I felt I was practicing above my scope of practice as it's not my role to arrange NFR orders.

Night shift 2 – on COSOPs (again!!) I had expressed concerns with management a week prior to my shift about staffing for night shift. The RN who was rostered on x4 night shifts is a new graduate RN with no ED or triage experience at all. A few staff raised their concerns, including the RN herself (she was very stressed about the upcoming shifts) with management highlighting that the RN was allocated to ED despite holding no qualifications or experience. The recent incidents at Tenterfield and Gulgong were highlighted but management decided they would have the new CNE on-call (this CNE had been working for 4 weeks at the site and has no rural/remote experience including triage and adults (paediatrics background only) and lives over 20mins away).

I arrive on shift and receive handover – 14 in patients (including a palliative care patient and 3 with dementia). During handover a patient presented to ED and the evening staff call the Dr in as they were on call until 2200hrs – 2 more ED patiens arrive during this

time. The Dr sees the 3 pts and I and the junior RN finish off their care. The EN has been alone on the ward looking after 14 pts since evening staff left. We are now on COSOPs until 0800hrs.

Shortly after another patient presents as a triage 3 (acute, severe abdominal pain) – while I was assessing this patient another patient arrived by ambulance and at this time the fire alarm is activated. As I am in-charge I have to go to the fire panel to assess the situation (hoping to god that it is a false alarm) leaving the junior RN to take handover from the ambulance and triage patient even though she is not qualified to do so. The EN is still on the ward working in isolation trying to calm a dementia patient who is wandering and stressing over the fire alarm. I call the on-call CNE in but I know it will be realistically at least 30mins before she arrives.

So myself, the RN, and the CNE are doing what we can to assess the 2 pts and contact the RaRMs Dr and patient flow unit back and forth to work out a plan and treatment for both pts – including IVC, PoCT path, ECG, analgesia, ect. Multiple times one of us had to go down to the ward to get equipment (IV pump) and stores as evening staff had had a very busy shift and had no time to restock ED. Both the patients had morphine, but the 2nd patient then developed hives and shortness of breath – so was treated as per the anaphylaxis protocol due to the morphine reaction. As I was drawing up the adrenaline the fire alarm reactivated so I had to leave the other 2 inexperienced staff members to check the fire panel again. The night continued in much the same way.

The ward patients did not receive their IV antibiotics on time as the EN could not check/give them alone – she was alone most of the night working in isolation managing 16 acute patients – including dementia, palliative patients who required meds/settling/toileting/pressure area care.

I'm grateful no maternity patients arrived overnight as I would have been in labour ward which is 40 metres away from the ward and 100 metres away from the ED.

IIMS completed – to go off into the never never!!"

"Staffing is by far the biggest (but not the only) barrier to delivering quality health care. Two nurses looking after a general ward and a

four-bed emergency ward is in no way a satisfactory situation. Frequently both nurses are required in the ED, this leaves the general ward unattended. If only one nurse is required in the ED, then both nurses are working in isolation. This is unfair on the staff, it is unfair on the patients, but more than that, it is unsafe. Too often we rely on kitchen staff to "keep an eye on the patients." There are no wardsmen, there are no security staff, there are no clerical staff after hours and frequently there is only a doctor on the end of the phone who is working in another busy emergency department in another hospital. This puts a huge responsibility on two nurses, especially the nurse in charge."

"Nurses are frequently asked to stay back or called in at short notice to cover sick leave because there are no casual staff available to cover these situations. We are being snowed under with paperwork which leaves even less time to deliver hands on care to our patients, and not surprisingly an increase in falls and pressure area injuries is the result."

"We are also expected to teach our student nurses while working in this environment, but often it is not possible to give them the direct supervision that we are obliged to give. These students are the future nurses that we will rely on. They need and deserve good training."

Understaffing has very serious consequences for the quality and safety of healthcare. Of all the members of the interdisciplinary healthcare team, the nurse is the only one who provides a continuous (24 hours/day, seven days/week) presence at the patient's bedside. Thus, the nurse is the member of the healthcare team most likely to pick up deterioration in a patient's condition and initiate interventions that minimise the impact of adverse events and prevent negative outcomes for the patient.

"I work in charge of an emergency department out of hours which is generally fine however on night shifts when there is only one registered nurse, the acuity of the department quickly exceeds the capacity of one nurse and it doesn't matter how senior or

experienced you are it is not safe. Recently in the ED by myself at night I have had a cardiac arrest, a STEMI[4], and an intubation/retrieval. I am looking at employment options outside NSW Health because I worry about being caught in a situation that causes serious harm to a patient."

"We need more nursing staff working on the ground. When I start work I hit the floor running, trying to keep up with my workload, and anticipating any new problems I may encounter during my shift. This often means missing my breaks due to lack of staffing to replace you on the floor. If you are lucky enough for a manager to relieve you for a break, you can guarantee the work during that period is there waiting for you on your return. I get home exhausted. It's extremely hard to give patients what they deserve in the way of personal care, and frequently medication is either missed or late. Management are just not listening to staff. Nurses are being blamed and performance managed when patients miss medications and there is no acknowledgement of the role of the excessive workload as a factor in such incidents. Staff are totally exhausted, sick leave is very high due to burn out, and high overtime rates as shifts are not filled. Our patients deserve more as do our nursing staff."

The evidence is clear that there is a link between staffing and outcomes in healthcare settings[5]. There is a limit to how many patients one nurse or midwife can care for safely and in a way that maintains the patient's comfort. When the patient load exceeds that number, patients are more likely to have poor outcomes.

An increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7% and every 10% increase

[4] ST-Elevation Myocardial Infarction (STEMI) is a very serious type of heart attack during which one of the heart's major arteries is blocked.
[5] https://www.nswnma.asn.au/wp-content/uploads/2019/02/Ratios-and-safe-patient-care-FINAL.pdf

in bachelor's degree nurses was associated with a decrease in this likelihood by 7%.[6,7]

All members of the interdisciplinary healthcare team have a role to play in prevention of adverse outcomes; however the depth and breadth of evidence – both domestic and international – describing the significant link between nurse-to-patient ratios/nursing hours per patient day and patient outcomes, provides a compelling case for mandated minimum staffing in inpatient settings. The growing body of evidence clearly demonstrates that inadequate nurse staffing leads to an increase in negative outcomes for patients and ultimately a greater burden of cost to both the healthcare budget and society.

"I have 25 years' experience in rural nursing. My concern is staffing levels in the facility I currently work in. There is one RN and one EN/EEN/AIN per shift, to care for 10 high care aged residents, possible 4 acute patients, and manage the emergency department which can be very busy. We don't have the support of the NSW government to provide adequate care to all our patients. My experience is that the care is always compromised, with toileting, feeding, showering not attended on time, and always rushed. Sometimes some of these things are missed.
This contributes to staff burnout, and risk of deteriorating mental health amongst staff is a real issue.
Our VMO is the town GP, but she has limited availability, frequently only 4 days per week, sometimes only 3. We then rely on Virtual Rural Generalist Program GPs who attend via telehealth. As mentioned before, one RN and EN in emergency situations means the other patients and residents (10 to 14 in number) will be left on their own devices - domestic staff try to be of assistance but after 6pm there is no one else. I feel that all the above is a safety concern; both for staff and patients who are entitled to the same level of care as people in the city."

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[6] Based on discharge data for 422,730 patients aged 50 years or older who underwent common surgeries in 300 hospitals in nine European countries.
[7] Aiken et al. (2014) Nurse staffing and education and hospital mortality in nine European countries: a retrospective study, The Lancet Vol 383, 9931: 1824-1830.

Understaffing is rife across NSW hospitals, but more so in regional, rural and remote areas. This compromises the quality and timeliness of patient care and increases the risks to nurses and midwives. In addition to issues with the numbers of staff, there are also significant concerns about inappropriate skill mix, e.g. for large numbers of new graduates working in high risk areas with insufficient supervision and support, or Assistants In Nursing (AINs) being used to replace RNs.

"Working a night shift in an MPS, where I was the RN in the 3-bed ED, with an attached 6-bed acute ward. The only other staff member in the entire hospital was an RN in the 21-bed attached aged care facility. A very ill patient arrived at the emergency in the early morning and was treated as per protocol by me and the other nurse. As a result, there was no one left to attend any of the 21 aged care residents, some were wanderers, some had dementia, some required regular care from nurses."

"I have worked in regional LHD for the last 30 years and we have virtually hit rock bottom in our efforts to provide safe, high quality healthcare to patients and their families. We keep asking for staff enhancements for our service to cope with the fact that activity has increased threefold. They firmly state there is no additional funding and instead, despite our workload statistics tripling, our budget seems to be cut each year by 5% regardless. Whenever a staff member leaves, we are told that staff member won't be replaced. When benchmarked against Sydney LHDs, we have similar casemix and statistics, but they have double and triple the number of staff and a far greater budget to purchase and maintain equipment."

Aside from patient safety, adequate staffing levels are also vital in:

- the prevention of violence, e.g. reducing levels of patient frustration and aggression due to excessive waiting times or being able to engage with and redirect mental health patients who may become agitated.
- the de-escalation of violence e.g. early observation of escalating behaviour provides the best opportunity to respond and de-escalate.

- the capacity to manage violent incidents that occur e.g. training provided by NSW Health in restraint requires a minimum of five responders. This means that the facility requires at least this many trained people to be available to respond to an incident.

"I did my new graduate remote rural -both hospitals have no doctor on site. There is usually only one RN and one EN on night shifts for the whole hospital. Day shifts there is one RN and one EN for the ward/ED and then two other nurses for the aged care site attached as they are multipurpose sites. You are expected to treat and triage patients whilst also looking after any patients on the wards and coordinating possible RFDS retrievals. Every so often there would be a critical emergency and with two-three nurses and the doctor being called in. The care delivered to patients is obviously nowhere near what a metro hospital would be, as is their chances of survival.

I am now working at a C1 hospital but still think that there is a HUGE difference between this and the referral hospital. I quite often have 6 patients and can have 10 with an Ain, no educator or in charge without patient load. Whereas when I work at the referral hospital I don't usually have more than 4 patients and there is an in-charge without a patient load and an educator. The nature of the work in remote/rural and the workload in the C1 hospital is very similar so I am moving to the referral hospital.

I think a lot of nurses feel this way. They are moving to the bigger hospitals with better nurse to patient ratios because why should we work harder and watch patients suffer?"

The Association is concerned that the Royal Commission into Aged Care Quality and Safety has recommended that Approved Aged Care Providers operating out of a MPS should be able to apply to the Aged Care Quality and Safety Commission for an exemption from the Quality and Safety Standard relating to staffing. It has long been a concern to our members that the residential aged care provision within an MPS has been regarded as requiring a lower skill level than the main hospital. This results in removal of registered and enrolled nurses from the residential care section to provide back-up staffing to the main hospital, or circumstances whereby a

registered nurse is unable to attend the residential side throughout their entire span of duty.

Having dedicated staffing ratios within the residential care section will guarantee there is no transfer of staff between areas, and ensure residents receive the quality care they deserve.

"I have worked in an MPS for 30yrs. We are often without doctors and nurse staffing is atrocious. For example, only 2 staff overnight to manage care for 24 aged care residents, 6 acute inpatients and 2 emergency beds.

Even though we have no security and police are usually 50 minutes away, we are required to manage scheduled mental health patients due to lack of beds or transport to the nearest gazetted unit.

There is no on-call person to escalate to in emergencies."

Many of the violent incidents that come to the attention of the Association occur at times when staffing levels are unsuitable. The safety of nurses and midwives in regional, rural and remote settings will be discussed in more detail later in this submission.

"I have worked as a community nurse in a small rural community for the last 16 years. In the last 2 years we have lost 1.4 RNs, leaving 1 FTE to run an ambulatory care clinic and attend home visits.

We do a lot of wound care, some complex, IV Baxter exchanges, catheter care, Palliative care and aged care. Recently some days have seen 16 clients in an 8-hour day. Plus answering the door, phone, ordering stock, attending to referrals, entering new registrations and dealing with problems as they arise with clients being seen. Our data proves increased activity, but we're still told we had to lose the only day that overlapped with 2 staff. This day was paramount to a good handover of clients and problem solving.

I often go home feeling emotional and stressed wondering if I can continue."

Population numbers are subject to proportionately substantial variations. There are a range of temporary groups that drive spikes of demand for care in regional, rural and remote health services. There are a number of settings in NSW that deal with transient employment models such as FIFO workers in the mining industry. For example, Parkes Hospital has been significantly impacted by mining workers as well as workers associated with the inland rail project. Similarly, large tourist events, festivals and grey nomads all rely on regional, rural and remote healthcare services. These spikes in demand have implications for workload, staffing and patient safety.

"With the growing lack of experienced nurses there is less & less support & mentoring for our new nurses. There is just so much work with not enough staff to do it. COVID has amplified this, we have no back up. Our small LHDs can't handle an influx of tourists or pandemics. We just don't have enough skilled people."

It can be an exciting environment but also a very stressful one as there is so much more responsibility for the nurse with very little support and limited resources. There are no permanent educators on most of these sites and not all the nurses working there have critical care experience or advanced life support. The "grey nomad" trend is a major issue as so many elderly people with multiple comorbidities and complex needs travelling out that way."

The geographical isolation of many services in NSW presents particular practice challenges to nurses and midwives. They often work without access to clinical supports and assistance. Their scope of practice is often extremely broad because they are frequently the only professional available to respond to a wide range of needs. They also experience pressure to work outside their scope of practice which can have disciplinary implications. Nurses and midwives frequently take on non-nursing/midwifery roles that would otherwise be staffed in metropolitan settings, such as pharmacy, pathology, x-ray, mortuary and domestic services. There is very

limited access to allied health, primary healthcare (including early intervention and prevention) and specialist services. Where specialist services are available, they are frequently limited to a few days per month or on an ad hoc basis.

"I am paediatric nurse working in a local rural hospital. If our ward is closed due to no children in the hospital, we are deployed to other wards to assist, and often take a patient load dealing with adults in surgical or medical situations. This practice can undermine safety. Recently, as senior nurse I was placed in charge of an adult surgical ward with a junior RN from paediatrics, a new graduate from another ward with 3 months experience and two ENs. Of the 3 RNs and 2 ENs covering the shift, only one was familiar with the ward. I expressed my concerns about this to the after-hours manager and placed 2 IIMS into the system. This is dangerous for patient care and safety as well as a risk to nursing staff who are being forced to work outside our scope of practice. This particular incident led to me going on stress leave for a month."

"Our facility does not have an on-site pharmacist - we have a remote clinical pharmacist that covers our health service. With the increasing complexity of medications, I worry about patient safety in this situation."

"More specialist services need to be based in regional Australia and stop de-skilling rural doctors by requiring them to send everything on to a referral hospital. Smaller hospitals need greater scope of care."

The lack of on-site doctors and limited service capabilities of many facilities in regional, rural and remote areas means that there is a high level of frequency of patient transfers and retrievals which can be very time consuming to arrange.

"We are a small rural ED operating without on-call medical officer services (telehealth phone only Monday to Friday and locum doctors on the weekends) as a fully functioning emergency department. There is poor governance, poor safety and increased risk to patients and staff alike. ***APPENDIX A*** *is an example of the complicated transfers resulting from lack of onsite medical officer coverage. In this scenario you had 4 different doctors, 7 different nurses (including nurse managers) and 8 different transfer co-ordination conversations. A total of 25 DIFFERENT PHONE CALLS to arrange transfer of one patient to receive medical assessment more than 12 hours after initial presentation to a supposedly fully functioning ED. There is push back from all facilities that we try to transfer their patients to because everyone is sick of dealing with the fact that we do not have a doctor for medical assessments!"*

"I work at a Base hospital in a regional area. In our hospital we often have patients waiting 3 days for transport for urology and orthopaedic care at another hospital. We need a 24 hour patient transport service or orthopaedics and urology based at our facility. These patients stay in the emergency department. A crowded and noisy environment. This is not safe for the patient, nor other patients waiting for treatment."

"Lack of support for the facility to keep certain patients within their role delineation. Facilities can look after patients but are constantly asked by larger facilities to send them for review. This review may take <24 hrs. These unnecessary transfers contribute to an immense budgetary burden for smaller rural health services."

"Working a night shift in an MPS, where I was the RN in the 3-bed ED, with an attached 6-bed acute ward. The only other staff member in the entire hospital was an RN in the 21-bed attached aged care facility. A sick very child arrived in ED and we were lucky to have

called the on-call doctor for a previous patient, so that he was present at the arrival of the child. The child required urgent transfer to the local regional hospital as there were no facilities or staff at the MPS to continue care, especially if there was a deterioration. The NSW Ambulance Service was called for an urgent 'lights and sirens' transfer, within the hour. After 2.5 hours and more phone calls the ambulance still had not arrived. When the ambulance arrived, the paramedics asked when I had called for them, as they were stationed 5 minutes away in a caravan park. It was difficult to continue observations, reassure patient and family, modify treatment, and at the same time be on the telephone via and understaffed and incompetent system. Again, the potential for a severe adverse outcome was high."

Several of our members raised the impact of ageing built environments and equipment on workflow efficiency and work health safety and security. The physical work environment plays an important role in decreasing risks associated with occupational violence and aggression. Physical changes to the workplace that eliminate or minimise the risks associated with violence are high order controls under the WHS Regulation 2017 and should be employed wherever possible.

"This health service building is >45 years old. Services keep increasing but the footprint of the facility stays the same. We keep cramming in more people to the same building. We now have much more equipment and larger items such as lifters, beds etc. The environment in which patients reside whilst hospitalised provides many hazards due to the size of the rooms and the amount of equipment such as walkers, lifters etc."

"I work in a small MPS with the main hospital 1.5 hrs away. For years now, we have been asking for an I-Stat machine which our nurses consider critical for our POC service. We were denied it even though we pointed out how many of the pathways it could be used for: chest pain, sepsis, stroke. We also have 2 residents on warfarin that would benefit. We have chest pains come through our

emergency department, but we are told we don't have the numbers to justify the expense. To me, this seems to degrade both our staff and our community. Please help."

"We also don't have necessary equipment maintained and when it breaks, we don't have the budget to get it fixed. My service is so backlogged it is unsafe for staff, patients and the community."

"I work in an MPS with 24 aged care beds. Predominately I work night shift and there are only 2 staff. The police station is not 24/7. Our next one is 60kms away. The hospital is old, we have doors out on to the veranda. Only some of these are alarmed and old-style sash windows that can be easily accessed."

Rural, regional and remote practice places a significant burden on nurses and midwives in terms of the need to manage higher complexity interventions such as chemotherapy and dialysis whilst maintaining generalist nursing and midwifery skills, including low frequency high risk clinical capability such as trauma response. Access to continuing education is a crucial mechanism by which nurses and midwives maintain their skills and knowledge but is difficult to access outside of metropolitan settings. Most significantly, the extent of understaffing means that nurses and midwives cannot be relieved to attend professional development opportunities.

"Rural nurses are not provided the access and training that our metro colleagues are given. Education is at our own expenses and being released to attend is not supported as there is no staff to replace on the floor clinical care."

While there is consensus in the literature about the link, unfortunately there is not clear consensus regarding a precise staffing ratio that maximises quality, safety and

efficiency. A nurse hours per patient day (NHPPD) formula has been implemented in parts of the system with good effect. There are a range of contextual factors that must be taken into consideration as we seek further implementation of minimum staffing standards, but it is also crucial that the process is guided by the available evidence.

Further, we are aware that many rural and remote services can only operate because staff provide on-call coverage in the event of emergencies. According to our members, this is almost always unpaid. This is a flagrant breach of the Award entitlements of nurses and midwives and it disrespects these people and their families. If a service cannot operate without a reliable on-call roster then this needs to be formalised and the cost of paying these allowances must be factored into operating costs.

Recommendations

- **That NSW Health adopts the NSWNMA 2018 Ratios claim as the minimum nursing numbers required on each shift. See Appendix C for details of this claim.**
- **That every aged care facility has a minimum of one registered nurse on duty 24/7.**
- **That staffing and funding for aged care facilities be re-considered with reference to the findings of the Aged Care Royal Commission and the ANMF National Aged Care Staffing and Skills Mix Project Report.[8]**
- **That NSW Health recognise minimum staffing ratios are necessary to provide safe patient care but may not be sufficient to ensure the safety of staff, especially in smaller facilities with very limited staffing numbers. In this case staffing numbers should be determined by ratios plus a risk assessment of numbers required to provide an effective duress response.**
- **That nurses and midwives are paid all their Award entitlements including on call entitlements wherever they are currently expected to be available to attend work outside their standard roster.**

The lack of onsite medical coverage poses many challenges for our members. Not only do they shoulder a huge burden of responsibility, they also describe widespread problems associated with accessing on-call and telehealth medical officers.

[8] National Aged Care Staffing and Skills Mix Project Report 2016 -- Meeting residents' care needs: A study of the requirement for nursing and personal care staff, Aust Nurs Midwifery J. 2017 Apr;24(9):28-33

It is acknowledged that whilst the Virtual Model of care is a necessity in circumstances where no medical coverage is available, the lack of physical presence of a medical officer on site in emergency situations presents huge challenges for the nurse who is responding to such situations. Rural and regional sites that are reliant on virtual medical officer coverage must have the option of calling in an on-call registered nurse, who is within 15 minutes of the site, for support.

Our members report that while, in theory, nurse managers/HSMs are on-call, they often live substantial distances away or are out of town on their time off which means they are not physically available to the nurses on duty in the emergency department. An expectation that nurse managers/HSM are on call 24/7 is unsafe and untenable.

"I live in an isolated town of nearly 5,000 people and we are 300km from the nearest facility with higher level services. In our town we operate on sporadic locums, usually a different doctor each time, and otherwise the virtual doctor service. This means almost no continuity of care for any patient, many of whom have significant chronic health conditions and co morbidities. We have GPs in town; however this service is also being propped up by locums, which again significantly impacts continuity of care.

As nurses, my colleagues and I are stressed, anxious and at times fearful going to work. Not having a doctor on site means we feel solely responsible for the journey and outcome of every patient that comes through the door. We are responsible for the head to toe assessment of the patient for the virtual doctor to use to decide the course of treatment. The doctor does not collect this information. We are told this is simply working to the top of our scope of practice, however we feel we are being used to replace the physical doctor.

I have no issue with working to the top of my scope, however I feel unsupported in doing so. There has been no training to suture wounds or apply plaster casts. We have very limited access to professional development. Why is it ok for people living in the country to have nurse-only treatment? Why is it ok for people living in the country to be denied access to a doctor when their condition requires it?

Patients who present to our facility with a wound that requires sutures must drive 600km round trip to the next doctor. Patients who require an ultrasound often have to do the same. Patients with a dislocation of a joint (eg shoulder) also must be transported to the

facility 300km away. Some people cannot be transported by private car so hospital transport is arranged but due to the increased demands on the service, the transport can be delayed. For non-urgent transfers, the delay can be days. The demands for air transfers for patients whose care needs are urgent, or whose health condition means it is not safe or appropriate to go by car, has also increased, as have delays. Some of the increase in demand is a direct result of not having onsite doctors. Resources have not been increased to meet this demand. Patients can wait overnight for a transfer for significant conditions, such as minor heart attacks, sepsis, or fractures.

What can be done to address this? State and federal governments can work collaboratively to redesign the health system to educate, attract and retain skilled health practitioners- Rural Generalist Doctors, Rural Generalist Nurses and Nurse Practitioners, supported by a combination of virtual and hands on specialist care. Better access to radiology services and allied health is also needed. Creating and supporting these positions will pay for itself in terms of savings on patient transfers, and more importantly- healthy communities into the future.

People living in rural areas contribute to the economy just as people in urban areas do, yet we do not have access to the basics which that economy claims to offer. Why? This issue requires urgent senior political attention and leadership across state and federal government, from all parties. Access to health care is a basic right of all Australians. Why are residents of rural postcodes being denied this?

"Frequently there is only a doctor on the end of the phone who is already working in another busy emergency department in another hospital."

"The 'on-call' doctor was called but did not answer the phone on several occasions. This doctor was billeted in a 'hospital-owned' house about 1/4 km away, so we asked two family members of the patient to drive there and wake the doctor. We had only two staff in the hospital, so none were able to leave. The family members returned as were unable to rouse anyone at the house. I woke the

CEO in the early hours of the morning, explained the issue, and she drove to the house, to also bang on the door, eventually waking everyone but the doctor on call. The others then woke him. The delay in time could have been catastrophic for the patient."

"People don't want to work in a hospital that doesn't have a doctor on shift all the time. It makes them feel unsafe. We have had agency nurses come and when they realise there is no doctor, they leave the next day."

"Having no doctor on-site or on-call most afternoons and after hours makes it very difficult to coordinate care. We must liaise with ED doctors at our referral hospital who are already busy physically seeing their own patients in their busy emergency department. The registered nurse has to spend a lot of time on the phone liaising with the doctor making sure you are not missing anything. This can place a lot of pressure and responsibility that would not be asked of a registered nurse who works in a tertiary hospital. Having a doctor on-site or at least on-call specifically for our small rural hospital would improve patient safety and outcomes."

"The model of relying on privately run GPs providing on call VMO services to public hospitals is OUTDATED and not functional and not how young doctors coming through medical school want to live their lives so it will become an increasing issue.

Doctors need to be employed by small hospitals as both on call for the hospital and to operate a GP practice out of the hospital - look to QLD Health for this model!"

Recommendations:

- **That the Nurse Practitioner (Generalist) model of care and role in regional and rural areas is properly implemented. This will require funding to be directed towards recruitment and development of additional Nurse Practitioners to work in rural and regional areas, particularly in sites without 24/7 medical officers reliant on virtual medical officer coverage.**
- **Where rural and regional sites do not have access to medical officers 24/7 and are reliant on virtual medical officer coverage, there must be a minimum of one registered nurse rostered on-call, and within 15 minutes to the site, to be present and provide physical in person support to respond to emergency events.**
- **Wherever there is an emergency department open 24/7, regardless of its delineation or classification however named, that facility requires minimum staffing of three nursing staff rostered on duty, two of whom are suitably qualified to attend to an acute emergency presentation.**

Inadequate technological infrastructure, especially unreliable internet coverage, impedes access to clinical information systems, telehealth consultations and the delivery of safe, high quality healthcare.

"I think the main problem for us in terms of Medchart is that it is heavily reliant on an internet connection that is not wholly reliable at a high standard all the time. The fact that this issue is intermittent is part of the problem. If it didn't work all the time it would be easier to know how to fix it or what exactly is wrong.

Sometimes it is very slow to load each page. This means that when you are waiting for each page to load 30 - 45 seconds per page and your patient may have 10 medications, it significantly impacts on how long it takes to actually perform the task of administering medication. If you are giving out 16 - 20 peoples' medication it can take an exceedingly long time to complete the task. It can take up to 60 seconds to save that each medication has been given. This also impacts negatively on the time required. It is very frustrating when you know how busy you are and know how much you need to do and you have no choice but to stand and wait for a page to load. I have resorted to breathing slow and deep and trying to be mindful of

the adrenaline like responses occurring in my body and deliberately try to calm them.

Reliability is an intermittent problem. You can follow the appropriate steps and believe Medchart has saved what you have just administered and then at the next pill round find that it has not been saved and is indicating the medication is late and still requiring administration. I think this is quite dangerous because it is possible that the next shift may readminister the medication because it looks as though it has not been given. We are aware and wary of doing that and generally try and check with the previous staff first.

It feels like the RN does nothing but give out the pills some days and there is so much more required of the job.

When first introduced, Medchart provided a problems sheet for us to fill in if any concerns. It was quite detailed and onerous to complete in an already time poor environment. We did complete pages of it and received no feedback. I acknowledge there may have been a breakdown in communication, I don't really know. We have designed a simpler version and intend to monitor intensely for 2 weeks using the speedy form to try and capture the issues I have raised here."

The Association also has concerns about excessive reliance on telehealth. While telehealth options exist for mental health and drug and alcohol resources in rural and regional areas, these are not always a suitable option, particularly in relation to immediate management.

Several of our members quite rightly raised the issue of incentives and the role these could play in improving staffing. There needs to be an honest acknowledgement that staffing in regional, rural and remote areas will necessarily rely on attracting a temporary workforce to some degree. If the current incentives are not enough to attract people in the competitive market for nurses and midwives, then they should be improved.

"I am a Registered Nurse and work mostly for an agency but sometimes do short term contracts for NSW Health. The reason I do short term contracts is that NSW Health only provide

accommodation for agency nurses and short-term contracts. When I started nursing, I couldn't get a graduate program, so I started working for QLD Health as a rural and remote nurse. With this job came RANIP (rural and remote incentive package) which included 2 flights per year to the nearest capital city and generous cash bonuses after each year of service. As well as this incentive came free furnished housing inclusive of electricity.

Often now I am tempted to remain in some of the many places I work in country NSW but I would need to buy furniture and very often the rentals in small country towns are either non-existent or very expensive. It's not an incentive to stay in one place in NSW. If I decide to settle in one town I will go back to QLD where there are incentives to accept the challenges of rural work.

You asked for my story, I hope this makes some of the pollies understand why health care professionals are in short supply in country areas and maybe think about some incentives for those of us who choose to help in the country areas."

The Association continues to have grave concerns about the safety of our members in many regional, rural and remote locations. The issue of occupational violence and aggression is a priority concern for the membership of the Association. Current arrangements for preventing and controlling violence in NSW hospitals are not effective, evidenced by the continuing number of violent incidents across the state.

Our members report increasing levels of exposure to violence as well as an increase in the severity of the incidents that are experienced. Member requests for assistance from the Association to deal with issues of violence and aggression across all areas of nursing & midwifery have increased markedly over the last few years.

While we know violence towards nurses and midwives is a very serious issue that is well documented, well researched and widely accepted to be a significant problem, quantifying the true extent of the issue is hampered by the lack of transparency and very poor incident reporting.

In order to better understand the nature and prevalence of violence and aggression currently experienced by nurses and midwives in NSW, the Association collaborated with researchers from the University of Technology Sydney on a project that looked at the experiences of NSW nurses and midwives with violence at work, involving over 3500 nurses and midwives, making it one of the largest studies undertaken on this topic worldwide. While this not specifically about regional, rural and remote health services, the research provides valuable insights into the issue of violence against nurses and midwives in NSW Health facilities and a copy of the report provided to the Association on this study is attached at Appendix B.

Key findings from the study include:

- 47% of nurses & midwives had experienced violence at work in the week prior to completing the survey.
- 80% of nurses & midwives had experienced violence at work in the 6 months prior to completing the survey.
- 76% perceived that the frequency of violent episodes was increasing.

The other thing that became very clear from the study is that exposure to violence is not restricted to nurses working in emergency departments or in mental health, with workers in a wide range of clinical and specialty areas reporting exposure to violence in the last six months.

The research by Dr Pich indicates that rural and remote nurses experience higher rates of violence and aggression than those in metropolitan areas. Common characteristics of these facilities include:

- Small numbers of staff, particularly overnight mean that there are insufficient numbers of staff to provide an internal duress response.
- Often do not have security staff, or if they do, they do not cover all shifts.
- May not have ready access to police.

The Association surveyed members working for NSW Health in the development of a previous submission in relation to workplace aggression and violence. The largest number of responses were from members working in smaller rural and regional facilities, with concerns primarily related to staffing numbers and the lack of security staff or police.

"My town is situated 2 hours north of the nearest regional centre. We have a local police station, but it is not open 24/7, and the nearest on-call police attend from 2 hours' drive away with no towns

in between. Our MPS consists of aged care beds (18 high care, 10 low care and 8 dementia specific in a separate secure wing), 6 acute/sub-acute beds and an emergency department with 2 beds.

Overnight staffing consists of 1 RN, 1 EN and 2 residential care assistants (one working in low care and one in the dementia unit).

Walk-ins to the ED often present out of hours due to escalating mental health issues and drug and alcohol consumption. At 9pm, an intoxicated person & a friend presented to the ED. As there was no one available immediately to open ED doors and assess as all staff were providing care to aged care residents at the other end of the facility, the male friend proceeded to smash through the glass doors into the ED.

The nurses confronted by aggressive intoxicated persons smashing the ED doors felt very unsafe, they had no internal duress capacity, no on-call police available and no alternative localised procedures in place to manage duress situations. In the absence of any localised procedure, the nurses set off fire alarms which got a response from the rural fire brigade and along with ambulance personnel assisted in resolving the immediate issue.

Following this incident nurses were subjected to social media harassment as well as verbal abuse and intimidation within the local community."

"I work in a small rural hospital. 25 acute beds,4 bed ED, 9 bed maternity. We only have security Friday, Saturday and Sunday night shift. All other times we have a duress alarm that if activated the security company rings approximately 5 mins later to see if we are ok. Not good enough! Our security man can only observe due to no training to intervene. We do not have a 24hr police service, so they must recall or travel 80kms from the next town. We are expected to hold mental health and sometimes violent patients overnight with one nurse in ED, and two nurses in the acute wards."

"I work in a rural hospital, with a 6 bed ICU -3 nurses. We admit mental health patients including acute psychosis from street drugs, alcohol, other reasons; even though none of us have mental health training. Scheduled or confused ward patients are admitted to HDU, just because they can have 1:2 nurse: patient ratio."

"We do not have security, only 2 nursing staff on duty and no police in our small town after hours, meaning the closest police would be 45 mins away. We also have 9 exits that the nurses must lock down every night. I would like to express my concerns about the lack of ANY security in our community health centre. We currently do not have working duress alarms."

"I work in a small rural MPS facility which have 29 beds (20 aged care and 9 acute, an emergency department (nurse led service). We don't have 24hr police in town. After hours all calls go to the nearest town, which is 30 minutes away. The hospital does not have 24hr hospital security assistants on duty which is a major concern for us. Duress alarms - have never worked properly since the system was installed and don't go anywhere - only internal to staff on duty."

"Most small hospitals and MPSs do not have security at all in this LHD. Minimum staffing in MPS-only 2 nurses on night duty, 3 on an AM and PM, all female nursing staff on this site. Police Station in the town but often covering neighbouring towns 30 minutes away."

Security staff have a very important role to play in the prevention and management of violence and aggression in NSW Health facilities, as has been found to be the case in reviews in other Australian jurisdictions. The Association supports the finding of the Victorian Public Health Service Security Model Review that highly trained security personnel are an essential component in the prevention,

management and response to workplace violence[9].

Unfortunately, it appears that the deployment and use of security across NSW Health facilities lacks consistency or any clear rationale, with rural and regional facilities often afforded limited or no access to on-site security, despite staff working in these facilities having very similar levels of exposure to violence. Our recent examination of violence experienced by nurses and midwives in NSW based on geographical location and found that people working in rural locations were actually more likely to have experienced violence and aggression at work in the previous six months than those in a major city.

Geographical area	Violence experienced in last six months
Major city	79%
Inner regional	82%
Outer regional	82%
Remote	81%

Hospital X is a small rural hospital consisting of a maternity unit, a 22 bed ward and an emergency department. At night there is one nurse working in isolation in the ED, one midwife in the maternity unit and 3 nurses in the ward. A security assistant was employed to work 4 nights per week, but the position was not replaced if he was sick or on leave. Nurses had made a number of requests for security to be provided 24/7, and for an increase in nursing numbers to ensure their safety.

On 21 November 2018 an aggressive incident occurred overnight. This was a night that there was no security on site and there were insufficient nursing staff to provide a duress response. The private security service took 45 minutes to arrive."

All nurses and midwives, regardless of where they are working, must have access to suitable duress arrangements in the event of an emergency. It is appreciated that

[9] Loss Prevention Group of Australia, Public Health Services Security Model review (C5965)

these arrangements will look different according to the type of workplace and its location, however staff must have the capacity to call for support when required and to receive a timely and effective duress response.

It must be recognised that people will not always be able to make a telephone call in the event of a violent episode and so this method cannot be relied on to call for assistance, particularly when nurses are working in isolation in the community.

Recommendations:

- **NSW Health should undertake a review of existing duress arrangements in place across regional/rural facilities. This should consider at a minimum, the staffing numbers across each shift, the availability of security staff by shift and the availability of external resources, including external security companies and police.**
- **The Association recommends visible, uniformed, unarmed security staff be positioned in close proximity to emergency departments, psychiatric units and other areas of the hospital where violent incidents may occur.**

We are also deeply concerned about the safety of community nurses and midwives working in community health who have a different set of risks than other nurses, with community centres rarely purpose built, and unlikely to have access to security or sufficient staffing numbers for a duress response.

Nurses visiting patients and mental health consumers and midwives visiting new mothers and babies in their homes are often working in isolation in environments not controlled by NSW Health, where risk can vary markedly from one visit to the next and where often the risk of violence relates to the presence of friends and family members.

We receive reports of incredibly unsafe practices including:

- Poor/no initial risk assessment prior to home visits
- Poor communication of emerging risk
- No access to duress beyond a mobile phone (which cannot always be accessed in an emergency and does not always have signal coverage)
- Nurses working in isolation in high risk environments
- No system to ensure nurses and midwives have safely exited the home at the conclusion of the home visit.

Recommendation:

- **Revise systems in place for community nurses and midwifery in keeping with chapters 16 & 17 of *Protecting People and Property – NSW Health policy and standards for security risk management in NSW Health agencies*.[10]**

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. From there, providing treatment early and preventing relapses is also critical.

Poor resourcing of mental health 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 generally to manage those who are most acutely unwell 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.

In community mental health we are seeing an increase in non-nursing mental health professionals managing clients on complex medication regimes leading to relapse and readmission that could have been avoided, as well as staff not backfilled when on leave.

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 is hard to see how being taken to the emergency department of a small rural hospital with minimal staffing and generally no staff with mental health training beyond a 30 minute on-line training session only to wait for hours for a telehealth mental health assessment before waiting many more hours for patient transport to be transferred to a larger facility with mental health beds is in the interests of an extremely unwell behaviourally disturbed patient.

[10] https://www.health.nsw.gov.au/policies/manuals/Pages/protecting-people-property.aspx

It is certainly unsafe for the staff who are trying to manage highly volatile patients despite having:

- no mental health training
- inadequate staffing to be able to implement a restraint if required
- no seclusion room
- no security staff
- no local police presence.

Another significant issue for our members in more isolated areas is an increase in inappropriate drop offs of intoxicated persons for mental health assessments.

The Association is regularly receiving reports from members that behaviourally disturbed intoxicated people are being taken to an ED or mental health unit by police for mental health assessment even though they are unable to be assessed until they are no longer intoxicated. This leaves an aggressive person in a hospital setting while they sober up rather than a police setting. While we appreciate the competing priorities for the police and the potential for serious health issues to be overlooked within a police environment, police environments are generally more suitable for the management of acute behavioural disturbances linked to drug or alcohol intoxication. If intoxicated persons are to be managed in a hospital setting, this needs to be a secure environment with suitable staffing arrangements in place to manage the risk.

"A behaviourally disturbed person is detained by a police officer who believes they are in need of an involuntary mental health assessment. It is 11pm. They are taken to the nearest declared mental health emergency assessment centre at a small rural hospital. There are 3 staff members rostered on, a single nurse working in the emergency department and 2 on the ward. There are no security staff at this time and the nearest police station is 90kms away.

There is no one with any mental health experience or qualifications and the assessment is to be done by video-link. If the patient is intoxicated, they cannot be assessed and are to remain in the ED until the assessment can be undertaken. Even if they are sober it could be 5 hours until the video-link conference occurs. Once the assessment occurs, if the patient is scheduled they will need to be

transferred to a hospital with mental health beds. It can take many hours to organise for the patient transfer, particularly overnight. All of this time you have nurses and other patients in a very high-risk situation."

"Community mental health nurses requested police assistance in working with consumer X. Police said consumer X was 'mouthy' but not a risk and the nurses were overreacting. Consumer X entered the community mental health centre and doused 2 nurses and the premises with petrol and threatened to set them on fire."

Nurses and midwives in regional, rural and remote parts of NSW are facing increased levels of violence arising from patient use of methamphetamines. While alcohol use is still responsible for greater numbers of aggressive and violent incidents, it is the nature of violence associated with 'ice' that makes it such a serious concern.

It is important to note that emergency departments are not the only places that nurses are facing ice related violence and aggression. In addition to the traditional areas of concern – emergency departments, drug and alcohol services and mental health units, the Association is also receiving reports of increasing ice related aggression across all areas of nursing, but most notably in cardiology. Methamphetamine is cardio-toxic and causes damage to heart muscles and arteries, it can also cause heart arrhythmias and endocarditis. Ice users are a very different patient cohort than traditional cardiology patients and wards are less likely to be designed with the management of violence as a key consideration, provision of duress alarms are not routine and nurses working in cardiology are unlikely to have appropriate training in the management of violence and aggression.

Methamphetamine is notorious for its association with violence characterised by its capricious and often bizarre nature and is a significant public health concern.[11] Based on data collected from wastewater analysis, methamphetamine use appears to disproportionately affect some regional areas in NSW and yet these are the areas least likely to have access to training, security or sufficient staff to allow for a

[11] McKetin, R., Lubman, D., Najman, J., Dawe, S., Butterworth, P., & Baker, A., (2014), Does Methamphetamine Use Increase Violent Behaviour? Evidence from a prospective longitudinal study. Addiction, 109, p798-806

duress response in an emergency.

> *The rate of methamphetamine-related hospitalisations increased rapidly from 12.2 per 100,000 population in 2010-11 to 137.9 per 100,000 population in 2018-19. The rate has stabilised slightly from 2015-16 onwards. Methamphetamine-related hospitalisation rates were higher in males, Aboriginal people, people aged 25-44 and people living outside of major cities.*[12]

Recommendations:

- **Increased funding for mental health services in regional, rural and remote areas to ensure suitable services are available at all levels of care provision, from community-based care through to Mental Health Intensive Care Unit (MHICU).**
- **That NSW Health develop plans to address shortages in mental health nursing staff, training, recruitment, and retention of mental health nurses. This should also include increased opportunities for Nurse Practitioners (Mental Health).**
- **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 for patients presenting to EDs under the influence of psychostimulants such as "ice", both for immediate management and longer term referral and treatment.**

[12] HealthStats NSW, Methamphetamine-related hospitalisations, http://www.healthstats.nsw.gov.au/Indicator/beh_illimethhos/beh_illimethhos_aria_snap, accessed 01/12/2020

APPENDIX A

23:25 Pt presented to hospital 1
00:28 Discussed with senior medical officer (SMO) hospital 2 who recommended transfer to hospital 3 under on-call GP for further assessment
00:44 RN contacted hospital 3 ED & advised to contact hospital 3 VMO
00:46 RN contacted hospital 3 VMO who asked staff to speak with hospital 3 ED regarding bed availability
00:54 RN contacted hospital 3 ED – no bed availability
01:00 pain relief given to patient
01:05 RN contacted hospital 2 ED SMO – who advised they would accept transfer and to book ambulance
01:15 ambulance booked
01:40 Call from ambulance co-ordinator – patient to remain in hospital 1 overnight and transfer scheduled for morning – advised this was in consultation with hospital 2 ED doctors
01:45 – 07:00 Observations stable
07:15 BP yellow zone (95/63) – clinical review attended. Discussed with hospital 2 ED SMO – bolus 500mLs IVT & escalation of earlier transfer due to deterioration
07:33 Call to ambulance – advised of deterioration and revised MAT of 30 minutes
07:38 Call from hospital 2 asking why patient wasn't going to hospital. Advised of above circumstances. Dr asked me to "try hospital 3 again" as I might get a "non-tired GP". I explained that as the previous shift had already followed this process, I would be escalating the situation to General Manager (GM). He agreed that that was appropriate "as that's what we have been doing here with our concerns"
07:43 Phoned GM to escalate concerns, message left
07:44 Phoned ambulance and advised I would call back in 20 minutes with destination as possible change required
07:50 GM returned call, given handover. Advised would S/W Manager at hospital 3 to determine plan
08:01 Phoned ambulance & advised please hold booking while arrange accepting facility
08:02 Call from GM – No ultrasound in hospital 3 therefore hospital 4 would be appropriate
08:10 Call from ASNSW confirming plan of call back to them when accepting facility known
08:10 Discussion with patient regarding hospital 4 for likely transfer. Patient distressed and requiring reassurance

08:58 Phoned hospital 4 VMO – he accepted patient post discussion however asked me to re-examine patient to rule out X and hospital 2 should be made aware that the patient will be heading in opposite direction to their emergency department and may end up being a transfer to them anyway.
09:10 Phoned hospital 4 back to advise Dr of diagnostic results however Dr busy and spoke with RN who said "could still be X, better to talk to with hospital 2".
09:20 Phoned hospital 2 EDSMO – advised of abdominal guarding on assessment. He said "you can send the patient here as it sounds like you've had the run around". I explained the hospital 4 are happy to accept patient, they just wanted me to make hospital 2 aware that hospital 4 is the opposite direction to hospital 2 should it turn out to be X.
09:27 Phoned hospital 4 again – Dr still busy. Spoke with RN – advised hospital 2 happy for patient to go there. Her response was "that sounds like a plan, otherwise we end up getting slammed here".
09:41 Phoned ambulance – advised booking back to transfer to hospital 2 and within 30 minutes given the already significant 2 hour delay in transfer for assessment. They advised they would call back.
09:55 Call from ambulance – crew currently on call out. They will escalate.
10:03 Call from hospital 4 VMO asking about assessment. I asked if he had spoken with hospital 4 RN, he said "yes but I'd rather hear from you to close the loop". I agreed. Advised of hospital 2 response. He wanted to reassure me that he was happy to have patient and "not giving the run around". I said I was fully aware and tried to relay that to hospital 2. Dr then stated he just wanted to remain professional, remove ambiguity and put patient care first. I agreed and so decision was made to send to hospital 2.
10:15 Advised patient of transfer now going back to hospital 2. Pt frustrated and teary about the "stress of the change ups".
10:32 Call from Aeromedical co-ordinator wanting handover to assess whether patient requires air transfer. I advised I didn't believe this the case but they requested handover anyway. This took 10 minutes. They then advised they'd call back with a decision.
10:55 Call from person identifying as 'retrieval' stating patient still suitable for road transfer and crew would be at hospital 1 within 20 minutes. Patient updated & relieved.
11:10 Patient departed hospital 1 by ambulance for hospital 2 ED.

APPENDIX B

Violence in Nursing and Midwifery in NSW: Study Report

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Project support
Christopher Oldmeadow: HMRI – statistical support
Matthew Clapham: HMRI – statistical support

Executive summary

Workplace violence is one of the most significant and hazardous issues faced by nurses and midwives globally with patients the most common source of this violence. It is a potentially life-threatening and life-affecting workplace hazard often downplayed as just" part of the job". Within this context the specialities of emergency, mental health and aged care have been reported to be at highest risk for episodes of violence. Violence includes a continuum of behaviours from verbal abuse and threats, sexual harassment through to physical assaults. It involves both explicit and implicit challenges to the well-being, safety or health of nurses and midwives at work (Mayhew & Chappell, 2005).

This cross sectional study of NSW nurses and midwives utilised an online questionnaire to achieve the study objectives, and was designed to uncover the experiences of participants with episodes of violence. The sample size of 3612 makes this one of the largest studies of its kind in Australia and globally and underscores the significance placed on the topic by NSW nurses and midwives. The data in this report demonstrate the achievement of the proposed aims and objectives of this study including:

1. Nurse/midwife reported incidence of episodes of violence from patients and/or family and friends and associated outcomes in the preceding six months;
2. Nurse/midwife reported incidence of the types of violent behaviours experienced;
3. Compared of the experiences of NSW nurses and midwives in the private and public sector with this violence;
4. Compared the experiences of NSW nurses and midwives in metropolitan, regional and remote areas with this violence;
5. Identified the experiences of NSW nurses and midwives with this violence in different clinical areas and patient-related services;
6. Identified the risk factors for violent episodes – including perpetrators, geographical location, clinical specialty;
7. Identified NSW nurses' and midwives' perceptions of risk prevention measures and risk management strategies adopted by their employers.

While some differences were identified, the overall experiences of NSW nurses and midwives with violence from patients and/or their relatives or friends was consistent across employment sector and geographical work area. The key results of this study include:

1. There were 1454 participants (1454/3101, 47%) who had experienced an episode of violence in the previous week and 2460 who had experienced violence in the six months prior to completing the survey (2460/3092, 80%).
2. The majority of nurses and midwives (81%) reported between one and 10 episodes, however 38 (2%) reported experiencing more than 10 episodes
3. Older and more experienced nurses and midwives reported less episodes of violence, with younger and less experienced participants at greater risk of violence.
4. Males were more likely to experience an episode of violence than females (88% to 78%).
5. More than half of participants working in all clinical areas had experienced an episode of violence during the preceding six months.
6. The rates of violence were highest for those working in the specialities of emergency, drug and alcohol and mental health.
7. The public health sector had a higher percentage of participants having been involved in violent episodes in the last six months compared to private (82% compared to 69%).
8. There was a reported injury rate of 28% as a result of an episode of violence.
9. Psychological injuries were the most common type of injury reported by participants, in a result that was consistent across geographical work areas and work sector.
10. Participants from metropolitan areas were more likely to report a physical or psychological injury than their regional and remote colleagues.
11. Verbally abusive behaviours were experienced at higher rates by those participants working in the public sector.
12. The majority of participants were selective in their reporting of episodes of violence, with 67% reporting only some or no episodes of violence.
13. Non-physical outcomes associated with being involved in an episode of violence, and impacting on nurses and midwives' professional role include: considering leaving the profession, powerlessness, burnout, depression, fear of future episodes, anxiety, altered sleep patterns and reduced empathy which may affect the quality of care provided to patients.
14. Nurses and midwives also reported a range of problems which affected their personal lives following involvement in an episode of violence, some of which were ongoing in nature, for example post traumatic stress disorder (PTSD).
15. There were some frequently identified nursing and midwifery behaviours associated with episodes of violence, many of which related to communication with patients.
16. Patients who presented with substance misuse, mental health issues, alcohol intoxication and/or cognitive impairment were perceived by participants to be of highest risk for potential violence.

17. Almost half of participants stated that they were not satisfied with their employer's immediate response.
18. Two-thirds of participants reported that they had not been provided with adequate information, support and follow-up following an episode of violence.
19. More than half of participants had not been given access to counselling following an episode of violence.
20. Mandatory training is often not made available to staff with many having to complete this at their own expense outside the workplace.
21. There is a reliance on online training for topics that require hands-on knowledge and practice to be effective, for example takedown training.

There is an obligation to act on the information that nurses and midwives have provided in this study and in the words of one participant: *"…please actually act on this information you collect and improve our working conditions, Too many good nurses are being harmed and no one seems to care…" (P198).*

Recommendations

1. Healthcare employers in all sectors need to review current strategies and update and amend them accordingly to ensure that nurses and midwives are afforded a safe work place.
2. Where policies and procedures exist to protect nurses and midwives, these should be enforced and penalties imposed on employers who do not comply.
3. Mandatory training should be made available for all nurses and midwives as applicable and provided at the place of employment at the employers' expense. Employers should be monitored regularly for compliance and appropriate actions taken where this does not occur.
4. Training should be offered in a face to face format where possible.
5. Reporting of episodes of violence should be encouraged and acted on in a timely manner by employers with feedback provided to affected nurses and midwives and consequences for perpetrators.
6. Nurses and midwives should be offered immediate and ongoing support by their employer following all episodes of violence.
7. Nurses and midwives should be included in all planning and policy development on the topic of violence as they represent the largest group in healthcare and are most vulnerable to violence from patients and their relatives and friends.

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Chapter 1 Background

Workplace violence is one of the most significant and hazardous issues faced by nurses globally and in response the International Council of Nurses issued a position statement in 2006 condemning "all forms of abuse and violence against nursing personnel" (International Council of Nurses, 2006). It is a potentially life-threatening and life-affecting workplace hazard often downplayed as just "part of the job" (Jones & Lyneham, 2000).

The Australian Institute of Criminology ranked the health industry as the most violent workplace in the country (Perrone, 1999). According to US statistics, healthcare workers are 5 to 12 times more likely to experience violence in the workplace than other workers (OSHA, 2015) and they are more likely to be attacked at work than prison guards and police officers (International Council of Nurses, 2009). Nurses are at the front line of violence in hospitals, particularly those working in the specialities of emergency, aged care and mental health (Phillips, 2016). The frequency and severity of violent incidents are both said to be increasing, however episodes of violence in healthcare remain vastly underreported (OSHA, 2015).

Patients are responsible for most of the violence committed against nurses, and this includes paediatric patients and their parents or carers (Gillespie et al, 2010, Pich et al, 2013). Relatives and friends, including parents and carers, who accompany patients have also been identified as perpetrators of violence (Jackson, Hutchinson, Luck, & Wilkes, 2013; Pich, Kable, & Hazelton, 2017) and this is particularly evident in research originating from non-western countries (Hasani et al., 2010; Senuzun Ergun & Karadakovan, 2005).

1.1 Definition of violence

NSW Health defines violence as any incident in which an individual is abused, threatened or assaulted and includes verbal, physical or psychological abuse, threats or other intimidating behaviours, intentional physical attacks, aggravated assault, threats with an offensive weapon, sexual harassment and sexual assault (SESLHD, 2018). The majority of this violence is service-related, that is violence that arises when providing services to clients, customers, patients or prisoners, perpetrated by patients or those accompanying them (SafeWork NSW, 2018).

1.2 Types of violence

Violence covers a range of behaviours from verbal abuse and threats through to physical violence.

1.2.1Verbal abuse

Verbal abuse has been identified as the most common form of violence, experienced by the majority of nurses and midwives, with estimates up to 100% affected in some locations, for example the emergency department where it can be a daily occurrence (Gacki-Smith et al., 2009; J. B. Lau, J. Magarey, & R. Wiechula, 2012).
Swearing has been identified as the most common form of verbal abuse (Pich, Hazelton, Sundin, & Kable, 2011) and demeaning swearing has been identified as the most offensive form of verbal aggression, particularly for female nurses (Stone, McMillan, Hazelton, & Clayton, 2011). Other types of verbal abuse include questioning professional skills and capabilities; and threats: including threats of complaint or legal action (Jackson et al., 2013), and threats of violence such as shooting, killing, blowing up, punching and stabbing with a needle (Jackson et al., 2013). Such abuse can occur face-to-face and over the phone, (Lyneham, 2000) and is not confined to the emergency department with nurses reporting that it can occur outside the department and after working hours (Gacki-Smith et al., 2009).

1.2.2Non-verbal hostility

Non-verbal hostility refers to overt behaviours by patients designed to intimidate or threaten nurses or gain their attention, for example crossing arms, glaring at staff, throwing their arms up in the air, pacing, and rolling eyes and shaking their heads while talking to staff (Jackson et al., 2013). Other examples include acts of symbolic violence such as punching a wall or throwing furniture (Winstanley & Whittington, 2004), and patients photographing or videoing staff on their mobile phones and threatening to "send it to the media" (Jackson et al., 2013).

1.2.3Physical

Physical violence is defined as physical contact that is intended to injure or harm another party (Nachreiner, Gerberich, Ryan, & McGovern, 2007). It includes any intentional physical contact, actual or threatened, and does not have to result in an injury to the victim (Victorian Government, 2005). The majority of physical violence occurs concurrently with verbal abuse, and this correlation may indicate that verbal violence can act as a predictor for potential physical violence (Lau, Magarey, & Wiechula, 2012).
Examples of physical violence include being hit, slapped, kicked, pushed, choked, grabbed and sexually assaulted (Nachreiner et al., 2007; SafeWork NSW, 2018). The use of weapons, both traditional and opportunistic, is reported in the literature. Opportunistic weapons refer to items readily available and used to threaten or harm nurses. Examples reported in the literature include intravenous equipment, poles, syringes (sometimes blood-filled), furniture (Lyneham, 2000), scalpels, oxygen flow

metres, ophthalmoscopes, stethoscopes and scissors (Pich, Hazelton, Sundin, & Kable, 2010).

1.3 Antecedents and precipitants

1.3.1 History of violence

The greatest risk factor in predicting future violent or threatening behaviour from an individual is reported to be a past history of violence (Ferns, 2005), and the greater the magnitude of violence, the greater the likelihood of future violence (Holleran, 2006). This includes any violence the person has experienced, for example domestic abuse, assault, and any convictions for violent crime (Holleran, 2006).

1.3.2 Clinical presentations

1.3.2.1 Alcohol and substance misuse

Crime statistics for hospital assaults in NSW for the year 2006 listed the top three antecedents as mental health related (32% of incidents), alcohol-related incidents (31%) and drug-related (17%) (Hilliar, 2008). Patients under the influence of alcohol and/or drugs, including ice, and those with mental health issues are the most likely to become violent, increasing the risk to nurses by up to six times (Pich et al., 2017).

1.3.2.2 Cognitive impairment

Clinical diagnoses that affect cognition are linked to an increased risk for violence. These include temporary organic causes, for example intracranial trauma, delirium and hypoxia, (Chapman & Styles, 2006; Liu & Wuerker, 2005) and those that are permanent in nature, for example dementia . Anxiety and agitation ($p = 0.047$) and delirium ($p = 0.010$) were found to be statistically significant factors associated with episodes of violence in a recent Australian study of 537 emergency department nurses (Pich et al, 2017).

1.3.2.3 Mental health issues

The authors of an Australian study of Australian emergency department nurses reported that mental health issues were significantly predictive of a participant having experienced an episode of violence (Pich et al, 2017). There is strong evidence that the potential for violence in such patients markedly increases in the presence of drug and/or alcohol abuse (Gillies & O'Brien, 2006), meaning that the risk of violence may be amplified where patients with mental health issues also present with alcohol intoxication and/or substance misuse. For the period 1996-2006 the proportion of assaults in NSW hospitals classified as mental health-related increased significantly: from 19% to 32% (Hilliar, 2008).

1.4 Consequences of episodes of violence on nurses and midwives

The impact of violence is far reaching and can have a lasting physical, psychological and professional impact on nurses and midwives. Verbal abuse can cause significant psychological trauma and stress to nurses, even if no physical injury has occurred, and this can persist for up to 12 months following an incident (Gerberich et al., 2004). The types of physical injuries sustained by nurses range from minor scratches and bruises through to serious injuries and even death. In 2011 a mental health nurse was stabbed to death by a patient (ABC News, 2011) and in 2016 a remote area nurse, Gale Woodford was abducted, raped and murdered in northern South Australia (Clark, 2018).

Exposure to patient-related violence can also affect the way nurses interact with their patients, and this includes feeling less empathy and a decline in the quality of care afforded patients (Lau, Magarey, & McCutcheon, 2004; Pich & Kable, 2014). A link between violence experienced by nurses and subsequent adverse events for patients has been identified, and includes the late administration of medications and an increase in the number of patient falls and medication errors (Roche, Diers, Duffield, & Catling-Paull, 2010).

The consequences of episodes of violence on nurses and midwives have a flow on effect to the health care system in terms of increased costs. These costs are reflected in loss of experienced staff (Chapman & Styles, 2006); sick leave, decreased productivity, staff turnover and attrition, and workers' compensation pay outs (Jackson, Clare, & Mannix, 2002). Quantifying the cost of patient violence is difficult as it includes intangible items such as loss of morale, difficulties with retention and recruitment of staff, impact on patient care and therapeutic relationships and negative public relations which are difficult to assign a dollar value.

1.5 Coping strategies

1.5.1 Debriefing

The use of debriefing after episodes of violence is supported in the literature; however informal debriefing is reported to be the most common method employed in the workplace (D. Gates, Gillespie, Smith, et al., 2011). Barriers to formal debriefing cited lack of time and a workplace culture that tolerates violence as part of the job (Farrell, Bobrowski, & Bobrowski, 2006; D. Gates, Gillespie, Smith, et al., 2011).

The National Institute for Health and Clinical Excellence guidelines for the prevention and management of violence recommend that a review should take place within 72 hours for all parties involved, however they provide little guidance on how this should take place (Bonner & McLaughlin, 2007). A lack of attention to the emotional effects

of violence can contribute to Post Traumatic Stress Disorder (D. Gates, Gillespie, & Succop, 2011). This is supported by other studies that show that counselling is most effective at the early stages of post-traumatic stress and should be offered to all those affected (Lange, Lange, & Cabaltica, 2000). Failure to acknowledge this can lead to increased costs in terms of workers compensation claims, job dissatisfaction and decreased morale (D. Gates, Gillespie, & Succop, 2011).

1.6 Risk management strategies

A level of management resistance has been reported in acknowledging that health care workers are at risk of patient-related violence despite the fact that nurses consistently report high expectations of assault as a consequence of their job (Nachreiner et al., 2007). At the same time there is a workplace culture perpetuated by a degree of complacency on the part of staff where violence is viewed as just "part of the job" (Jones & Lyneham, 2000; McPhaul & Lipscomb, 2004). Strategies to prevent and manage violence include the use of security guards, duress alarms; workplace design and access to training.

1.7 Reporting

Reporting is an integral component of clinical governance and its primary purpose is to increase the safety of patients, visitors and staff, and ultimately to improve the quality of care. However in the case of episodes of violence, the incidence remains difficult to quantify and is grossly underestimated due to a lack of reporting (Jones & Lyneham, 2000).

1.8 Risk management strategies

The best strategy for managing aggression and violence is prevention; however in clinical environments such as the emergency department this is not always possible. Violence should be dealt with promptly and positively by management, and staff should be supported and followed up with understanding.

1.8.1Training

Minimisation of violence requires early recognition of signs or cues and timely de-escalation (Presley & Robinson, 2002). De-escalation has been defined as the reduction of the intensity of a conflict or a potentially violent situation, and researchers have described a "turning point", where nurses have the opportunity to act and contain or prevent violence (Lau et al., 2012).

According to the literature the amount and type of training provided to staff varies widely and as a result many staff report that they do not feel that they have the necessary skills to effectively manage episodes of violence (Lee, 2001; Pich et al.,

2011). Training is consistently identified as important by nurses (D. Gates, Gillespie, Smith, et al., 2011), however it is reported to be largely sporadic and fragmented in nature with a lack of consistency between trainers and programs (Lee, 2001; Pich & Kable, 2014). While aggression minimisation training is compulsory for those working in high risk clinical areas like the emergency department, there are large numbers of nurses who have either had not completed any training or who have not completed the regular refresher programs required (Pich, 2014).

1.8.2Security

The use of visible on-site security services is frequently cited as a measure to aid in the management of episodes of violence; however their effectiveness is dependent on their ability to respond in a timely fashion (D. M. Gates, Ross, & McQueen, 2006). This is also true of personal duress alarms worn by nurses (Lyneham, 2001). The presence of security is described as both a preventative strategy, by acting as a deterrent, and a reactive strategy to manage episodes of violence (D. Gates, Gillespie, Smith, et al., 2011). The type of security reported in the literature varied widely and ranged from unarmed security guards based outside the emergency department to security personnel in the emergency department armed with firearms and Tasers (D. Gates, Gillespie, Smith, et al., 2011).

In Australia security guards are not present in all emergency departments, and are often ill equipped to deal with the levels of violence they encounter. In some smaller hospitals there is no security provided after hours, however regional nurses experience the same levels and types of violence as their metropolitan colleagues(Pich et al., 2017).

1.8.3Environmental measures

Environmental controls such as restricted access to clinical areas (Early & Hubbert, 2006) and the use of security screens at triage can reduce the risk of violence from outside the department; however they do not prevent violence once patients have been admitted into the department (Jones & Lyneham, 2000). In fact it is not possible to have impenetrable hospital security and zero risk in the context of health care because in the majority of cases they are designed to be accessible to the public (Kelen, Catlett, Kubit, & Hsieh, 2012). Isolation or seclusion of violent patients or those identified as being at risk of violence has also been identified as an important strategy in their management (D. Gates, Gillespie, Smith, et al., 2011)

1.8.4Policies and procedures

The presence of a definitive policy on the management of violent patients may serve to mitigate the risk of violence and aggression (Anderson, FitzGerald, & Luck, 2009). One such policy incorporates the concept of Zero Tolerance, which originated in the

United States and refers to specific actions that will not be tolerated or accepted (Wand & Coulson, 2006).
This concept has been adopted by a number of health departments, for example New South Wales Health, in an attempt to create a safe working environment as required by the Workplace Health and Safety legislation. NSW Health state that a Zero Tolerance Response means that appropriate action will be taken to protect employees, patients and visitors from the effects of violent behaviour (NSW Health, 2003). The intent of this policy is to maintain effective risk management strategies and to avoid inappropriate action where violent behaviour is the result of an underlying medical condition (Hodge & Marshall, 2007). However it has been argued that zero tolerance is an ineffective response to violence in health settings, one that impinges on the rights of patients and the ability of clinicians to develop a therapeutic relationship due to its inflexible nature (Holmes, 2006).

1.9 Conclusion

Violence remains a significant workplace hazard and something that emergency nurses encounter on a regular basis, however it is often overlooked and rationalised as "part of the job" of being nurse. The strategies currently in place are inadequate and must be reviewed and updated to deal with levels of violence that continue to increase in frequency and severity. The requirements under Work Health and Safety legislation for a safe workplace for all staff mean that this must be a priority. This will guarantee a safe workplace and bring to an end the tragic headlines involving nurses as victims of violence.

Chapter 2 Study aims and objectives

2.1 Research question

What is the nurse and midwife reported incidence of violence from patients and/or their relatives in a range of health care settings?

2.2 Study aims

The aim of the research broadly is to investigate the experiences of the members of the NSW Nurses and Midwives' Association (NSWNMA) with violence from patients and/or friends or relatives in their workplace to provide a snapshot in time of these experiences.

2.3 Study objectives

To achieve this aim, the objectives of the study are:

1. To measure the frequency of individual nurses and midwives reported exposure to violence from patients and/or family and friends and associated outcomes in the preceding six months;
2. To identify the types of violent behaviours experienced by NSW nurses and midwives;
3. To compare the experiences of NSW nurses and midwives in the private and public sector with this violence;
4. To compare the experiences of NSW nurses and midwives in metropolitan, regional and remote areas with this violence;
5. To identify the experiences of NSW nurses and midwives with this violence in different clinical areas and patient-related services;
6. To identify the risk factors for violent episodes – including perpetrators, geographical location, clinical specialty;
7. To identify NSW nurses' and midwives' perceptions of **risk prevention measures** and **risk management strategies** adopted by their **employers.**

2.4 Expected Benefits and Outcomes

The study was expected to contribute to the development of policies and procedures and their implementation in public and private clinical settings about episodes of violence and the safety of nurses and midwives. It has also contributed to the body of research on this topic.
The potential impact of this study is its contribution to the epidemiological evidence regarding precipitants, antecedents and outcomes associated with violence against nurses and midwives from patients and/or their friends and relatives, including:

- Clinical environments;
- Sector of employment, i.e.: public, private and not for profit;
- Geographical locations, i.e. metropolitan, regional and remote;
- Nursing/midwifery activities associated with episodes of violence.

2.5 Advisory panel

An advisory panel was established to assist the investigator with specialist advise when required. The members included:

1. Veronica Black and Lesley Gibbs from the NSW Nurses and Midwives' Association;
2. Christopher Oldmeadow and Matthew Clapham from the Hunter Medical Research Institute for statistical consultation.

Chapter 3 Methods

3.1 Study Design

This study utilised a cross-sectional design to survey a sample of the membership of the NSW Nurses and Midwives' Association, and was conducted by the University of Technology, Sydney. An online survey was used to establish nurse and midwife reported incidence of episodes of violence and resultant workplace injury and effects on the nursing and midwifery workforce.

3.2 Study Population and Recruitment

All members of the NSW Nurses and Midwives' Association were emailed a link to an online survey in Survey Monkey©.

3.3 Recruitment

When ethics approval was received the NSW Nurses and Midwives' Association emailed all members in their database with an invitation to take part in the survey on 4 July 2018 (Appendix 1). The email included a link to the Participation Information

Statement (Appendix 2) and a link to the online survey in Survey Monkey © (Appendix 3).
Participation was voluntary and consent was deemed to be given through the completion of the questionnaire. All completed questionnaires were non-identifiable. Two reminder emails were sent on July 13 2018 and 19 August 2018 and Reminder postcards (Appendix 4) were circulated to members of the NSW Nurses and Midwives' Association on July 25 2018 at their 2018 Professional Day.

3.4 Study Instrument

Data relating to episodes of violence were collected using a 74-item questionnaire, divided into six sections (Appendix 3).
Section 1: Study Eligibility;
Section 2: General Information;
Section 3: Violence Experienced or Witnessed by you;
Section 4: Actions Taken After an Episode of Violence;
Section 5: Factors Associated with Violence;
Section 6: Management and Prevention of Episodes of Violence.
The development of the questionnaire was conducted in three stages and designed using Survey Monkey © software.

Stage 1

This stage involved the development of the questions for the purpose of measuring the proposed objectives of the study. It included reference to key literature on the topic as well as some relevant NSW Health policy documents. The study aims and objectives were the primary reference point for development of the questionnaire. The following definitions were used on the questionnaire to orient participants:

- The term "violence" was modified from a definition by Mayhew and Chappell and defined as verbal abuse and threats, sexual harassment as well as physical assaults (Mayhew & Chappell, 2005). It could involve both explicit and implicit challenges to the well-being, safety or health of nurses and midwives at work.
- The term "patient(s)" also included residents, mothers, consumers and clients.
- The term "residents, friends, visitors" referred to people accompanying or visiting the patient, resident, mother, consumer or client.

Recall bias represents a major threat to the internal validity of studies that rely on self-reported data (Hassan, 2006). Recall of information depends entirely on memory that can often be imperfect and thereby unreliable (Hassan, 2006). Participants may experience interference: that is as an individual experiences an increasing number of events, the probability of recalling any one of those events specifically declines. If information required by a question is not available, the respondent may use other less relevant information to answer the question (Coughlin, 1990). Therefore an optimal recall period is essential to reduce

measurement errors and facilitate accurate responses, and short recall periods are preferred (Norquist, Girman, Fehnel, DeMuro-Mercon, & Santanello, 2012). After reviewing similar studies a decision was made to use a six month recall period in an attempt to minimise recall bias in this study, and to also include a question about episodes during the last week (D. M. Gates et al., 2006; Gillespie, Gates, Miller, & Howard, 2010).

Table 1: Study aims addressed in questionnaire

Aim	Study aim	Questions	Content of questions
1	To measure the **frequency** of individual nurses and midwives reported exposure to violence from patients and/or family and friends and **associated outcomes** in the preceding six months..	13-16 20-29 69-70	Involved in an episode of violence in the previous week and/or preceding six months; Estimate how many episodes; Outcomes and impact on participants.
2	To identify the **types of violent behaviours** experienced by NSW nurses and midwives.	17-19	Types of verbal abuse and physical behaviour
3	To compare the experiences of NSW nurses and midwives in the **private** and **public** sector with this violence.	8 13-29 71	Work sector of main nursing/midwifery job Involved in an episode of violence in the previous week and/or preceding six months; Estimate how many episodes; Outcomes and impact on participants Safety at work
4	To compare the experiences of NSW nurses and midwives in **metropolitan**, **regional** and **remote** areas with this violence.	11-12 13-29 71	Type of area and postcode Involved in an episode of violence in the previous week and/or preceding six months; Estimate how many episodes; Outcomes and impact on participants Safety at work
5	To identify the experiences of NSW nurses and midwives with this violence in different **clinical areas** and **patient-related services.**	9 13-29 71	Clinical area or speciality Involved in an episode of violence in the previous week and/or preceding six months; Estimate how many episodes; Outcomes and impact on participants Safety at work
6	To identify the **risk factors** for violent episodes – including perpetrators, geographical location, clinical specialty	2-12 41-51	Diagnoses or clinical signs and symptoms; Nursing activities; Patient specific factors and behaviours; Staffing issues;
7	**To identify NSW nurses' and midwives' perceptions of** risk prevention measures **and** risk management strategies **adopted by their** employers	30-40 52-68 72-73	Measured the organisational reporting of episodes and subsequent response from management; Focused of management response to and prevention of episodes of patient-related violence.

Stage 2

Stage 2 assessed previous studies relevant to this survey. The second stage in the development of the questionnaire included a search of the literature and identification of previous studies relevant to the study. Relevant items were identified and adopted or modified and then incorporated into the survey (Table 1).

The literature was used to construct lists of emotional and professional responses following episodes of patient-related violence. Effects reported in the literature include feelings of guilt, self-doubt, feelings of professional incompetence (Arnetz & Arnetz, 2001); anger, powerlessness, unhappiness, degradation, shame, fear, astonishment, antipathy towards the perpetrator (Astrom et al., 2004) and sleeplessness (Jackson et al., 2002). In addition nurses have reported feeling more cautious as well as being afraid to be at work, leading to a situation where patients are avoided (Pich, 2014) .

In Section 6 of the questionnaire lists were provided of diagnoses or clinical signs/symptoms of patients who displayed violent behaviour. The literature reports that certain diagnoses or medical conditions may be a risk factor for episodes of patient-initiated violence, particularly those associated with cognitive dysfunction (May & Grubbs, 2002), for example hypoxia, confusion and disorientation (Ferns, 2005); traumatic brain injury (Holleran, 2006); organic brain disorders and developmental delay (Quintal, 2002) and dementia (Badger & Mullan, 2004). People with mental health diagnoses have also been also been identified as a risk group for potential violence, (Catlette, 2005), especially involuntary psychiatric patients (Nijman, Bowers, Oud, & Jansen, 2005).

A list was also constructed of nursing and midwifery activities that were reported to be occurring at the time of violent episodes and the location in the department where such episodes occurred. Questions 41 to 51 measured contributing and precipitating factors for patient-related violence and the literature was sourced to compile lists for patient specific factors and behaviours; staffing issues and environmental factors.

Section 3 measured types of violent behaviour and lists of the types of verbal abuse and physical behaviours were constructed from the literature. Verbal behaviours identified in the literature include rudeness, shouting, sarcasm, swearing, unjustified criticism, ridicule in front of others, threat of personal harm to the person, their family or property, rumour mongering (Farrell et al., 2006) as well as sexual innuendo (Crilly, Chaboyer, & Creedy, 2004). Physical behaviours identified include a range of behaviours, for example being pushed (Crilly et al., 2004); punched, kicked, scratched, slapped, head butted, restrained, choked, bitten and strangled (Farrell et al., 2006; Ferns, 2005).

Section 6 of the questionnaire focussed on the management and prevention of episodes of patient-related violence and lists of risk prevention/minimisation measures and follow up strategies were compiled.

Stage 3

This stage involved testing and validation of the questionnaire and involved the use of an expert panel. The panel was made up of members of clinical speciality groups from the NSW Nurses and Midwives' Association, including aged care, midwifery and mental health. The questionnaire was circulated to all members of the expert panel for testing and to provide advice about the draft questionnaire. These comments were subsequently used to make some minor changes to the form. This stage confirmed both the face and content validity of the questionnaire

3.5 Promotion of the Survey

The survey was promoted by the NSW Nurses and Midwives' Association by the distribution of an email invitation and reminders. In addition a reminder postcard was circulated to members of the association at their annual Professional Day.

3.6 Ethical Considerations

Ethical approval for the study was obtained from the Human Research Ethics Committee of the University of Technology prior to distribution of the survey.

3.7 Data Storage

Data security was maintained by ensuring that the questionnaires on Survey Monkey © were only accessible by the researcher and statistician through a unique log in.

3.8 Data Analysis

Statistical analyses were programmed using SAS v9.4 (SAS Institute, Cary, North Carolina, USA) by a qualified statistician.
Frequencies of answers to non open ended questions were summarised as frequencies and percentages of non-missing responses.
Groups of interest based on survey responses were compared using Chi-square or Fisher's exact tests with p-values and percentages of non missing group responses. Fisher's exact tests was used when there were more than 20% of the expected frequencies less than 5, variable with excessive low counts were left without p-values.

Chapter 4 Results

4.1 Sampling results

The total membership of the NSWNMA at the time of sampling was 62954. The final figures for participation are shown in Table 2. The response rate for this study was

6%. The total number of eligible participants with a completed questionnaire was 3416.
NB: Some respondents did not answer every question in the survey and consequently the denominator varies in the results reported throughout

Table 2: Sampling results

Potential participants	Numbers	Number of participants
Email invitations sent	62954	
Non responders	59328	
Responses	3626	
Returned, Question 1 = ineligible	269	3497
Returned, Question 1 not answered	81	3416
Eligible participants – returned completed questionnaire	3416	

4.1.1Characteristics of participants

The characteristics of participants are reported in Table 3.

Table 3: Characteristics of participants

Variable	Category	Total (%)*
Employment sector (n = 3545)	Public	2585 (78%)
	Private	517 (16%)
	Not for profit	225 (7%)
Region (n = 3524)	Major city (metropolitan)	1487 (46%)
	Outer regional e.g. Tamworth	804 (25%)
	Inner regional e.g. Newcastle	802 (25%)
	Remote e.g. Broken Hill	140 (4%)
	Very remote	21 (1%)
Mode of employment (n = 3347)	Full-time	1758 (52%)
	Part-time	1295 (39%)
	Casual	249 (7%)
	Agency/temporary	55 (2%)
Gender (n = 3327)	Female	2909 (87%)
	Male	409 (12%)
	Other	21 (1%)
Nursing role (n = 3357)	Registered Nurse	2598 (77%)
	Enrolled Nurse	377 (11%)
	Registered Midwife	224 (7%)
	Assistant in Nursing	158 (5%)

Age (n = 3347)	18-25 years	235 7%)
	26-35 years	531 (16%)
	36-45 years	583 (17%)
	46-55 years	901 (27%)
	56-65 years	981 (29%)
	>65 years	116 (3%)
Number of years nursing/midwifery experience (n = 3446)	1-5	657 (19%)
	6-10	543 (16%)
	11-20	656 (19%)
	21-30	582 (17%)
	>31	1008 (29%)
Hours per week of patient care (n = 3357)	1-10	123 (4%)
	11-20	284 (8%)
	21-30	656 (20%)
	31-40	1560 (46%)
	41-50	367 (11%)
	>50	367 (11%)

4.1.2Composition of study sample by clinical area

Participants were drawn from a variety of clinical areas as shown in Table 4. There were 401 participants who indicated that they visited patients/clients in their homes as part of their work.

Table 4: Study sample by clinical area

Clinical speciality	Sample count	Sample %
Medical/surgical	750	24
Mental health	547	18
Aged care	483	16
Emergency Department	297	10
Intensive Care Unit/High Dependence Unit/Coronary Care Unit	200	7
Midwifery	224	7
Perioperative	174	6
Community health	135	4
Family & Child health/paediatrics	114	4
Rehabilitation/disability	101	3
Drug & Alcohol	52	2
TOTAL	3077	1

4.2 Incidence and characteristics of episodes of violence

There were 1454 participants (1454/3101, 47%) who had experienced an episode of violence in the previous week and 2460 who had experienced violence in the six months prior to completing the survey (2460/3092, 80%). The majority of participants were of the opinion that violence was an inevitable part of their job and that it was increasing in frequency and severity.

For participants who had experienced an episode of violence in the preceding six months, there was a downward trend with greater years of experience (88% to 72%), with a similar trend with age (94% to 68%). Males were more likely to experience an episode of violence than females (88% to 78%) and midwives less likely (61% versus 79-81%). See Table 5.

Table 5: Episodes of violence compared to demographic data

			Q15 Have you been involved in one or more episodes of violence in the last 6 months?				
Question Number	*Question*	*Category*	*No (n=632)*	*Yes (n=2460)*	*Total (N=3092)*	*Chi-Square*	*p-value*
q0002	Number of years of nursing/midwifery experience?	1-5	70 (12%)	526 (88%)	596 (19%)	62.9	<0.0001
		6-10	68 (16%)	351 (84%)	419 (14%)	.	
		11-20	122 (20%)	491 (80%)	613 (20%)	.	
		21-30	114 (21%)	422 (79%)	536 (17%)	.	
		30	257 (28%)	670 (72%)	927 (30%)	.	
		Missing	1	0	1	.	
q0003	Average number of hours per week of patient care during the last month?	1-10	45 (44%)	57 (56%)	102 (3.3%)	72.8	<0.0001
		11-20	73 (28%)	186 (72%)	259 (8.4%)	.	
		21-30	156 (26%)	448 (74%)	604 (20%)	.	
		31-40	245 (17%)	1206 (83%)	1451 (47%)	.	
		41-50	59 (18%)	277 (82%)	336 (11%)	.	
		50	54 (16%)	286 (84%)	340 (11%)	.	
		Missing	0	0	0	.	
q0004	Is your main nursing/midwifery job?(Select only ONE option)	Full time	265 (16%)	1358 (84%)	1623 (52%)	41.6	<0.0001
		Part time	284 (24%)	912 (76%)	1196 (39%)	.	
		Casual	68 (30%)	155 (70%)	223 (7.2%)	.	
		Agency/Temporary	15 (30%)	35 (70%)	50 (1.6%)	.	
		Missing	0	0	0	.	
q0005	What is your age?	18-25 years	13 (6.0%)	203 (94%)	216 (7.0%)	61.7	<0.0001
		26-35 years	71 (15%)	417 (85%)	488 (16%)	.	
		36-45 years	99 (18%)	440 (82%)	539 (17%)	.	
		46-55 years	189 (23%)	648 (77%)	837 (27%)	.	
		56-65 years	223 (25%)	676 (75%)	899 (29%)	.	
		66 years	34 (32%)	71 (68%)	105 (3.4%)	.	
		Missing	3	5	8	.	
q0006	What is your gender?	Female	576 (22%)	2096 (78%)	2672 (87%)	19.3	<0.0001
		Male	46 (12%)	339 (88%)	385 (13%)	.	
		Other	2 (25%)	6 (75%)	8 (0.3%)	.	
		Missing	8	19	27	.	
q0007	What type of registration/classification applies to your MAIN nursing/midwifery job?	Registered Nurse	447 (19%)	1941 (81%)	2388 (77%)	50.5	<0.0001
		Registered Midwife	82 (39%)	126 (61%)	208 (6.7%)	.	
		Enrolled Nurse	73 (21%)	282 (79%)	355 (11%)	.	
		Assistant in Nursing	30 (21%)	111 (79%)	141 (4.6%)	.	
		Missing	0	0	0	.	

More than 50% of participants from all clinical areas had experienced an episode of violence in the preceding six months. The rates were highest for those working in the specialities of emergency, drug and alcohol and mental health (Table 6).

Table 6: Episodes of violence experienced by clinical area

Clinical area	Number of participants (n = 3092)	% Sample
Mental health	481/514	94%
Drug & Alcohol	44/47	94%
Emergency	264/CHECK	94%
ICU/HDU/CCU	159/187	85%
Medical/surgical	561/681	82%
Rehabilitation/disability	73/91	80%
Aged care	335/424	79%
Perioperative	106/165	64%
Community health	74/126	59%
Midwifery	121/208	58%
Family & Children's health/paediatrics	60/107	56%

The public sector had a higher percentage of participants having been involved in violent episodes in the last six months compared to private (82% compared to 69%). Participants who visited patients or clients in their homes as part of their jobs were less likely to have experienced episodes of violent (65% compared to 82%) (Table 7).

Table 7: Epsiodes of violence by work sector and clinical sector

			Q15 Have you been involved in one or more episodes of violence in the last 6 months?				
Question Number	*Question*	*Category*	*No (n=632)*	*Yes (n=2460)*	*Total (N=3092)*	*Chi-Square*	*p-value*
q0008	In what sector do you work in your MAIN nursing/midwifery job?NB: The term public refers to employment by the NSW Ministry of Health.The term private refers to employment by a private for profit organisation e.g.	Public	436 (18%)	1973 (82%)	2409 (79%)	41.3	<0.0001
		Private	146 (31%)	323 (69%)	469 (15%)	.	
		Not for Profit	39 (21%)	151 (79%)	190 (6.2%)	.	
		Missing	11	13	24	.	
q0009	What clinical area or specialty is your MAIN nursing/midwifery job?	Midwifery	87 (42%)	121 (58%)	208 (7.3%)	268.5	<0.0001
		Medical/Surgical	120 (18%)	561 (82%)	681 (24%)	.	
		Emergency Department	18 (6.4%)	264 (94%)	282 (10%)	.	
		ICU, HDU or CCU	28 (15%)	159 (85%)	187 (6.6%)	.	
		Aged care	89 (21%)	335 (79%)	424 (15%)	.	
		Drug and Alcohol	3 (6.4%)	44 (94%)	47 (1.7%)	.	
		Mental health	33 (6.4%)	481 (94%)	514 (18%)	.	
		Community health	52 (41%)	74 (59%)	126 (4.4%)	.	
		Family and Child Health or paedatrics	47 (44%)	60 (56%)	107 (3.8%)	.	
		Perioperative	59 (36%)	106 (64%)	165 (5.8%)	.	
		Rehabilitation /disability	18 (20%)	73 (80%)	91 (3.2%)	.	
		Missing	78	182	260	.	
q0010	In your MAIN nursing/midwifery job - do you visit patients in their homes?	Yes	132 (35%)	242 (65%)	374 (12%)	59.0	<0.0001
		No	492 (18%)	2205 (82%)	2697 (88%)	.	
		Missing	8	13	21	.	
q0011	What type of area is your MAIN nursing/midwifery job located?	Major city	295 (21%)	1081 (79%)	1376 (46%)	8.9	0.0630
		Inner Regional e.g. Newcastle	135 (18%)	599 (82%)	734 (24%)	.	
		Outer Regional e.g. Tamworth	137 (18%)	605 (82%)	742 (25%)	.	
		Remote e.g. Broken Hill	26 (19%)	111 (81%)	137 (4.6%)	.	
		Very Remote	7 (41%)	10 (59%)	17 (0.6%)	.	
		Missing	32	54	86	.	
q0017	If YES - what type of violence did you experience?	Verbal abuse and/or non physical behaviours	38 (2.0%)	1844 (98%)	1882 (76%)	2.8	0.0954
		Physical abuse/violence	6 (1.0%)	599 (99.0%)	605 (24%)	.	
		Missing	588	17	605	.	

4.2.1Number of episodes of violence

Study participants were asked how many episodes of violence they had experienced in the preceding six months. The number of episodes ranged from 1 to 100 with the majority reporting between 1-20 episodes (n = 2014/2488, 81%). See Table 8.

Table 8: Number of episodes of violence

Number of episodes	n = 2488 (%)
1-20	2014 (81%)
21-40	278 (11%)
41-60	89 (4%)
61-80	44 (2%)
81-100	25 (1%)
>100	38 (2%)

4.2.2Type of violence

4.2.2.1 Verbal abuse

Verbal or non-physical violence was the most common type of violence reported, with 1888/2494, 76% of participants experiencing an episode in the previous six months. Physical abuse/violence was reported by 24% of participants (606/2494). The most common types of verbal or non-physical violence experienced by participants were:

- Swearing – 84%;
- Rudeness – 80%;
- Anger – 79%;
- Shouting – 74%;
- Making unreasonable demands – 73%.

In addition a quarter had experienced sexually inappropriate behaviour (Table 9). The use of social media (5%) and taking of photographs (9%) was reported by 14% of participants, with the latter was significant for metropolitan nurses and midwives compared to those working in regional and remote areas (11% compared to 7% and 4%, p= 0.0046)..

Participants from metropolitan areas were more likely to experience unreasonable demands from patients that those from regional and remote areas (78% compared to 74% and 67%, p = 0.0163). In addition a statistically a significant difference was noted for "name calling" with regional and remote nurses and midwives more likely to experience this than their metropolitan counterparts (58% and 56% compared to 50%, p = 0.0027).

Participants provided additional details in a comments section – examples are detailed below:

"…demeaning inappropriate personal questions…" (P32); "…stalking me at home…"(P183); "…death threats…"(P1258); "…threatened to kill my kids and family…"(P95); "…in worst instance 23yr old ice user threatened to 'knife rape', also threatened to 'kill my kids and family' and threatened to have his friends follow me home…"(P901); "…Physically beaten by a patient, punched on left check, right side of head and repeated in left shoulder. Ended up with Bursitis in left shoulder and ridiculed by DON for going to A&E for treatment…"(P1704); "…Doused with diesel and threatened with weapon… (P2001);"…racist comments…(P5)"; "…just released ex-prisoner (Manslaughter) allowed to harass staff without boundary by mental health Administration…"(P621).

NB: DON refers to a Director of Nursing.
NB: "P" refers to participant

Table 9: Type of verbal/non-physical violence

Type of verbal/non physical violence	n = 2761 * (%) response
Swearing	2310 (84%)
Rudeness	2214 (80%)
Anger	2181 (79%)
Shouting	2046 (74%)
Making unreasonable demands	2008 (73%)
Insulting/questioning professional ability e.g. incompetent, incapable, threatening registration	1767 (64%)
Sarcasm	1674 (61%)
Name calling	1545 (56%)
Stepping into personal space	1249 (45%)
Threatening comments – to self, family or property	1109 (42%)
Ridicule in front of others	1109 (40%)
Unjustified criticism	1064 (39%)
Symbolic violence e.g. punching/hitting glass/desk at triage	1032 (37%)
Staring	899 (33%)
Gesturing	890 (32%)
Sexually inappropriate behaviour	699 (25%)
Berating	685 (25%)
Formal complaints without cause	512 (19%)
Rumour mongering	462 (17%)
Taunting	461 (17%)
Taking photographs	259 (9%)
Use of social media	128 (5%)

*** Participants could choose multiple responses**

A statistically significant difference was identified between the type of violence experienced and geographical work area (p = 0.0114). There was slightly more physical violence (as opposed to verbal) in regional areas compared to metropolitan (27% compared to 22%) (Table 10).

Table 10: Type of violence experienced by geographical work area

Question Number	*Question*	*Category*	*Metro (n=1487)*	*Regional (n=1606)*	*Remote (n=161)*	*Chi Sq*	*P-value*
q0017	If YES - what type of violence did you experience?	Verbal abuse and/or non physical behaviours	848 (78%)	897 (73%)	102 (83%)	9.0	**0.0114**
		Physical abuse/violence	246 (22%)	325 (27%)	21 (17%)	.	
		Missing	393	384	38	.	

The majority of verbally abusive behaviours were experienced at higher rates by those participants working in the public sector, see Table 11 for specific details.

Table 11: Type of verbal abuse behaviours compared by work sector

Question Number	Question	Category	Verbal				Physical			
			Public (n=1506)	Private (n=260)	Chi Sq	P-value	Public (n=485)	Private (n=73)	Chi Sq	P-value
q0018	Please indicate which of the following types of VERBAL ABUSE AND/OR NON-PHYSICAL BEHAVIOURS you have observed and/or witnessed during episodes of violence (Select ALL that apply).	Swearing	1283 (85%)	193 (74%)	19.4	<0.0001	442 (91%)	51 (70%)	27.9	<0.0001
		Not Selected	223 (15%)	67 (26%)	.		43 (8.9%)	22 (30%)	.	
		Name calling	855 (57%)	119 (46%)	10.9	0.0010	346 (71%)	36 (49%)	14.3	0.0002
		Not Selected	651 (43%)	141 (54%)	.		139 (29%)	37 (51%)	.	
		Making unreasonable demands	1159 (77%)	186 (72%)	3.6	0.0582	356 (73%)	40 (55%)	10.7	0.0011
		Not Selected	347 (23%)	74 (28%)	.		129 (27%)	33 (45%)	.	
		Sarcasm	953 (63%)	148 (57%)	3.8	0.0507	300 (62%)	33 (45%)	7.3	0.0069
		Not Selected	553 (37%)	112 (43%)	.		185 (38%)	40 (55%)	.	
		Insulting/questioning professional ability e.g. Incompetent,	986 (65%)	168 (65%)	0.1	0.7888	331 (68%)	40 (55%)	5.2	0.0232
		Not Selected	520 (35%)	92 (35%)	.		154 (32%)	33 (45%)	.	
		Ridicule in front of others	594 (39%)	114 (44%)	1.8	0.1809	201 (41%)	27 (37%)	0.5	0.4702
		Not Selected	912 (61%)	146 (56%)	.		284 (59%)	46 (63%)	.	
		Anger	1202 (80%)	190 (73%)	6.0	0.0141	412 (85%)	51 (70%)	10.2	0.0014
		Not Selected	304 (20%)	70 (27%)	.		73 (15%)	22 (30%)	.	
		Threatening comments to self, family or property	618 (41%)	79 (30%)	10.5	0.0012	311 (64%)	24 (33%)	25.8	<0.0001
		Not Selected	888 (59%)	181 (70%)	.		174 (36%)	49 (67%)	.	
		Shouting	1112 (74%)	175 (67%)	4.8	0.0287	421 (87%)	55 (75%)	6.6	0.0099
		Not Selected	394 (26%)	85 (33%)	.		64 (13%)	18 (25%)	.	
		Rudeness	1246 (83%)	214 (82%)	0.0	0.8663	385 (79%)	47 (64%)	8.2	0.0043
		Not Selected	260 (17%)	46 (18%)	.		100 (21%)	26 (36%)	.	
		Rumour mongering	221 (15%)	58 (22%)	9.7	0.0018	83 (17%)	10 (14%)	0.5	0.4655
		Not Selected	1285 (85%)	202 (78%)	.		402 (83%)	63 (86%)	.	
		Sexually inappropriate behaviour	347 (23%)	53 (20%)	0.9	0.3446	198 (41%)	22 (30%)	3.0	0.0815
		Not Selected	1159 (77%)	207 (80%)	.		287 (59%)	51 (70%)	.	
		Taunting	224 (15%)	31 (12%)	1.6	0.2113	141 (29%)	11 (15%)	6.3	0.0122
		Not Selected	1282 (85%)	229 (88%)	.		344 (71%)	62 (85%)	.	
		Staring	513 (34%)	53 (20%)	19.1	<0.0001	222 (46%)	17 (23%)	13.1	0.0003
		Not Selected	993 (66%)	207 (80%)	.		263 (54%)	56 (77%)	.	
		Berating	351 (23%)	68 (26%)	1.0	0.3190	160 (33%)	15 (21%)	4.6	0.0327
		Not Selected	1155 (77%)	192 (74%)	.		325 (67%)	58 (79%)	.	
		Gesturing	490 (33%)	59 (23%)	10.0	0.0015	219 (45%)	22 (30%)	5.8	0.0157
		Not Selected	1016 (67%)	201 (77%)	.		266 (55%)	51 (70%)	.	
		Unjustified criticism	587 (39%)	126 (48%)	8.3	0.0040	191 (39%)	21 (29%)	3.0	0.0815
		Not Selected	919 (61%)	134 (52%)	.		294 (61%)	52 (71%)	.	
		Stepping into personal space	657 (44%)	93 (36%)	5.6	0.0180	303 (62%)	31 (42%)	10.6	0.0011
		Not Selected	849 (56%)	167 (64%)	.		182 (38%)	42 (58%)	.	
		Symbolic violence e.g. punching/hitting glass/desk at triage	528 (35%)	51 (20%)	24.0	<0.0001	307 (63%)	38 (52%)	3.4	0.0652
		Not Selected	978 (65%)	209 (80%)	.		178 (37%)	35 (48%)	.	
		Formal complaints without cause	257 (17%)	67 (26%)	11.2	0.0008	82 (17%)	7 (9.6%)	2.5	0.1114
		Not Selected	1249 (83%)	193 (74%)	.		403 (83%)	66 (90%)	.	
		Use of social media	62 (4.1%)	11 (4.2%)	0.0	0.9321	31 (6.4%)	4 (5.5%)	.	1.0000*
		Not Selected	1444 (96%)	249 (96%)	.		454 (94%)	69 (95%)	.	
		Taking photographs	141 (9.4%)	16 (6.2%)	2.8	0.0932	59 (12%)	5 (6.8%)	1.8	0.1839
		Not Selected	1365 (91%)	244 (94%)	.		426 (88%)	68 (93%)	.	

4.2.2.2 Physical violence

The types of physical violence reported by more than half of those surveyed were:

- Grabbing – 60%;
- Hitting – 60%;
- Destructive behaviour – 55%;
- Spitting – 53%;
- Kicking – 53%;
- Pushing – 53%;
- Punching – 52%.

In addition 805 participants reported inappropriate physical or sexual contact and 35 indicated that they had been sexually assaulted (Table 12).

Participants provided additional detail in a comments sections and quotes included: *"…Lighting a fire in department…" (P18); "…Punching a wall…"(P994); "…Petrol attack…"(P1114); "…Head butting…" (P87); "…have had semen thrown at me…" (P891)'; "attacked by a large confused man. I required surgery and now have a pin in my shoulder…"(P173); "…bleach thrown on me…" (P329); "…petrol attack…" (P500)' "…doused with diesel and threatened with weapon…" (P188).*

Table 12: Types of physical violence

Type of physical violence	N = 1957 * (%)
Grabbing	1179 (60%)
Hitting	1166 (60%)
Destructive behaviour e.g. punching safety glass, table etc.	1084 (55%)
Spitting	1038 (53%)
Kicking	1032 (53%)
Pushing	1029 (53%)
Punching	1011 (52%)
Scratching	809 (41%)
Grabbing and twisting a body part	719 (37%)
Throwing/struck with an object	664 (34%)
Use of non-traditional weapons e.g. sharps, IV poles, chair	583 (30%)
Biting	575 (29%)
Inappropriate physical contact	558 (29%)
Body fluids thrown e.g. blood, urine, faeces	388 (20%)
Pulling hair/jewellery/clothing	377 (19%)
Restraining/immobilising staff	250 (13%)
Inappropriate sexual conduct	247 (13%)
Damage to personal property e.g. tyres slashed	175 (9%)
Choking/strangling	168 (9%)
Use of a traditional weapon e.g. knife	105 (9%)
Sexual assault	35 (2%)

* Participants could choose multiple responses

A statistically significant difference was identified for the following physical violent behaviours, which were more common in regional areas compared to metropolitan and remote: "grabbing" (39% versus 32% and 25%, p = 0.0004); "hitting" (35% compared to 31% and 25%, p = 0.0412); "twisting and pulling a body part" (24% versus 18% and 13%, p = 0.0007). Participants who worked in metropolitan areas were more likely to experience "use of a traditional weapon e.g. knife" (11% versus 4.6% and 4.8%, p = 0.0212); "use of non-traditional weapons e.g. sharps (77% compared to 70% and 71%, p = 0.0320) and "choking/strangling" (15% versus 7.7% and 4.8%, p = 0.0187) than those working in regional and remote locations. Participants working in the public sector reported physically violent behaviours at a higher rate than their colleagues in the private sector, in a finding that was statistically significant, see Table 13 for details.

Table 13: Type of Physical violence by employment sector

			Verbal				Physical			
Question Number	Question	Category	Public (n=1506)	Private (n=260)	Chi Sq	P-value	Public (n=485)	Private (n=73)	Chi Sq	P-value
q0019	Please indicate which of the following PHYSICAL behaviours you have observed or witnessed during episodes of violence (Select ALL that apply).	Pushing	476 (32%)	61 (23%)	7.0	0.0084	310 (64%)	42 (58%)	1.1	0.2921
		Not Selected	1030 (68%)	199 (77%)	.		175 (36%)	31 (42%)	.	
		Destructive behaviour e.g. punching safety glass/table etc	612 (41%)	48 (18%)	46.6	<0.0001	295 (61%)	31 (42%)	8.8	0.0030
		Not Selected	894 (59%)	212 (82%)	.		190 (39%)	42 (58%)	.	
		Damage to personal property e.g. tyres slashed	88 (5.8%)	9 (3.5%)	2.4	0.1196	55 (11%)	2 (2.7%)	5.1	0.0237
		Not Selected	1418 (94%)	251 (97%)	.		430 (89%)	71 (97%)	.	
		Use of a traditional or weapon e.g. knife	46 (3.1%)	3 (1.2%)	3.0	0.0849	39 (8.0%)	2 (2.7%)	2.6	0.1056
		Not Selected	1460 (97%)	257 (99%)	.		446 (92%)	71 (97%)	.	
		Use of non traditional weapons e.g.sharps, IV poles, chair	311 (21%)	15 (5.8%)	32.6	<0.0001	187 (39%)	17 (23%)	6.4	0.0116
		Not Selected	1195 (79%)	245 (94%)	.		298 (61%)	56 (77%)	.	
		Grabbing	546 (36%)	69 (27%)	9.2	0.0024	351 (72%)	53 (73%)	0.0	0.9671
		Not Selected	960 (64%)	191 (73%)	.		134 (28%)	20 (27%)	.	
		Spitting	561 (37%)	59 (23%)	20.6	<0.0001	259 (53%)	31 (42%)	3.0	0.0812
		Not Selected	945 (63%)	201 (77%)	.		226 (47%)	42 (58%)	.	
		Hitting	507 (34%)	61 (23%)	10.6	0.0011	364 (75%)	57 (78%)	0.3	0.5749
		Not Selected	999 (66%)	199 (77%)	.		121 (25%)	16 (22%)	.	
		Kicking	485 (32%)	56 (22%)	11.9	0.0006	311 (64%)	43 (59%)	0.7	0.3880
		Not Selected	1021 (68%)	204 (78%)	.		174 (36%)	30 (41%)	.	
		Punching	445 (30%)	46 (18%)	15.5	<0.0001	344 (71%)	45 (62%)	2.6	0.1075
		Not Selected	1061 (70%)	214 (82%)	.		141 (29%)	28 (38%)	.	
		Grabbing and twisting a body part	317 (21%)	42 (16%)	3.3	0.0701	218 (45%)	37 (51%)	0.8	0.3590
		Not Selected	1189 (79%)	218 (84%)	.		267 (55%)	36 (49%)	.	
		Biting	268 (18%)	24 (9.2%)	11.8	0.0006	164 (34%)	31 (42%)	2.1	0.1484
		Not Selected	1238 (82%)	236 (91%)	.		321 (66%)	42 (58%)	.	
		Scratching	366 (24%)	44 (17%)	6.8	0.0093	240 (49%)	40 (55%)	0.7	0.3976
		Not Selected	1140 (76%)	216 (83%)	.		245 (51%)	33 (45%)	.	
		Choking/strangling	81 (5.4%)	4 (1.5%)	7.1	0.0076	55 (11%)	4 (5.5%)	2.3	0.1290
		Not Selected	1425 (95%)	256 (98%)	.		430 (89%)	69 (95%)	.	
		Pulling hair/jewellery/clothing	167 (11%)	19 (7.3%)	3.4	0.0666	116 (24%)	21 (29%)	0.8	0.3694
		Not Selected	1339 (89%)	241 (93%)	.		369 (76%)	52 (71%)	.	
		Throwing/struck with an object	341 (23%)	25 (9.6%)	22.9	<0.0001	208 (43%)	17 (23%)	10.1	0.0015
		Not Selected	1165 (77%)	235 (90%)	.		277 (57%)	56 (77%)	.	
		Restraining/immobilising staff	124 (8.2%)	7 (2.7%)	9.9	0.0016	79 (16%)	14 (19%)	0.4	0.5369
		Not Selected	1382 (92%)	253 (97%)	.		406 (84%)	59 (81%)	.	
		Inappropriate physical contact	253 (17%)	38 (15%)	0.8	0.3807	179 (37%)	17 (23%)	5.2	0.0230
		Not Selected	1253 (83%)	222 (85%)	.		306 (63%)	56 (77%)	.	
		Inappropriate sexual conduct	107 (7.1%)	16 (6.2%)	0.3	0.5780	85 (18%)	10 (14%)	0.7	0.4173
		Not Selected	1399 (93%)	244 (94%)	.		400 (82%)	63 (86%)	.	
		Sexual assault	15 (1.0%)	1 (0.4%)	.	0.4927*	13 (2.7%)	2 (2.7%)	.	1.0000*
		Not Selected	1491 (99.0%)	259 (99.6%)	.		472 (97%)	71 (97%)	.	
		Body fluids thrown e.g. blood, urine, faeces	202 (13%)	20 (7.7%)	6.6	0.0102	120 (25%)	10 (14%)	4.3	0.0374
		Not Selected	1304 (87%)	240 (92%)	.		365 (75%)	63 (86%)	.	

4.2.2.3 Verbal and physical violence compared

There were no differences identified between participants working in metropolitan areas/major cities in the public or private sector for episodes of verbal abuse, however those working in the public sector reported a higher number of episodes of physical violence. Similarly there were no differences noted for nurses working in remote areas between the public and private employment sector.
In inner regional areas, for example Newcastle, verbal and physical violence were more common in the private sector than the public. In outer regional areas, for example Tamworth, verbal abuse was experienced at higher levels in the public sector, however there were no differences identified for physical violence. Table 14.

Table 14: Type of violence and employment sector and geographical work area.

			Verbal				Physical			
Question Number	*Question*	*Category*	*Public (n=1506)*	*Private (n=260)*	*Chi Sq*	*P-value*	*Public (n=485)*	*Private (n=73)*	*Chi Sq*	*P-value*
q0011	What type of area is your MAIN nursing/midwifery job located?	Major city	684 (46%)	113 (46%)	17.4	**0.0016**	213 (45%)	25 (36%)	.	0.5710*
		Inner Regional e.g. Newcastle	337 (23%)	67 (27%)	.		137 (29%)	26 (38%)	.	
		Outer Regional e.g. Tamworth	378 (26%)	53 (21%)	.		112 (23%)	16 (23%)	.	
		Remote e.g. Broken Hill	81 (5.5%)	10 (4.0%)	.		14 (2.9%)	2 (2.9%)	.	
		Very Remote	2 (0.1%)	4 (1.6%)	.		2 (0.4%)		.	
		Missing	24	13	.		7	4	.	

4.3 The consequences of episodes of violence

In this section we describe the consequences to nurses and midwives following episodes of violence.

4.3.1Injuries

There were 815/2861 participants (28%) who reported that they had suffered a physical or psychological injury as a result of an episode of violence. A statistically significant difference was identified between geographical work area with those working in metropolitan areas more likely to experience a physical or psychological injury as a result of an episode of physical violence that their regional and remote colleagues (48% compared to 41% and 19%, p = 0.0231).
Of these 259 participants sought medical attention (259/809, 32%) and 309 took time off work as a result of their injuries. The amount of time taken off ranged from the rest of the shift to more than one year, with 1-6 days the most common time frame

(Table 15). There were 78 participants (78/778, 10%) who indicated that their injury or illness resulted in a permanent disability and change of work duties of the inability to work.

Table 15: Time taken off work due to injury

Length of time	**n = 309 (%)**
Rest of shift	47 (15%)
1-6 days	151 (49%)
1-4 weeks	57 (18%)
1-12 months	46 (15%)
1 or more years	8 (3%)

Participants could also add comments to elaborate on this question and responses included:

"…I ended up resigning…" (P129); "…random days, when too distressed to attend work…" (P52); "…forced retirement…" (P41); and "…remain on leave after 6 weeks…" (P229).

No statistically significant differences were identified between geographical work area or work sector for the outcomes: seeking medical assistance following an episode of violence, time taken off work or permanent disability/inability to work.

The most common location of injuries sustained was listed as injury to psychological state. This was reported by 71% or participants, and this result was in excess of all other responses as illustrated in Table 16.

Table 16: Location of injury

Location	N = 742* %)
Psychological state	**526 (71%)**
Shoulders and arms	203 (27%)
Hands and fingers	158 (21%)
Face – including eyes and ears	110 (15%)
Head (other than eye, ear and face)	82 (11%)
Back	78 (11%)
Neck	71 (10%)
Chest	47 (6%)
Abdomen	41 (6%)
Hips and legs	40 (5%)
Feet and toes	10 (1%)

* Participants could choose multiple responses

In a finding similar to that for location of injury, psychological injuries were the most common type of injury reported, with almost three-quarters of those surveyed experiencing this type of injury following an episode of violence (Table 17).

Table 17: Type of injury

Type of injury	n = 690 (%)
Psychological	**508 (74%)**
Bruising	248 (36%)
Abrasion/graze	135 (20%)
Muscle damage	95 (14%)
Exposure to hazardous/infectious substance	62 (9%)
Laceration/cut/stab wound	38 (6%)
Tendon damage	33 (5%)
Nerve damage	29 (4%)
Head injury	24 (3%)
Fracture	14 (2%)
Internal injury	6 (1%)
Burn	5 (1%)

* Participants could choose multiple responses

4.4 Outcomes following an episode of violence

In addition to reporting injuries, participants also reported other effects (consequences) associated with episodes of violence. These included emotional and professional responses that impacted on their personal and working lives.

4.4.1 Emotional response

Participants reported a range of ongoing emotional responses following an episode of violence, some of which indicated negative coping strategies, for example "increase in use of alcohol or other substances/medications". A number of the responses were long-term in nature, including those linked to Post Traumatic Stress Disorder (PTSD), for example "weight loss/gain", "nightmares and flashbacks" and "altered sleep patterns". PTSD itself was selected as a response by 8% of participants. In addition some responses impacted the nursing practice of participants, for example "withdrawal from people/situations" and "fear/anxiety re future episodes" (Table 18). No significant differences in emotional responses following an episode of violence were found between metropolitan, regional and remote work locations.

Participants working in the private sector who had experienced verbal abuse were more likely to experience the following emotional responses than their colleagues working in the public sector: "degradation: (29% versus 20%, $p = 0.0006$); "depression/low mood" (30% versus 21%, $p = 0.0008$); "altered sleep patterns (33% compared to 26%, $p = 0.0343$). Those working in the public sector who had experienced an episode of physical violence were more likely to report "unhappiness" than those in the private sector (47% versus 33%, $p = 0.0257$).

Table 18: Emotional responses following episodes of violence

Response	**n = 1851 (%)**
Unhappiness	1168 (63%)
Powerlessness	1082 (58%)
Anger	1048 (57%)
Fear/anxiety re future episodes	1028 (56%)
Anxiety	912 (49%)
Shock/surprise	894 (48%)
Altered sleep patterns	737 (40%)
Depression/low mood	605 (33%)
Irritability	588 (32%)
Degradation	560 (30%)
Withdrawal from people/situations	474 (26%)
Emotional blunting	355 (19%)
Self blame	328 (18%)
Nightmares/flashbacks	317 (17%)
Guilt	316 (17%)
Shame	274 (15%)
Increase in use of alcohol or other substances/medications	248 (13%)
Weight loss/gain	238 (13%)
Panic attacks	228 (12%)
Relationship issues	179 (10%)
Post traumatic stress disorder (PTSD)	139 (8%)

* Participants could choose multiple responses

4.4.2Professional responses

Participants reported a range of professional responses following an episode of violence that impacted on their nursing practice and working lives (Table 19).

Table 19: Professional responses following episodes of violence

Response	n = 1774 (%)
Reduced morale	1029 (58%)
Burnout/stress	918 (52%)
Considered leaving current clinical area/speciality or department and moving to a lower risk unit/department	745 (42%)
Decline in quality of care afforded patients	313 (18%)
Considered leaving nursing/midwifery altogether	719 (41%)
Avoidance of patients	655 (37%)
Lack of empathy	580 (33%)
Diminishing/minimising the event	481 (27%)
Depersonalising the event	335 (19%)
Conflict with co-workers	319 (18%)

* Participants could choose multiple responses

Nurses and midwives working in metropolitan areas who had experienced verbal abuse were found to be more likely to experience "burnout/stress" than those working in regional and remote areas, in a finding that was statistically significant (36% versus 30% and 31%, p = 0.0207). Participants from regional areas who had experienced physical violence reported higher rates of "depersonalising the event" than their metropolitan colleagues (18% compared to 13%, p = 0.0473).

Nurses and midwives working in the public sector were more likely to experience "avoidance of patients" (23% versus 11%, p , 0.0001) and "lack of empathy towards patients" (23% compared to 11%, p < 0.0001) than those in the private sector, in a statistically significant finding.

4.4.3Coping strategies

Informal methods of coping were favoured by participants following an episode of violence, for example debriefing with other staff or with family and friends. Formal methods such as formal structured debriefing and counselling were reported by 16% or less of participants (Table 20).

Table 20: Actions effective for dealing with episodes of violence

Action	n = 2368 (%)
Informal debriefing with other staff after an episode	1748 (74%)
Talking with friends and family after an episode	314 (55%)
Talking with Nurse Unit Manager/managers after an episode	828 (35%)
Formal group debriefing after an episode	374 (16%)
Employer counselling services e.g. Employee Assistance Program (EAP)	328 (14%)

Private counselling services	280 (12%)
Took no action	256 (11%)
Talking with union or professional association e.g. NSWNMA	214 (9%)
Nothing helped	87 (4%)
Talking with Human Resources or Work health & Safety Representative	80 (3%)

*participants could choose multiple responses

4.5 Management response to episodes of violence

For the most significant episode of violence in the preceding six months, almost half of participants stated that they were not satisfied with their employer's immediate response (n = 899/1878, 48%) and two-thirds reported that they had not been provided with adequate information, support and follow-up (n = 1489/2220, 67%). Participants reported no response from their employers and being blamed for the episode (Table 21). The majority of participants (n = 1479/1701, 87%) indicated that no immediate changes were implemented by their organisation, department or unit or following an episode of violence. This finding was significant for those working in metropolitan and regional areas compared to those in remote areas (87% versus 75%, p = 0.0329). When asked if they had been offered access to a recognised counselling service following an episode of violence, more than half of participants had not (n = 1018/1704, 60%).

Participants working in remote areas reported less satisfaction with their employer's immediate response that those working in regional and metropolitan areas in a statistically significant finding (85% versus compared to 58% and 47%, p = 0.0389).

Table 21: Immediate response

Response	**n = 1568 (%)**
No response	663 (42%)
Offered immediate support	554 (35%)
Offered counselling/debriefing	429 ((27%)
Warning given to offender e.g. written or verbal	258 (16%)
Blamed you	172 (11%)
Involved police	92 (6%)

*participants could choose multiple responses

Nurses and midwives from metropolitan areas who had experienced physical violence were more likely to receive "immediate support" (30% versus 21% and 9.5%, p = 0.0091) and "counselling/debriefing" (28% compared to 16% and 24%, p = 0.0022) following an episode than those working in regional and remote areas. For those who had experienced verbal abuse, metropolitan participants were more likely to report that a warning had been given to an offender (13% versus 7.2% and 9.8%, p = 0.0008) while those working in remote areas were statistically more likely to

involve the police following an episode of violence than metropolitan and regional participants (8.8% versus 2.9% and 2.2%, p = 0.0009).
Participants from the public sector were more likely to receive support following an episode of violence than their colleagues in the private sector, for episodes of verbal abuse or physical violence (Table 22).

Table 22: Reporting byy work sector

			Verbal				Physical			
Question Number	Question	Category	Public (n=1506)	Private (n=260)	Chi Sq	P-value	Public (n=485)	Private (n=73)	Chi Sq	P-value
q0030	For the most significant episode of violence in the last 6 months, were you satisfied with your employer's immediate response?	Yes	323 (33%)	45 (26%)	3.6	0.1629	139 (38%)	12 (24%)	6.7	0.0353
		No	483 (50%)	92 (54%)	.		189 (53%)	28 (57%)	.	
		N/A	160 (17%)	34 (20%)	.		31 (8.6%)	9 (18%)	.	
		Missing	540	89	.		126	24	.	
q0031	For the most significant episode directed at you during the previous 6 months, how did your employer immediately respond? (Select ALL that apply)	Offered immediate support	314 (21%)	35 (13%)	7.6	0.0057	128 (26%)	13 (18%)	.	0.1478*
		Not Selected	1192 (79%)	225 (87%)	.		357 (74%)	60 (82%)	.	
		Offered counselling/debriefing	237 (16%)	26 (10%)	5.8	0.0164	115 (24%)	8 (11%)	.	0.0147*
		Not Selected	1269 (84%)	234 (90%)	.		370 (76%)	65 (89%)	.	
		Warning given to offender e.g. written or verbal	150 (10%)	21 (8.1%)	0.9	0.3430	58 (12%)	8 (11%)	.	1.0000*
		Not Selected	1356 (90%)	239 (92%)	.		427 (88%)	65 (89%)	.	
		Involved police	49 (3.3%)	4 (1.5%)	2.2	0.1344	28 (5.8%)	2 (2.7%)	.	0.4070*
		Not Selected	1457 (97%)	256 (98%)	.		457 (94%)	71 (97%)	.	
		Blamed you	78 (5.2%)	31 (12%)	17.4	<0.0001	29 (6.0%)	5 (6.8%)	.	0.7920*
		Not Selected	1428 (95%)	229 (88%)	.		456 (94%)	68 (93%)	.	
		No response	376 (25%)	59 (23%)	0.6	0.4318	126 (26%)	23 (32%)	.	0.3229*
		Not Selected	1130 (75%)	201 (77%)	.		359 (74%)	50 (68%)	.	
q0032	For the most significant episode of violence in the last 6 months, were you offered access to recognised counselling services?	Yes	380 (41%)	48 (29%)	7.5	0.0061	163 (46%)	13 (28%)	5.1	0.0242
		No	551 (59%)	115 (71%)	.		193 (54%)	33 (72%)	.	
		Missing	575	97	.		129	27	.	
q0033	Thinking of your most significant episode, did your organisation/department/unit introduce any immediate changes subsequently?	Yes	124 (13%)	21 (13%)	0.0	0.8825	40 (11%)	6 (13%)	0.1	0.7170
		No	802 (87%)	141 (87%)	.		316 (89%)	40 (87%)	.	
		Missing	580	98	.		129	27	.	
q0035	For the most significant episode of violence in the last 6 months, do you think that you were provided with adequate information, support and	Yes	415 (34%)	53 (25%)	5.6	0.0176	137 (32%)	15 (25%)	1.1	0.3016
		No	812 (66%)	155 (75%)	.		297 (68%)	45 (75%)	.	
		Missing	279	52	.		51	13	.	

Immediate managers or team leaders were reported to be approachable and supportive following an episode of violence by 45% of participants (n = 832/1848), however the majority reported that they were not supportive (296/1848, 16%) or only sometimes supportive (452/1848, 39%). When asked the same questions about upper management only a quarter of participants perceived them to be supportive and approachable (452/1837, 25%). The majority felt that they were not supportive (720/1848, 39%) or only supportive sometimes (665/1837, 36%).

4.6 Reporting

The majority of participants were selective in their reporting of episodes of violence, while 22% indicated that they did not report any episodes (Table 23).

Table 23: Reporting

	n = 2374 (%)
Reported ALL episodes	794 (33%)
Reported SOME episodes	1063 (45%)
Reported NO episodes	517 (22%)

Participants working in the private sector who had experienced verbal abuse were more likely to report all episodes than those in the public sector (40% versus 28%, p = 0.0001) (Table 24).

Table 24: Reporting by work sector.

			Verbal				Physical			
Question Number	Question	Category	Public (n=1506)	Private (n=260)	Chi Sq	P-value	Public (n=485)	Private (n=73)	Chi Sq	P-value
q0037	Did you report these episodes?	Yes - reportedALL episodes	385 (28%)	89 (40%)	18.2	0.0001	194 (44%)	34 (53%)	2.0	0.3724
		Yes - reported SOME episodes	633 (49%)	76 (35%)	.		204 (47%)	24 (38%)	.	
		No episodes reported	288 (22%)	55 (25%)	.		40 (9.1%)	6 (9.4%)	.	
		Missing	220	40	.		47	9	.	

Where participants did report an episode of violence, a mix of formal and informal reporting mechanisms were used (Table 25). Participants working in metropolitan and remote areas who had experienced an episode of physical violence were more likely to complete an electronic report than those from regional areas (71% and 61%, p = 0.0428).

Table 25: Reporting mechanisms

Reporting mechanism	**n = 1881 (%)**
Verbally to manager/team leader	1396 (63%)
Documented in patient notes	1258 (67%)
Completed an electronic report e.g. IIMS, Riskman	1181 (63%)
Informally at handover	930 (49%)
Completed a paper report	257 (14%)
To police	124 (7%)
Reported to Safework NSW	32 (2%)

*participants could choose multiple responses

Participants working in the private sector who had experienced episodes of verbal and physical violence were more likely to complete a paper report form and electronic report for both verbal and physical episodes of violence than those working in the public sector.

A number of the reasons for non-reporting related to workplace culture, for example the belief that nothing would change in the long-term; that it was an accepted and

expected part of the job and lack of follow up. In addition there were 390 participants who perceived that the perpetrator was not responsible for their actions due to their clinical or personal circumstances (Table 26) Nurses and midwives who had experienced verbal abuse were more likely to cite the "too many episodes/too busy" response than their regional and remote counterparts in a finding that was statistically significant (17% versus 13%, p = 0.0480).

Table 26: Factors that influence the reporting of episodes of violence

Factor	**n = 1025 (%)**
Don't expect anything to change in the long-term	576 (56%)
It is an accepted/expected part of the job	419 (41%)
Lack of follow up/don't expect anything to change	397 (39%)
Feel person was not responsible for their actions or had a diminished responsibility e.g. cognitively impaired, substance abuse, mental health issues, emotional distress	390 (38%)
Time constraints	389 (38%)
Too many episodes/too busy to report	381 (37%)
Process too complicated	228 (22%)
Feel you can manage these episodes effectively	212 (21%)
Fear of being blamed for the episode	181 (18%)
Fear of lack of support from colleagues	146 (14%)
Not sure how to report	72 (7%)

* Participants could choose multiple responses

4.7 Factors associated with violence – antecedents and precipitants

4.7.1 Patient specific factors

Participants were asked to rank a range of patient specific factors from highest to lowest in terms of the risk for potential episodes of violence (Table 27).

Table 27: Patient-specific factors (ranked)

Rank	**Factor** (n = 1895)
1	Past history of violence
2	Illicit substance misuse
3	Alcohol intoxication
4	Mental health diagnoses
5	Unrealistic expectations of staff and health system
6	Dementia
7	Acute pain
8	Cognitive dysfunction e.g. hypoxia
9	Cultural issues

Participants reported that patients and family or friends responsible for episodes of violence came from all age groups (Table 28) and that episodes occurred across all time periods and days of the week and no one period was a higher risk than others in terms of perception of risk for violence.

Table 28: Age of perpetrators of violence

Age group	**n = 1857 (%)**
<16 years	21 (1%)
16-25 years	172 (9%)
26-35 years	533 (29%)
36-45 years	325 (18%)
46-55 years	178 (10%)
56-65 years	156 (8%)
66-75 years	194 (10%)
>76 years	278 (15%)

A range of signs and symptoms were identified by participants as risk factors for potential violence and mental health issues, anxiety and agitation and substance misuse were reported by more than half of the sample. Table 29.

Table 29: Signs and symptoms of patients

Sign/symptom	**n = 1742 (%)**
Mental health issues	1260 (72%)

Anxiety and agitation	1059 (61%)
Substance misuse	936 (54%)
Dementia	943 (48%)
Delirium	689 (40%)
Alcohol intoxication	646 (37%)
Disorientation/confusion	622 (36%)
Pain	459 (26%)
Fear	376 (22%)
Cognitive dysfunction e/g/ hypoxia	275 (16%)
Trauma	184 (11%)

* Participants could choose multiple responses

Mental health issues (78%) and substance misuse (57%) were also identified as risk factors for violence from family or friends of patients, with alcohol intoxication the third most common response (46%).

4.7.2Staffing specific factors

Participants were asked to rank a number of staffing issues from highest to lowest in terms of the risk of potential violence they perceived them to have. The responses related to the numbers of staff, the experience and skill of staff and workload (Table 30).

Table 30: Staffing-specific factors (ranked)

Rank	**Factor** (n = 1895)
1	Inadequate staffing
2	Workload and time management
3	Inadequate skills mix
4	Lack of staff skills to manage episodes of violence
5	Nursing practice and attitudes of individual nurses
6	Inadequate communication with patients and relatives, friends or visitors e.g. about waiting times
7	Lack of training e.g. in de-escalation techniques, restraint, dementia care
8	Professional communication issues e.g. handover/documentation

The main nursing or midwifery activities associated with episodes of violence were not invasive or intrusive and were often associated with communication, with 18% not involved in a nursing/midwifery activity when they encountered violent behaviour (Table 31). These activities included:

- Communicating with patients and/or relatives, friends or visitors of patients – 61%;
- Assisting with Activities of Daily Living – 36%;
- Managing reactions to delays – 34%;
- Giving oral medications – 31%;
- Assessing patients/taking patient history – 24%.

Table 31: Nursing/midwifery activities associated with episodes of violence

Activity	**n = 1806 (%)**
Communicating with patients and/or relatives, friends or visitors of patients	1093 (61%)
Assisting with Activities of Daily Living	653 (36%)
Managing reactions to delays	607 (34%)
Giving oral medications	557 (31%)
Assessing patient/taking history	434 (24%)
Positioning/turning/lifting patients	446 (25%)
Mobilising or transferring patients	420 (23%)
Giving injectable medications	334 (18%)
Restraining patients	349 (19%)
Not engaged in any nursing/midwifery activities at the time of the event	321 (18%)
Assisting patients and/or relatives, friends or visitors of patients in waiting room	294 (16%)
Assisting patients at meal times	272 (15%)
Conducting invasive procedures e.g. cannulation. Dressings	215 (12%)
Triaging	208 (12%)
Moving patients in and out of seclusion	174 (10%)

***** Participants could choose multiple responses

4.7.3Environmental specific factors

Participants were asked to rank a range of environmental factors as risk factors for violence from highest to lowest risk for potential violence and these results are shown in Table 32.

Table 32: Environmental specific factors (ranked)

Rank	**Factor** (n = 1895)
1	Long waiting times/delays
2	Noise levels
3	Personal space issues
4	Lack of privacy
5	Environmental factors e.g. lighting and temperature
6	Over-crowding
7	Workplace design

Participants encountered episodes of violence in a variety of areas, including those outside of the clinical environment, for example car parks. Table 33. There were 45 midwives who reported episodes of violence in the birthing suite.

Table 33: Location of episodes of violence

Location	n = 1741 (%)
Rooms or wards	1292 (74%)
Corridors	653 (38%)
Shared communal spaces e.g. dining room, garden	459 (26%)
Waiting room	373 (21%)
Bathrooms	336 (19%)
Observation/seclusion room	312 (18%)
Ambulance bay	124 (7%)
Resuscitation room	106 (6%)
Transferring patient to another department/hospital	97 (6%)
Patient's home	94 (5%)
Birthing suite	45 (3%)
Not in the department e.g. car park	44 (3%)

* Participants could choose multiple responses

4.8 Risk prevention strategies

A number of risk prevention strategies were reported by participants, related to the use of security personnel, workplace design and training (Table 34). The most common strategies were:

- Duress alarms – 77%;
- Access to training paid by the employer – 59%;
- Restricted access – 57%;
- Signage e.g. Zero Tolerance posters – 52%;
- Security personnel based outside the department – 46%.

Table 34: Risk prevention strategies

Strategy	N = 1772 (%)
Duress alarms – hardwired and/or personal	1370 (77%)
Access to training paid for by employer e.g. aggression minimisation training, dementia management	2054 (59%)
Restricted access to the department e.g. key or card access	1008 (57%)
Signage e.g. Zero Tolerance posters	914 (52%)
Security personnel available but based elsewhere in hospital	814 (46%)
Police called if a situation deteriorates	759 (43%)
Use of patient management plans	640 (36%)
CCTV	614 (35%)
Clear policies for management of aggression	606 (34%)
Safety glass at triage	481 (27%)
Enclosed nurses' station	474 (27%)
Consultation with management about prevention	377 (21%)
Increased security after hours	304 (17%)
Security personnel based in department	228 (13%)
Increased security measures after hours	228 (13%)
Access to training not paid for by employer e.g. course to be completed at external organisation	207 (12%)

* Participants could choose multiple responses

4.8.1Training

Participants were asked to comment on three main type of training: dementia training, de-escalation training and takedown training. The aim of takedown training is to physically restrain a patient by bringing them to a horizontal position, something typically seen in mental health, including forensic, areas.
In cases where training was noted to be mandatory, not all participants had completed this training and others had completed this training at their own expense outside their place of work. Training was often online or mix of face to face and online, which has implications given the hands on nature of these training techniques and the potential risks associated with them. Table 35.

Table 35: Training

Type of training	Available at main workplace	Is this training mandatory?	Mode of completion	Mode of delivery(
Dementia training	YES (41%)	YES (11%) NO (53%) N/A (37%)	Place of work (35%) Outside work (at own expense) (16%) Not completed (49%)	Face to face (11%) Online (43%) Mix of face to face and online (46%)
De-escalation training	YES (71%)	YES (52%) NO (32%) N/A (17%)	Place of work (67%) Outside work (at own expense) (6%) Not completed (27%)	Face to face (32%) Online (21%) Mix of face to face and online (47%)
Takedown training	YES (34%)	YES (27%) NO (30%) N/A (43%)	Place of work (46%) Outside work (at own expense) (4%) Not completed (50%)	Face to face (52%) Online (8%) Mix of face to face and online (4%)

4.8.2Policies and procedures

Participants were of the opinion that their organisations' policies and procedures related to the prevention and management of violence were only somewhat effective or not effective as detailed below:

- Effective – 12.4%;
- Somewhat effective – 46.2%;
- Not effective – 41.4%.

The public sector had a lower proportion of participants who perceived the policies to not be effective than those working in the private and not for profit sectors (40% compared to 45% and 47%), in a result similar to those working in regional areas compared to major cities (43-47% to 38%). Participants who had been involved in an episode of violence in the preceding six months were more likely to say that the policies were ineffective (44% compared to 22%) No statistically significant difference was found between the type of violence experienced and the effectiveness of policies (Table 36).

Table 36: Effectiveness of policies by work sector and geogrphical wok location

			Q68 Do you think that your organisations policies and procedures related to prevention and management of violence are effective?				
Question Number	*Question*	*Category*	*Yes (n=219)*	*No (n=732)*	*Somewhat (n=817)*	*Chi Sq*	*P-value*
q0008	In what sector do you work in your MAIN nursing/midwifery job?NB: The term public refers to employment by the NSW Ministry of Health.The term private refers to employment by	Public	166 (12%)	579 (40%)	687 (48%)	20.1	**0.0005**
		Private	28 (13%)	100 (45%)	93 (42%)	.	
		Not for Profit	24 (23%)	49 (47%)	31 (30%)	.	
		Missing	1	4	6	.	
q0011	What type of area is your MAIN nursing/midwifery job located?	Major city	116 (15%)	295 (38%)	375 (48%)	18.7	**0.0166**
		Inner Regional e.g. Newcastle	40 (9.2%)	188 (43%)	205 (47%)	.	
		Outer Regional e.g. Tamworth	42 (10%)	199 (47%)	179 (43%)	.	
		Remote e.g. Broken Hill	11 (13%)	39 (44%)	38 (43%)	.	
		Very Remote	1 (25%)	1 (25%)	2 (50%)	.	
		Missing	9	10	18	.	
q0015	Have you been involved in one or more episodes of violence in the last 6 months?	Yes	158 (10%)	685 (44%)	705 (46%)	69.5	**<0.0001**
		No	59 (28%)	47 (22%)	108 (50%)	.	
		Missing	2	0	4	.	
q0017	If YES - what type of violence did you experience?	Verbal abuse and/or non physical behaviours	121 (10%)	500 (43%)	535 (46%)	1.4	0.5069
		Physical abuse/violence	41 (10%)	190 (47%)	177 (43%)	.	
		Missing	57	42	105	.	

4.9 Risk management

There were a number of risk management strategies that participants reported were being used in their place of work (Table 37). Patient specials, where a dedicated staff member is assigned to care for a patient, was the top response, listed by more than half of those surveyed.

Table 37: Risk management strategies

Risk management strategy	**n = 1335 (%)**
Patient specials	684 (51%)

Use of restraint – chemical and/or physical	549 (41%)
Changes to physical environment e.g. additional exits, swipe card access	349 (26%)
Review of policies/procedures	641 (26%)
Skills mix e.g. replace like with like (RN with RN)	329 (25%)
Limiting/banning visitors	321 (24%)
Use of seclusion	309 (23%)
Increased training opportunities	263 (20%)
Increase staffing levels	246 (18%)
Increased security personnel	225 (17%)
Refusal of service	215 (16%)
More stringent admission criteria	106 (8%)

* Participants could choose multiple responses

Chapter 5 Discussion

This aim of this study was to survey the members of the NSWNMA on their experiences with episodes of violence from patients and or their relatives and friends in the workplace. While the final response rate was relatively low (6%), the total number of participants in this study was 3416, making it one of the largest surveys of nurses and midwives on this topic. This highlights the importance that nurses and midwives place on this issue.

The demographic profile of the study sample is consistent with workforce statistics for nurses in Australia. .For example 59% of participants were over the age of 45, with 32% aged 56 or older, indicative of an ageing workforce. The average age of nurses and midwives registered in Australia is 44.4 years, and the proportion aged 50 and over grew from 38.3% to 39.0% during the period 2011-2014, (AIHW, 2016). The majority of participants were female (87%) and this is consistent with workforce statistics which show that in 2015, 90% of practising nurses and midwives registered in Australia were female (AIHW, 2016). The majority of participants were registered nurses (77%) with lesser numbers of registered midwives (7%), enrolled nurses (11%), and assistants in nursing (5%). This is consistent with nursing workforce statistics. In 2015, 76.4% of employed nurses registered in Australia were registered nurses, 8.4% were midwives and 15.2% enrolled nurses (AIHW, 2016).

In this study the survey sample contained a similar number of participants from metropolitan (n =1487) and regional areas (n = 1606) with 161 participants from remote areas.. Census data shows that the per capita ratio of nurses to population in remote areas (915.4 per 100, 000) was lower than in metropolitan areas (1,175.8 per 100,000) and regional areas (1,272.9 per 100,000) (Australian Bureau of Statistics, 2013).

5.1 Nurse and midwife reported incidence of episodes of violence

The majority of nurses and midwives (80%) had experienced violence in the six months prior to the study, and for many this had occurred as recently as the week preceding the survey (47%). Age and years of experience were associated with a decrease in the likelihood of experiencing an episode of

violence, while males were more likely to experience an episode of violence than females and midwives less likely than all classifications of nurses. Participants reported experiencing between one and 100 episodes in the six months prior to completing the survey . The majority of nurses and midwives (81%) reported between one and 10 episodes, however 38 (2%) reported experiencing more than 10 episodes. These results were consistent across metropolitan and regional/remote areas. The public sector had a higher percentage of participants having been involved in violent episodes in the last six months compared to private (82% compared to 69%).

The types of episodes reported included both verbal and physical violence as per the definition of violence provided to participants. Verbal abuse was the most common form of violence experienced, reported by 76% of participants, with 24% indicating that they had experienced physical violence in the six months prior to completing the survey. These findings are consistent with the literature where reported rates for verbal abuse against nurses as high as 98% (D. M. Gates et al., 2006) and 100% have been reported (Catlette, 2005; May & Grubbs, 2002). These high levels of verbal abuse are not isolated to the Australian context, but are consistently reported in studies from around the world (Atawneh, Zahid, Al-Sahlawi, Shahid, & Al-Farrah, 2003; Crilly et al., 2004; Lyneham, 2000; Winstanley & Whittington, 2004).

A US study of 7,169 emergency nurses reported that 12% had experienced physical violence and 43% verbal abuse, during a seven-day period (Emergency Nurses' Association, 2011). A large study of 6,300 US nurses found that rates of violence were a concern with over 13 per 100 nurses reporting at least one episode of physical assault in the past year, and at least 38 per 100 nurses reporting at least one episode of threat, sexual harassment or verbal abuse (Nachreiner et al., 2007). A study of Tasmanian nurses reported that 64% (n = 1540) of respondents had experienced some form of aggression at work in the preceding four weeks (Farrell et al., 2006).

Although these studies collected data over a variety of time periods, all of them report unacceptably high rates of episodes of violence towards nurses.

5.2 Injuries

There was a reported injury rate of 28% as a result of an episode of violence, with participants from metropolitan areas more likely to report a physical or psychological injury than their regional and remote colleagues. Researchers in a US study reported that health care support occupations had an injury rate of 20.4 per 10,000 workers due to assaults, and health care practitioners had a rate of 6.1 per 10,000; compared with the general sector rate of only 2.1 per 10,000 (D. Gates, Gillespie, & Succop, 2011).

5.3 Outcomes associated with episodes of violence

In addition to reporting injuries, participants also reported emotional and professional responses, as a consequence of exposure to violent episodes, that impacted on their personal and working lives. The evidence on the topic supports this finding, and illustrates that the consequences of patient-related violence are far reaching (Chapman & Styles, 2006) and include both physical and psychological harm to nurses as well as a financial cost to the health care sector and a negative impact on the quality of patient care (Howerton Child & Mentes, 2010).

Psychological injuries were the most common type of injury reported by participants, in a result that was consistent across geographical work areas and work sector. Verbal abuse is reported to have more negative and longer lasting ramifications for nurses, with both short and long term effects reported in the literature (Howerton Child & Mentes, 2010). Even in the absence of physical injury, nurses have been found to experience moderate to severe psychological reactions for up to 12 months following an episode of patient-related violence (Gerberich et al., 2004).

Participants reported a range of ongoing emotional responses following an episode of violence, some of which impacted their nursing practice, for example "withdrawal from people/situations" and "fear/anxiety re future episodes". No significant differences in emotional response following an episode of violence was found between metropolitan, regional and remote work locations.

The personal lives of participants were also affected by problems such as altered sleep patterns; increased use of alcohol or other substances/medications; relationship issues; weight changes; depression or low mood and feelings such as anger, powerlessness, unhappiness, degradation and shame as well as PTSD. Similar outcomes have been reported in other studies, including antipathy towards the perpetrators, shame, fear, astonishment, powerlessness, unhappiness, degradation, a sense of resignation, indifference and guilt (Astrom et al., 2004); anger, frustration and intrusive thoughts about the episode (Gillespie et al., 2010); self-doubt, feelings of professional incompetence ; and sleeplessness . Long-term effects such as Post Traumatic Stress Disorder and burnout have also been reported (Camerino, Estryn-Behar, Conway, van Der Heijden, & Hasselhorn, 2008; Pich, 2014).

In addition participants reported a range of professional responses following an episode of violence that impacted on their nursing practice and working lives. Those working in metropolitan areas who had experienced verbal abuse were found to be more likely to experience "burnout/stress" than those working in regional and remote areas, while participants from regional areas who had experienced physical violence reported higher rates of "depersonalising the event" than their metropolitan colleagues. Nurses and midwives working in the public sector were more likely to experience "avoidance of patients" and "lack of empathy towards patients" than those in the private sector. Turkish researchers in one study reported that 84% of nurses were of the perception that nurses would be less productive after experiencing verbal and/or physical violence (Senuzun Ergun & Karadakovan, 2005).

Thus patient-related violence has significant implications for patient safety, the quality of care that is provided and can indirectly lead to a deterioration in the care provided, not just for the patient involved but for all subsequent patients cared for by the affected nurse (Lau et al., 2004). This can take the form of increased medication, and the use of seclusion and restraints (Astrom et al., 2004). A link has also been proposed between abuse from patients and care-giving errors, further suggesting that nurses' role may be compromised as a consequence of abuse (Shields & Wilkins, 2009). A link to patient safety was reported in an Australian study, that found that over two-thirds of nurses who had experienced aggression reported that it "frequently" or "occasionally" contributed to their potential to make errors or affect their productivity (Farrell et al., 2006).

More than half of the participants reported feelings of burn out and over 40% considered leaving their current clinical area or the nursing profession. Nurses who "burn out" suffer from emotional and physical symptoms, lose joy in providing care, distance themselves from others and can go on to view their patients as objects and spend less time with patients who they perceive as abusive (D. M. Gates et al., 2006).Thus the negative effects of patient-related violence extend to the workplace and can lead to difficulties with the recruitment and retention of nurses, decreased productivity and efficiency, increased absenteeism and fewer resources for nurses (Howerton Child & Mentes, 2010). In addition

these issues have a flow on effect to increased costs related to the recruitment of additional nurses and through workers compensation claims.
Informal methods of coping were favoured by participants following an episode of violence, for example debriefing with other staff or with family and friends. Formal methods such as formal structured debriefing and counselling were reported by 16% or less of participants. These findings were consistent across geographical work areas and work sector. A lack of attention to the emotional effects of violence can contribute to PTSD symptoms which has a negative impact on the productivity of nurses. Immediate intervention, during the first hours or days following exposure to a traumatic event, can prevent such serious, long-term complications (D. Gates, Gillespie, & Succop, 2011). Researchers in one US study reported that while management and employee participants supported the use of debriefing after violent incidents, it was rarely done, and when it did occur it was informal in nature. Barriers to debriefing reported in the literature included lack of time and a workplace culture that tolerated violence as "part of the job" (D. Gates, Gillespie, Smith, et al., 2011; Pich, 2014)

5.4 Factors associated with episodes of violence

Participants from all clinical areas had experienced an episode of violence in the preceding six months at rates of over 50%. The rates were highest for those working in the specialities of emergency, drug and alcohol and mental health. This finding is consistent with the literature on the topic that e occurrence of patient-related violence varies substantially between clinical environments, with the specialities of emergency, aged care and mental health reporting the highest rates of violence (Estryn-Behar et al., 2008).
A range of signs and symptoms were identified by participants as risk factors for potential violence and mental health issues, anxiety and agitation and substance misuse were reported by more than half of the sample. Mental health issues (78%) and substance misuse (57%) were also identified as risk factors for violence from family or friends of patients, with alcohol intoxication the third most common response (46%).
These factors are consistently reported in the literature as being causative factors in patient-related violence (D. M. Gates et al., 2006). Crime statistics for hospital assaults in NSW for the year 2006 listed the top three antecedents as mental health related (32% of incidents), alcohol-related incidents (31%) and drug-related (17%) (Hilliar, 2008). In addition for the period 1996-2006 the proportion of assaults classified as mental health-related increased significantly: from 19% to 32% (Hilliar, 2008). An Australian study found that patients under the influence of alcohol and/or drugs, including ice, and those with mental health issues are the most likely to become violent, increasing the risk to nurses by up to six times (Pich et al., 2017).
The main nursing or midwifery activities associated with episodes of violence were typically associated with communication, with 18% of participants not involved in any activity when they encountered violent behaviour.
The most common types of verbal or non-physical violence experienced by participants were swearing, rudeness, anger, shouting and making unreasonable demands with the majority of these behaviours experienced at higher rates by those participants working in the public sector. These results are consistent with the body of literature on the topic with swearing or "being cursed at" typically reported as the most common type of behaviour in verbal abuse (Crilly et al., 2004; Emergency Nurses' Association, 2011). In addition a quarter had experienced sexually inappropriate behaviour. A

study of 3,465 US emergency department nurses reported that 70% had been harassed with sexual language and innuendo (Gacki-Smith et al., 2009). The use of social media (5%) and taking of photographs (9%) was reported by 14% of participants, with the latter significant for metropolitan nurses and midwives. This finding illustrates how these behaviours can extend beyond the work environment for participants.

The types of physical violence reported by more than half of those surveyed included grabbing, hitting, destructive behaviour, spitting, kicking, pushing and punching, with participants working in the public sector reporting these behaviours at a higher rate than their colleagues in the private sector. In addition 805 participants reported inappropriate physical or sexual contact and 35 indicated that they had been sexually assaulted.

These findings are consistent with physical behaviours reported in the literature which include being pushed/shoved, punched, kicked, scratched, slapped, hit, spat on, head butted and having hair pulled (Crilly et al., 2004; Ferns, 2005; Gacki-Smith et al., 2009; Pich, 2014); being grabbed and pulled (Emergency Nurses' Association, 2011).

5.5 Organisational risk prevention and management strategies

This section discusses data from all participants about organisational risk prevention and management of episodes of violence.

5.5.1 Reporting

Participants reported episodes of violence selectively to their organisations, with more than two-thirds admitting that they only reported some" and not "all" episodes. Significant differences were identified between the public and private sector, with privately employed nurses and midwives who had experienced verbal abuse were more likely to report all episodes. Reporting mechanisms included a mix of formal and informal methods with some statistically significant differences identified. Participants working in metropolitan and remote areas were more likely to complete an electronic report than those from regional areas, while those working in the private sector were more likely to complete a paper and electronic report for both verbal and physical episodes of violence than those working in the public sector.

The reasons provided for non-reporting were often related to workplace culture, for example the belief that nothing would change in the long-term; that it was an accepted and expected part of the job and lack of follow up. Metropolitan nurses and midwives who had experienced verbal abuse were more likely to cite the "too many episodes/too busy" response than their regional and remote counterparts in a finding that was statistically significant.

These findings are is consistent with the literature on the topic where patient-related violence is said to be inadequately documented, under-reported and poorly managed when it is reported (Howerton Child & Mentes, 2010; Sato, Wakabayashi, Kiyoshi-Teo, & Fukahori, 2013). Under-reporting of violent events occurs when an individual is victimised and does not report the event to an employer, police or through other means (Findorff, McGovern, Wall, & Gerberich, 2005). Under-reporting of episodes of patient-related violence is acknowledged consistently in the literature to the point where it is referred to as a "global phenomenon" (Ferns, 2005). Estimations of under-reporting range from 20% (Lyneham, 2000) to 90% (Mayhew & Chappell, 2005) and it has been referred to as the "dark figure" of workplace violence (Farrell et al., 2006).

The consequences of under-reporting are far-reaching. Accurate and consistent reporting is important to measure the true scope of the phenomenon and to inform and facilitate the development of policies and programs to adequately address violent behaviour. Voluntary incident reporting is an integral part of clinical governance programs, designed to increase the safety of patients, visitors and staff and consequently to improve the quality of care

Almost 50% of participants were not satisfied with their employer's immediate response while two-thirds reported that they had not been provided with adequate information, support and follow-up following an episode of violence. This finding was significant for those working in metropolitan and regional areas compared to those in remote areas. Participants working in remote areas reported less satisfaction with their employer's immediate response that those working in regional and metropolitan areas. The majority of participants indicated that no immediate organisational changes were implemented following an episode of violence. The majority of participants also perceived that their organisations' policies and procedures related to the prevention and management of violence were only somewhat effective or not effective at all.

Policy and practice interventions may mitigate the risk of violence and aggression while concomitantly addressing staff dissatisfaction with the status quo (Anderson et al., 2009). The policy of Zero Tolerance towards violence has been adopted in health services internationally including the United Kingdom and Australia. The origins of the policy date back to the zero tolerance approach used in New York in the 1970s to manage and reduce crime in the city (Bond, Paniagua, & Thompson, 2009). Many participants in the study commented on an apparent disconnect between the policy ideal and its implementation in the workplace.

In cases where training was noted to be mandatory, not all participants had completed this training and others had completed this training at their own expense outside their place of work. Training was often online or mix of face to face and online, which has implications given the hands on nature of these training techniques and the potential risks associated with them.

5.6 Study strengths and limitations

Strengths

This study had a large sample size that was representative of the nursing and midwifery workforce in Australia, in terms of gender, age, years of experience and work fraction. The large sample size makes this one of the largest studies of violence against nurses and midwives in Australia and globally. While previous studies have largely focused on the clinical specialities of emergency, mental health and aged care, this study has extended into other clinical contexts in an attempt to capture the experiences of all nurses and midwives. It has identified that self-reported rates of violence are over 50% for all clinical areas.

Limitations

Due to the type of data collection, there is a potential for non-response bias and self-selection bias. Under-reporting may be an issue, which is consistent with previously reported studies, however is expected to be better than the reporting rates based on routine monitoring and voluntary reporting of violent episodes in healthcare organisations. A retrospective approach was utilised in the study and involved respondents reporting data for a period of six months prior to completing the questionnaire. This approach might be subject to recall bias and associated under-reporting however it is considered

to be unlikely to substantially affect the results and is a limitation of many similar studies with which the current study has been compared.

5.7 Achievement of study objectives

This study has achieved the following objectives, including reporting:

To achieve this aim, the objectives of the study are:

8. Nurse/midwife reported incidence of episodes of violence from patients and/or family and friends and associated outcomes in the preceding six months;
9. Nurse/midwife reported incidence of the types of violent behaviours experienced;
10. Compared of the experiences of NSW nurses and midwives in the private and public sector with this violence;
11. Compared the experiences of NSW nurses and midwives in metropolitan, regional and remote areas with this violence;
12. Identified the experiences of NSW nurses and midwives with this violence in different clinical areas and patient-related services;
13. Identified the risk factors for violent episodes – including perpetrators, geographical location, clinical specialty;
14. Identified NSW nurses' and midwives' perceptions of risk prevention measures and risk management strategies adopted by their employers.

Conclusions

NSW nurses and midwives experience workplace violence from patients and/or their relatives and friends at high levels and are subjected to verbal abuse and physically violent behaviours on a regular basis. The impact of these episodes is far reaching and can have a long-lasting effect both personally and professionally. This can lead to a flow on effect to the care provided to patients under their care, potentially compromising patient safety.

The levels of violence experienced by nurses and midwives working in healthcare in NSW would not be tolerated in other industries and goes against the requirements of workplace health and safety guidelines to provide a safe working environment. This violence is reported to be increasing in both severity and frequency and therefore must be viewed as a priority by all healthcare employers, including NSW Health, to ensure the future safety of . the nursing and midwifery workforce.

There is an obligation to act on the information that nurses and midwives have provided in this study and in the words of one participant: *"…please actually act on this information you collect and improve our working conditions, Too many good nurses are being harmed and no one seems to care…" (P198).*

Recommendations

1. Healthcare employers in all sectors need to review current violence prevention nd management strategies and update and amend them accordingly to ensure that nurses and midwives are afforded a safe work place.
2. Where policies and procedures exist to protect nurses and midwives, these should be enforced and penalties imposed on employers who do not comply.
3. Mandatory training should be made available for all nurses and midwives as applicable and provided at the place of employment at the employers' expense. Employers should be monitored regularly for compliance and appropriate actions taken where this does not occur.
4. Training should be offered in a face to face format where possible.
5. Reporting of episodes of violence should be encouraged and acted on in a timely manner by employers with feedback provided to affected nurses and midwives and consequences for perpetrators.
6. Reporting records should be made freely available to independent organisations like the NSWNMA.
7. Nurses and midwives should be offered immediate and ongoing support by their employer following all episodes of violence.
8. Nurses and midwives should be included in all planning and policy development on the topic of violence as they represent the largest group in healthcare and are most vulnerable to violence from patients and their relatives and friends.
9. NSW Health must take the lead on this issue and make a serious commitment to the prevention and management of episodes of violence to ensure the safety of the future nursing and midwifery workforce.

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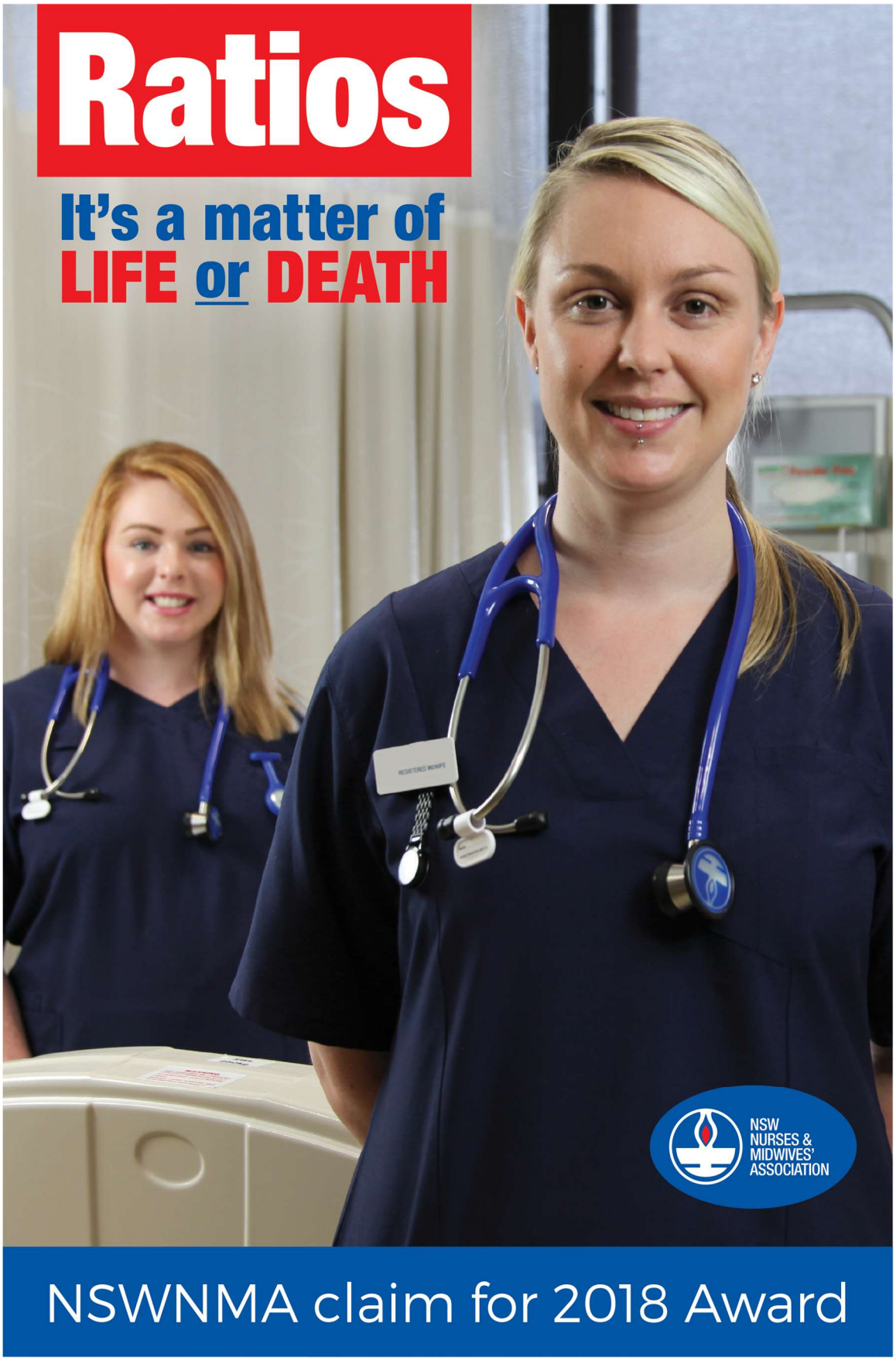
APPENDIX C


Ratios
It's a matter of
LIFE or DEATH
NSW
NURSES &
MIDWIVES'
ASSOCIATION
NSWNMA claim for 2018 Award

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Nurses and midwives are dedicated to providing safe care for all patients. They know what levels of staffing are necessary to provide safe and efficient healthcare in 2018. International research and local experience in New South Wales, Victoria and Queensland shows a direct correlation between staffing levels and improved patient outcomes. It confirms an increase in nursing numbers and skill mix delivers better patient outcomes and limits adverse events.

Nurses and midwives have a professional responsibility to advocate for staffing improvements on behalf of patients and, call on the Berejiklian Government to urgently put patient safety first by improving and expanding mandated nurse to patient ratios on every shift, in every NSW public hospital.

With the strongest fiscal position in the country and a robust economic outlook, the Berejiklian Government can deliver more transparent, legally enforceable ratios throughout the Public Health System. It is unacceptable that we continue to lag behind Victoria and Queensland, after both governments introduced nurse to patient ratio legislation in 2016.

Unless the Berejiklian Government commits to deliver better ratios for NSW in 2018, the state's frontline nursing and midwifery workforce will buckle under burn-out and rising attrition rates, due largely to poor skill mix and excessive workloads. Clause 53 of the current Award explicitly states 'The employer has a responsibility to provide reasonable workloads for nurses', yet this staffing arrangement has been flagrantly ignored.

The Government can no longer disregard its duty of care to staff or patients and must complete the work of 2011, when phase 1 of ratios were first introduced. Official hospital data confirms the Government's preferred 'Nursing Hours Per Patient Day' staffing model is flawed. It is being deliberately manipulated and undermined, prompting the need for a simpler, more transparent and accountable ratios system.

In addition to improving and expanding ratios for every shift on every day with the right skill mix:

- nurses and midwives are seeking staffing for 'Specials' to be separate and in addition to the mandated ratios or rostered staffing;
- 'in charge of shift' nurses not to be allocated a patient load and be in addition to the minimum ratios;
- where AINs and AIMs are rostered to work in an identified unit or ward, they will not be allocated a patient load and will be in addition to the ratios claim;
- new ACORN standards apply;
- an improved maternity services claim.

The NSW Nurses and Midwives' Association 2018 Claim seeks to improve staffing levels across non-tertiary hospitals to become the same as tertiary referral city hospitals, ensuring all patients receive the same standard of nursing care, regardless of where they live.

Further details of our 2018 Ratios and Pay Claim follow:

2018 Claims for Improved Staffing

Ratios required for safe patient care will be applied on a shift by shift basis and will be based on the number of patients in each ward, unit or service. The relevant minimum ratios claim will apply to the patients who have been clinically assessed to require nursing care in that specialty, whether they are receiving nursing care in a bed, treatment space, room or chair or any other space regularly used to deliver care.

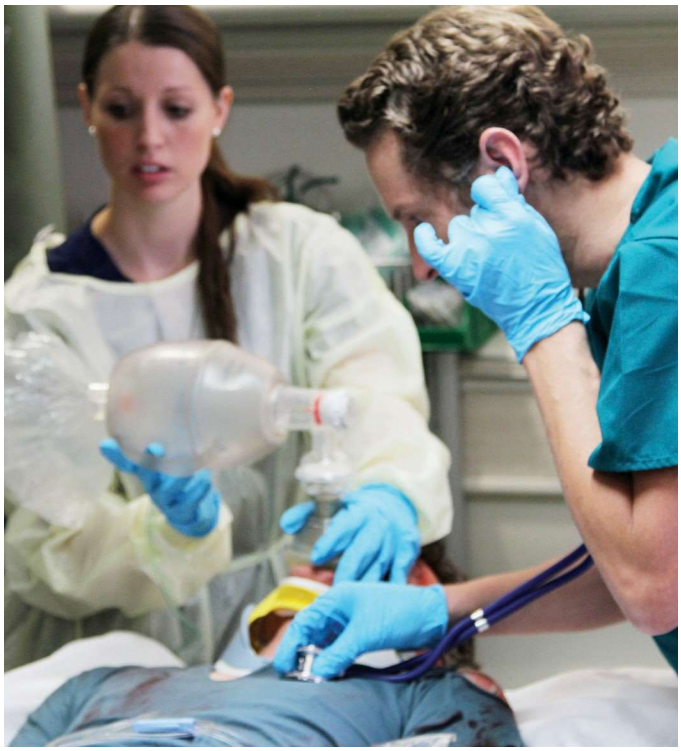
Only nurses providing direct clinical care are included in the minimum ratios. Other staff positions such as NUMs, NMs, CNEs, CNCs, dedicated administrative support staff and wardspersons are additional to the requirements of the minimum ratios.

In addition, nurses who are allocated "in charge" of shift (however named) will not be allocated a patient load and will be rostered in addition to the ratio claims below.

Nursing staff used to provide patients clinically assessed as needing specialised care will be rostered in addition to the ratio claims below.

Where Assistants in Nursing or Assistants in Midwifery are rostered to work in an identified unit or ward they will not be allocated a patient load and will be rostered in addition to the ratio claims below.

All wards, units and services will be staffed with nurses who have the relevant skills and knowledge for that speciality.



Except in specific circumstances wards or units will generally be staffed with a minimum of 85% Registered Nurses with the relevant skills and knowledge for that speciality.

Where the proportion of Registered Nurses on each shift in any ward as at the date of a new Award is higher than the new Award provision, that proportion shall not be reduced.

Where the existing ratio or skill mix provided in any particular ward or unit is better than the provisions of a 2018 Award, the existing ratio or skill mix shall not be reduced.

GENERAL ADULT INPATIENT WARDS

This minimum claim applies to all general adult inpatient wards in NSW Hospitals across the state to ensure patients receive the same level of safe nursing care, regardless of where they live or are treated.

Wards will be staffed with nurses who have the relevant skills and knowledge for that specialty.

Ratios required for safe patient care will be applied on a shift by shift basis and will be based on the number of patients being treated in each ward or unit. The ratios claim applies to patients who occupy beds in mixed function wards as well as wards used totally as medical or surgical.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

Except in specific circumstances wards or units will generally be staffed with a minimum of 85% Registered Nurses with the relevant skills and knowledge for that specialty.

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
Medical/Surgical wards	1:4 + in charge	1:4+ in charge	1:7

CRITICAL CARE (Adult, Paediatric and Mental Health)

This minimum claim applies to Critical Care units, including Intensive Care Units, High Dependency Units and Coronary Care Units.
Wards will be staffed with nurses who have the relevant critical care skills and knowledge for critical care. Additional nursing staff (e.g. access nurse) may be clinically required and if so, should be provided.
Nurses who are part of a response team (however named) will be provided in addition to the minimum ratios. The Ratios will apply to patients who are clinically assessed as requiring critical nursing care even if they are not situated in a designated ICU or HDU (however named).

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
ICU / PICU / MHICU (however named)	1:1 + in charge	1:1 + in charge	1:1 + in charge
HDU / Close Observations (however named)	1:2 + in charge	1:2 + in charge	1:2 + in charge
CCU	1:2 + in charge	1:2 + in charge	1:2 + in charge

EMERGENCY DEPARTMENT (Adult, Paediatric and Mental Health Assessment Centres*)

This minimum claim applies to adult and paediatric emergency departments according to their NSW Health designated emergency department level. This claim applies to beds, treatment spaces, rooms and any chairs or spaces regularly used to deliver care.

The claim includes emergency departments, emergency medical units, and medical assessment units (whether co-located with an ED or not) and other such services however named.

The skill mix for each Emergency Department will include a minimum of 90% Registered Nurses who have the relevant skills and knowledge for this specialty and will be provided on every shift.

Where the proportion of Registered Nurses for each Emergency Department as at the date of this Award is higher than 90%, that proportion shall not be reduced.

Additional hours above the minimum ratio must also be provided to roster in charge of shift and triage nurses, on all shifts without an allocated patient load.

Minimum ratios will not include Clinical Initiative Nurses or any other nurse however named whose role has been introduced for a specific purpose. These roles are considered to be in addition to the ratios below.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
Resuscitation Beds	1:1	1:1	1:1
Level 4-6 Emergency Departments	1:3 + in charge + triage	1:3 + in charge + 2 triage	1:3 + in charge + triage
Level 3 Emergency Departments	1:3 + in charge + triage	1:3 + in charge + triage	1:3 + in charge
Level 2 Emergency Departments	1:3 + in charge	1:3 + in charge	1:3 + in charge
Level 1 Emergency Departments	No separate dedicated RNs		
EMUs	1:3 + in charge	1:3 + in charge	1:4 + in charge
MAUs	1:4 + in charge	1:4 + in charge	1:4 + in charge

*Mental Health Triage and Assessment Centres (however named) will be staffed in accordance with the above ratios for Levels 4–6 Emergency Departments.

INPATIENT MENTAL HEALTH

This minimum claim applies to all inpatient mental health wards/units, 'outlying' inpatient mental health beds and for the care of inpatient mental health patients who are occupying non designated inpatient mental health beds.

Additional nurses will be provided when seclusions are used or when a patient requires level 1 and 2 Observations. Additional nurses will also be required in the following circumstances: diversional therapists and nurses working in ECT or group therapy nurses, nurse escorts, and nurses who are part of a response team (however named).

The skill mix for inpatient mental health will include a minimum of 85% Registered Nurses who have the relevant mental health skills and knowledge levels in mental health will be provided on every shift.

Additional Registered Nurses will be provided for peak times (e.g. admissions, discharges answering phones).

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

The minimum ratio claim for Adult Inpatient Mental Health will apply to acute and subacute units.

In the event that an adolescent is placed in an adult ward, an additional RN will be allocated to provide 1:1 care.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
Adult Inpatient Mental Health – acute and subacute	1:3 + in charge	1:3 + in charge	1:5
Child and Adolescent	1:2 + in charge	1:2 + in charge	1:4
Acute Mental Health Rehabilitation	1:4 + in charge	1:4 + in charge	1:5
Long Term Mental Health Rehabilitation	1:6 + in charge	1:6 + in charge	1:10
Older Mental Health	1:3 + in charge	1:3 + in charge	1:5
MHICU/PICU (however named) or patients assessed requiring this care*	1:1 + in charge	1:1 + in charge	1:1 + in charge
HDU/Close Observations (however named) or patients assessed requiring this care*	1:2 + in charge	1:2 + in charge	1:2 + in charge

In addition mental health nurses will be provided clinical supervision in accordance with the Australian College of Mental Health guidelines, Standards of Practice for Mental Health Nurses, as follows:

Clinical Supervision will be provided to all mental health nurses:

- 2 hours face to face paid clinical supervision leave per fortnight; and
- Paid face to face training in specialised mental health including de-escalation and responding to mental health emergencies.

* Refer to Critical Care claim for complete details.

PAEDIATRICS

This minimum claim applies to all paediatric general inpatient wards including medical, surgical and combined medical surgical wards.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

Additional hours above the minimum ratio must be provided for nurse escorts and work that in general adult hospitals would be described as 'ambulatory care'.

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
Paediatrics General Inpatient Wards	1:3 + in charge	1:3 + in charge	1:3 + in charge

NEONATAL INTENSIVE CARE UNITS (NICU)

The minimum ratios claim applies to ICU, HDU and Special Care Nurseries in Neonatal Intensive Care Units.

A minimum of 85% Registered Nurses who have the relevant critical care health skills and knowledge levels will be provided on every shift.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

In addition, additional hours must be provided for work that may be described as discharge nurse, neonatal family support and transport nurse (including retrieval).

The Special Care Nurseries claim does not apply to special care nurseries that perform CPAP, where the HDU claim will apply instead.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
ICU	1:1 + in charge	1:1 + in charge	1:1 + in charge
HDU	1:2 + in charge	1:2 + in charge	1:2 + in charge
Special Care Nurseries (without CPAP services)	1:3 + in charge	1:3 + in charge	1:3 + in charge

PERIOPERATIVE SERVICES

Australian College of Operating Room Nurses Standards for Perioperative Nursing in Australia 14th edition (known as ACORN standards) as amended from time to time will apply to all Perioperative Services in NSW Hospitals.

REHABILITATION

This minimum claim applies to dedicated hospitals and rehabilitation wards or units.

A minimum of 85% Registered Nurses who have the relevant skills and knowledge will be provided on every shift. The skill mix for general rehabilitation wards or units will be at least two (headcount) Registered Nurses on every shift. There will be no more than one (headcount) Enrolled Nurse with the relevant skills and knowledge for this specialty and maximum of one (headcount) AIN with the relevant skills and experience in a general rehabilitation wards/units.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
Rehabilitation	1:4 + in charge	1:4 + in charge	1:7

COMMUNITY HEALTH AND COMMUNITY MENTAL HEALTH SERVICES

The nature of Community Health and Community Mental Health services does not lend itself to a ratios system.

Instead, the application of a limit of face to face client contact hours in any shift will be a starting point to put patients first.

Community Health and Community Mental Health services require a limit of 4 hours of face to face client contact per 8 hour shift, averaged over a week to be applied in order to provide safe patient care.

The nature of the work of Community Mental Health Services Acute Assessment Teams requires them to have a limit of 3.5 hours of face to face client contact per 8 hour shift, averaged over a week to provide such care.

Work that is not included in this 'face to face hours' claim includes travel, meal breaks and administration (eg. phone calls to other health professionals or suppliers, paperwork), otherwise known as 'indirect care'. '

Face to face hours may also be known as 'direct care'.

In addition, Community Mental Health nurses will be provided Clinical Supervision which includes:

- 2 hours face to face paid clinical supervision leave per fortnight; and
- Paid face to face training in specialised mental health including de-escalation and responding to mental health emergencies.

SHORT STAY WARDS

The following minimum claim applies:

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
High Volume Short Stay	1:4	1:4	1:7
Day Only Units	3.5 hours of face to face patient care. This includes nursing staff time spent doing preparations, transfer and post-operative care prior to discharge.		

DRUG AND ALCOHOL UNITS

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
Drug and Alcohol Inpatients (discrete standalone units)	1:4	1:4	1:7
Drug and Alcohol Outpatients	Each initial assessment: 90 minutes. Subsequent visits: 30 minutes (this includes case management). Dosing visits: 5 minutes.		

PALLIATIVE CARE (wards and outlying beds)

This minimum claim for Palliative Care will apply to Palliative Care wards, 'outlying' palliative care beds, and for the care of palliative patients who are occupying non palliative care beds.

A minimum of 85% Registered Nurses who have the relevant skills and knowledge will be provided on every shift.

Where there is a patient occupying an 'outlying' bed a Registered Nurse with the relevant skills and knowledge will be allocated to their care.

Additional hours above the minimum ratio must also be provided to roster in charge of shift nurses, on all shifts without an allocated patient load.

Where Assistants in Nursing are rostered to work they can only be used to assist a Registered Nurse to perform specific duties such as manual handling and activities of daily living and will be in addition to the minimum ratios claim.

SPECIALTY / WARD TYPE	RATIOS AM	PM	NIGHT
Palliative Care	1:4 + in charge	1:4 + in charge	1:7

MATERNITY SERVICES

The Award will be varied to include the additional principles for Birthrate Plus® sites and for maternity services where Birthrate Plus® does not operate.

- The staffing numbers required as a result of applying the agreed Birthrate Plus® methodology will be considered a minimum and apply only to midwifery hours. The existing provisions in Clause 53 Staffing Arrangements will apply to all maternity services.
- Additional midwives will be provided when patient care cannot be sufficiently met from the midwives available.
- Maternity Services must undergo a Birthrate Plus® reassessment:
  - A minimum of every 3 years to monitor workloads and to recommend any necessary adjustments;
  - If major changes occur or are necessary to the model of care, service delivery or community practices;
  - At the request of employees, the employer or the NSWNMA, where there are major changes to the Unit Statistics e.g. caesarean, epidural, induction rate.
- Patients identified as outliers in a maternity service will require additional nursing staff to provide safe patient care, staff within the maternity service will not be used.

POSTNATAL WARD OR UNIT SKILL MIX ACROSS ALL MATERNITY SERVICES

Experienced midwives will be on duty at all times.

Newborns will be counted in patient numbers when determining reasonable workloads in postnatal wards.

Further, additional midwives will be provided for peak times involving admissions and discharges.

In charge of shift will not be allocated a patient load.

Where Assistants in Midwifery are rostered to work they will not be allocated a patient load and will be in addition to the midwives rostered.

Assistants in Nursing are not permitted as part of the profile (either as permanent, casuals or agency).

STAFFING MODEL: MATERNITY SERVICES WHERE BIRTHRATE PLUS® DOES NOT OPERATE.

This minimum staffing claim applies to all Maternity Services that do not use Birthrate Plus®. Generally, these units have under 200 births per year.

Intrapartum workload:

1:1 midwifery care in labour and birth.

1:1 ratio is a minimum and would increase to reflect the additional needs of higher risk categories of women.

Antenatal Care:

1.5 hours per booking-in visit.

Antenatal Care – Inpatients:

Minimum of 3 hours per case – need to assess the workload including non-admitted Occasions of Service. The hours would increase as risk factors increase.

Postnatal Care – Inpatients:

A minimum of 6 hours per case. This would increase to reflect the additional needs of higher risk categories of women.

Travel Allowance – Community Midwifery: As with Birthrate Plus, a travel allowance (time factor) of 17.5% is added to the time allocated for each woman. This will be increased to 20% in some facilities to reflect local distances travelled.

Leave Relief, Mandatory and Essential Education for Midwives:

Leave relief of additional 18.7% FTE is factored in when determining appropriate staffing.

Unplanned Antenatal workload in Intrapartum Services:

The Birthrate Plus score sheet is used to attach hours to the additional work.

Additional workload within Intrapartum services:

Additional hours are allocated to women with a 16 to 20 week gestation pregnancy loss and also for women with a pregnancy loss less than 15 weeks where cared for in the Birthing or antenatal/maternity unit.

Allocated midwife hours – elective caesarean section:

A minimum 4 hours per elective caesarean section.

Antenatal Care – Outpatients clinics: Hours are determined by the type of treatment required.

Parental Education:

The Birthrate Plus score sheet is used to attach hours to the additional work.

Midwifery Models of Care:

Hours are allocated for total continuity of care i.e. all antenatal, intrapartum and postnatal care provided in the woman's home, community facility or hospital. Hours are inclusive of the new born assessment for normal risk cases.

Normal risk = 41 hours per case.

Note: No high risk births in the **total continuity of care** model. This is because women who have or develop risk will not be cared for within this type of model. This is due to the need for obstetric and/or medical and inpatient care.

Midwifery Models of Care:

Hours allocated for **partial continuity of care** i.e. all antenatal, intrapartum care with only postnatal care in the home. Care may occur in a woman's home, community facility or hospital. Hours are inclusive of the new born assessment for normal risk cases.

Hospital postnatal care can be provided by hospital midwives (see above for hours).

Normal risk = 36 hours per case.
High risk = 40 hours per case.

Postnatal care in the Home:

A **minimum** of 3 hours per case and would increase to reflect the additional needs of higher risk categories of women.

In addition, a travel allowance appropriate to the maternity service (see above) is added to the mean hours.

OUTPATIENTS CLINICS IN THE HOSPITAL SETTING

This minimum staffing claim applies across all Peer Groups.

ALL NEW REFERRALS

Initial assessments 90 minutes.

FOLLOW UP CLINICS

Minor consultation and clinical review clinics:

15 minutes: 4 patients per hour.

Medium consultation clinics:

30 minutes: 2 patients per hour.

Complex treatment clinics within a multidisciplinary team:

60 minutes: 1 patient per hour.

Certain Clinics may require 2 nurses for particular procedures (e.g. Vac dressings)

Hospital in home ambulatory clinic:

3.5 hours of face to face patient care. In addition:

- Appropriate hours for case management should be included in the funded FTE to maintain a safe and holistic level of care for patients. This principle is inherent in the needs for patients in the community.
- Appropriate time for travel in the context of the local geography and traffic conditions must be factored into hours required for clinical workload.

Oncology and Dialysis:

1:1 plus in charge for complex patients.

1:3 plus in charge for non-complex patients.

Infusion/Treatment Centres:

1:1 plus in charge for complex patients.

1:3 plus in charge for non-complex patients.

EXPLANATORY NOTES

Outpatient Clinic Type

Minor Consultation: Anti-coagulant screening, orthopaedic review, phone triage, screening tests, screening results, minor wound dressing, BCG vaccination.

Medium Consultation: Excision of minor lesions, rheumatology, cardiology respiratory function, immunology, co-morbidities /drug resistant/CALD clients, non-compliant, counselling /education, wound assessment and dressing, psycho-geriatric review.

Complex Clinics: Administration of infusions of less than 1 hour, complex wound assessment and treatment/dressing, complex burns dressing, biopsies, lumbar puncture; multiple co-morbidities and complex management.

Oncology – Complexity Criteria	Weight/ Score
2 or more anti-neoplastic drugs	2
Vesicant drugs (requires continual observation of infusion site during drug administration)	2
Potential for hypersensitivity reaction	2
Multiple vital sign measurement during infusion/ transfusion	2
ECG recording prior to or during/infusion	2
Pre-treatment checking of blood results	1
Pre-treatment assessment of toxicities from previous cycles/days of anti-neoplastic drug administration in the current course	1
Baseline vital signs prior to administration of anti- neoplastic drug therapy or infusion or procedure	1
Observation period/measuring of vital signs post completion of anti-neoplastic drug therapy or infusion or procedure	1
Other assessments prior to treatment, e.g. urinalysis, weight	1

Total Score (if >5, categorised as a 'complex patient') Criteria: For any treatment with a score of 5 or more, the treatment is complex. This would have the advantage of enabling a 'complexity rating' of new therapies.

Infusion / Treatment Clinics

1:1 Phototherapy and Dermal clinics, Toxicity of treatment, Portacath access, Blood Transfusions, Biological agent injections, Iron infusions etc

1:3 All other infusion types.

Fair Pay Rise

NSWNMA members claim a 4% increase to pay and wage-related allowances per year, commencing from the first full pay period on or after 1 July, 2018.

Year on year, significant increases in productivity have occurred on the part of frontline nurses and midwives throughout the public health system.

Evidence of this increased productivity is contained within available Bureau of Health Information data, such as rising emergency department presentations and broader hospital throughput.

Section 3 of the existing Wages Policy states:

> 3.1.3. Public sector employees may be awarded increases in remuneration or other conditionsof employment that do not increase costs by more than 2.5 per cent per annum.
>
> 3.1.4. Increases in remuneration or other conditions of employment that increases employee related costs by more than 2.5 per cent per annum can be awarded, but only if sufficient employee related cost savings have been achieved to fully offset the increasedemployee related costs…

The current NSW Treasurer and Minister for Industrial Relations is also on the public record stating:

> "…our policy isn't just a blunt cap of 2.5 per cent – it allows higher wage rises if they are offset by productivity savings." (Daily Telegraph, 19 March 2018)

New South Wales enjoys a strong financial position, with a budget surplus of $5.6 billion and economic growth the strongest in Australia.

It is therefore imperative frontline public sector nurses and midwives are recognised for their increased productivity and are remunerated accordingly.

Additional Improved Staffing

STAFFING FOR SPECIALS

Additional Nurses/Midwives will be allocated to patients who have been clinically assessed as needing specialised care in addition to mandated Ratios/rostered nursing hours for all wards or units.

CLINICAL NURSE / MIDWIFERY EDUCATORS

An increased number of new graduates continues to be employed. To ensure new practitioners consolidate their practice, additional CNEs/CMEs need to be employed.

Achieving better skill mix will take more support than is currently provided, to meaningfully relieve pressure for the most experienced RN/RMs.

The government can and must fund more CNEs/CMEs and not just on day shifts. This is a practical way to thoroughly and safely assist new practitioners to consolidate their practice.

In addition to the minimum ratios claims, there shall be 1.4 Full Time Equivalent Clinical Nurse Educators/ Clinical Midwife Educatorsemployed for every 30 nursing staff, and a proportion thereof where there are less than 30 such staff in a unit/service. CNEs/CMEs should be rostered across all shifts, seven days a week.

The day –to- day Operation of Staffing Ratios

APPLYING THE STAFFING RATIO TO ACTUAL PATIENT NUMBERS

The methodology used to apply the nurse:patient ratio shall be consistent with the principle of ensuring that the number of nurses available to work is commensurate with the number of patients requiring care.

Average occupancy may not reflect variations in patient numbers and therefore may not match the staff to periods of peak demand.

Consequently, the nurse:patient ratio will be calculated on actual patient numbers in a given ward/unit or service. If a ward/unit has 30 beds and only 26 beds are generally occupied, the four "unused" beds may only be used when additional staff are available to meet the ratio requirements.

While the nurse:patient ratio will apply to the number of beds that are generally occupied, any occupancy of additional beds is subject to:

1. Additional beds being available; and
2. Nurses being rostered to the level required to meet the nurse:patient ratio for the duration of the occupancy of additional beds.

Where demand requires fewer beds, staffing may be adjusted down or redeployed prior to the commencement of shifts subject to compliance with relevant Award provisions or an individual's employment contract.

APPLYING THE STAFFING RATIO WHERE THERE ARE UNEVEN BED NUMBERS

Where the actual number of occupied beds in a unit (or the equivalent for example in EDs) is not evenly divisible by the maximum number of patients in the applicable ratio, an additional staff member will be used in proportion with the ratio.

For example, a 28 bed ward with a ratio of 1:4 would require a staffing level of 7 FTE positions. A 30 bed ward using the same ratio would require 7.5 FTE positions (i.e. with a 1:4 ratio, every additional patient would increase staffing by
0.25 FTE nurses).

The outcome will be subject to compliance with relevant Award provisions, in particular Clause 53(iii) Principles.

Changes to Existing Award Provisions

The following existing arrangements require improvement to contribute to a workplace environment conducive to safe patient care:

- Vary Clause 4(xvi) (a), Hours of Work and Free Time of Employees Other Than Directors of Nursing and Area Managers, Nurse Education to provide that days off must be consecutive, except by agreement.
- Vary Clause 8, Rosters, to require local hospital management to display rosters at least four weeks prior to the first working day of the roster and specify that rosters must be built to:
  - ensure compliance with Clause 53 Staffing Arrangements;
  - ensure training is in paid time;
  - include paid handover; and
  - include an appropriate skill mix and ensure early career nurses or novice practitioners are not the most senior nurse on shift or allocated in charge.
- Vary Clause 11 Leave for Matters arising from Family Violence to increase special leave from 5 to 20 days and include the provisions from the model clause.
- Vary Clause 34 Maternity, Adoption and Parental Leave to provide for the payment of superannuation during paid parental leave.
- Vary Clause 34 Part C Parental leave (iii) Entitlements to increase leave from one week to two weeks in line with the recommendation of the Productivity Commission's Report into Paid Parental Leave.
- Vary subclause (ii) Principles in Clause 53 Staffing Arrangements to include the following new principle:
  - a staffing review in consultation with the NSWNMA will be conducted when a ward/unit/service is created, reconfigured or has changes proposed to the model of care. No changes will occur without agreement by the NSWNMA.
- NSWNMA and NaMO will work cooperatively over the term of the next Award to review the appropriate remuneration for NUMs/MUMs.
- Enrolled nurses who meet the criteria will be classified as Special Grade by personal grading, instead of by employer appointment.

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